Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54738762M
Compliance #: H54738604C

Date Concluded: June 1, 2026

Name, Address, and County of Licensee Investigated:
Bayside Manor LLC
640 Third Street
Gaylord, MN 55334
Sibley County

Facility Type: Nursing Home

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the residents when the facility failed to supervise them when resident-2 touched resident-1 under her skirt.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility ensured the residents were supervised at the time of the incident. Resident-1 and resident-2 were in a common area with multiple staff and residents in the area. Resident-2 watched staff and when staff turned around he touched resident-1's upper thigh area under her skirt. Facility staff provided closer observation after they noticed resident-2 watching staff and resident-1's skirt hiked above her knees. Staff reported they never saw resident-2 sexually touch resident-1 but reported his unusual behavior to management. Facility management reviewed surveillance video and observed resident-2 touching resident-1 under her skirt. Resident-2 did not have a history of sexually inappropriate behaviors prior to the incident. The facility implemented interventions to keep the residents safe immediately.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident-1's family member. The investigation included review of resident-1 and resident-2's medical records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

Resident-1 resided in a nursing home. Resident-1's diagnoses included dementia, Parkinson's disease, and depression. Resident-1's service plan included assistance with medication management, bathing, grooming, mobility (wheelchair), and incontinence care with brief changes. Resident-1 had difficulty communicating due to Parkinson's disease and cognition. Resident-1 was unable to complete trauma and cognitive assessments due to advanced cognitive impairment. Resident-1 was not oriented to person, place, or time. She also received hospice services.

Resident-2 resided in an assisted living facility that connected to the nursing home. Resident-2's diagnoses included Alzheimer's dementia with behavioral disturbances and hallucinations, depression, and heart failure. Resident-2's service plan included assistance with safety checks, medication management, bathing, meals, and housekeeping. Resident-2 had no history of inappropriate sexual behaviors prior to the incident.

The internal investigation indicated while resident-2 was visiting the nursing home area, he was acting unusual. Resident-2 was watchful of staff while sitting next to resident-1 in the common area. Unlicensed personnel (ULP)-2 noticed resident-1's skirt was bunched up. ULP-2 pulled resident-1's skirt down below her knees but noticed it hiked up again a few minutes later. Resident-1 was unable to adjust her skirt independently due to weakness. ULP-2 pulled resident-1's skirt down again. While working at a computer nearby, ULP-2 noticed resident-2 watching her. ULP-2 approached the residents again and observed resident-1's skirt bunched up on her lap. ULP-2 pulled resident-1's skirt down to cover her knees and resident-2 left the area. Facility staff denied they witnessed resident-2 touching resident-1. Resident-2's unusual behavior was reported to a member of management who investigated the allegation. The member of management determined unwanted physical contact had occurred. The incident was reported to the police. Resident-2 was restricted from the nursing home area, and a one-to-one staff was assigned to supervise resident-2. Resident-1 was assessed, and no skin injuries or psychological concerns were noted.

The surveillance video showed resident-1 and resident-2 sitting next to each other with several other residents sitting nearby. The residents were seated in a common area and appeared to be facing a television. Throughout the video, multiple staff members were observed in the common area. At one point, five staff members were observed working in the area. Resident-2 watched staff closely. When staff turned or were not looking, resident-2 reached his hand under resident-1's skirt and rubbed her upper thigh area multiple times. It was unclear if resident-2 touched resident-1's genital area as her skirt was covering resident-2's hand. A staff

member was observed adjusting resident-1's skirt and heard visiting with the residents. Resident-2 left the area shortly after that.

A provider's note indicated another resident was observed on video surveillance touching resident-1's pubic area. The incident was unwitnessed by staff. Resident-2 was questioned by law enforcement and "admitted to the act." In the surveillance video, resident-1 did not appear distressed during the incident. Resident-1 was unable to participate in a trauma assessment, but staff continued to monitor for emotional distress and changes in mood.

Resident-1's skin assessments completed before and after the incident indicated no changes were noted to resident-1's skin.

Resident-2's care plan was updated with more frequent observations and one to one supervision while in the nursing home area during group activities.

A facility schedule from the date and time of the incident indicated six nursing staff were working during the incident. Additional kitchen staff were also present in the area during the incident. They were observed on surveillance footage cleaning the dining room located just behind where the residents were seated. Staff were trained on vulnerable adult maltreatment before the incident occurred.

A law enforcement report indicated a surveillance video was reviewed. Resident-2 was observed watching staff's movement. When staff were not observing the residents, resident-2 lifted resident-1's skirt and made "skin to skin contact" with resident-1's leg. Resident-2 continued to rub resident-1's leg and vaginal area. At the time of the incident, staff were observed in the area, approached resident-1 and spoke to her. It was noted that resident-1 wore an incontinence brief. Resident-2 was interviewed and admitted to touching resident-1's leg but denied he touched her vaginal area.

During an interview, a family member said a resident from a different area of the facility (resident-2) ran his hand up and down resident-1's leg. He said resident-2 "went up as far as her vagina" but the police never charged resident-2 with a crime. Resident-1 was unable to report what happened during the incident, but surveillance cameras recorded the incident. The family member said the facility reported the incident to him and did not watch the surveillance video.

During an interview, nurse-2 said he overheard ULP-1 and ULP-2 discussing concerns about resident-2's behavior. They thought resident-2 was acting suspicious while sitting next to resident-1. He said he reported their concerns to the on-call nurse. Management investigated the incident. He said he received training on vulnerable adult maltreatment. He said staff were present in the area during the incident.

During an interview, nurse-1 (a member of management) said nurse-2 called and reported the allegation. Nurse-1 completed the internal investigation. She said resident-1 lived in the nursing

home area and resident-2 resided in the assisted living area. After the incident, resident-2 was no longer allowed in the nursing home area unless a staff member was present with him. Resident-2 did not have a history of inappropriate sexual behaviors.

During an interview, a member of management said nurse-2 reported resident-2 exhibited suspicious behavior while sitting next to resident-1. The member of management reviewed a surveillance video and observed resident-2 sitting next to resident-1 in a common area facing the television. Several other residents and staff were in the common area throughout the video. Resident-2 was observed touching resident-1's upper thigh area under her dress multiple times. Resident-2 watched staff closely and moved his hand away from resident-1 when staff looked at him. Resident-2 had no history of inappropriate sexual behaviors. She said assisted living residents were often in the nursing home area for shared group activities. Resident-2 visited the nursing home area for activities. After this incident, resident-1 was assessed, and no skin changes or psychological concerns were noted. Immediately after the incident, a staff member was assigned to resident-2 for continuous supervision, and he was not allowed in the nursing home area. The incident was reported to the police. The police did not file charges against resident-2.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided re-education to all staff. The facility increased resident-1's level of supervision and restricted resident-2 from contacting resident-1.

Action taken by the Minnesota Department of Health:

MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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
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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54738762M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the	20000		

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

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20000	Continued from page 1 electronic documents.	20000		