Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 23, 2025

Administrator
Bayside Manor LLC

640 THIRD STREET
GAYLORD, MN 55334

RE: CCN: 245473
Cycle Start Date: December 5, 2025

Dear Administrator:

On December 5, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On November 22, 2025, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide

to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bayside Manor LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 5, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Manor LLC	640 THIRD STREET , GAYLORD, Minnesota, 55334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 12/3/25, 12/4/25, and 12/5/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H54738604C (2676270) and a deficiency was issued at F600 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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	F0600	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0600 SS = SQC-J	Continued from page 1 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 10/14/25, 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	F0600		

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F0600 SS = SQC-J	Continued from page 2 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 began touching R1's vaginal area. -While AP was touching R1's vaginal area, AP would constantly look around. Clips of video surveillance recordings of the incident were provided on 12/4/25 and reviewed. The recorded footage was consistent with law enforcements report. Administrator explained the entire recordings was not available because the video system deleted	F0600		

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F0600 SS = SQC-J	Continued from page 3 after seven days. R1's progress note dated 11/22/25 at 10:54 a.m., identified call placed to hospice and medical doctor to update on status of R1. At 11:27 a.m., social service director (SS)-D met with R1 and watched the birds. R1 appeared calm and at baseline with no anxiety or distress noted. R1's weekly skin inspection dated 11/22/25, identified R1 had no skin issues. R1's physician rounding note dated 11/25/25, identified R1 was seen following an incident on where "another resident (AL-R) from the Assisted Living facility was at the facility and observed on camera footage reaching into R1's pubic area and touching her. The incident was unwitnessed by staff but captured on camera footage. The alleged perpetrator admitted to the act when questioned by police." R1 did not appear distressed during the incident. R1 is unable to participate in a trauma assessment due to her current inability to answer questions. Staff are monitoring for behavioral changes or signs of distress. The facility investigation dated 11/25/25, identified staff observed AL-R acting unusually, watching staff closely and remaining near a resident he is not typically around. Staff also noted R1's skirt appeared bunched up on more than one occasion, which was concerning as she is unable to adjust her knee-length skirt independently due to her weakness. Staff did not witness any specific incident, as reflected in their statements, but discussed the situation felt abnormal. RN informed of these concerns. Administrator initiated an investigation and was able to substantiate that unwanted physical contact had occurred. AL-R admitted during an interview to engaging in unwanted physical contact with R1. During an observation on 12/3/25 at 3:52 p.m., R1 was in a Broda wheelchair, with family member (FM)-A sitting beside her, looking at the bird aviary. During an observation on 12/4/25 at 10:31 a.m., R1 was at an activity, she was wearing a skirt. At 2:46 p.m., FM-A sat next to R1 in front of the bird aviary, family member (FM)-A had a cellphone and was sharing the screen between them with a video and music playing. During an interview on 12/4/25 at 2:50 p.m., FM-A stated R1 wears a skirt because of their religious beliefs and specifically from a passage from Deuteronomy 22:5 where it stated that a woman should not wear men's clothing. R1 was a very chaste and pure woman. Even in her younger years if someone asked her to have intercourse, she would have said no. R1 would have "kicked the guy in the mouth or hollered or done something." FM-A did not think R1 even realized what was happening when it was going on. FM-A wondered if the incident was recorded on tape for 40 minutes, "why was no one at the facility more eyes open on it?" During a phone interview on 12/4/25 at 10:47 a.m., trained medication assistant (TMA)-A stated she was not	F0600		

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F0600 SS = SQC-J	Continued from page 4 sure how often AL-R came to facility, but he would act “normal” when he came over to sit and watch television with all the residents. AL-R did not normally sit by R1. TMA-A stated on 11/21/25, the whole living room was full watching television, and staff needed to have an eye kept on them. During a follow-up phone interview on 12/4/25 at 2:11 p.m., TMA-A reiterated that someone needed to be watching the residents, and they should not be left alone. TMA-A told nursing assistant (NA)-A to keep an eye on R1 and AL-R because they were sitting there, and she had never seen AL-R talk to R1. TMA-A was unsure if R1 could make her own decisions and if it was her involved in the situation, where AL-R put his hand on her thigh, she would not like it all. TMA-A ended the call with “what does it matter what I think?, I saw nothing, I know nothing.” During a phone interview on 12/4/25 at 11:36 a.m., NA-A stated AL-R came to the facility daily. On 11/21/25, TMA-A asked NA-A to sit and watch AL-R because she thought she noticed AP touching R1. NA-A then went to the common area where R1 an AL-R were sitting and found R1’s skirt pulled up above her knees, so she pulled it down. NA-A then went back to nurses’ station, every few seconds she would look up from her work to see R1’s skirt up above her knees again and AL-R’s hand would move away from R1, however, she never saw AL-R move R1’s skirt up or touch her. NA-A explained when she wasn’t looking, she felt like AL-R was watching her. At no point did NA-A move AL-R away from R1 or tell him to leave R1 alone because she “did not know how to handle a situation like that.” NA-A told TMA-A that “what [TMA-A] thought happened, did happen”, and they told RN-A. After the incident, NA-A asked family member (FM)-A if R1 ever wore pants. FM-A told NA-A no, it was a religious belief; women always wore skirts and men always wore pants or suits. During a follow-up interview on 12/4/25 at 1:43 p.m., nursing assistant (NA)-A further explained when she thought AL-R was watching her, she thought but was unsure if AL-R was watching her to see if she was watching him, however him watching was what caught her attention and made her feel uneasy. NA-A had to walk over to R1 three times because she had noticed R1’s skirt up. The most she saw was AL-R's hand on the handle of R1’s wheelchair. AL-R left about five minutes after NA-A pulled her skirt down for the third time. NA-A was irritated that the situation went on for 45 minutes. NA-A was not sure if AL-R was pulling up R1’s skirt but indicated she suspected he was moving R1’s skirt up because of how he was looking around. NA-A reiterated she did not know what to do or how to handle the situation and was fearful of AL-R's reaction if she moved R1 away from him. R1 would not be able to say no or get away in a situation like what happened; she is unable to get her	F0600		

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F0600 SS = SQC-J	Continued from page 5 hands to the wheels of her wheelchair and staff must move her. During an interview on 12/3/25 at 3:41 p.m., registered nurse (RN)-A stated AL-R comes to facility, walks the corridors, and will sit in the common television area and have conversations with staff and residents and leave. RN-A did not witness the incident on 11/21/25 but overheard NA-A and TMA-A talking about it around 11:00 p.m. on 11/21/25, when they were finished with their shift. RN-A was unsure why he did not notify Administrator or director of nursing (DON) immediately. On 11/22/25 at 6:00 a.m., RN-A returned for a shift at facility and remembered the incident from the evening prior, so she notified the Administrator and DON. R1 was a very quiet resident; RN-A never thought R1 would be able to have a conversation with AL-R because she did not have capacity to engage or start a conversation with anyone. R1 would sometimes have appropriate answers to questions but sometimes would give “off the wall” responses. RN-A was provided education which included the two-hour timeframe for reporting suspected abuse. During a phone interview on 12/4/25 at 9:27 a.m., AL-R stated he was at facility to visit a female resident that used to live by him. R1 was sitting out in the area and stated her leg hurt. AL-R called to staff, and they did not listen, so AL-R went to R1 and rubbed her leg. AL-R stated he was just trying to be kind. During an interview on 12/4/25 at 11:02 a.m., regional nurse consultant (RNC)-A stated R1 did not have a mood/behavior, or psychological assessment after the incident because R1 was severely cognitively impaired and would not be able to have the back-and-forth discussion or answer questions appropriately. During an interview on 12/5/25 at 11:33 a.m., social worker (SW)-A stated she came to the facility on 11/22/25 and sat with R1 by the bird aviary. R1 did not appear or act any different than she would on any other day, conversation veered away from topic. SW-A was at facility until 5:00 p.m. and would occasionally check on R1 during that time. SW-A interviewed residents and included education on who they should report to if they have any concerns. SW-A did not discuss what staff should have done in the situation. During an interview on 12/5/25 at 9:26 a.m., DON, clinical manager (CM)-A, and licensed practical nurse (LPN)-B were present. When they became aware of the incident on 11/22/25, a skin check was completed on R1, staff checked all residents to ensure they felt safe at the facility, AL-R had not had unwanted contact with them and immediately began staff education on abuse and neglect. It was the expectation staff would ensure the safety of the resident immediately by removing them from the	F0600		

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F0600 SS = SQC-J	Continued from page 6 situation and immediately report. During an interview on 12/5/25 at 9:04 a.m., Administrator stated she found out about the incident on 11/22/25 at 7:34 a.m. Administrator immediately banned AL-R from the facility and put AL-R on 1:1 supervision at his adjoining facility. Administrator initiated education on abuse and abuse prevention with staff that included a verbal quiz. Administrator conducts quarterly drills with staff, in which a resident participated to time how long an accusation of abuse would take to reach her. During an interview on 12/5/25 at 11:27 a.m., Administrator, resident service coordinator (RSC)-A, and director of nursing (DON) were interviewed together. DON, and RSC-A did not watch the video of the incident, and Administrator stated she watched the video twice, including once with the police officer. Administrator and DON stated NA-A was a reliable witness and cares for all the residents. Administrator indicated AL-R historically made lewd comments to staff a lot but comments were “nothing crazy, comments that you hear typically in a nursing home, like dirty jokes. "None of them had heard him make comments in front of residents. The facility Abuse Prohibition/Vulnerable Adult policy dated 11/2025, identified the purpose was to protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. To promptly report, document and investigate all incidents of alleged or suspected abuse/neglect, to identify and remedy any potentially abusive situations…instances of abuse, irrespective of any mental or physical condition. It includes verbal, sexual, physical and mental abuse. The PNC IJ that began on 11/21/25, was removed on 11/22/25, when it was verified, the facility implemented the following: Education began on 11/22/25 and was completed on 12/3/25, for all staff and covered the topics of: -definitions and types of abuse -staff responsibilities for prevention and reporting -mandatory reporting timelines and procedures -internal facility reporting process -resident rights and protections -zero-tolerance policy and disciplinary actions -AP banned from facility 11/22/25 -assessment of R1 for injury and mental anguish as able	F0600		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 23, 2025

Administrator
Bayside Manor LLC
640 THIRD STREET
GAYLORD, MN 55334

Re: Event ID: 1DD3C1-H1

Dear Administrator:

The above facility survey was completed on December 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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Bayside Manor LLC	**640 THIRD STREET , GAYLORD, Minnesota, 55334**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/3/25, 12/4/25, and 12/5/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H54738604C (2676270). No orders were issued. Minnesota Department of Health is documenting the State	20000		

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Manor LLC	**640 THIRD STREET , GAYLORD, Minnesota, 55334**

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20000	Continued from page 1 Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		