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	12/11/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 document review the facility failed to destroy expired over the counter medication (OTC) for 1 of 2 sampled medication rooms. In addition, the facility failed to ensure 1 of 1 resident's (R10) lorazepam (anti-anxiety medication) was immediately removed from 1 of 2 medication carts and not co-mingled and stored with in-use medications for other residents. Findings include: Observation and interview on 12/08/25 at 12:25 p.m., of 1 of 2 sampled medication rooms located across from the dining room with registered nurse (RN)-B, identified over the counter (OTC) medications and house stock medications that was both in bottles stored in multiple plastic bags and in blister packs. The medications were placed in a pile on the counter in the medication room. RN-B identified the nurse consultant from the local pharmacy had visited the facility last month for a routine visit. The consultant completed an audit of the medication carts and medication room and found expired medications that were placed in the medication room to be destroyed by the nursing staff. In addition, the facility implemented assigning an overnight nurse to complete medication destruction as a part of their duties, however, the nurse no longer worked at the facility. Day shift staff nurses were informed to complete medication destruction as a part of their duties, when available, however, the OTC medications remained in the medication room and had not been destroyed. Review of December 2025 Medication Destruction/Return log of the above identified medications waiting for destruction listed: 1) House stock loratadine (used to treat allergies) 10 milligrams (mg). The quantity total was 267 tablets.2) House stock of aspirin (pain reliver) 325 mg. The quantity total was 100 tablets. 3) House stock of Prostat liquid supplement (liquid protein used for wound healing) bottle. The quantity was 30 ounces.4) OTC vitamin B6 (multivitamin) 25 mg. The quantity total was 100 tablets. 5) OTC docusate (used to treat constipation) 100 mg. The quantity total was 68 tablets.6) OTC ibuprofen (pain reliver) 200 mg. The quantity total was 54 tablets.7) House stock of apple cider vinegar (used for weight loss, blood sugar regulation, and digestive health) 300 mg tablets. The quantity was 250 tablets.8) House stock of glucosamine and chondroitin (used to treat joint pain) 750/600 mg supplements. The quantity was 250 tablets.9) OTC guaifenesin (cold medicine used to help clear mucus) 400 mg. The quantity was 100 tablets. 10) OTC zinc (used to treat immune system and wound healing) 50 mg. The quantity was 100 tablets.11) OTC cetirizine (used to treat allergy medication) 10 mg. The quantity was 3 tablets.12) OTC magnesium oxide (used to treat indigestion, upset stomach, or constipation) 400mg. The quantity was 15 tablets. Review of undated continuous Non-Controlled Drug Destruction Inventory sheet for medication awaiting destruction identified: 1) OTC magnesium oxide (supplement used to treat migraines and constipation) 400mg. The quantity was 15 tablets.2) OTC melatonin (used to treat insomnia) 1 mg. The quantity was 16 tablets. Observation and interview on 12/08/25 at 12:40 p.m., with RN-B during a controlled narcotic count on the medication cart assigned to the Oak wing identified R10 had one blister pack containing lorazepam. Review of the pharmacy label on the lorazepam blister pack order was to give 0.5 milligram (mg) tablet once with an RX # 403171669 and an expiration date of 6/27/25. The narcotic (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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was found to be expired 164 days after the order was discontinued. Review of the Controlled Drug Receipt/Record/Disposition form for R10's lorazepam noted it had been received on 6/28/24. RN-B acknowledged R10's narcotic was discontinued and remained in the double locked medication cart, as directed until the medication was to be destroyed. RN-B stated R10 was admitted [DATE]. Review of June 2024, Medication Administration Record (MAR) identified R10 had taken 0.5 mg, 1 tablet as needed for anxiety 30 minutes prior to dental/vision/doctor appointments on 6/27/24 at 08:47 a.m. The order date was ordered on 1/25/24 and was discontinued on 5/07/25. R10's medication was not removed after the medication was discontinued and remained in the cart and remained co-mingled with in-use medications for other residents. Interview on 12/10/25 at 3:01 p.m., with RN-C, who is a nurse consultant for Polaris pharmacy identified, she had last visited the facility on 11/24/25 to complete her quarterly medication audits. During her visit to the facility, she would perform audits on the medication carts, medication rooms and observation of medication administrations. Once her audits were completed, she was to provide a copy of her audits to the director of nursing (DON) of her findings. She acknowledged it was not uncommon to find expired medications, however, the audits were completed to ensure the facility was aware of her findings. Review of RN-C's Polaris Rx Medication Unit Review sheet audit identified on: 1) 10/09/25, under Nurse Cart identified melatonin was expired on 11/2025 and loratadine was expired on 10/2025.2) 10/09/25, under Section D. Narcotic Records Review that R10 had expired lorazepam dated 6/27/25.3) 11//24/25, under additional comments identified aspirin 325 mg was expired on 8/2025 and 10/2025, vitamin B6 was expired on 5/2025, 8/2025, and 11/2025, stool softeners was expired on 9/2025 and magnesium oxide tablets was expired on 8/2025. Interview on 12/10/2025 at 4:24 p.m., with director of nursing (DON) identified the facility did not have a process in place for licensed nursing staff, including nurse managers to review on a routine basis and destroy medications when they are found to be expired or discontinued. Her expectation would be to revise and implement addition assignment for nurses working on the day shift to complete medication destruction, in a timely manner of expired or discontinued medications. Review of May 2022 Medication Destruction for Non-Controlled Medications policy identified the facility was to remove unused, unwanted and non-returnable medications to a secured storage area until destroyed. The licensed healthcare professional witnessing the destruction of medications on the medication disposition form must ensure the date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed, and signature of witnesses. Review of May 2022 Controlled Substance Disposal policy identified the facility's director of nursing, along with consultant pharmacist was responsible of the facility's compliance with Federal and State laws and regulations with handling of controlled medications. Controlled medications that was to remain in the facility after a resident has been discharged or the medication order was discontinued was disposed of in the facility by the administrator, director of nursing and/or consultant pharmacist, by returning to the Drug Enforcement Administration (DEA), or retained for destruction by an agent of the DEA, or send to the appropriate state agency or pharmacy as directed. When controlled medication was destroyed the facility, licensed staff as allowed by state law was to witness the destruction and ensure the information was recorded in the individual controlled substance accountability record/book.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to ensure staff followed sanitary guidelines on appropriate food handling during 1 of 1 meal service. This had the potential to affect all 29 residents who received meals served from the kitchen. Findings include: Observations on 12/9/25 of the noon meal service identified multiple incidents of potential cross contamination. At:12:00 a.m., Cook-A applied gloves and arranged serving utensils on top of the covered steam table pans. She removed the covers from the food items on the steam table and picked up a plate, picked up the individual menu choice slip and plated food items which were them placed on the tray to be delivered by dining room staff. 12:08 p.m., she picked up a menu slip, read it and placed it on the tray located on top of the steam table shield. Wearing her same gloves she went to the refrigerator, opened the door with her gloved hands, retrieved 1/2 an unwrapped sandwich with her same gloved hand and returned to the steam table where she placed the sandwich on the plate, and continued with serving the meal foods. Cook-A used a scoop to dish up chicken nuggets which she put on a plate, and using her same gloved hands, held the nuggets with her left gloved hand as she cut them into bite sized pieces with a knife, she picked up from the ledge area of the steam table. At 12:09 p.m. she used her right gloved hand and pushed up her glasses and returned to serving without any glove change or hand hygiene. Cook-A continued with serving as she picked up a breadstick with her same gloved hand and placed it on the plate with the cut-up chicken pieces. 12:11 p.m., she repeated the process of scooping chicken nuggets onto a plate and using her same gloved hand to hold and cut up the chicken. She repeated this process several times, with no glove change or hand hygiene. At 12:12 p.m. she again pushed up her glasses with her same gloved hands and continued to repeat the same process of serving. 12:16 p.m. cook-A again went to the refrigerator, opened the door with her same gloved hands, retrieved a tray containing dishes of pears and returned to the steam table where she placed the tray of pears to be included on the trays being served. Still no glove change or hand hygiene performed. Cook-A continued the same process of using her same gloved hands to hold and cut the chicken into bite size pieces as she prepared each plate of food. 12:18 p.m. cook-A picked up a small container of cranberry sauce she reported she had forgotten to place on a resident's tray and took it into the dining room where she placed it onto a resident's plate. She returned to the kitchen, picked up a dish of pears and returned to the dining room and placed it on a resident's tray. Cook-A returned to the kitchen, still no glove change or hand hygiene and resumed her process of picking up a plate, scooping and cutting up chicken nuggets and dishing other food items onto the plate, and delivered it to the dining room and placed on the table for a waiting resident. Upon return to the kitchen without changing her gloves or performing hand hygiene she resumed serving from the steam table. She repeated this process two more times without glove change or hand hygiene. 12:25 p.m. cook -A reported there were only 2 more residents needing to be served, and she proceeded to repeat her process of holding chicken with her gloved hand as she cut it up, picked up a breadstick and placed it onto the plate and placed the plate on the tray to be taken to the dining room. 12:30 p.m., she returned to the steam table, used a tong to pick up an un-breaded chicken breast from a container on the steam table, placed it on a plate and using her same gloved hands picked up a knife and used to left hand to hold the chicken as she cut it into bite sized pieces. Interview on 12/9/25 at 12:31 p.m. with cook-A reported this was her normal routine. She normally washed her hands before the meal service and applied gloves when she began serving a meal. She would use the same pair of gloves throughout the meal services without changing her gloves and performing hand hygiene. She confirmed did not usually change her gloves or perform hand hygiene during the serving process after completing specific tasks. When staff were busy, she assisted by delivering plates to residents in the dining room and was not aware of the potential of cross contamination from going out of the kitchen or using her same gloved hands to touch other items ant then food during the serving process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/9/25 at 12:35 p.m. with the certified dietary manager (CDM) identified he was not aware cook-A was not changing her gloves or performing hand hygiene when she touched potentially contaminated items such as the refrigerator door, or other items in the kitchen. Cook-A should not be leaving the steam table to deliver trays to residents and agreed she should have changed her gloves and performed hand hygiene before returning to resume serving food if she left the steam table to retrieve items from another area of the kitchen. He expected food service employees followed policies for safe food handling and hand hygiene practices. Review of the April 2019 Food Preparation and Service policy identified appropriate measures were to be utilized to prevent potential cross contamination. Food service staff were to ensure hand hygiene and infection control practices were followed to prevent the potential of food borne illness. The policy identified gloves were to be worn when handling food directly and changed between tasks. The policy failed to identify gloves should be changed and hand hygiene performed if the person serving handled other items or food and especially if the person serving left the kitchen and then returned to resume serving the meal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to have a current, ongoing system of surveillance for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that included facility staff. This had the ability to affect all 29 residents. Findings include: EMPLOYEE SURVEILLANCEReview of the current Staff listing with Title identified a total of 57 current facility staff: 1 administrator, 1 business office manager (BOM), 18 NA's, 9 DA's. 6 cooks (C), 1 DM, 1 director of nursing/infection preventionist (DON), 1 health information management staff (HIM), 1 licensed practical nurse (LPN), 1 LPN coordinator, 1 maintenance assistant, 1 maintenance director, 7 nurse aides in training, 2 registered nurses (RN),1 RN manager, 1 social worker (SW), 1 AA, and 1 AA director (AAD). Review of the employee surveillance data sheet for the past year, that the facility identified was used as the employee infection control (IC) tracker, labeled Staff Illnesses was used to capture employee illnesses or other reasons for absenteeism from work. The list captured only 22 of the current 57 facility staff and had 1 previous employee listed: 1 dietary manager (DM), 1 health information assistant (HIM), 12 nurse aides (NA) (including former staff member (NA-C)), 1 activity aide (AA-A), 4 unknown staff, and 1 dietary aide (DA).The form noted each staff member, the location they worked and absences numbered 1 through 8. Staff absences were noted on the form for dates and reason for the absence. The document was shared to all department heads, who were expected to fill out the form for their respective employees. The form had limited data. Sampled staff data that was captured was as follows:Activity Aid (AA)-A, was noted to be COVID positive and was absent from work on 2/13/25 through 2/19/25. No other data was captured. Nursing assistant (NA)-A who was noted to be absent from work on 1/2/25 and had body aches listed. NA-A was also listed as absent on 2/1/25, with nausea/vomiting. No other data was captured for the illnesses.NA-B was noted to have diarrhea and was absent from work on 12/27/25. No other data was captured for the illness. The Staff Illnesses log failed to include surveillance of all staff, identify critical data such as the date of symptom onset, the last date worked, the location or unit the staff had last worked, when symptoms had resolved, the date they were allowed to return to work, or what national standards the facility would use to determine appropriateness for the above staff to return to work. Interview on 12/9/25 at 9:27 a.m., with the dietary manager (DM) identified when staff call in and report illnesses, he would complete a form and list the employees name, department they worked in, and their symptoms. He then gave that form to an (unidentified) office person. He was unable to recall what staff he would give the form to. Interview on 12/9/25 at 9:40 a.m., with the licensed practical nurse (LPN)-A identified when staff call in for their shift and report illness, he would the staff ask about their symptoms. He would then report the staff illness call-in and symptoms to the scheduler, so the facility could attempt to cover the shift. He was aware staff should not return to work at least 24 after a fever has resolved or 72 hours after nausea, vomiting, or diarrhea resolved. LPN-A was unaware of any guidance or direction from management to advise an employee about when they could return to work. Interview on 12/9/25 at 10:03 a.m., with the administrator identified she was not aware of the form that the facility was using for staff illness and did not know who the dietary manager (DM) would be submitting his employee absence forms to. She expected supervisors of each department to use the staff log noted above to document staff illnesses and absences. In addition, she would expect the infection preventionist (IP) to incorporate staff illness reports into her infection control (IC) program for surveillance. She was not aware prior to the survey that the infection preventionist was not using that log for surveillance of staff illnesses. She noted staff were to follow the employee handbook for return-to-work guidance. Interview on 12/8/25 at 7:44 p.m., with the infection preventionist and the nurse consultant identified staff were to call in to their unit supervisor for absences. The call-in were to be logged onto the shared Staff Illness document mentioned above. She tried to look at it at least once a week. She does not monitor call ins from other departments as much as I should. The November 2024, Infection Prevention and Control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Program policy identified the facility would use surveillance tools for recognizing the occurrence of infections, monitoring employee infections, and detecting unusual pathogens with infection control implications. The information obtained from infection control surveillance activities will be reviewed month over month and compared with that from the facilities baseline and used to assess the effectiveness of established infection prevention and control practices. Standard criteria are used to distinguish community-acquired from facility acquired infections. Data gathered during surveillance was used to oversee infections and spot trends. The Facility was to have established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including situation when these individuals should report their infections or avoid the facility (for example, draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrheal stools). There was no mention of standards of practice that were to be used to determine the appropriate length of time employees should be prohibited from work or criteria to return to work, if all staff were captured, nor critical data required in order to comprehensively oversee surveillance. Review of the current, undated, Employee Handbook, page 55 provided identified staff who were out sick or on an extended leave must ensure adequate communication with their manager so an anticipated return to work date and/or time has been discussed. There was no mention of standards of practice that were to be used to determine the appropriate length of time employees should be prohibited from work or criteria to return to work.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, document review, the facility failed to ensure 1 of 1 resident (R27) was free from verbal abuse. Findings include: Review of the 12/1/25 at 9:14 a.m., report to the State Agency (SA) identified on 11/30/25 at around 5:00 p.m., NA-C was assisting to turn R27 with NA-D and NA-E when he placed his hand on NA-E's breast. NA-C responded by smacking R27's hand away and raised her voice at him. NA-D reported the incident to the charge nurse, who notified the director of nursing (DON) (identified had received the call at 4:36 p.m.). The DON instructed RN-D to have the NAs provide a written statement and place it under the DON's office door for review the next morning. Review of NA-C's 11/30/25, timecard identified she continued to work her assigned shift providing patient care until the end of her shift at 10:30 p.m. There was no indication the facility administrator was notified of the incident until 8:00 a.m. on 12/1/25. NA-C was later suspended on 12/1/25 following notification of the administrator and pending the investigation. Review of the 12/5/25, 5-day investigation results identified the facility staff interviewed multiple residents and staff and there were no additional allegations of mistreatment by NA-C. Both NA-D and NA-E who were present with NA-C during the incident on 11/30/25 confirmed she had raised her voice at R27. The facility confirmed verbal abuse took place, but due to conflicting staff statements and R27's inability to participate in the interview process, (due to his impaired cognition), physical abuse was not substantiated. Following completion of the investigation the facility terminated NA-C's employment following interview on 12/4/25 due to substantiated verbal abuse. R27's 12/8/25, Significant Change Minimum Data Set (MDS) assessment identified his cognition was moderately impaired. He required extensive assistance with activities of daily living (ADLS), required the assistance of 2 staff for transferring with a mechanical lift, and utilized a Broda type wheelchair (a specialized, ergonomic mobility device known for exceptional comfort, posture support and pressure relief), and was transported by staff. He had diagnoses of Dysarthria (a motor speech disorder that makes it hard to articulate works clearly), following a stroke, had cognitive communicative deficit, and mild cognitive impairment. R27's current, undated care plan identified alteration in communication due to cognitive communication deficit and cerebral infarction. R27 was identified to be a vulnerable adult, therefore at risk of abuse due to decreased cognition and physical abilities. Staff were to monitor him for emotional distress and mood and/or behavioral changes and follow facility abuse reporting policy. Interview on 12/9/25 at 4:55 p.m. with the DON reported RN-D phoned her on 11/30/25 at 4:35 p.m., to report the incident and stated the situation was chaotic and everyone was busy. She confirmed with staff R27 was not harmed, and then requested RN-D to have the involved staff write a statement and place it under her office door for review upon arrival the morning of 12/1/25. She reported she did not think of the incident as potential or actual abuse at that time. Upon arrival on 12/1/25, the DON reported she reviewed the written statements. At that time, she became aware of the allegation NA-C had smacked R27's hand and raised her voice. She then reported the incident to the administrator on 12/1/25 at 7:44 a.m The administrator had immediately informed her she should have been notified immediately on 11/30/25 and re-educated her on the steps for reporting an alleged abuse situation and protecting residents. It was confirmed NA-C had finished working her shift providing resident care, and no action was initiated until the following morning. The investigation was initiated with appropriate notifications completed, and interviews of residents and staff. The DON confirmed NA-C had been allowed to finish working her shift on 11/30/25 providing residents' their care and had not been suspended until following notification to the administrator on 12/1/25. Interview and timecard review on 12/09/25 at 3:04 p.m., with the administrator and regional director of operations (RDO) confirmed the incident occurred on 11/30/25 at 5:00 p.m The DON was phoned and updated, but the administrator was not notified until 12/1/25 a.m The employee involved continued to work providing residents' care for the remainder of her shift. She was not placed on suspension until 12/1/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following review of documentation by the DON and administrator. The report was filed to the SA on 12/1/25 at 9:14 a.m., (16 hours after the incident was reported). They both confirmed the alleged incident was abuse and should have been filed within 2 hours of notification of the incident, the administrator notified immediately, and any staff members suspected of potential or actual abuse were to be suspended immediately and not allowed to finish the remainder of their shift. Review of NA-C's timecard identified she was terminated related to the substantiated allegation of verbal abuse, effective 12/4/25. Review of NA-C's personnel file identified a final warning had been issued August 2, 2025, for misconduct regarding a Vulnerable Adult report. Following the substantiated verbal abuse allegation NA-C's employment was terminated on 12/4/25. Review of NA-C's timecard identified she had worked the remainder of her scheduled shift on 11/30/25, but no additional shifts were identified. Interview on 12/09/25 at 3:27 p.m. with NA-E confirmed the report that R27 reached out and placed his hand on the side of her breast. She responded by telling him that was inappropriate and pulled his hand away and placed it on his chest. She did not think he did it intentionally as he was afraid of falling and would attempt to grab or hold on to objects or people when being turned toward the edge of the bed. NA-E was focused on keeping R27 on the bed. She did report NA-C had spoken loudly to R27 as they were working with him. Interview on 12/9/25 at 3:37 p.m., with RN-B reported she was familiar with NA-C and there had been incidents of her attitude, which she defined as a negative acceptance of provided education. NA-C became defensive when coaching was provided. RN-B reported she was not aware of any additional complaints of mistreatment from residents or staff related to NA-C. RN-B confirmed she was aware of the policy for abuse. Interview on 12/10/25 at 3:54 p.m., with NA-C reported she had been assisting NA-E with R27, and NA-D was observing because she was training. As he was being changed, R27 reached over placed his hand on NA-E's breast. She reported NA-E was upset and told R27 not to do that. She intervened and reached over and tapped his hand. She stated she did not hit him hard and denied raising her voice. She did not know why she was being investigated for this incident and reiterated she had only tapped him on his hand and denied hitting or yelling at him. Attempts to contact RN-D were made on 12/9/25 at 3:30 p.m. and again 12/10/25 at 3:00 p.m. without success and unable to leave a voice mail requesting a return call. Attempts to contact NA-D were made on 12/9/25 at 3:35 p.m. and again on 12/10/25 at 4:30 p.m. without success and unable to leave a message requesting a return call. Review of the November 2025 Abuse Prohibition/Vulnerable Adult Policy identified staff were to notify the supervisor and facility administrator immediately and take necessary steps to protect residents from any possible subsequent incidents of misconduct. An incident that alleged staff to resident abuse directed the involved staff member was to be suspended until the investigation was completed, in addition to notification of corporate Human Resources. Abuse was defined as willful, meaning the individual acted deliberately, not necessarily intending to cause injury or harm the vulnerable adult. Suspected abuse was to be reported to the SA within 2 hours of being informed of the allegation of abuse. Review of the undated Monarch Abuse Prohibition/Vulnerable Adult Policy identified staff were to identify and intervene for any potential abuse situations. Staff were also responsible for reporting any situation that could be considered abuse according to facility policy and procedure. The supervisor was to be notified immediately upon becoming aware of an alleged incident to determine any actions necessary. If the incident was an alleged staff to resident occurrence the staff person was to be immediately suspended pending completion of the investigation in addition to notification of HR, the facility administrator was to be notified immediately for incidents of actual or alleged resident abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion. Suspected abuse was to be reported to the SA using the online reporting process not later than 2 hours after the notification of suspected abuse.

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	245473	A. Building B. Wing	12/11/2025

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

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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 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 document review the facility failed to ensure an as needed psychoactive medication Lorazepam (antianxiety medication) was not used beyond 14 days without a rationale for continued use and an identified review date for 2 of 5 sampled residents (R2 and R11) reviewed for unnecessary medications.Findings include: R2's 11/28/25, date accepted comprehensive Minimum Data Set (MDS) assessment identified R2's cognition was moderately impaired. R2 had no behaviors, and he required partial assistance for cares. R2 took an antidepressant, diuretic, opioid, anticonvulsant, and insulin daily and was on hospice. R2's 12/10/25, medical diagnosis list identified chronic kidney disease with heart failure, diabetes, localized edema (swelling), major depressive disorder, history of a heart attack, and a history of alcohol abuse in remission. R2's 11/11/25, hospice orders and care plan identified he was admitted to hospice services on 11/11/25 for chronic kidney disease with heart failure, cancer of the kidney, end stage heart failure with high doses of diuretic (fluid medication) to manage edema. Medication changes within last 2 weeks had included scheduled Tylenol with all other current medication meeting the residents' symptom needs. There was no mention of anxiety. The care plan identified R2 was alert, withdrawn, with a flat affect. R2's 11/11/25, hospice standing orders identified for symptoms of anxiety: lorazepam oral/sublingual 0.5 milligrams (mg) every 4 hours as needed (PRN) for anxiety. If not effective, staff may increase to 1 mg. and required a provider prescription. R2's November 2025, medication administration record (MAR) identified an order for lorazepam oral tablet 0.5 mg give 1 tablet by mouth every 4 hours PRN for anxiety/nausea/vomiting/insomnia. Start with 1 tablet by mouth or under the tongue every 4 hours. If 1 tablet is not effective, increase dose to 2 tablets (1mg) start date of 11/11/25. The order had no identified end date. Interview on 12/9/25 at 10:04 a.m., with registered nurse (RN)-A the facility consultant nurse identified that a facility nurse had entered the lorazepam PRN order from the hospice standing orders upon admission to hospice. She confirmed there was no end date on the lorazepam PRN order. Anti-anxiety PRN orders had 14 days unless the provider documented a rationale with an identified review date even if it was a hospice order. Interview on 12/10/25 at 11:17 a.m., with the consulting pharmacist identified she would expect that all psychoactive PRN medications to have an end date identified. She reported an anti-anxiety PRN order, could be extended beyond 14 days only if the provider documented a rationale and an identified review date. She revealed that the order had been placed following her last visit so she would not have been aware of the order until her visit to the facility today. Review of the May 2025, Psychotropic Medication Use policy identified psychotropic PRN orders would be limited to 14 days unless the provider documented a rationale to extend the medication beyond 14 days. Anti-psychotic PRN orders would be limited to 14 days and could not be renewed unless the provider evaluated the resident for appropriateness of the medication. All psychotropic medication would be reviewed during care conferences, target behavior meetings and by the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist during their review. R11's 10/14//25, Significant Change MDS assessment identified severe cognitive impairment, she needed staff assistance for activities of daily living (ADLS) and used a wheelchair for mobility. R11 received daily medications for anxiety, depression, an antibiotic, opioid for pain, an anticonvulsant, and antipsychotics and was receiving hospice services. She had diagnosis of Parkinson's Disease with dsyskinesia (involuntary and uncontrollable movements), dementia with behaviors, anxiety, and major depressive disorder. R11's 10/14/25, Care Area Assessment (CAA) was triggered for Behavioral symptoms for refusal of cares. R11's had orders for quetiapine for dementia, lorazepam for restless, and mirtazapine for depression. R11's 10/3/25, hospice standing orders identified for symptoms of anxiety: lorazepam oral/sublingual 0.5 milligrams (mg) every (Q) 4 hours as needed (PRN) for anxiety. If not effective may increase to 1 mg and required provider prescription. R11's November 2025, Medication Administration Record (MAR) identified an order for lorazepam oral tablet 0.5 mg give 1 tablet by mouth BID for restlessness beginning 11/21/25. The order had no identified end date. A second order for Lorazepam 0.5 mg, 1 tablet PO Q2H PRN for anxiousness, restlessness, and nausea. If ineffective, staff may increase dose to 1 mg (2 tablets). Indication feeling anxious or restless with a start date of 11/21/25 and no identified end date. R11's 11/19/25, hospice orders and care plan identified she was admitted to hospice services 10/6/25, with a terminal diagnosis of Parkinson's disease with dyskinesia (involuntary movements) with fluctuations, loss of weight, frequent falls, dementia, sepsis (life-threatening infection) due to an unspecified organism, and chronic pain syndrome. There were no medication changes in the last 2 weeks. R11's current Medication Administration Record (MAR) listed orders for lorazepam 0.5 milligrams (mg) by mouth (PO) twice daily (BID) for restlessness started 11/14/25. Staff may give 0.5 mg PO every (Q) 2 hours(H) as needed (PRN) anxiousness, restlessness beginning 11/14/25. There was no end date identified for reassessment of the need to continue the lorazepam. R11's current, undated care plan identified she was at risk for alteration in her psychosocial well-being due to adjustment to placement, Parkinson's with dyskinesia, and sleep disorder. The care plan identified staff were to administer medications as ordered, but there was no indication of the for 14-day reassessment for continued use of Lorazepam. Interview on 12/9/25 at 10:04 a.m., with registered nurse (RN)-A, the facility consultant nurse identified that a facility nurse had entered the lorazepam PRN order from the hospice standing orders upon admission to hospice. She confirmed there was no end date on the lorazepam PRN order. Anti-anxiety PRN orders were limited to 14 days unless the provider documented a rationale, even if it was a hospice order. Interview on 12/10/25 at 11:17 a.m., with the consulting pharmacist identified she would expect that all psychoactive PRN medications to have an end date identified. She reported an anti-anxiety PRN order, could be extended beyond 14 days only if the provider documented a rationale and an identified a new review date. She revealed the order had been placed following her last visit, so she would not have been aware of the order until her visit to the facility today. Review of the May 2025, Psychotropic Medication Use policy identified psychotropic PRN orders would be limited to 14 days (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unless the provider documented a rationale to extend the medication beyond 14 days. Anti-psychotic PRN orders would be limited to 14 days and could not be renewed unless the provider evaluated the resident for appropriateness of the medication. All psychotropic medication would be reviewed during care conferences, target behavior meetings and by the pharmacist during their review.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to ensure safety for 1 of 4 sampled residents (R27) by suspending 1 of 1 nursing assistant (NA)-C, following an allegation of abuse. Findings include: Review of the 12/1/25 at 9:14 a.m., report to the State Agency (SA) identified on 11/30/25 at around 5:00 p.m., NA-C was assisting to turn R27 with NA-D and NA-E when he placed his hand on NA-E's breast. NA-C responded by smacking R27's hand away and raised her voice at him. NA-D reported the incident to the charge nurse, who notified the director of nursing (DON) (identified had received the call at 4:36 p.m.). The DON instructed RN-D to have the NAs provide a written statement and place it under the DON's office door for review the next morning. Review of NA-C's 11/30/25, timecard identified she continued to work her assigned shift providing patient care until the end of her shift at 10:30 p.m. There was no indication the facility administrator was notified of the incident until 8:00 a.m. on 12/1/25. NA-C was later suspended on 12/1/25 following notification of the administrator and pending the investigation. Review of the 12/5/25, 5-day investigation results identified the facility staff interviewed multiple residents and staff and there were no additional allegations of mistreatment by NA-C. Both NA-D and NA-E who were present with NA-C during the incident on 11/30/25 confirmed she had raised her voice at R27. The facility confirmed verbal abuse took place, but due to conflicting staff statements and R27's inability to participate in the interview process, (due to his impaired cognition), physical abuse was not substantiated. Following completion of the investigation the facility terminated NA-C's employment following interview on 12/4/25 due to substantiated verbal abuse. R27's 12/8/25, Significant Change Minimum Data Set (MDS) assessment identified his cognition was moderately impaired. He required extensive assistance with activities of daily living (ADLS), required the assistance of 2 staff for transferring with a mechanical lift, and utilized a Broda type wheelchair (a specialized, ergonomic mobility device known for exceptional comfort, posture support and pressure relief), and was transported by staff. He had diagnoses of Dysarthria (a motor speech disorder that makes it hard to articulate works clearly), following a stroke, had cognitive communicative deficit, and mild cognitive impairment. R27's current, undated care plan identified alteration in communication due to cognitive communication deficit and cerebral infarction. R27 was identified to be a vulnerable adult, therefore at risk of abuse due to decreased cognition and physical abilities. Staff were to monitor him for emotional distress and mood and/or behavioral changes and follow facility abuse reporting policy. Interview on 12/9/25 at 4:55 p.m. with the DON reported RN-D phoned her on 11/30/25 at 4:35 p.m., to report the incident and stated the situation was chaotic and everyone was busy. She confirmed with staff R27 was not harmed, and then requested RN-D to have the involved staff write a statement and place it under her office door for review upon arrival the morning of 12/1/25. She reported she did not think of the incident as potential or actual abuse at that time. Upon arrival on 12/1/25, the DON reported she reviewed the written statements. At that time, she became aware of the allegation NA-C had smacked R27's hand and raised her voice. She then reported the incident to the administrator on 12/1/25 at 7:44 a.m The administrator had immediately informed her she should have been notified immediately on 11/30/25 and re-educated her on the steps for reporting an alleged abuse situation and protecting residents. It was confirmed NA-C had finished working her shift providing resident care, and no action was initiated until the following morning. The investigation was initiated with appropriate notifications completed, and interviews of residents and staff. The DON confirmed NA-C had been allowed to finish working her shift on 11/30/25 providing residents' their care and had not been suspended until following notification to the administrator on 12/1/25. Interview and timecard review on 12/09/25 at 3:04 p.m., with the administrator and regional director of operations (RDO) confirmed the incident occurred on 11/30/25 at 5:00 p.m The DON was phoned and updated, but the administrator was not notified until 12/1/25 a.m The employee involved continued to work providing residents' care for the remainder of her shift. She was not placed on suspension until 12/1/25 following review of (continued on next page)

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	245473	A. Building B. Wing	12/11/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation by the DON and administrator. The report was filed to the SA on 12/1/25 at 9:14 a.m., (16 hours after the incident was reported). They both confirmed the alleged incident was abuse and should have been filed within 2 hours of notification of the incident, the administrator notified immediately, and any staff members suspected of potential or actual abuse were to be suspended immediately and not allowed to finish the remainder of their shift. Review of NA-C's timecard identified she was terminated related to the substantiated allegation of verbal abuse, effective 12/4/25. Review of NA-C's personnel file identified a final warning had been issued August 2, 2025, for misconduct regarding a Vulnerable Adult report. Following the substantiated verbal abuse allegation NA-C's employment was terminated on 12/4/25. Review of NA-C's timecard identified she had worked the remainder of her scheduled shift on 11/30/25, but no additional shifts were identified. Interview on 12/09/25 at 3:27 p.m. with NA-E confirmed the report that R27 reached out and placed his hand on the side of her breast. She responded by telling him that was inappropriate and pulled his hand away and placed it on his chest. She did not think he did it intentionally as he was afraid of falling and would attempt to grab or hold on to objects or people when being turned toward the edge of the bed. NA-E was focused on keeping R27 on the bed. She did report NA-C had spoken loudly to R27 as they were working with him. Interview on 12/9/25 at 3:37 p.m., with RN-B reported she was familiar with NA-C and there had been incidents of her attitude, which she defined as a negative acceptance of provided education. NA-C became defensive when coaching was provided. RN-B reported she was not aware of any additional complaints of mistreatment from residents or staff related to NA-C. RN-B confirmed she was aware of the policy for abuse. Interview on 12/10/25 at 3:54 p.m., with NA-C reported she had been assisting NA-E with R27, and NA-D was observing because she was training. As he was being changed, R27 reached over placed his hand on NA-E's breast. She reported NA-E was upset and told R27 not to do that. She intervened and reached over and tapped his hand. She stated she did not hit him hard and denied raising her voice. She did not know why she was being investigated for this incident and reiterated she had only tapped him on his hand and denied hitting or yelling at him. Attempts to contact RN-D were made on 12/9/25 at 3:30 p.m. and again 12/10/25 at 3:00 p.m. without success and unable to leave a voice mail requesting a return call. Attempts to contact NA-D were made on 12/9/25 at 3:35 p.m. and again on 12/10/25 at 4:30 p.m. without success and unable to leave a message requesting a return call. Review of the November 2025 Abuse Prohibition/Vulnerable Adult Policy identified staff were to notify the supervisor and facility administrator immediately and take necessary steps to protect residents from any possible subsequent incidents of misconduct. An incident that alleged staff to resident abuse directed the involved staff member was to be suspended until the investigation was completed, in addition to notification of corporate Human Resources. Abuse was defined as willful, meaning the individual acted deliberately, not necessarily intending to cause injury or harm the vulnerable adult. Suspected abuse was to be reported to the SA within 2 hours of being informed of the allegation of abuse. Review of the undated Monarch Abuse Prohibition/Vulnerable Adult Policy identified staff were to identify and intervene for any potential abuse situations. Staff were also responsible for reporting any situation that could be considered abuse according to facility policy and procedure. The supervisor was to be notified immediately upon becoming aware of an alleged incident to determine any actions necessary. If the incident was an alleged staff to resident occurrence the staff person was to be immediately suspended pending completion of the investigation in addition to notification of HR, the facility administrator was to be notified immediately for incidents of actual or alleged resident abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion. Suspected abuse was to be reported to the SA using the online reporting process not later than 2 hours after the notification of suspected abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review, the facility failed to ensure the administrator and State Agency (SA) were notified within 2 hours of an allegation of physical and verbal abuse for 1 of 1 resident (R27). Findings include: Review of the 12/1/25 at 9:14 a.m., report to the State Agency (SA) identified on 11/30/25 at around 5:00 p.m., NA-C was assisting to turn R27 with NA-D and NA-E when he placed his hand on NA-E's breast. NA-C responded by smacking R27's hand away and raised her voice at him. NA-D reported the incident to the charge nurse, who notified the director of nursing (DON) (identified had received the call at 4:36 p.m.). The DON instructed RN-D to have the NAs provide a written statement and place it under the DON's office door for review the next morning. Review of NA-C's 11/30/25, timecard identified she continued to work her assigned shift providing patient care until the end of her shift at 10:30 p.m. There was no indication the facility administrator was notified of the incident until 8:00 a.m. on 12/1/25. NA-C was later suspended on 12/1/25 following notification of the administrator and pending the investigation. Review of the 12/5/25, 5-day investigation results identified the facility staff interviewed multiple residents and staff and there were no additional allegations of mistreatment by NA-C. Both NA-D and NA-E who were present with NA-C during the incident on 11/30/25 confirmed she had raised her voice at R27. The facility confirmed verbal abuse took place, but due to conflicting staff statements and R27's inability to participate in the interview process, (due to his impaired cognition), physical abuse was not substantiated. Following completion of the investigation the facility terminated NA-C's employment following interview on 12/4/25 due to substantiated verbal abuse. R27's 12/8/25, Significant Change Minimum Data Set (MDS) assessment identified his cognition was moderately impaired. He required extensive assistance with activities of daily living (ADLS), required the assistance of 2 staff for transferring with a mechanical lift, and utilized a Broda type wheelchair (a specialized, ergonomic mobility device known for exceptional comfort, posture support and pressure relief), and was transported by staff. He had diagnoses of Dysarthria (a motor speech disorder that makes it hard to articulate works clearly), following a stroke, had cognitive communicative deficit, and mild cognitive impairment. R27's current, undated care plan identified alteration in communication due to cognitive communication deficit and cerebral infarction. R27 was identified to be a vulnerable adult, therefore at risk of abuse due to decreased cognition and physical abilities. Staff were to monitor him for emotional distress and mood and/or behavioral changes and follow facility abuse reporting policy. Interview on 12/9/25 at 4:55 p.m. with the DON reported RN-D phoned her on 11/30/25 at 4:35 p.m., to report the incident and stated the situation was chaotic and everyone was busy. She confirmed with staff R27 was not harmed, and then requested RN-D to have the involved staff write a statement and place it under her office door for review upon arrival the morning of 12/1/25. She reported she did not think of the incident as potential or actual abuse at that time. Upon arrival on 12/1/25, the DON reported she reviewed the written statements. At that time, she became aware of the allegation NA-C had smacked R27's hand and raised her voice. She then reported the incident to the administrator on 12/1/25 at 7:44 a.m The administrator had immediately informed her she should have been notified immediately on 11/30/25 and re-educated her on the steps for reporting an alleged abuse situation and protecting residents. It was confirmed NA-C had finished working her shift providing resident care, and no action was initiated until the following morning. The investigation was initiated with appropriate notifications completed, and interviews of residents and staff. The DON confirmed NA-C had been allowed to finish working her shift on 11/30/25 providing residents' their care and had not been suspended until following notification to the administrator on 12/1/25. Interview and timecard review on 12/09/25 at 3:04 p.m., with the administrator and regional director of operations (RDO) confirmed the incident occurred on 11/30/25 at 5:00 p.m The DON was phoned and updated, but the administrator was not notified until 12/1/25 a.m The employee involved continued to work providing (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' care for the remainder of her shift. She was not placed on suspension until 12/1/25 following review of documentation by the DON and administrator. The report was filed to the SA on 12/1/25 at 9:14 a.m., (16 hours after the incident was reported). They both confirmed the alleged incident was abuse and should have been filed within 2 hours of notification of the incident, the administrator notified immediately, and any staff members suspected of potential or actual abuse were to be suspended immediately and not allowed to finish the remainder of their shift. Review of NA-C's timecard identified she was terminated related to the substantiated allegation of verbal abuse, effective 12/4/25. Review of NA-C's personnel file identified a final warning had been issued August 2, 2025, for misconduct regarding a Vulnerable Adult report. Following the substantiated verbal abuse allegation NA-C's employment was terminated on 12/4/25. Review of NA-C's timecard identified she had worked the remainder of her scheduled shift on 11/30/25, but no additional shifts were identified. Interview on 12/09/25 at 3:27 p.m. with NA-E confirmed the report that R27 reached out and placed his hand on the side of her breast. She responded by telling him that was inappropriate and pulled his hand away and placed it on his chest. She did not think he did it intentionally as he was afraid of falling and would attempt to grab or hold on to objects or people when being turned toward the edge of the bed. NA-E was focused on keeping R27 on the bed. She did report NA-C had spoken loudly to R27 as they were working with him. Interview on 12/9/25 at 3:37 p.m., with RN-B reported she was familiar with NA-C and there had been incidents of her attitude, which she defined as a negative acceptance of provided education. NA-C became defensive when coaching was provided. RN-B reported she was not aware of any additional complaints of mistreatment from residents or staff related to NA-C. RN-B confirmed she was aware of the policy for abuse. Interview on 12/10/25 at 3:54 p.m., with NA-C reported she had been assisting NA-E with R27, and NA-D was observing because she was training. As he was being changed, R27 reached over placed his hand on NA-E's breast. She reported NA-E was upset and told R27 not to do that. She intervened and reached over and tapped his hand. She stated she did not hit him hard and denied raising her voice. She did not know why she was being investigated for this incident and reiterated she had only tapped him on his hand and denied hitting or yelling at him. Attempts to contact RN-D were made on 12/9/25 at 3:30 p.m. and again 12/10/25 at 3:00 p.m. without success and unable to leave a voice mail requesting a return call. Attempts to contact NA-D were made on 12/9/25 at 3:35 p.m. and again on 12/10/25 at 4:30 p.m. without success and unable to leave a message requesting a return call. Review of the November 2025 Abuse Prohibition/Vulnerable Adult Policy identified staff were to notify the supervisor and facility administrator immediately and take necessary steps to protect residents from any possible subsequent incidents of misconduct. An incident that alleged staff to resident abuse directed the involved staff member was to be suspended until the investigation was completed, in addition to notification of corporate Human Resources. Abuse was defined as willful, meaning the individual acted deliberately, not necessarily intending to cause injury or harm the vulnerable adult. Suspected abuse was to be reported to the SA within 2 hours of being informed of the allegation of abuse. Review of the undated Monarch Abuse Prohibition/Vulnerable Adult Policy identified staff were to identify and intervene for any potential abuse situations. Staff were also responsible for reporting any situation that could be considered abuse according to facility policy and procedure. The supervisor was to be notified immediately upon becoming aware of an alleged incident to determine any actions necessary. If the incident was an alleged staff to resident occurrence the staff person was to be immediately suspended pending completion of the investigation in addition to notification of HR, the facility administrator was to be notified immediately for incidents of actual or alleged resident abuse, injury of unknown origin, neglect, financial exploitation, or involuntary seclusion. Suspected abuse was to be reported to the SA using the online reporting process not later than 2 hours after the notification of suspected abuse.