STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	1601 St Louis Avenue Duluth, MN 55802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40945 Based on observation, interview, and document review, the facility failed to ensure residents were free from mental and emotional abuse for 4 of 4 residents (R1, R2, R3, R4) when nursing assistant (NA)-A took humiliating photographs of residents and video recordings of residents which NA-A then posted on Snapchat (social media). In addition, the facility failed to ensure residents were free from physical abuse when NA-A physically abused R1 when assisting R1 into bed. NA-A also video taped this abuse and posted on Snapchat. These actions had the potential to cause serious psychosocial and physical harm to residents. This deficient practice resulted in an immediate jeopardy (IJ). The IJ began on 6/17/24, when the Minnesota Department of Health received an allegation that NA-A shared numerous pictures and videos on social media of R1, R2, R3 and R4. The pictures contained exposed resident private areas, residents in underwear, lewd gestures from NA-A to residents, and videos of NA-A abusing a resident. The administrator and director of nursing (DON) were informed of the IJ on 6/24/24, at 5:32 p.m. The IJ was removed on 6/26/24, at 4:11 p.m. but non-compliance remained at the lower scope and severity, of a level 2 at an E-pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 6/24/24, at 10:25 a.m. during an interview reporter (R)-A stated she had been sent pictures and videos of various residents currently at the facility by NA-A. R-A stated NA-A had been taking and sending pictures for months, however the images and videos seemed to be getting worse in nature. R-A stated she had called the facility administrator sometime between Thanksgiving 2023 and Christmas 2023 and informed him that NA-A was taking pictures of residents and posting them on Snapchat. R-A stated the facility administrator told her that if NA-A was taking photos he would be aware due to the fact that there were cameras in the facility. NA-A stated she had told the administrator that she had proof of this however he did not request to see the photos. R-A stated the photos and videos NA-A had been taking and posting on social media seemed to be getting worse. R-A stated she had both video and photos that she would send to the state agency (SA). R-A stated NA-A had been taking video and photos for approximately 12 months and the last time NA-A had posted residents on social media was a week ago. On 6/24/24, at 12:24 p.m. the SA received both video and photos sent by R-A. The photos and videos were reviewed and revealed the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	1601 St Louis Avenue Duluth, MN 55802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/24/24, at 12:34 p.m. review of an undated video which lasted approximately 29 seconds revealed the following. Nursing assistant (NA)-A is seen setting up a camera to record her interaction with R1. NA-A is seen aggressively throwing R1 into bed. NA-A is then seen removing R1's shoes and throwing them on top of R1's bare chest and hitting him in the face with one of the shoes. R1 is heard mumbling what sounds like ouch. NA-A proceeds to give R1 the middle finger. On 6/24/24, review of photographs revealed a picture taken by a cell phone by an unidentified staff giving R1 the middle finger while R1 was seated in his wheel chair. On 6/24/24, review of photographs revealed a picture taken by a cell phone with R2 lying in her bed holding a cell phone with a picture of a penis with the caption Not XXX (included the name of the resident) showing me the dick pick she gets. On 6/24/24, review of photographs taken by a cell phone revealed R3 lying on his back in his bed with only his underwear on. On 6/24/24, review of photographs taken by a cell phone revealed a picture of R4 lying in her bed on her left side with no clothing on. R4's bare back, buttocks, wound dressing on sacral region and female genitalia exposed along with what appears to be Kleenex with BM. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included cerebral palsy, congenital deformities of the hip, and mental disorder. R1's MDS indicated R1's cognition was moderately impaired. R1's care plan dated 8/23/23, indicated R1 had a self-care deficit related to weakness and required assistance with activities of daily living (ADLs) and requires extensive assist by staff to turn and reposition in bed and assist with feeding and meal set up. R1's care plan also indicated R1 had a risk and a potential for abuse due to physical impairments, communication impairments and cognitive impairments. R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had diagnosis which included history of stroke, immobility and depressive disorder. R2's MDS indicated R2 was alert and orientated. R2's care plan dated 5/23/23, indicated R2 required extensive assist with ADLs such as transferring, repositioning, and dressing. R2's care plan also indicated a potential communication problem and difficulty communicating her needs related to slurring of speech. R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had diagnosis which included psychological development and anxiety disorder. R3's MDS indicated R3 cognition was moderately impaired. R3's MDS also indicated lacks insight, is impulsive and misinterprets information. R3's care plan dated 5/29/24, indicated R3 uses antidepressants related to medication, anxiety and depression. R3's care plan also indicated R3's behaviors included restlessness, extreme fixation on events to the point of emotional distress, inappropriate boundaries. R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 had diagnosis which included morbid obesity, right below the knee amputation and pressure ulcer of the sacral region. R4's MDS indicated R4 was alert and orientated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	1601 St Louis Avenue Duluth, MN 55802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R4's care plan dated 5/15/23, indicated R4 required extensive assist with ADLs such as transferring, repositioning, and dressing. R4's care plan indicated R4 has a history of misconstrued relationships with staff as being more than professional without the knowledge of the caregiver. Resident may attempt to have inappropriate caregiver relationships by using social media to contact or get information about caregiver. R4 will maintain a professional only relationship with caregiver and staff will provide education to resident as needed regarding appropriate and inappropriate relationship with caregivers. On 6/24/24, at 1:05 p.m. NA-A was shown video and interviewed: -NA-A was shown the video of a female staff setting up a camera to record her interaction with R1. NA-A verified the staff in the video was herself. NA-A verified she aggressively threw R1 into bed. NA-A verified she removed R1's shoes and throwing them on top of R1's bare chest and hitting him in the face with one of the shoes. NA-A verified she gave R1 the middle finger prior to shutting off the phone. NA-A verified it was her cell phone used to take this video. NA- A verified she had posted this picture on the social media site Snapchat. -NA-A was shown the picture with R1 being given the middle finger by an unidentified staff. NA-A verified she had taken this picture of herself giving R1 the middle finger with her cell phone and also had posted this picture on the social media site Snapchat. -NA-A was shown the picture with R2 lying in her bed holding a cell phone with a picture of a penis with the caption Not XXX (included the name of the resident)showing me the dick pick she gets. NA-A verified she had taken this picture with her cell phone and also had posted this picture on the social media site Snapchat. -NA-A was shown the picture that revealed R3 lying on his back in his bed with only his underwear on NA-A verified it was her cell phone used to take this photo. NA-A verified she had posted this picture on the social media site Snapchat. -NA-A was shown the picture of R4 lying in her bed on her left side with no clothing on. R4's bare back, buttocks and female genitalia exposed along with what appears to be Kleenex with BM. NA-A verified it was her cell phone used to take this photo. NA-A verified she had posted this picture on the social media site Snapchat. On 6/24/24 at 1:05 p.m., NA-A was interviewed and stated she was aware of the facilities no phone policy while providing care to the residents. NA-A further stated she was aware of the no posting of any residents on social media. NA-A stated this was for the resident's privacy. NA-A stated throwing a resident into bed and throwing shoes on top of a resident could cause injury. NA-A further stated she had no excuse for taking and posting of the pictures. NA-A stated her actions were considered abusive. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	1601 St Louis Avenue Duluth, MN 55802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/24/24 at 1:19 p.m. the facility administrator and director of nursing (DON) were interviewed. The facility administrator stated cell phones were not allowed on the floor. The facility administrator further stated posting of any residents on social medical was not allowed and would be a violation of the resident's privacy. The DON and administrator both indicated their expectation was that all staff were following the cell phone policy and social medial polices which were important to ensure all residents privacy. When shown the video and photos, facility administrator instructed the DON to remove NA-A immediately from the floor and to call the police. The administrator denied ever receiving a phone call where it had been reported to him that NA-A had been taking abusive and humiliating photos and videos of residents and then posting them on social media. On 6/24/24, NA-A was terminated for violation of the facilities social media policy. A facility form titled Disciplinary Action Form dated 6/24/24, which was signed by NA-A, HR-A, DON, and administrator indicated the reason for termination as Violation of Social Media Policy. The form also included NA-A's comment I have no excuse for my actions, and I am extremely sorry for what I did. On 6/24/24, at 2:09 p.m. R3 was interviewed and stated he would be embarrassed to have a picture taken of him in his underwear. R3 further stated he would never want someone to see him without his clothing on. R3 also stated NA-A always had her phone on her when she is providing cares for him. On 6/25/24, at 12:15 p.m. Medical Director (MD)-A was interviewed and stated the administrator had emailed him on 6/25/24, informing him that a NA had been taking photos and videos of residents and posting them on Snapchat. MD-A stated this event was tragic and law enforcement had been notified. MD-A stated from what he was told by the facility administrator there were no words to describe the videos and photos NA-A had taken of residents and posted on social media. MD-A stated he did not want to see the videos or photos however from what he had been told they were horrific. MD-A stated as the medical director his expectation was that all staff were following facility policies and procedures to ensure resident safety and prevent abuse from occurring, On 6/26/24, at 1:25 p.m. FM-A was interviewed and stated he was the responsible party and brother for R1. FM-A stated the facility had called to informed him that R1 had been mistreated by a staff. FM-A stated the facility informed him it involved staff being rough with R1 and it was on video. FM-A stated R1 would not be able to recall any events due to his medical conditions. FM-A stated he cannot believe this happened to R1 and his expectation was that staff were following rules which would prevent these things from occurring. On 6/26/24, at 2:18 p.m. FM-B was interviewed and stated he was the responsible party and brother for R3. FM-B stated the facility had called to inform him that a staff had taken a photo of R3 in his underwear and posted it somewhere. FM-B stated he was very upset that this had occurred and was going to contact local law enforcement himself. FM-B further stated during a visit on 6/26/24, R3 had told FM-B that NA-A had taken pictures of another residents' feces and showed it to R3. FM-B stated this was awful and never should have happened to R3. On 6/26/24, at 2:37 p.m. NA-B was interviewed and stated she had witnessed NA-A giving residents the middle finger as well as throwing food at residents. NA-B stated giving the middle finger to a resident and throwing food at a resident was considered abuse. NA-B stated she had not reported this to facility leadership. NA-B further stated staff was afraid of NA-A and NA-A could be loud and aggressive but had never seen NA-A be physically abusive towards residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	1601 St Louis Avenue Duluth, MN 55802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/27/24, at 9:27 a.m. R4 was interviewed and stated she had been informed by the local law enforcement that NA-A had taken a picture of her with no clothing on and completely exposed and posted the photo on Snapchat. R4 started to cry during the interview and stated she considered NA-A her friend and didn't understand why she would do this to her. R4 stated she felt violated and humiliated. R4 further stated she feared that because this was on social media, she would have no idea how many people had seen the photograph of her unclothed. R4 stated she hoped that NA-A was charged legally so that NA-A could never do this to another person. R4 further stated NA-A was always on her phone when providing care on the unit but never thought she was using her phone to take pictures of her. R4 stated she felt safe at the facility. On 6/27/24, at 948 a.m. R2 was interviewed and stated she had been informed by the local law enforcement that NA-A had taken a picture and posted it on social media. R2 stated she had been told it was a picture taken by a cell phone with R2 lying in her bed holding a cell phone with a picture of a penis with the caption Not XXX (included the name of the resident) showing me the dick pick she gets. R2 started to cry and stated she was so embarrassed and concerned that others had seen this photo which was on the Internet. R2 further stated she was upset that her privacy was violated but felt safe at the facility. The IJ was removed on 6/26/24, at 4:11 p.m. when it was verified the facility had submitted and implemented an acceptable removal plan which included policy review and appropriate education and training of all employees, including licensed nurses, nursing assistants, therapy staff, activity staff, dietary staff and housekeeping staff. This was verified through interviews, policy review and education transcripts/training attendance records. The facility policy titled Abuse Prevention Policy revision date 1/9/24, directed staff to provide a safe living environment to all residents of the facility and to provide guidelines for investigating and reporting of suspected maltreatment. The policy description of abuse included the following, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Which included the following: -Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. -Use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability Sexual harassment and sexual abuse. -Physical abuse, hitting, slapping, kicking, biting, scratching, pushing, pinching or any other corporal punishment. -Mental abuse, unnecessary exposure of residents, inappropriate teasing, ridiculing, patronizing speech or behavior toward a resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Residence and Rehabilitation Center	1601 St Louis Avenue Duluth, MN 55802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All health care workers, regardless of place of employment, who provide services in a facility are mandated reporters. The facility policy titled Videotaping, Photographing, and Other Imaging of Residents review date 12/8/21, included the purpose of the policy is to ensure residents will be protected from invasion of privacy and/or abuse that might occur from photographs, videotapes, digital images, and recordings during resident care or other facility activities. The policy directed that staff may not take or release images or recordings of any resident without explicit written consent, transmitting unauthorized images of any resident through email, Internet or social media is considered a violation of resident rights and any image or recording taken that may be construed as humiliating or demeaning to a resident or residents is considered resident abuse and will be reported and investigated as such. The facility policy titled Telephones, Employee Use of review date 7/21, directed staff cellular phones may be used for personal calls and text messaging ONLY when the employee is on authorized meal and break periods. Employee cell phones will remain off and/or silent during all other work hours and failure to comply with cellular phone policies may result in disciplinary action.