STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Facility Reported Incident (FRI) 61588.Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent a fall, adequate supervision with use of a razor, and ensure reassessment and follow-up for exit-seeking for three Residents (R7, R23, & R38) of 12 residents reviewed for accidents/hazards/supervision. This deficient practice resulted in harm for R7 who incurred a fall with major injury (right pubis fracture), a tongue injury related to unsupervised access to hazardous hygiene supplies, and lack of accurate assessment data to ensure resident safety. This part of this citation is related to complaint intake #2605430 Findings include: Resident #7 (R7) Review of R7's admission Record, retrieved 9/9/25 at 12:56 p.m., revealed R7 was admitted to the facility on [DATE] with current diagnoses that include the following, in part: fracture of the right pubis (pelvic fracture), pain in left knee, contracture of right ankle, contracture of left ankle, unsteadiness on feet, and abnormalities of gait and mobility. R7 was noted to be their own responsible party for decision-making. Review of R7's Minimum Data Set (MDS) assessment, dated 7/12/25, revealed R7 scored 11 of 15 on the Brief Interview for Mental Status (BIMS) reflective of a moderate cognitive impairment. Section GG – Functional Abilities documented 03 (partial/moderate assistance – less than half the effort) for the following, in part: toileting hygiene, toilet transfer, and walking 10 feet. R7 was noted to have incurred one fall, with no injury, since the prior MDS assessment, and R7 used a manual wheelchair for mobility. Review of R7's previous MDS quarterly assessment, dated 4/23/25, revealed R7 scored 6 of 15, on the BIMS reflective of a moderate cognitive impairment. Review of the Fall Investigative Summary for R7, revealed the following, in part: . Date of Fall 8/13/25, Time of Fall 1700 (5:00 p.m.) Location of Fall: Residents room, Fall reported by Employee. Name of individual reporting fall: [Licensed Practical Nurse (LPN C)]. Injuries sustained during fall: Yes, bump to head and skin tear right elbow. Injuries required medical attention: No, not at time of fall. Name of witnesses to fall: Unwitnessed . Summary of Interview with person's reporting the fall: '[Certified Nurse Aide (CNA E)] put her on the toilet and told resident to hit call light when she's finished. Resident reported not wanting to bother anyone, so she got up herself and fell in the process.' Her PCP (primary care provider) was contacted, and no orders were given. Summary of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interview with witness/witnesses: N/A notated. Summary of interview with resident. 'Resident states she walked herself from the toilet to the door that leads to the hallway and when she went to turn around, she lost her balance' . Summary of investigator's findings: Resident had an unwitnessed fall on 8/13/25. PCP (primary care provider) was notified and there was (sic) no recommendations made for outside evaluation. On 8/28/25, Resident (R7) was sent to ER (Emergency Room) for increased anxiety, pain, and increased depression. Upon evaluation, a right pelvic fracture was discovered. Due to the location of the fracture, it is suspected it was a result of the fall on 8/13/25 . Signature – Investigating Representative: NHA (Nursing Home Administrator), Date: 9/3/25. During an interview on 9/9/25 at 11:31 a.m., LPN C said she was present when R7 was found on the floor in their room. LPN C stated, I was there when [R7] was sitting on the toilet. CNA E told [R7] she would be right back. [R7] didn't want to bother anyone so [R7] got . up (off the toilet). When asked if a post-fall assessment was completed, LPN C said an assessment was completed while R7 was on the floor. When asked about vitals and neuros following the fall, LPN C said no vitals or neuros were assessed prior to R7 being moved from the floor to the wheelchair. LPN C said neuros were assessed once R7 got up. LPN C stated, I asked [R7] if she could get up and she said yes. We gait-belted [R7] and we two-personed (sic) (used two people to assist) her into her wheelchair. [CNA E] was the aide who put [R7] on the toilet . I can't remember who came and told me in the dining room. I was in the dining room already for dinner. When asked again if R7 had a gait belt on, while observed on the floor post-fall, LPN C stated, [R7] didn't have a gait belt on. We had to put one on [them]. During an interview on 9/9/25 at 11:42 a.m., CNA E was asked about her knowledge of R7's fall with major injury on 8/13/25. CNA E confirmed she was the staff member who placed R7 on the toilet in [R7's] room. [R7] had rung her bell, and I came and put [R7] on the toilet. When specifically asked about gait belt usage with transfer to and from the toilet, CNA E stated, When we put people on the toilet we leave the gait belt on them. I was gone maybe 10 to 15 minutes (estimated time R7 left on toilet). It was not that long. CNA E said she and LPN C had gone back to assess R7 post-fall. When asked what R7's transfer status was at the time of the 8/13/25 fall, CNA E stated, [R7] was a limited assist of one for transfers. CNA E continued to state, I remember going in there (R7's room) and there were other people in the room (after R7's fall) and they already had her in the wheelchair before I got in there and remember [R7] saying she was going to close the door and down they went. During an interview on 9/9/25 at 2:21 p.m., the NHA was asked for the neuro checks that were completed post-fall on 8/13/25 for R7. The NHA said she would print them out and provide them to this Surveyor. On 9/9/25 at approximately 2:25 p.m., observation of the surveillance video of the 100 hall on 8/13/25 prior to and post-fall for R7 was observed with the NHA. The NHA did acknowledge no surveillance timeline had been completed during the investigation and the NHA was unable to identify all staff that entered and exited R7's room during the time period reviewed. The times and observations on the 100 Hall on 8/13/25 included the following, which revealed CNA F was the first staff member to respond to R7's fall followed by LPN D: 4:50:39 p.m. – CNA E enters R7's room. 4:53:44 p.m. – LPN C enters R7's room. 4:53:50 p.m. – both LPN C and CNA E exit R7's room. (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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	235144	A. Building B. Wing	09/10/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	informed her (CNA F) that R7 was on the toilet prior to CNA E leaving the floor and going to the dining room. CNA F stated, Nobody (no staff member) told me they were leaving the floor, or that R7 was left on the toilet. I thought CNA E had toileted R7 and brought her down to the dining room. When asked what the expectation between staff was, when a resident was left on a toilet, and the staff member was leaving the floor, CNA F stated, That you tell another staff member that they are leaving so they can monitor that resident closely. When asked what limited assistance and a gait belt with toileting meant to her, CNA F stated, That you stay with the resident and monitor them until they are off of the toilet. CNA F confirmed R7 did not have a gait belt on when CNA F found [R7] on the room floor. When shown the CNA Incident Report, dated 8/13/25, with her name on the bottom of the form, CNA F stated, That is not my signature. The Incident Report clearly noted: Nurse Aide signatures: for two lines included on the form for signatures. Review of R7's Care Plans on 9/9/25 at 1:19 p.m., revealed the following Toileting and Transfer interventions, in part: Toileting Care Plan revision 5/14/25 (in place at time of fall) – TOILETING- I require limited staff assistance of 1 and a gait belt to use the toilet. I dribble urine and need limited assist for toileting hygiene cares when I am incontinent. Date Initiated: 10/02/2024 Revision on: 05/14/2025. Toileting Care Plan revision following identification of right pubic fracture (8/28/25) - TOILETING- I require extensive assist of 2 and a gait belt to use the toilet. I dribble urine and need limited assist for toileting hygiene cares when I am incontinent. Date Initiated: 10/02/2024 Revision on: 08/28/2025. TRANSFERRING- I require limited staff assistance of 1 and a gait belt for transfers using my FWW. Date Initiated: 10/02/2024 Revision on: 05/14/2025 (In Effect at Time of Fall). TRANSFERRING- I require extensive staff assistance of 2 and a gait belt for transfers. Date Initiated: 10/02/2024 Revision on: 08/28/2025. Review of an SBAR (Situation/Background/Appearance/Review) Communication Form completed on 8/13/25 at 5:04 p.m. by LPN C revealed the following in part: Does the resident have pain? Yes. New. Back of head. Right elbow. (No reference to right thigh pain). The SBAR Communication Form was faxed to Physician L on 8/13/25 at 17:25 (5:25 p.m.) per the fax receipt. Physician L's written response of no further orders was faxed back to the facility on 8/22/25, eight days after the form was faxed to the physician. Review of an 8/28/25 SBAR Communication Form, completed upon transfer to the acute care hospital, revealed the following, in part: Situation: Altered mental status. Falls. Pain (uncontrolled). This started on 08/19/2025. Since this started it has gotten worse. Completed by Registered Nurse (RN) G. During an interview on 9/10/2025 at 8:53 a.m., RN G was asked about the SBAR Communication Form she had completed on 8/28/25. RN G said that she had been concerned about R7 since the fall. RN G said R7's anxiety and pain appeared to be escalating. Review of R7's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2025, revealed the following changes, in part: 1. Physician order for Clonazepam (anti-anxiety medication) was changed from 0.5 mg once daily to (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	two times daily on 8/21/25. 2. Pain Assessment for the first 12 days of August (prior to the fall) had the following self-reported pain documentation: No pain level above Level 5. Level five: 1 Level four: 1 Level three: 6 Level two: 6 Level one: 1 Level zero: 23 3. Pain Assessments for August 13 through August 31, 2025 (R7 hospitalized [DATE] – 8/30/25) Level six: 3 Level five: 9 Level four: 4 Level three: 3 Level two: 6 Level one: 3 Level zero: 19 4. Acetaminophen physician order for 650 mg (milligrams) by mouth every 4 hours as needed for pain, administered 7 times between 8/1/25 and 8/13/25, prior or R7's fall on August 13th, administered 30 times between 8/13/25 (following R7's fall) and 8/31/25 (R7 was hospitalized [DATE] – 8/30/25). Review of R7's Progress Notes revealed the following, in part: Effective Date: 08/28/2025 13:00 (1:00 p.m.) Type: Resident (R7) was in dining room and wouldn't eat. (R7) Was freaking out that table was going to fall on her. Crying she couldn't see people. Her head hurt. At this time daughter [Family Member (FM H] walked in and we disguise (sic) (perhaps meant discussed) options. [FM H] wants resident sent to clinic. Clinic nurses advise to send to ER. Facility bus was to take resident to ER. Report was given to [Unit Manager] I and [FM H] would be following her up there (to ER). Review of the acute care hospital discharge documentation for R7's transfer to the ER on [DATE] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and inpatient stay in the hospital until 8/30/28, revealed the following discharge documentation, in part: 1. X-ray of R7's right hip, on 8/28/25, identified a comminuted (broken in multiple places), displaced (bones moved out of their normal position), right pubic fracture (more likely to occur from a high-energy event such as a fall or accident). 2. HIP (History of Present Illness): . She is also complaining of right knee and hip pain and occasionally complains of headaches. She has fallen occasionally in the past with her most recent fall on 8/13 when she was found seated on the floor of her room (based on report from FM H documented in the discharge documentation). She reported that she tried to walk to the bathroom herself and fell striking the right side of her body and her head .She states her pain is 10 out of 10 . She eventually states her knees and hips hurt as well as the middle part of her back . Review of Physician Visit Progress Notes found no documentation of a physician visit following R7s fall on 8/13/25, prior to R7's discharge to an acute care hospital on 8/28/25. During an interview on 9/9/25 at 2:45 p.m., the NHA and Director of Nursing (DON) were both asked if staff should be using a gait belt with resident transfers unto and off of the toilet. The NHA stated, Yes, if it was in the care plan. We would also anticipate they would use a gait belt if it wasn't in the care plan. When asked for any witness statements from nursing staff that responded following R7's fall on 8/13/25, the NHA stated, I do not have any interviews with the staff that went into the room. When asked if family was notified of the fall, the DON acknowledged family was not notified promptly of the fall because R7 is her own person and responsible for her own decisions. When asked about the delay in written receipt of the SBAR faxed to the physician on 8/13/25 and received back on 8/22/25, the NHA said she would hope the written response would be within a day and commented that the Physician L was also contacted via the telephone in an attempt to get the written response returned promptly. When asked about Witness Statements, the NHA (who completed the investigation) said she did not have any Witness Statements from the staff who responded to R7's fall. The DON said she had received a Witness document from CNA F, signed 8/13/25. The DON presented the handwritten statement to this Surveyor at this time and stated, It was my error. I did not give it to [the NHA]. The following documentation was requested at this time: Fall and Post-Fall Assessment policies, and second request for neurological checks (second request) completed on R7 post-fall. During an interview on 9/9/2025 at 3:45 p.m., LPN D (the first LPN to respond to R7's fall on 8/13/25) confirmed R7 had no gait belt on when found on the floor. When asked if she had fully assessed R7 prior to moving her off the floor, including completion of vitals and/or neuros, LPN D said she did not complete any assessment of the R7. LPN D said she did go to retrieve a dressing for wound care, because R7 had hit her head. LPN D said she was not the nurse on that hall and was not the nurse providing care to R7 on 8/13/25. LPN D confirmed staff that leave a resident on the toilet, and leave the Hall, should inform the staff they are working with, so that the staff could monitor the resident. During an interview on 9/10/25 at 8:15 a.m., the DON was asked how facility staff monitor vitals for residents. The DON said vitals were taken with a vital machine (attached to a pole with wheels). Asked if the DON would have any concern that a vitals machine was not observed going into R7's room prior to or following her fall, and before she was wheeled down to the dining room for dinner, the DON acknowledged R7's vitals should have been assessed prior to movement from the floor to the wheelchair. (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/10/2025 at 8:24 a.m., the DON and NHA were observed walking down that hall and the DON was overheard saying she said the machine (vital machine) was in the dining room. When asked if they were talking about R7's fall and failure to obtain vitals prior to removing the resident from the floor, both the DON and NHA acknowledged that vitals were not obtained prior to moving the resident off the floor into her wheelchair with a gait belt and taken down to dinner on 8/13/25. During a telephone interview on 9/10/2025 at 11:33 a.m., FM H was asked if she was notified of R7's fall on 8/13/25. FM H stated, They usually call when things happen. I don't know why they didn't notify me about this occasion. On other falls they have called me . I was not notified on 8/13/25. She (R7) showed me her elbow. That is the only reason I knew she fell. They said they did the vitals protocol after she fell . Review of the Accidents and Supervision policy, last reviewed 6/12/25, revealed the following, in part: Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: . Implementing interventions to reduce hazard (s) and risk (s). 5. Supervision – Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency, b. Based on the individual residents assessed needs and identified hazards in the resident environment. Review of the Incidents and Accidents policy, implemented 7/18/25, revealed the following, in part: .7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so .10. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks per protocol and document on the neurological flow sheet .11. The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital. Review of the Falls policy, implemented 6/17/24, revealed the following, In part: When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment c. Complete an incident report d. Notify physician and family. e. Review the residents' care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. During the Exit Conference on 9/10/25 at approximately 5:00 p.m., the DON acknowledged a neurological check form was unable to be located showing neuros were performed on R7 post-fall on 8/13/25. Resident #23 (R23) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/29/25 at 8:00 AM, an anonymous complaint was reported to the State Agency (SA), which stated R23 was in his room with a razor, cut his tongue, is on a blood thinner and staff had a hard time stopping the bleeding. The anonymous complainant stated that the razor R23 used was the same kind the facility uses on residents. The anonymous complainant stated that they were unsure if a staff member left the razor in the bedside cabinet drawer or how R23 obtained the razor. On 9/2/25 at 2:40 PM, an observation was made of R23 in his room. R23 was sitting in his wheelchair and was observed to have a bruise with various colors of yellow, green, and purple around his right eye and a scab above his right eyebrow. R23 was asked if he had recently cut his tongue and replied with a nodding his head up and down. R23 was unable to explain how he had cut his tongue or with what. Review of R23's progress note, dated 8/26/25 at 1:31 PM, read in part .Resident has a cut on his tongue which was bleeding. He had blood dripping from his mouth down his chin. On inspection showed a elongated cut to left lateral tongue. He is not sure how he did it. Treated with rolled absorbent gauze in mouth as in a dental sponge. The nurse changed x 2 and then bleeding stopped. Review of R23's progress note, dated 8/27/25 at 12:42 PM, read in part SN (skilled nurse) was informed by CNA (certified nurse aide) that resident cut his tongue with a razor on a previous shift. Review of R23's minimum data set (MDS) assessment, dated 8/18/25, revealed under section GG for Personal hygiene section GG0130 Self-Care: Marked for Partial/moderate assistance which includes shaving. On 9/2/25 at 2:50 PM, an interview was conducted with R23's roommate who was asked if he knew how R23 got a razor and replied, It was my razor. I guess the staff left the razor in the bathroom and he (R23) got a hold of the razor and cut his tongue and was bleeding. On 9/5/25 at 9:00 AM, an interview was conducted with CNA F who was asked about R23 cutting their tongue and replied, I don't know anything about it that is what the social worker said. Talk to the social worker. On 9/5/25 at 9:33 AM, an interview was conducted with Social Services Director U who was asked how R23 but his tongue and replied, He did it shaving with a razor. One of the aides told me. Social Services Director U was asked if R23 was safe to have a razor and replied, No and I am not sure why he even had a razor or how he got a razor. I guess it just got left in his room by a staff person. He is not supposed to be shaving himself. On 9/5/25 at 9:40 AM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked if there was an incident and accident report completed for R23 having a razor and cutting his tongue and replied, Not that I am aware of. On 9/5/25 at 9:45 AM, an interview was conducted with the Director of Nursing (DON) who was asked if R23 was safe to have a razor or to be shaving himself and replied, No. A CNA told me he was shaving and had his tongue out. He should have not had a razor. The DON confirmed there was no incident and accident report completed after R23 cut his tongue with a razor. Review of policy titled, Accidents and Supervision, dated 6/12/25, read in part Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	adequate supervision and assistive devices to prevent accidents.5. Supervision.is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Review of policy titled, Incidents and Accidents, dated 7/18/25, read in part Policy: It is the policy of this facility for staff to utilize Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.Policy Explanation: The purpose of incident reporting can include.Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences.Compliance Guidelines.5. The following incidents/accidents require an incident/accident report but are not limited to.self-inflicted injuries.12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. Resident #38 (R38) On 9/3/25 at 10:54 AM, R38 was observed in the doorway of another resident's room. The doorways to rooms [ROOM NUMBER] were observed with mesh-type barriers with stop sign notifications on the barriers. The barriers extended across the doorways and were secured with Velcro on each end to attach each end to the doorframes. The electronic medical record (EMR) of R38 documented admission to the facility on 3/12/25. The primary diagnosis of R38 was dementia with psychotic disturbance. An Activities of Daily Living (ADL) care plan in the EMR indicated R38 was independent with transfers, was able to ambulate, and utilized a wheelchair independently for locomotion. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R38 had a primary medical condition of non-traumatic brain dysfunction and experienced hallucinations. Further review of the MDS revealed R38 received antipsychotic medication on a routine basis and scored three of fifteen on the BIMS (Brief Interview for Mental Status) indicating R38 had severe cognitive impairment. The MDS coded R38 as independent with wheelchair mobility. A progress note dated 9/3/25 at 4:07 AM documented, in part: . around 0100 [1:00 AM] resident started to try escaping, tried going through dining room door, pulling at the blinds, broke one of the dining room blinds. Attempted to elope out of the front door, breaking the door open. This RN called patients family who tried talking to her, resident to calm down some, this RN sat and talked w/ [with] her at front of building, around 0400 [4:00 AM] pt [patient] did go into her room but refuses to get into bed or change into pajamas. Resident also is seeing her sister rose outside, stating she needs to get to her before she gets to [sic] cold. A progress note dated 9/3/25 at 8:38 AM documented: Cameras reviewed. Resident did appear to be looking to get out of the building, checking windows, and moving around the perimeter of the dining room and entryway. Resident did push on front door at 02:33:58 [2:33 AM, 58 seconds] and it came off the track. Staff was there with resident and was able to redirect while they put the door back on the track. Maintenance contacted to have door looked at for proper functioning. The EMR of R38 was reviewed on 9/3/25 at 9:30 AM, 9/3/25 at 2:27 PM, 9/4/25 at 8:13 AM, 9/4/25 at 1:20 PM, and 9/5/25 at 7:54 AM. The EMR did not contain an assessment to evaluate R38's risk for elopement after R38 attempted to exit the facility on 9/3/25. None of the care plans for R38 included (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the resident's elopement attempt on 9/3/25 or interventions to minimize the risk of recurrence. There was no documentation regarding increased supervision or interventions to mitigate recurrence. CNA R was interviewed on 9/4/25 at 1:20 PM. CNA R was asked if the facility had a list of residents who were at risk for elopement. CNA R said there was no list of residents who at risk for leaving the facility unsupervised. When asked how staff knew which residents required increased supervision and monitoring for potential elopement from the facility, CNA R said residents at-risk for elopement wear a WanderGuard™ bracelet (part of a wander management system designed to ensure the safety of individuals, particularly the elderly or those with dementia, by preventing them from wandering away). R38 was observed in the dining room on 9/4/25 at 1:28 PM. A WanderGuard™ bracelet was not visible on the extremities or on the wheelchair of R38. There was no notation in the EMR regarding a WanderGuard™ bracelet for R38. CNA S and CNA T were interviewed on 9/4/25 at 2:32 PM. CNA S confirmed there was no listing of residents who were at risk for elopement from the facility. When asked the names of residents who were at risk for elopement, CNA S said the residents with a WanderGuard™ bracelet were the residents at risk for elopement. When asked how the staff knew which residents required increased supervision and monitoring for potentially exiting the facility unsupervised, CNA R reiterated the residents with WanderGuard™ bracelets were the residents at risk and said if a resident did not have a WanderGuard™ bracelet then the resident was not at risk for elopement from the facility. The nurse manager, RN I, was interviewed on 9/4/25 at 2:02 PM. RN I was asked when elopement assessmen

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to ensure a Registered Nurse (RN) was available for eight consecutive hours during a 24-hour period. This deficient practice had the potential for unmet care needs which could affect all 52 residents that reside in the facility.Findings include:Review of the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ Staffing Data Report for Fiscal Year (FY) Quarter 2 2025 (January 1-March 31) revealed the facility triggered for No RN hours with infraction dates being: 3/16/25, 3/22/25, 3/23/25 and 3/29/25.Review of facility document reflecting staffing data for the day, dated Saturday March 29th, 2025, revealed no RN coverage for 24-hour period.During an interview on 9/4/25 at approximately 11:00 a.m., Human Resources Manager B reported there was not an RN working on the Schedule for Saturday March 29th, 2025.Review of the timesheets revealed there was no RN in the facility from March 28th at 7:11 pm through March 30th at 7:15 a.m., reflective of an absence of an RN for eight consecutive hours in a 24-hour period.During an interview on 9/5/25 at 7:52 a.m., the Nursing Home Administrator (NHA) acknowledged that on 3/29/25 there was not an RN in the facility for eight consecutive hours in a 24-hour period.

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review for one of five Certified Nurse's Aides (CNA's) at least every 12 months. This deficient practice resulted in the potential for inadequate care and unmet resident care needs for all 52 residents residing in the facility.Findings include:Review of facility personnel records demonstrated that CNA O was hired on 4/16/24 with no performance review.During an interview on 9/4/25 at approximately 10:55 a.m., the Director of Nursing acknowledged there was no performance evaluation completed for CNA O and stated, The facility does not have a policy regarding performance evaluations or when they should be completed.During an interview on 9/5/25 at 7:52 a.m., the Nursing Home Administrator (NHA) acknowledged the performance review for CNA O was not completed and should have been completed annually.

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	235144	A. Building B. Wing	09/10/2025

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Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure written communication of Monthly Medication Review (MMR) recommendations to the physician for five Residents (#2, #5, #6, #37, and #38) of five residents reviewed for MMRs. This deficient practice resulted in the absence of written MMR recommendations for the last year and had the potential to affect all 52 residents in the facility. Findings include:Resident #2 (R2), #5 (R5), #6 (R6, #37 (R37), #38 (R38)On 9/10/2025 at 9:10 a.m., an interview with the Director of Nursing (DON), (NHA), and Unit Manager/Registered Nurse (RN) I was conducted. When asked if there was a monthly pharmaceutical review report showing who the pharmacist had seen each month for Monthly Medication Reviews (MMR) reviews, all three agreed there were no written pharmacy recommendations that resulted from the MMRs for any resident in the facility in the last year, including R2, R5, R6, R37, and R38. An interview via telephone or in-person was requested with the facility's consulting Pharmacist J.During a telephone interview on 9/10/2025 at 9:21 a.m., Pharmacist J acknowledged there were no written pharmacy recommendations for any resident in the facility in the last year, including R2, R5, R6, R37, and R38. Pharmacist J stated, If the doctor doesn't want the Gradual Dose Reduction (GDR), (required per regulation), I read the doctor's note (monthly physician note)and I read they don't want a GDR (then) I don't make the recommendation. When asked to clarify, Pharmacist J continued, The physician has already said he doesn't want a GDR (in the progress note). If it (GDR) was something that I was going to recommend a GDR, but they already have written they don't want a GDR, that is kind of why I respond the way that I do. It is already written in his note. When asked if there had been any recommendations for lab draws, increased monitoring, or consideration of blood pressure monitoring in the last year, Pharmacist J stated, I could look through my notes to [the DON]. They (DON) have asked me to look at something and I have in the past. When asked if the review that the facility requested was put into the medical record of the resident when it was completed, Pharmacist J stated, No, it is just in my correspondence with [the DON]. When asked if monthly pharmacy reports were sent to the DON, Pharmacist J stated, I do, yes, as far as the med room inspections. Pharmacist J provided an example of reviewing a patient when the frequency of administration of a medication need to change (such as once daily to two times daily) and then sending a message, via email, to the DON regarding that change. When asked to clarify that if there was a medication frequency change recommendation [Pharmacist J] went through [the DON] to do that and no physician recommendation was completed, by written communication, telephone, or email, Pharmacist J stated, I guess I have just been making [the DON] aware of the recommendation. Pharmacist J confirmed he was making pharmacy recommendations, but they were sent to [the DON) via emails but acknowledged that he did not know, in every case, that there was follow-up with the physician. Pharmacist J stated, I have never made a (written) recommendation that [was] submitted to the physician . If I am notified after a fall I review those meds. When asked if he was notified of R7's fall on 8/13/25 that resulted in a fall with major injury, Pharmacist J stated, No I was not. During an interview on 9/10/2025 at 9:32 a.m., the Nursing Home Administrator (NHA) was asked what was expected of the facility consultant pharmacist. The NHA stated, The expectation is that he is communicating any discrepancies, and he would be reporting the recommendations to the medical doctor. When asked if those recommendations could be verbal, the NHA stated, It would probably be best if it was done in writing. The pharmacist should have a recommendation to the physician, with a cc (carbon copy) to [the DON] so she can follow up with the physician to ensure it is completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

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Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure performance improvement projects/activities were conducted to ensure problem areas were identified, tracked, and improvement attained. This deficient practice resulted in lack of improvement in previously deficient finding areas which has the potential to affect all residents residing in the facility. Findings include: During an interview on 9/10/25 at 3:10 p.m., the Nursing Home Administrator (NHA) was asked what the QAPI (Quality Assurance Performance Improvement) committee had been working on. The NHA stated, Putting out fires. When asked what performance improvement projects (PIPs) the facility had been working on in the last year, the NHA (two months in new position) was uncertain of what projects had been implemented. The NHA was asked if they would like another staff member present for the QAPI task interview, and she responded affirmatively. The Director of Nursing (DON) was added to the QAPI interview. During an interview on 9/10/25 at 3:21 p.m., the NHA and DON were asked to provide examples of PIPs the facility had conducted in the last year. The DON said they have not done any PIPs in the last year because the former NHA said the facility got cited anyway, so they weren't going to do them (PIPs) anymore. The DON stated, Historically, most managers would have one PIP. No PIPs were available for discussion or review. Review of the QAPI (Quality Assessment Performance Improvement) Change Process policy, implemented 6/12/25, revealed the following, in part: . 5. The facility must conduct distinct performance improvement projects, based on the scope and complexity of facility services and available resources, identified in the facility assessment. 6. The facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. 7. Performance Tracking - a. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained . c. At least annually, the facility conducts a self-assessment to determine the facility's performance improvement culture. Corrective action is taken as appropriate .

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure quality assessment and assurance (QAA) committee meetings were held quarterly with the participation of all required members. This deficient practice resulted in the absence of a required QAA member (Medical Director) in the second quarter of 2025, which had the potential to affect all facility residents. Findings include: During an interview on 9/10/25 at 3:10 p.m., the QAA committee sign-in sheets were reviewed with the Nursing Home Administrator (NHA). Committee meeting sign-in sheets were located by the NHA, detailing the only one QAA committee meeting was held in the second quarter of 2025 (6/12/25). The Medical Director, Physician V's signature was absent from the sign-in sheet, indicating he was not present at the June 2025 meeting. The NHA was asked for QAA committee sign-in sheets for April and May of 2025. The NHA stated, I don't believe there was a QA meeting in April or May of 2025. No sign-in sheets for any additional QAA committee meetings in the second quarter were provided for review.

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nurses Aide (CNA) training of no less than 12 hours per year was completed for one CNA O of five CNA's reviewed for nurse aide training hours. This deficient practice resulted in the potential for unmet resident care needs for all 52 residents that reside in the facility.Findings include:During an interview on 9/4/25 at 10:41 a.m., Human Resources Manager B revealed the annual 12-hour CNA training is based on the CNA hire date.Review of facility document titled Bayside Village Staff Disaster Notification provided from the Director of Nursing (DON) revealed CNA O was hired on 4/16/24 and had only 9 hours of training in a year.Review of Facility Assessment (FA) last reviewed 8/21/25, read in part .Required in-service training for nurse aide.must be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.During an interview on 9/5/25 at 7:52 a.m., the Nursing Home Administrator (NHA) acknowledged the CNAs must have 12 hours of training a year.

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a homelike environment as evidenced by serving residents their meals on institutional trays and having a common area with a worn down and deteriorating conditions of furnishings and wall finishes at the nursing station. Findings include: On 9/3/25 at 11:40 an observation was made of the facilities nurses' station. The nurses' station entrances were both observed to have lifted and peeled off paneling on the side and corners of the entrance. On the front wall of the nurses' station there was one area of wallpaper that was missing and one area of wallpaper the size of a small basketball that was peeled off and hanging. On 9/3/25 at 11:50 AM, an interview was conducted with Registered Nurse (RN) G who was asked if the nurses' station was very homelike and if she would leave the condition of the station in her own home and replied, No, it looks rough and could use a revamp. We can't even keep anything like scissors or resident information lying around. Because the nurses' station does not lock on the entrance areas and residents get inside and one resident has the one entrance all marked up because they get their wheelchair caught on the side trying to get in. On 9/5/25 at 9:33 AM, an interview was conducted with the Social Services Director U, who was asked about the condition of the nurses' station and replied, It is not very functional for the nurses, and it needs a lot of TLC (tender loving care). It needs to be repaired. During the breakfast meal on 9/3/2025 at 8:45 AM, Residents were observed in the facility dining room with their meals in front of them on institutional trays. Meal trays were being distributed by staff in no particular order. Residents were not served together with their tablemates. During the lunch meal on 9/3/2025 at 12:25 PM, the meal was also served on trays and was observed along with Dietary Manager (Staff) Y. Staff Y was asked why the facility staff were serving resident meals on trays, Staff Y said, That is a good question. The DON (Director of Nursing) asked me why the food is served on the trays also. The CNAs (Certified Nurse Aides) just put them on the table. Staff Y concluded, If the trays were not used it would be a better dining experience. Staff Y was asked if there was a dietary policy regarding this aspect of meal service, but none was presented by the close of the survey.

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:- provide written information on the facility's bed hold policy for five Residents (#27, #15, #2, #3, and #7).- provide written transfer notifications to the resident, and resident's representative for four Residents (#15, #2. #3 and #7).of five residents reviewed for transfers out of the facility. Findings include: Resident #27 (R27) was transferred to the hospital Emergency Department (ED) on 7/26/25. There was no documentation in the Electronic Medical Record (EMR) indicating the resident/responsible party was provided a bed hold notice. During an interview on 9/4/25 at 2:25 p.m., the Nursing Home Administrator (NHA) reported, the facility had not been giving bed hold information to the resident/responsible party when discharged to the hospital. Review of policy titled Transfer and Discharge date implemented 4/11/25, read in part .Emergency transfers to acute care.the facility will.provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge in a form and a manner that the resident can understand.provide a notice of transfer and the facility's bed hold notice policy to the resident or representative. Review of policy titled Bed Hold Notice date implemented 4/11/25, read in part .It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave.the facility will keep a signed and dated copy of the bed-hold notice information given tot the resident and or resident representative in the residents file and or medical record. Resident #3 (R3) was hospitalized on [DATE]. The EMR did not specify the facility provided written notice of the reason for the transfer or written notice of the bed hold policy to R3 or R3's resident representative. Resident #7 (R7) was hospitalized on [DATE]. The EMR did not specify the facility provided written notice of the reason for the transfer or written notice of the bed hold policy to R7 or R7's resident representative. During an interview on 9/4/2025 at 12:13 PM, the Nursing Home Administrator and Director of Nursing both agreed they did not send a written notification of transfer explaining the reason for hospitalization or an explanation of the current bed hold policy to the resident or responsible party. Resident #15 (R15) was admitted to the facility on [DATE]. The EMR revealed R15 was transferred to the ED on 8/5/25 and was subsequently admitted to the hospital. There was no documentation in the medical record indicating R15 or R15's resident representative was provided with written notification of the reason for the transfer. The EMR did not include the provision of the facility bed hold policy to R15 or R15's resident representative. Resident #2 (R2) was initially admitted to the facility 10/12/22. Review of the EMR disclosed R2 was transferred to the ED on 7/22/25 and 8/27/25. The EMR did not specify the facility provided written (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notice of the reason for the transfer or written notice of the bed hold policy to R2 or R2's resident representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one medication cart of three medication carts reviewed were attended and or locked and all resident medications were secured and or consumed for one Resident (#27) of fifteen residents reviewed for medication storage. Findings include: On 9/4/25 at 12:11 PM, an interview was conducted with Registered Nurse (RN) A who was asked about medication pass and where she was in the process and replied, I have a couple more to do. I have to go check on a resident for feeding assistance. RN A walked away from her medication cart and left it unlocked/unattended and walked into an adjacent resident room [ROOM NUMBER]. On 9/4/25 at 2:30 PM, an observation was made of the 300-hall medication cart that was located at the entrance of the 300-hall unlocked and unattended. This Surveyor walked over to the 300-hall medication cart and opened several drawers which were in a resident common area. RN A was sitting at the nurses' station and was asked how often she leaves her medication cart unlock and unattended and replied, Oh, no! Is it unlocked? This Surveyor then opened the third drawer and replied, Yes, it is. On 9/10/2025 at 2:30 PM, an interview was conducted with the Director of Nursing (DON) who was asked what her expectation was of the medications carts and if they should be locked when nurses are not attending them or preparing medications and replied, Yes, the medication carts should be locked at all times if not attended by a nurse. Review of policy titled, Medication Storage, dated 7/18/25, read in part Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Review of policy titled, Medication Administration, dated 7/18/25, read in part, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines.15. Observe resident consumption of medication. Resident #27 (R27) Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 2/24/22. R27 scored 15 out of 15 on the BIMS (Brief Interview for Mental Status) assessment reflective of intact cognition. During an observation on 9/3/25 at 12:46 p.m., R27 had a medicine cup on his bedside table with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antacid medication. During an interview on 9/3/25 at 12:47 p.m., R27 reported that the nursing staff leaves the medication at bedside sometimes. Review of the Electronic Medical Record (EMR) revealed R27 did not have a physician order to self-administer medication and R27 did not have self-administration of medication assessment that had been completed. Review of policy titled Medication Administration last reviewed/revised 7/18/25, read in part .medications are administered by licensed nurses or other staff who are legally authorized to do so.as ordered by the physician and in accordance with professional standards of practice.administer medication as ordered.observe resident consumption of medication. Review of policy titled Medication Storage last reviewed/revised 7/18/25, read in part .All drugs and biologicals will be stored I locked compartments ie. Medication carts, cabinets, drawers.medication rooms.only authorized personnel will have access t the keys to locked compartments.During a medication pass, medications must be under the direct observation of the person administering medication or locked in the medication storage area/cart.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to attempt a gradual dose reduction for one resident (Resident #37) out of five residents reviewed for psychotropic drug use. Findings include:Resident #37 (R37)Review of R37's minimum data set (MDS) assessment, dated 9/9/25, revealed medical diagnoses of hypertension, diabetes mellitus, dementia, depression, and aphasia (a condition where a person finds that they have slight or serious difficulty with either their language or their speech). Review of R37's MDS, section E: Behaviors lacked any documentation of having behaviors. On 9/9/25 at 10:40 AM, an observation was made of R37 resting in his wheelchair in the day room with his eyes closed. Review of R37's physician order, dated 8/21/24, revealed quetiapine (an antipsychotic medication) 25 milligrams (mg) twice daily for dementia without behavioral disturbances and escitalopram (antidepressant medication) 10 mg once daily. On 9/10/25 at 11:15, an observation was made of R37 resting with his eyes closed in the day room sitting in his wheelchair. R37 was asked how he was doing and how his day was going and R37 did not respond or open his eyes. Review of R37's task for behavior monitoring question one: What behavior(s) was observed? That included physical, verbal, and socially inappropriate behaviors in the last 30 days were blank and no behaviors were checked as exhibited by R37. Review of R37's monthly medication regimen reviews from the pharmacy, dated 8/27/24 through 8/28/25, revealed no recommendations and no gradual dose reduction (GDR). Review of R37's GDR request for quetiapine and escitalopram, dated 6/9/25, revealed the lack of a last GDR, previous failed attempt, behavioral care recommendations, behavior notes, and a declination on 6/17/25 from Physician K stating to continue same meds - GDR contraindicated given his history of behaviors in past and currently stable with no side effects. On 9/10/25 at 11:20 AM, an interview was conducted with Social Services Director U who was asked if there was a specific area where staff was to be charting on behaviors or if R37 had any behaviors in the last three months and replied, Actually he (R37) has been good lately. Staff are to document behaviors in the electronic medical record in the tasks area and in a binder then I follow up with the resident who is having any behaviors. Social Services Director U was asked to see any documented behaviors for R37 and had two communication logs for behaviors on 3/19/25 and 6/10/25 both in the evening. Review of R37's social services progress note, dated 7/9/24, read in part Writer completed well check on resident. Resident was in the hall at this time roaming safely in the facility. Resident was pleasant. When asked resident said he was good.No concerns at this time. Review of R37's social services progress note, dated 6/30/24, read Writer completed well check on resident. At this time resident is roaming safely through the facility. Resident mood is pleasant, no behavioral concerns at this time. Resident is not agitated or being aggressive. When asked resident states he's doing good, and then smiles. Review of R37's social services progress note, dated 3/10/24, read Resident pleasant during assessment. Mood was stable. Review of R37's social services progress note, dated 3/10/24, read Resident pleasant during assessment. Mood was stable. Review of R37's social services progress note, dated 1/21/24, read Writer did wellness check up with resident. Residents mood was stable. Resident smiling and laughing. On 9/10/25 at 1:30 PM, an interview was conducted with Physician K who was asked why a GDR was not completed in the last year for R37 and replied, He (R37) is stable and is contraindicated for having a GDR. I am afraid of doing a GDR because I don't want to lose ground and take a step back. Physician K was asked if there was a risks verses benefits completed for R37 and replied, No. Physician K did not give any real clinical contraindication for the lack of a GDR. Review of physician progress note, dated 6/17/25, read in part .is doing well and has no complaints.Nursing staff has no concerns.He is awake, alert, happy. Review of physician progress note, dated 4/29/25, read in part The resident is doing well and has no complaints. Staff reports no increased behaviors.He seems to be always happy and is jovial and joking with Examiner. Review of physician progress note, dated 2/25/25, read in part The resident is (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing well and has no complaints. Staff reports no increased behaviors.He seems to be always happy and is jovial and joking with Examiner. On 9/10/25 at 1:40 PM, an interview was conducted with the Director of Nursing (DON) who was asked why R37 did not have an attempted GDR for his quetiapine or escitalopram and replied, There should at least be one attempt to see how R37 would respond. Review of policy titled, Gradual Dose Reduction of Psychotropic Drugs, dated 6/12/25, read in part, Policy: Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.Policy Explanation and Compliance Guidelines: 1. Reducing the need for and maximizing the effectiveness of medications shall be considered for all residents who use psychotropic drugs. Therefore, dose reductions and behavioral interventions are part of medication management.2. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts).4. The timeframes and duration of attempts to taper any medication shall depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacological characteristics of the medications.c. Opportunities during the care process to consider whether the medications should be continued, reduce, discontinued, or otherwise modified include: i. During the monthly medication regimen review by the pharmacist.

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	235144	A. Building B. Wing	09/10/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review the facility failed to ensure the PASARR (Preadmission Screening/Annual Resident Review) level I ([one] (DCH-3877) was obtained annually for one Resident (#6) of two residents reviewed for PASARR requirements . Findings include:Review of R6's electronic medical record (EMR) revealed an initial admission to the facility on 3/25/2022 with diagnoses including depression, unspecified hallucinations, unspecified psychotic disorder with delusions due to known physiological condition, anxiety disorder, and Alzheimer's disease. A review of R6's Minimum Data Set (MDS) quarterly assessment, dated 7/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 2 of 15 indicating severe cognitive impairment. Section E under Behavioral Symptoms revealed R6 was coded as having physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurring every 1 to 3 days.A review of the active physician's orders for R6 included an antipsychotic drug quetiapine, prescribed on 7/21/2024, as well as a current order for an antidepressant drug sertraline prescribed 9/27/2024. The care plan for R6 included focus areas which read in part: I have potential to demonstrate behaviors aeb (as evidenced by) I sometimes exhibit physical and verbal behaviors towards others, refuses cares, mediations, and interventions.- I have impaired cognitive function or impaired thought processes r/t (related to) Alzheimer's diagnosis, delusions and hallucinations, impaired decision making, short-term memory loss.- Trauma Informed Care: I have a history of trauma that can negatively impact my care and treatment.- I use antipsychotic medications: Seroquel (quetiapine) r/t Alzheimer's disease with hallucinations and psychotic disorder with delusions.The EMR for R6 contained a PASARR Level one (DCH - 3877) dated as filed 3/26/24 and marked as ARR (ANNUAL RESIDENT REVIEW). A current annual PASARR Level I (DCH - 3877) for 2025 annual resident review could not be located in the EMR.During an interview on 9/4/2025 at 1:57 PM, the Director of Nursing (DON) stated she does the PASSAR's and took the lead in that area. She reviewed the EMR for R6 and could not find a current annual PASSAR level I (DCH-3877). The DON said, PASSAR's are definitely a work in progress. There is not a level I (for R6) since 3/26/24. The undated facility policy titled Resident Assessment - Coordination with PASARR Program read in part, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder (MD), intellectual disability (ID) or a related condition receives care and services in the most integrated setting appropriate to their needs.

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	235144	A. Building B. Wing	09/10/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review the facility failed to update a comprehensive care plan for 1 Resident (#23) of 15 residents reviewed for care plans. Findings include:Resident #23 (R23)On 9/2/25 at 2:40 PM, an observation was made of R23 in his room, sitting in his wheelchair. R23 was observed with a bruise with various colors of yellow, green, and purple around his right eye and a scab above his right eyebrow. R23 was asked if he had fallen and how and replied by pointing to the bathroom and nodding yes. R23 was not able to say when he had fallen.Review of R23's incident and accident report, dated 8/18/25 at 3:20 PM, read in part Un-witnessed fall.Incident description: Nursing description: Was told by and aid ?[Resident's name] fell and is bleeding from his head.' Upon arriving in room, resident was sitting on the edge of the bed with blood dripping from his forehead (sic). Resident description: Resident stated he fell and hit his head on the floor coming from the bathroom. Resident stated ?I hit my head on the floor when I fell.' ?I was coming from my bathroom.'.Immediate action taken: Description: Pressure applied, neuro check WNL (within normal limit).Ambulance was called to take resident to the hospital for evaluation and treatment. Review of R23's progress note, dated 8/18/25 at 10:38 PM, read in part .Resident fell in his room and has a laceration that required sutures.Diagnosis: Fall, right forhead (sic) laceration required 3 sutures.discharged at 6:00 PM. Review of R23's care plan, dated 11/6/23, read in part Focus: I had a fall with no injury. Revised on: 3/2/25. Goal: To minimize my risk of falls with serious injury thru the next review date. Revised on 3/2/25. Interventions/Tasks: I have been educated to call and wait for staff assistance when I transfer to minimize my risk for falls. Date initiated: 3/1/25. My bed has been positioned against the wall per my preference to establish boundaries. This does not restrict my movement in bed or my ability to get into and out of bed. Date initiated: 6/2/25. No other interventions, added interventions, or updated care plan for fall with injury to prevent further falls.Review of R23's fall risk assessment, dated 8/15/25, revealed a blank assessment which had not been completed.Review of R23's fall risk assessment, dated 6/1/25, revealed R23 was at risk of falling. Review of R23's progress note, dated 8/29/25 at 8:10 AM, read in part Writer educated by nurse that.ambulance coming to get resident to take (local ER name) to be evaluated.Review of R23's emergency room (ER) visit, dated 8/29/25 at 8:40 AM, revealed a return to the ER for adding an additional three sutures to stop bleeding. Review of a progress note, dated 8/29/25 at 11:56 AM, read in part Area to forehead with stitches from previous fall, bleeding without stopping. Pressure applied for 20 mins (minutes) with no relief. Res (resident) transported to (local ER name) for evaluation via ambulance.Res returned from ED (emergency department) with 3 new stitches to area.Review of a progress note, dated 9/1/25 at 5:34 PM, read in part Res has picked one if not two stitches out of forehead causing excessive bleeding. Compression dressing applied x 2 resulting in bleed throughs. Res continues on (brand name anticoagulant) [rivaroxaban] 20 mg (milligrams) daily.Review of ER visit, dated 9/1/25 at 8:35 PM, revealed R23 had stitches removed from his forehead, electrocautery was performed, and silver nitrate was applied to his forehead. A bandage was also applied to prevent R23 from picking at the area of his forehead. On 9/5/25 at 9:45 AM, an interview was conducted with the Director of Nursing (DON) who was asked about the process after a resident falls and replied, Well first assess them, then treat them, completed and incident report, and update the care plan to prevent further falls. The DON was asked what added interventions were put in place for R23 after his fall and replied, I don't see a note from me in the risk management note. Review of policy titled, Fall Prevention Program, dated 6/12/25, read in part Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Policy Explanation and Compliance Guidelines.g. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes.9. When any resident experiences a fall, the facility will.e. review the resident's care plan and update.Review of policy (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Fall Risk Assessment, dated 6/12/25, read in part Policy: It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. Policy Explanation and Compliance Guidelines: 1. The risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified.3. An At Risk for Falls care plan will be completed for each resident.5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice.

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	235144	A. Building B. Wing	09/10/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain physician orders for supplemental oxygen and ensure respiratory equipment was changed, labeled, and appropriately stored for two Residents (#13 & #27) of two residents reviewed for respiratory care and services. Findings include: On 9/2/25 at 2:49 PM, Resident #13 (R13) was observed with a nebulizer (a drug delivery device used to administer medications into the lungs) on the bedside stand. The tubing attached to the nebulizer was unbagged and labeled with the date 7/30/24. The nebulizer tubing was placed directly atop the nebulizer without a barrier beneath the tubing. On 9/2/25 at 2:49 PM, an oxygen concentrator was observed adjacent to R13's bed. The nasal cannula tube (tubing that delivers supplemental oxygen) was unbagged and undated. The nasal cannula tubing was placed directly atop the concentrator without a barrier between the concentrator and the tubing. R13 said she used oxygen when she experienced respiratory difficulty and received respiratory treatments through the nebulizer when needed for shortness of breath. Review of the electronic medical record (EMR) disclosed R13 was admitted to the facility 11/9/23. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R13 experienced shortness of breath with exertion and utilized supplemental oxygen therapy while a resident. Further review of the MDS revealed R13 had a medical diagnosis of COPD (Chronic Obstructive Pulmonary Disease – irreversible lung and airway damage). R13 had a BIMS (Brief Interview for Mental Status) score of 15 indicating R13 had intact cognition. The physician's orders for R13 did not include an order for supplemental oxygen. A care plan for the use of supplemental oxygen was not located in the EMR. There was no physician documentation regarding the use of supplemental oxygen. On 9/3/25 at 3:16 PM and 9/4/25 at 9:02 AM, during an observation, the nebulizer tubing remained unbagged and without a barrier and labeled with the date 7/30/24. The nasal cannula tubing continued to be unbagged and undated without a barrier between the tubing and the oxygen concentrator. The Director of Nursing (DON) was interviewed on 9/10/25 at 8:40 AM. The DON confirmed a physician's order was required to implement and utilize supplemental oxygen. The DON said the facility had standing orders to implement supplemental oxygen when indicated. When queried regarding the process to implement standing orders, the DON said nurses were required to enter a physician's order into the EMR and the order should be brought to the attention of the physician, so he is aware the standing order was implemented. The DON verified supplemental oxygen was expected to be incorporated into the respiratory care plan, and tubing should be changed and dated at least weekly and as needed. Resident #27 (R27) Review of MDS assessment dated [DATE], revealed admission to the facility on 2/24/22, with active diagnoses including COPD. R27 scored 15 out of 15 on the BIMS assessment reflective of intact cognition. During an observation on 9/3/25 at 12:53 p.m., R27 had an oxygen concentrator next to his bed and an (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen tank on his wheelchair. The oxygen tubing on the wheelchair was not marked. The oxygen tubing on the concentrator had a date of 8/12/25. During an interview on 9/3/25 at 12:55 p.m., R27 revealed he was unaware of when the oxygen tubing was last changed. During an observation on 9/4/25 at 10:02 a.m., the oxygen tubing for R27 was wrapped around the right wheel of the wheelchair, under the wheelchair, and R27 was sitting on the oxygen tubing and nasal cannula. During an interview on 9/4/25 at 10:04 a.m., Registered Nurse (RN) A reported the oxygen tubing was not properly stored and the oxygen tubing was not dated. RN A reviewed the oxygen concentrator and acknowledged the oxygen tubing had a date of 8/12/25 and reported the oxygen tubing was supposed to be changed weekly. Review of doctor's orders with a start date of 8/18/25 revealed the oxygen tubing was to be changed weekly on Mondays on night shift. Review of doctor's orders dated 8/9/25, read in part Oxygen sats (O2 sats) check two times daily or as needed. Place resident on 2-4 Liters(L) if O2 saturation is less than 90. Place O2 on resident when sleeping or napping as his O2 saturations decrease when he sleeps. Review of O2 sats revealed that O2 sats were not obtained on 8/10/25, 8/11/25, 8/12/25, 8/13/25, 8/15/25, 8/16/25, 8/17/25, 8/19/25, 8/21/25, and 8/23/25 through 9/4/25. Review of R27's care plan revealed no interventions for monitoring oxygen saturation (O2 sats), changing oxygen tubing, or proper storage of oxygen tubing. During an interview on 9/5/25 at 8:43 a.m., the DON acknowledged there were no interventions in the care plan regarding changing oxygen tubing, monitoring oxygen saturation, or proper storage of oxygen tubing. Review of policy titled Oxygen Administration last reviewed/revised 7/18/25, read in part .oxygen is administered under orders of a physician.the residents care plan shall identify the interventions for oxygen therapy based upon the resident's assessment and orders, such as but not limited to: A. the type of oxygen delivery system. B. when to administer, such as continuous or intermittent and/or when to discontinue. C. equipment setting or the prescribed flow rates. D. monitoring of SpO2 (oxygen saturation levels and/or vital signs as ordered.staff shall.change oxygen tubing and mask/cannula weekly and as needed and.keep delivery devices (oxygen tubing) covered in a plastic bag when not in use.

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	235144	A. Building B. Wing	09/10/2025

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview, and record review, the facility failed to ensure physician assessments and visit progress notes, including review of the program of care and resident condition, were available in the medical record of one Resident (#25) of 15 residents reviewed for physician visits. This deficient practice resulted in potential delinquent execution of care, unmet care needs, and lack of coordination of care. Findings include:Resident #25 (R25) was admitted to the facility 12/9/21. Review of the electronic medical record (EMR) disclosed a primary diagnosis of acute embolism and thrombosis of the deep veins of the left lower extremity. During an interview with Registered Nurse (RN) I on 9/10/25 at 11:05 AM, RN I said she contacted the physician of R25 on 7/16/25 to report medication errors that occurred with R25 for eight consecutive days, from 7/8/25 through 7/15/25. When RN I was asked if the physician assessed R25 after the medication errors were reported, RN I said, I don't know.The EMR of R25 was reviewed on 9/10/25. The most recent physician documentation available in the EMR was dated 12/27/24. On 9/10/25 at 2:01 PM, the Director of Nursing (DON) was asked if the physician had assessed or visited R25 in the year 2025. The DON said he had been in the facility and assessed R25 but could not recall the last visit. The DON was asked where the physician assessments and documentation were located. The DON said the physician documents would be in progress notes or in documents in the EMR. The surveyor and DON reviewed the EMR or R25. No physician visit notes or documentation for R25 was in the EMR since December of 2024. The DON said the physician should document findings at each visit and the documentation should be in the EMR.On 9/10/25 at 2:11 PM, The Administrator (NHA) asserted the physician had visited R25 since December 2024. The NHA was asked if the EMR contained documentation by the physician of the physician's assessment of the resident and the resident's current medical regimen and needs since 12/27/24. The NHA confirmed there was no documentation in the EMR indicating the physician had assessed R25 since 12/27/2024.The policy Physician Visits and Physician Delegation dated as revised 6/12/24 read, in part: .The licensed Nurse should: . f. Remind the physician to date and sign all orders and write a progress note. The physician should: . b. resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by a physician. c. Review the resident's total program of care including medications and treatments at each visit. D. Date, write and sign a progress note for each visit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure physician visits were completed timely for two Residents (#7 & #8) of 15 sampled residents reviewed for physician visits. This deficient practice resulted in extended time frames between physician visits and the potential for unaddressed medical needs.Findings include:Resident #7 (R7)Review of R7's admission Record, retrieved 9/9/25 at 12:56 p.m., revealed R7 was admitted to the facility on [DATE] with a primary admitting diagnosis of generalized anxiety disorder. R7 was their own responsible party for decision making.Review of Physician Visit Progress Notes, retrieved on 9/9/25 at 2:01 p.m., revealed R7 had the following physician visits completed by Physician L following R7's admission to the facility:1. 10/21/24 - initial Physician Visit completed, documented as a late entry on 10/24/24. Completed by Physician L.2. 11/19/24 - second Physician Visit was documented by Physician L.3. 1/28/25 - third Physician Visit was documented as a late entry on 2/2/25, greater than 60 days from the previous physician visit. Resident #8 (R8)Review of R8's admission Record, retrieved Resident R8 was admitted to the facility on [DATE] with diagnoses that included the following, in part: pulmonary embolism, pneumonia, and unspecified dementia. R8 had a guardian in place for decision making.Review of R8's Physician Visit Progress Notes revealed physician/practitioner visits were completed as follows. 6/24/25 - first documented physician visit completed by Physician L nearly two months following R8's admission to the facility. 8/26/25 - second Nurse Practitioner (NP) visit completed by NP M More than two months from the previous physician visit. 9/9/25 - third NP visit completed by NP M. On 9/10/2025 at 11:20 a.m., an interview was completed with the Nursing Home Administrator (NHA) and Director of Nursing (DON) regarding the untimely physician/practitioner visits completed for R7 and R8. Upon review of the Physician Visit Progress Notes and R7's and R8's complete medical record, both the NHA and DON acknowledged physician visit documentation present in both R7's and R8's medical record revealed physician visits were not completed at 30-day intervals for the first 90 days following admission. The NHA and DON acknowledged difficulty with completion of timely physician visits by Physician L. Review of all facility residents, by the NHA, revealed Physician L was the primary physician for only Residents R7 and R8 residing in the facility.Review of the Physician Visits and Physician Delegation policy, revised 7/18/25, revealed the following, in part: Policy: It is the policy of this facility to ensure the physician takes an active role in supervising the care of residents . The Physician should . b. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by State Law . d. Date, write and sign a progress note for each visit . h. At the option of the physician, required visits in SNFs (Skilled Nursing Facilities), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist . 3. The Director of Nursing or Designee should: a. Conduct monthly audits for timeliness of physician visits. b. Contact the physician regarding an overdue physician's visit. Record the physician's response regarding the overdue visit in the nurse's notes. c. Notify the Medical Director of the need to make a visit, for the attending physician, if he/she is unable to visit. 4. The Medical Director should: a. Visit residents who are not seen by their attending physician or alternate physician according to schedule. B. Document a progress note and orders for care as needed. c. Notify the attending physician and family of the results of the visit.

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	235144	A. Building B. Wing	09/10/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent administration of unnecessary medications for one Resident (#10) of five residents reviewed for unnecessary medication.Findings include:This citation is related to complaint intake #2605430Resident #10 (R10)On 8/29/25 at 8:00 AM, an anonymous complaint was reported to the State Agency (SA), stating R10 was given the wrong medication from a facility nurse. Resident #23's (R23's) blood pressure medication was given to R10 who already had low blood pressure and the complainant was concerned for R10. The anonymous complainant stated that there was no documentation of the incident in R10's electronic medical record.Review of R10's progress note, dated 8/28/25 at 7:41 AM, read in part Resident vitals are 140/73 (blood pressure) - 56 (heart rate).Resident was given the wrong medication on previous shift.Review of R10's progress note, dated 8/28/25 at 2:47 PM, read Vital (sic) were checked from watch od med (medication) error. On 9/5/25 at 9:20 AM, an interview was conducted with Registered Nurse (RN) W who was the on-call manager at the time of the medication error incident. RN W was asked if she was made aware of the medication error at the time it had occurred and replied, No, I did not find out about it until the next day when I came to work. RN W was then asked if the nurse who made the medication error had filled out an incident and accident report or called the doctor and replied, You would have to ask the Director of Nursing (DON). I am not sure what happened. The nurse who made the medication error would be responsible for that. On 9/5/25 at 9:50 AM, an interview was conducted with the DON who was asked about the medication error made on R10 and replied, The nurse was disciplined. There is a medication discrepancy report. I will get the report for you.Review of R10's medication discrepancy report, dated 8/26/25, revealed R10 received an incorrect medication identified as Lopressor (a beta blocker used to treat hypertension, angina, and or heart failure) 25 milligrams (mg). The description of the error read, Preparing medications with 2 cups side by side per hs (nighttime) meds (medications) [R10's name] and [R23's name]. By mistake put his (R23's) metoprolol in her (R10's) cup. Did not realize until she (R10) had them in her mouth as I (RN A) was pouring them in. To (sic) late to take out of mouth. She (R10) swallowed them.Review of R10's blood pressure, dated 8/26/25 through 8/28/25, revealed the lack of any blood pressures recorded on 8/26/25 or 8/27/25.Review of R10's heart rate, dated 8/26/25 through 8/28/25, revealed the lack of any recorded heart rate on 8/26/25 or 8/27/25. Review of R10's face sheet, dated printed 9/9/25, revealed an admission to the facility on 4/1/25, with medical diagnoses of Alzheimer's disease, insomnia, essential tremor, muscle weakness, and cognitive communication deficit. R10's husband as her durable power of attorney (DPOA)/emergency contact. R10 lacked a diagnosis of high blood pressure, heart failure, or angina. Review of R10's minimum date set (MDS), dated [DATE], revealed a brief mental interview for status (BIMS) score of 4 out of 10 indicating sever cognitive impairment. On 9/5/25 at 9:30 AM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked if nurses were allowed to set up more than one resident medication at the same time and replied, No, it is best practice to only set up one residents medication at a time to reduce any medication errors. The NHA was asked if R10's vital signs should have been recorded directly into R10's electronic medical record and replied, Yes, the nurse should have been documenting in the chart that the doctor was called and making notes on how she (R10) was doing related to making the medication error. On 9/5/25 at 9:50 AM, an interview was conducted with the DON who was asked if R10's husband was contacted or if an incident and accident report was filled out and replied, No, she did not think so. No incident and accident report were provided to the Surveyor and R10's electronic medical record lacked any documentation that R10's husband was made aware of the medication error. Review of policy titled, Medication Administration, dated 7/18/25, read in part, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte Street L' Anse, MI 49946

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines.3. Identify resident by photo in the MAR (medication administration record) .10. Review MAR to identify medication to be administered.11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.20. Correct any discrepancies and report to nurse manager.Review of policy titled, Incidents and Accidents, dated 7/18/25, read in part Policy: It is the policy of this facility for staff to utilize Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident.Policy Explanation: The purpose of incident reporting can include.Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences.Compliance Guidelines.5. The following incidents/accidents require an incident/accident report but are not limited to.medication or treatment errors.8. The supervisor or other designee will be notified of the incident/accident.11. The resident's family or representative will be notified of the incident/accident and any orders obtained.12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information.

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	235144	A. Building B. Wing	09/10/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to Intake 2565663Based on interview and record review, the facility failed to ensure one Resident (R25) of one resident reviewed for significant medication errors received medications at the frequency ordered by the physician. This deficient practice resulted in inaccurate medication dosages and the potential for subtherapeutic drug levels, blood clot formation, and cerebrovascular accident (CVA - stroke). Findings include: Intake 2565663 alleged Resident #25 (R25) was administered Xeljanz (a medication for rheumatoid arthritis - a chronic, inflammatory disease of the joints that may damage other parts of the body including the lungs, heart, and blood vessels) instead of Eliquis (a blood-thinning medication used to treat or prevent blood clots) during the month of [DATE]. The intake alleged the facility was aware of the error but had not implemented interventions to minimize the risk of recurrence of the medication errors.The electronic medical record (EMR) of R25 was reviewed on [DATE]. The physician's orders included an order dated [DATE] that read: Eliquis Tablet 5 MG [milligrams] Give 5 mg by mouth two times a day for prevention related to ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF LEFT LOWER EXTREMITY (I82.402); UNSPECIFIED ATRIAL FIBRILLATION [an irregular and rapid heart rhythm that can lead to blood clots in the heart, stroke, and heart failure] (I48.91). The Eliquis was scheduled to be administered each morning and each evening.The physician's orders for R25 included an order dated [DATE] that read: Xeljanz XR Tablet Extended Release 24 Hour 11 MG (Tofacitinib Citrate ER) Give 1 tablet by mouth in the morning related to RHEUMATOID ARTHRITIS, UNSPECIFIED.On [DATE] at 10:51 AM, Licensed Practical Nurse (LPN) Q confirmed the medication errors occurred and asserted she was the nurse who identified the errors. LPN Q said the evening shift nurses were administering Xeljanz XR instead of Eliquis and said the medication errors with these medications had occurred with R25 more than once across several doses. LPN Q was asked if she reported the errors. LPN Q said the first time the error was identified she verbally reported it to the Director of Nursing (DON), and the second time the errors occurred she texted the DON.LPN Q said she could not recall the date she initially became aware of the first medication error with the Eliquis and Xeljanz for R25 but said, It was within the past couple of months. LPN Q said R25 was prescribed Eliquis twice daily (once in the morning and once in the evening) and Xeljanz once daily (in the morning). LPN Q, who works the day shift, asserted she initially recognized the error when she repeatedly ran out of the supply of R25's Xeljanz but had an overabundant the supply of Eliquis in the medication cart. LPN Q said after the first time the errors were identified she began dating the individual tablet blisters of Xeljanz and Eliquis with the date to be administered. LPN Q said she also placed sticky-notes on the blister packs of Xeljanz that read NOT ELIQUIS to alert the evening shift nurses to the difference between the medications. LPN Q asserted the errors in the medication administrations recurred a few weeks later despite the medications being labeled. LPN Q said she independently made the decision to place the dates and sticky-notes on the medications. LPN Q surmised the errors occurred because the evening shift nurses were not looking at the medication label on the blister packs and were instead erroneously mistaking the Xeljanz for Eliquis because the medications had a similar color, shape, and appearance.LPN Q said the second time the medication administration errors occurred she realized the errors were made over a period of eight days - from [DATE] through [DATE]. LPN Q said she knew the error dates because she dated the medications in the blister packs and the dates did not match up. She said there continued to be additional availability of Eliquis in the blister packs with the dates [DATE] - [DATE] but a diminishing supply of Xeljanz. LPN Q said she was frustrated because the medication error recurred. LPN Q provided a text message she sent to the DON. The text was dated [DATE] at 7:53 AM. The text message read: They have been giving Xeljanz in steady [sic] of liquid [Eliquis] in the evening since [DATE]. Again. The text message included a photograph of the blister packs. LPN Q clarified that liquid in the text (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	message was meant to be Eliquis and said the DON knew the medication to which LPN Q was referring because the error kept repeating with the same medications being given to the same resident, R25. LPN Q said she was unaware if anything was done in response to the recurring medication errors. She said she did not contact the physician. She said she was unaware if labs were obtained or if any increased monitoring was completed because of the medication errors. Registered Nurse (RN) I was interviewed on [DATE] at 11:05 AM. RN I confirmed she was the nurse manager. RN I was queried regarding knowledge of medication errors that occurred with R25. RN I said she was aware of concerns with the evening shift nurses administering Xeljanz instead of Eliquis. When asked how she became aware of the medication errors, RN I said, The first time it happened it was brought up in our morning meeting. She said she was unable to recall who brought it up in the meeting or if any interventions were discussed to mitigate recurrence of the medication administration errors. RN I said the second time she found out the medication errors recurred was on [DATE] when she was told by LPN Q when RN I arrived to work at the facility. RN I said there was also a text thread the morning of [DATE] among the DON, RN I, and two nurses who no longer were employed at the facility. RN I said, The text said the medication error was continuing and ongoing since [DATE]. RN I said when she got the text, she contacted the physician, and the physician asked what was going to be done to prevent recurrence of the medication administration errors. RN I said she told the physician the facility was looking into it. RN I said the physician did not provide any amended or additional orders. RN I said she and the Administrator (NHA) discussed contacting the consultant pharmacist but said she did not know if the pharmacist was ever notified. RN I confirmed nothing was documented in the EMR of R25 regarding the medication errors. RN I said an incident report should have been completed but said she never saw an incident report on the errors in medication administration of Xeljanz and Eliquis for R25. RN I said she was unaware if any follow-up or educational endeavors had been completed with the nurses involved in the errors. RN I said she did not know if an investigation had been completed to determine the cause of the error, the nurses who were involved, or what impact the errors may have had on R25. RN I was asked if R25 was monitored for potential ill-effects because of the error. RN I replied, Not to my knowledge. RN I reiterated she did not have knowledge of any further actions or follow-up with nurses on the evening shift who were involved in the medication errors. RN I said she was unaware of any monitoring or audits resulting from the medication administration errors. The EMR of R25 did not document medication errors with Eliquis and Xeljanz XR. There was no mention of a medication error in the progress notes or assessments of R25. The [DATE] Medication Administration Record (MAR) did not reflect errors with the administration of Eliquis or Xeljanz XR. The MAR indicated the medications were administered as prescribed. The most recent physician documentation in the EMR was [DATE].The facility's consultant pharmacist (RPh) was interviewed on [DATE] at 9:26 AM. When asked if the facility notified him of medication errors with Xeljanz and Eliquis administrations for R25, the pharmacist said he was never made aware of medication errors with R25. The DON was interviewed on [DATE] at 11:54 AM. The DON confirmed being made aware the evening nurses were administering Xeljanz instead of Eliquis to R25. The DON acknowledged she received a text from LPN Q about the ongoing medication administration errors. The DON said she could not recall the date of the text because she deleted the text. The DON was asked if a medication error report or incident report was filled out or if an investigation had been completed into the medication error or if any efforts were implemented to minimize the risk of the medication error occurrences. The DON said she thought a nurse who was no longer employed by the facility completed an incident report and investigated the medication errors. The DON was asked for contact information for the nurse, but the contact information for the nurse was not provided by the end of the survey.When asked if the medication error should have been documented in the EMR of R25, the DON replied, Absolutely. When asked why the EMR of R25 did not include follow-up documentation and interventions to prevent the risk of recurrence, the DON said, I couldn't tell you. The DON said all evening shift nurses were involved in medication errors with the Eliquis and Xeljanz for R25. The DON (continued on next page)

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	235144	A. Building B. Wing	09/10/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the nurses received medication administration education and competency observations after the error was identified on [DATE]. The competencies and education were requested.Review of all provided nurse competencies for medication administration revealed only two medication administration competencies were completed after [DATE] - one for a nurse who was no longer employed at the facility and one for a nurse who worked the day shift. No medication competencies were completed for the nurses who work the evening shift.The DON indicated the facility utilized an online educational forum for continuing education for the nurses and said the nurses may have completed medication administration training through the online education venue after the medication errors were reported on [DATE]. A report for medication administration education via the online platform was requested. The report revealed no nurses were provided with education through the online training venue after the medication errors were identified.The July MAR was reviewed to determine the night nurses who administered Xeljanz, but documented Eliquis as administered from [DATE] - [DATE]. Four different nurses signed out the medication as administered. A handout was provided by the DON along with a document containing nurse signatures and the signatures of Certified Nurse Aides (CNA). The DON said the document with signatures reflected receipt of the education. The handout included a one-page document titled Medication Administration. The document contained bullet points indicating there were 6 Rights of Medication Administration. One bullet point read: Right Medication - Does the blister pack/bottle match the MAR. The signature page was reviewed and revealed three of the four nurses involved in the medication error did not sign or date indicating three of the four nurses did not receive the education.R25 was admitted to the facility [DATE] with a primary diagnosis of acute embolism (blood clot that lodges in a blood vessel and obstructs blood flow) and thrombosis (blood clot) of the deep veins of the left lower extremity. Additional diagnoses included but were not limited to rheumatoid arthritis, atrial fibrillation, and atherosclerotic heart disease (ASHD).According to https://www.xeljanz.com/ra: .Blood clots in the lungs (pulmonary embolism, PE), veins of the legs (deep vein thrombosis, DVT), and arteries (arterial thrombosis) have happened more often in people who are [AGE] years of age and older and with at least 1 heart disease (cardiovascular) risk factor taking XELJANZ 5 mg twice daily or XELJANZ 10 mg twice daily. Blood clots in the lungs have also happened in people with ulcerative colitis. Some people have died from these blood clots www.eliquis.bmscustomerconnect.com states the following, in part: . Take ELIQUIS exactly as prescribed by your healthcare provider. Take ELIQUIS twice every day, and do not change your dose. Eliquis lowers your chance of having a stroke by helping to prevent clots from forming. If you stop taking ELIQUIS, you may have an increased risk of a clot forming in your blood.The undated policy Medication Errors read, in part: .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors.The facility shall ensure medications will be administered as follows: a. According to physician's orders. B. Per manufacturer's specifications regarding the preparation and administration of the drug. 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition.b. Monitor and document the resident's condition.c. Document actions taken in the medical record.the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report.