STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Manor LLC	640 Third Street Gaylord, MN 55334

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to protect 1 of 2 residents (R1), who did not have the capacity to consent from inappropriate touching from an assisted living resident (AL-R) who was visiting. This resulted in an immediate jeopardy (IJ) when R1 was inappropriately touched repeatedly over the course of approximately 38 minutes without intervention by staff. The IJ began on 11/21/25, when staff members suspected AL-R of inappropriate touching and did not remove and/or intervene to stop the touching which resulted in AL-R repeatedly inappropriately touching of R1's thighs and in-between her legs by AL-R. The Administrator, director of nursing (DON), resident service coordinator, and regional director of operations (via phone) were notified of the past non-compliance (PNC) IJ on 12/5/25 at 1:50 p.m. The facility immediately implemented and began corrective action on 11/22/25, with ongoing education and the deficient practice was corrected, 11/22/25 prior to the start of the survey and was therefore issued as a PNC IJ. Findings include R1's face sheet dated 12/4/25, identified diagnoses of Parkinson's with dyskinesia (involuntary erratic movements), and dementia (affects cognitive ability including language and problem solving). R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and never/rarely made decisions, sometimes had the ability to understand others and make needs known, used a wheelchair and was dependent on staff to move locations, dependent on staff for dressing, incontinent of bowel, bladder, required hygiene assistance with toileting, and assistance with eating. R1's care plan dated 7/10/25, identified R1 was a vulnerable adult and at risk for decreased cognitive and physical abilities with a goal to remain free from abuse or neglect. Corresponding interventions included (but not limited to) directed staff to follow vulnerable adult and abuse reporting policy. The care plan also included a risk for alteration in cognition related to adjustment of placement with interventions that included allow R1 time to communicate his/her needs/wants, document changes in orientation, provide and maintain consistent environment, provide cues, reorientation, supervision as needed. The communication care pan informed staff R1 was very soft spoken with interventions that directed staff to face R1 when speaking and allow time to answer. The care plan also informed staff R1 required total assist with locomotion in Broda (specialized wheelchair for improved comfort and mobility) wheelchair, did not walk, assist of two staff with mechanical stand and step by step cues. Police incident report indicated the administrator reported an allegation of criminal sexual conduct on 11/22/25 at 8:28 a.m. for an incident that had occurred on 11/21/25 between alleged perpetrator (assisted living resident (AL-R)) and R1. The report identified the officer arrived at the facility on 11/22/25 at 8:58 a.m. and met with administrator and regional director of operations in which the following information was discussed/disclosed; R1 was not alert, orientated, and incapable of decision making. AL-R was believed to have slight mental/cognitive decline but still capable of decision-making. The administrator stated on 11/21/25 at 5:50 p.m., AP entered the facility and placed himself to the right of R1 who was positioned in front of the television. Between 5:57 p.m. and 6:38 p.m., facility surveillance system showed AP lifted up R1's skirt and made skin to skin contact to the area of R1's leg with his hand. At different points during this time period, AP removed his hand when he became aware of the presence of facility staff and would scan the area to see if staff were present, then return to placing his hand to the area of R1's leg. Exactly what other parts of R1's anatomy were touched by AP could not be determined. At 6:37 p.m., a facility staff member went to speak to R1 for unknown reasons. Following the staff members departure, AP resumed groping of R1. At 6:44 p.m., AP left the common area. Administrator noted AP had a reputation for making lewd comments to facility staff but no other issues since his arrival at facility in 2015. The administrator had informed law enforcement to ensure the safety of all residents, facility protocol was put in place wherein a qualified staff member would monitor AP at all times until 11/24/25, at which time the staff would reassess the situation and determine further steps, AP was banned from facility, and family notified of situation. The report also identified on 11/26/25, police officer returned to facility and met with Administrator. Video footage reviewed with Administrator and identified AP sitting next to R1. During the video: -AP would occasionally scan the surrounding. -AP would position his left hand on R1's arm rest and R1's right leg over her skirt. -AP would then lift up R1's skirt and start touching her right leg. -AP would then stop touching R1's leg and bring her skirt back down to cover her legs. -AP would then lift R1's skirt back up and touch her leg again. -AP would then reach higher on R1's leg touching her in the vaginal area. -AP would immediately move his hand away from R1's vaginal area when another resident was passing them. -As soon as the resident passed, AP