STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	04/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to protect the resident's right to be treated with dignity related to unauthorized video recording in the resident's room for two residents (#8 and #9) out of two residents reviewed and failed to ensure timely incontinence care for one resident (#7) out of seven residents observed. Findings included: 1. During a facility tour on 4/11/2026 at 9:40 a.m. an observation was made of room [ROOM NUMBER] with a warning notice posted on the door reading, NOTICE, THIS AREA IS UNDER 24-HOUR VIDEO SURVEILLANCE. An interview was conducted with the private caregiver of Resident #9. She stated the family installed the video surveillance to monitor Resident #9's care 24-hours a day. She stated the camera was positioned to face Resident #9's bed. She stated it was not meant for the roommate, Resident #8. Record review of Resident #8's medical record revealed there was no consent signed related to being in a room that was under video surveillance 24-hours a day.Review of Resident #8 and #9's care plans revealed there were no plans of care related to the operations of the camera and the intent to ensure the protection of both residents' right to privacy.An interview was conducted with Staff A, Registered Nurse (RN)/Weekend Supervisor on 4/11/2026 at 12:46 p.m. Staff A stated the camera in room [ROOM NUMBER] was for Resident #9 and it had been there for a couple months. She stated the resident was monitored by the family 24-hours a day from their home. She stated she did not know how many family members had access to the surveillance. Staff A stated the camera recorded visual only, and there was no audio. Staff A said, I don't think it records the care of the other resident, but I also cannot speak of how wide the camera view is.On 4/11/2026 at 12:50 p.m. an interview was conducted with Resident #8. She stated she did not know if the camera in the room was recording her. She said, Oh God, I hope not. I try to be careful especially when walking to the bathroom. Resident #8 stated no one had spoken to her about the video surveillance. She said she did not sign a consent to be in a room with on-going video surveillance. The resident stated she did not know anything about the operations of the camera and whether the other resident's family members could hear her or not. Resident #8 confirmed no one at the facility had discussed this with her. She said, I don't know if they can hear me. I truly hope not. That's invading my privacy.On 4/11/2026 at 1:16 p.m. an interview was conducted with the Regional Nurse Consultant (RNC), the [NAME] President of Operations (VPO), and the Nursing Home Administrator, (NHA). The NHA said she was sorry she missed to have Resident #8 sign the consent form. She stated the previous roommates of Resident #9 had signed consents. She stated she believed the admission staff had spoken to the resident, but she may have forgotten. The NHA confirmed the consent was not documented. Regarding the 24-hour video surveillance of a resident's room, The NHA said, I know, trust me, we do not want the cameras we are trying to find Resident #9 a private room. She said she has had some problems with the family because the CNAs (Certified Nursing Assistants) are supposed to turn the camera away during care. She stated the family complains the CNAs do not turn the camera back to position to face Resident #9. The NHA stated she could not speak of the peripheral view of the camera. She stated she does not know how far the camera can see around the room. The NHA stated the agreement with Resident #9's family (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was for the camera to be on video only. The NHA said, I believe what the family says. I can't confirm if they do not turn on the audio. The NHA stated she could not guarantee Resident #8 was not recorded. Regarding the facility not having control of what the family sees or hears in a room that is dually occupied, the RNC said, I agree, we will fix that. We will speak to the resident.Review of the admission record for Resident #8 revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of wedge compression fracture. Review of a minimum data set (MDS) dated [DATE] revealed Resident #8 had a brief interview for mental status (BIMS) score of 15 out of 15 indicating intact cognition.Review of the admission record for Resident #9 revealed the resident was readmitted to the facility on [DATE] with a primary diagnosis of Alzheimer's disease. Review of a minimum data set (MDS) dated [DATE] revealed Resident #9 had a brief interview for mental status (BIMS) score of 00 out of 15 indicating impaired cognition.Review of a facility policy titled, Use of Video Monitoring/Camera in Resident Room, Revised 9/11/2025, revealed a purpose: HIPAA (Health Insurance Portability and Accountability Act) and state statutory and/or common law privacy protections establish broad privacy rights. The presence of a video camera in a resident's room could potentially violate the privacy rights of other residents of the Center. If a video camera also records audio, the unauthorized recording of another person may violate the state's wiretapping law and could result in criminal penalties. Because the Center values transparency and accountability, and considers the health, safety, and privacy of its residents to be the top priority, the Center appreciates and will attempt to honor any request to allow a non-concealed, stationary, video-only camera in a resident's room, subject to certain conditions being met.Authorization and consent: If the resident shares a room with another resident, the resident's roommate or the roommate's authorized representative must consent to the installation and use of a video camera prior to its installation by signing the attached Private Video Camera Notice Consent and Authorization of Roommate and/or Responsible Party Form SHCO20002.10B. If the roommate and/or the roommate's authorized representative refuses to sign the Roommate Authorization and Consent Form, then the Center will make a reasonable attempt to accommodate the resident who wants to install a video camera by offering to move such resident to another shared room or by offering such resident a private room, both are subject to availability. If the resident elects to move to a private room, the resident will be responsible for paying the private room rate. If a shared room is not available at the time, the Center will offer to move the resident at such time as a shared room becomes available.2. On 4/11/2026 at 10:02 a.m. Resident #7, was heard yelling from her room saying, Somebody help me. Resident #7 was observed emotionally agitated, showing anger and physical frowning of the face. She asked, Are you here to help me? The resident stated she was upset because she was waiting to be toileted. She said two staff members had responded to her calls and they said to wait. She said, it had been 2 hours. The resident stated the weekends are bad because no one answers call lights. She stated she had to call the Receptionist, twice, because the CNA never came back. Resident #7 said, I have to go now or I will soil myself. I hate that.On 4/11/2026 at 10:04 a.m. an interview was conducted with Staff B, RN. She confirmed Resident #7 had been calling for help. She said the resident said she had to go to the bathroom, about 30 minutes or so prior. Staff B, RN said she told one of the CNAs who went to the room, and she saw her walking out. She stated she assumed the CNA, (Staff C) had provided care at the time. An observation was made of Staff D, CNA on 4/11/2026 at 10.06 a.m. responding to Resident #7 after the surveyor intervention. Resident #7 could be heard from the hallway crying and saying, Oh! No!, I waited too long, I'm soiled now, I didn't want this. Staff D, CNA said to the resident, I apologize. I have 25 patients. I was taking care of other people. Staff D proceeded to assist Resident #7.On 4/11/2026 at 10:08 a.m., an interview was conducted with Staff D, CNA. She said the resident notified her she needed to go to the bathroom, about 30-45 minutes earlier. She said she was taking care of other residents. She stated she had asked the other CNA (Staff C) for help, but the other CNA was busy too. Staff D, CNA said, I apologize. I should have asked someone else for help.On 4/11/2026 at 10:12 a.m., an interview with Staff E, RN observed in the same hallway revealed the expectation (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was for the CNAs to get to the resident right away. He stated he would normally help CNAs if they let him know a resident needed care. He stated, No, she shouldn't be waiting that long to be toileted. He stated no one notified him Resident #7 needed help.On 4/11/2026 at 10.15 a.m. a follow -up interview was conducted with Staff A, RN. She said she heard from the Receptionist that [Resident #7] had called twice asking to be changed and the receptionist told her someone would help her. Staff A said the receptionist said the resident was calling downstairs for help, as she needed to be assisted to the bathroom. She said the resident told the Receptionist she had waited for help for may be 20 minutes or so. Staff A said she had just been notified and went to the room and found the CNA (Staff D) assisting the resident. Staff A, RN said the CNAs and nurses should have responded to the resident. She said, It's not acceptable for the resident to wait and end up soiling themselves. She stated anyone can toilet the resident.On 4/11/2026 at 10.28 a.m. an interview was conducted with the Receptionist. She confirmed Resident #7 called twice for help. She said the first time she called she was trying to get someone to toilet her. She said this was approximately 9:15 a.m. She stated the resident called the second time and said she had been waiting over 2 hours to be toileted. The receptionist said she paged the nurse. She stated once she pages the nurse, she would not know if they responded to the resident or not. The Receptionist said the resident called again and said no one had come. She said this was close to 10 a.m. She said she paged the nurse again. She stated she was not sure if anyone had responded.An interview with the NHA on 4/11/2026 at 1:20 p.m. revealed she looked at the cameras, and it showed staff were in and out of the room. She said they attended to her. The NHA stated she thought someone changed her at 7a.m. and again when she called the first time. The NHA stated their expectation was for residents to be attended to in a timely manner. Review of the admission record revealed Resident #7 was admitted to the facility on [DATE] with a primary diagnosis of metabolic encephalopathy. Review of a minimum data set (MDS) dated [DATE] revealed Resident #7's cognition was not documented. Resident #7 presented to be alert and oriented during the interview. Section GG revealed the resident utilized a wheelchair for ambulation and was dependent on staff for toileting/hygiene.Review of a care plan for Resident #7 revealed a focus for incontinent of bowel/bladder initiated on 2/17/2026. The goal showed attempts to have fewer episodes of incontinence will be provided through next review. Attempts to improve level of function will be provided through next review date. Interventions included assist with toileting as needed and Peri care after each incontinent episode. A review of the same care plan revealed an ADL (activities of daily living) self-care performance related to decreased activity tolerance. The interventions revealed the resident was dependent on staff for toilet use.Review of a facility policy titled, Resident Dignity & Personal Privacy, effective 4/2024, revealed a purpose: The center provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. Procedure: 1. Care for residents in a manner that maintains dignity and individuality:Assist the resident with grooming; groom appropriately and to resident's desire.