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	06/26/2026

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and document review, the facility failed to properly dispose of medications in the second-floor medication storage room. This had the ability to affect any resident who received medications from the second-floor medication storage room. Findings include: During a tour of the second-floor medication room with licensed practical nurse (LPN)-D on 6/25/26 at 9:23 a.m., multiple medications were observed to be expired. LPN-D stated that he wasn't sure of the process to remove the expired medications and I would have to follow up with director of nursing (DON). LPN-D stated that a lot of the medications in the medication storage room were overflow. Expired medications included the following: -saline nasal gel, expired 4/28/25-magnesium chloride, expired 4/9/26-docusate sodium, expired 12/4/25-cephalaxin, filled 9/16/25-Tylenol assigned to R19, expired 6/18/25. During an interview on 6/25/26 at 12:34 p.m., the director of nursing (DON) stated the nurse managers, or her audit medication carts monthly, but she had not audited the second-floor medication storage room. The expectation would be that nurses would put the expired medications in in the medication disposal bank on the first floor. Facility policy, Storage of Medications, undated, identified that discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure meals were palatable for 8 of 14 residents (R17, R12, R10, R4, R5, R58, R61, R81) who expressed dissatisfaction with palatability of meals. In addition, the facility failed to ensure the temperature of foods was maintained when transported to resident rooms. Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], identified R17 was moderately cognitively intact. During an interview on 6/22/26 at 2:30 p.m., R17 stated the food was pretty much terrible. During an observation on 6/24/26 at 1:02 p.m., R17 was no longer in the main dining room. He had eaten only a few bites of the meal which was a French dip sandwich, French fries, and a creamy cucumber salad. R12's quarterly MDS dated [DATE], identified R12 was cognitively intact. During an interview on 6/22/26 at 3:15 p.m., R12 stated the food was poor quality, said the cooks didn't know how to cook, and went on to state the hot food was not hot, and ice cream was served melted. R12 stated they were also not able to get oil and vinegar for a salad. During an observation and interview on 6/23/26 at 12:55 R12 stated she had not received any dressing for the salad. The meal was nacho chicken, shredded lettuce and tomato, refried beans, corn, and frosted marble cake. R10's quarterly MDS dated [DATE], identified R10 was cognitively intact. During an interview on 6/22/26 at 12:45 p.m., R10 stated the eggs were served cold and overcooked. R10 stated there was no variety and no seasoning. During an observation and interview on 6/23/26 at 12:59 p.m., R10 had a lunch of chicken breast, corn, refried beans, he touched his food and stated it was cold. R4's quarterly MDS dated [DATE], identified R4 was cognitively intact. During an interview on 6/22/26 at 5:33 p.m., R4 stated the food had gone downhill, the hot food was not hot, and the cold food was not cold. R5's quarterly MDS dated [DATE], identified R5 was cognitively intact. During an interview on 6/22/26 at 3:00 p.m., R5 stated that lots of the food was bad. R81's quarterly MDS dated [DATE], identified R81 was cognitively intact. During an interview on 6/22/26 at 1:11 p.m., R81 stated the food was awful, no taste for the potatoes, (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the chicken was dry and in general the food was overcooked. During an observation and interview on 6/23/26 at 1:00 p.m., R81 stated his food was awful, staff had removed it to reheat it. During an observation on 6/23/26 at 12:20 p.m., a speed cart arrived with a plastic covering. The entrees were covered as were the beverages. At 12:27 p.m., staff added coffee to cups and placed them on the meal trays At 12:30 p.m., staff began passing out the meal trays to the residents who were eating in their rooms At 12:41 p.m., a second tray arrived on another hallway with a plastic covering, staff performed hand hygiene and began passing out the meal trays to resident who were eating in their rooms During an interview on 6/26/26 at 8:15 a.m., the director of nursing (DON) stated they were aware of the food complaints since February. R58's quarterly Minimum Data Set (MDS) dated [DATE], identified R58 was cognitively intact. R61's quarterly MDS dated [DATE], identified R61 was cognitively intact. During an observation on 6/24/26 at 12:44 p.m., lunch trays were being delivered to resident rooms from an open ladder rack with plates in insulated serving dishes and milk cartons on the tray. The culinary director (CD) took temperatures on the last room tray served. The roast beef on a bun was 100.4 degrees Fahrenheit (F), the cup of au jus was 106.5 degrees F, and the carton of milk was 54.3 degrees F. During an interview on 6/24/26 at 12:44 p.m., CD confirmed the temperatures of foods on the last tray served were not what they expected for food quality. They stated their main concern was related to quality and palatability, and indicated safety would be a concern if it had been greater than 2 hours. During resident council interview on 6/25/26 at 9:57 a.m., R58 and R61 indicated the food concerns had not been fully addressed. They stated food quality and temperature were not great, food was always cold when eating in their room, and cold food was not always reheated by staff when requested. During an interview on 6/25/26 at 10:33 a.m., activity director (AD), indicated they were aware of the cold food concerns. They brought all food concerns to Quality Assurance and Performance Improvement (QAPI) and the food department manager. During an interview on 6/26/26 at 8:45 a.m., the director of nursing (DON) stated they expected trays delivered to resident rooms were hot, and cold items cold. They had concerns about food quality. Review of Resident Council meeting minutes: Resident Council Meeting minutes dated 2/12/26 at 10:00 a.m., with 18 residents attending, indicated concerns about cold food and needing staff to reheat the food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council Meeting minutes dated 4/9/26 at 10:00 a.m., with 15 residents attending, indicated residents were asked for any concerns, compliments, or suggestions for dietary. Resident Council Meeting minutes dated 6/11/26 at 10:00 a.m., with 22 residents attending, indicated concerns about food quality including food being overcooked and rubbery. Food Temperatures policy dated 2026, instructed that foods sent to the units for distribution will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 consistently track and monitor dishwasher temperatures for both the wash and rinse cycles, and take timely action to correct the temperatures, for 1 of 1 dishwasher. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher. Additionally, the facility failed to ensure proper sanitary storage of cleaning products and personal protective equipment and failed to ensure staff appropriately covered facial hair.Findings include: Dishwasher temperatures:During an observation on 6/25/26 at 9:38 a.m., dietary aide (DA)-A was operating the dirty side of the dishwasher and DA-B was removing dishes on the clean side of the dishwasher. DA-A completed a wash cycle. On the dishwasher, the rinse temperature was observed to be 180 degrees Fahrenheit (F), and the wash temperature gauge was not functioning.During an interview on 6/25/26 at 10:11 a.m., DA-A stated dishwasher temperatures were logged by staff working the clean side of the dishwasher every shift. DA-A started a wash cycle, observed the temperature gauges, and confirmed the wash temperature gauge was not functioning. DA-A stated this was not good because the wash temperature was not known.During an observation on 6/25/26 at 10:15 a.m., dishwashing logs for May 2026 and June 2026 were reviewed and included columns labeled wash and rinse for each meal. The June 2026 dishwashing temperature log had no temps logged for all meals 15 out of 25 days, no temps were logged for dinner, and all recorded breakfast rinse temps were logged below 180 degrees F, ranging from 170-175 degrees F, with no follow-up notations. The May 2026 dishwashing temperature log had no temps logged for all meals 23 out of 31 days and no temps were logged for dinner.During an interview on 6/25/26 at 10:17 a.m., cook (C)-A reviewed the dishwasher temperature logs for May 2026 and June 2026. C-A confirmed that temperatures were not logged consistently, and several recorded rinse temperatures were below 180 degrees F and was concerned that dishes were not heated for proper sanitation.During an interview on 6/25/26 at 10:19 a.m., DA-B stated dishwasher temperatures were logged every shift. DA-B confirmed they had not logged the morning temperatures and stated they were running late that morning.During an interview on 6/25/26 at 10:29 a.m., culinary director (CD) observed the dishwasher running and confirmed the wash temperature gauge was not moving and the rinse temperature was 175 degrees F. CD asked DA-B about the wash gauge and DA-B stated, sometimes it works, sometimes it doesn't. CD was concerned that if the dishwasher was not reaching appropriate temperatures, it may not be killing germs. CD stated they expected staff to log temperatures twice daily and let them know if there were issues. CD stated the dishwasher was leased from Ecolab, they needed to call for service, and asked staff to use the 3-compartment sink until it was resolved.During an interview on 6/25/26 at 12:55 p.m., Ecolab technician identified the dishwasher as a high-temperature dishwasher and confirmed the wash temperature gauge had failed. They stated the minimum wash temperature for the machine was 160 degrees F and the minimum rinse temperature was 180 degrees F. They identified during their service call on 6/25/26, a T60 test strip applied to a ceramic plate during dishwasher run had turned black which verified the dish reached 160 degrees F and was sanitized.The dishwasher temperature gauges indicated wash temperature minimum was 160 degrees F and rinse temperature minimum was 180 degrees F.A copy of dishwashing logs for May 2026 and June 2026 were requested but not received.Cleaning Dishes Using a Dish Machine policy dated 2026, instructed that proper temperatures and machine function should be verified prior to use, and staff should check the dish machine gauges throughout the cycle to ensure proper temperatures for sanitation. It identified for a high-temperature dishwasher that the wash cycle reaches 150 to 165 degrees F and the rinse cycle reach 180 degrees F.Ecolab manufacturer instructions dated 2020, identified the following water temperature requirements:Wash temperature (hot water sanitizing) 160 FRinse temperature (hot water sanitizing) 180 FSanitary Storage:During a kitchen observation on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/25/26 at 9:45 a.m., a closet between the kitchen and the entrance to the dirty side of the dishwasher was observed to be open and disorganized with open chemical containers, open boxes of gloves, and more than a dozen flies swarming and landing on the closet contents.During an interview on 6/25/26 at 10:36 a.m., CD observed the closet and stated they had not seen the closet before as they were new to the facility. CD identified the open chemicals as partially full Ecolab Solitaire dish detergent. CD stated they expected the closet to be closed, organized, and the chemical containers covered. CD had concerns for contamination from the flies.Chemical storage policy, personal protective equipment storage policy, and pet control policy were requested but not received.Facial Hair:During a kitchen observation on 6/25/26 at 11:50 a.m., other kitchen staff (O)-D was placing fruit and dessert cups on resident trays on a ladder rack. O-D was observed to have a full beard and mustache that were not covered with a facial hair net.During an interview on 6/25/26 at 11:50 a.m., O-D stated hairnets are required for facial hair, confirmed they should have a hairnet covering their beard, and stated the concern was for hair falling into the food.During an interview on 6/25/26 at 12:37 p.m., CD stated hair nets are required if facial hair was long enough to grab. CD was concerned for hair falling into food and possibly carrying pathogens if facial hair was not covered while serving food.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were informed of and consented to medications prescribed and given for mental health intervention for 1 of 5 residents (R2) reviewed for unnecessary medications.Findings include:R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact.R2's diagnoses included heart failure, renal insufficiency, schizoaffective disorder, non-Alzheimer's dementia, and arthritis.R2's care plan dated 6/26/26, identified R2 uses psychotropic medications related to behavior management. R2's provider orders dated 8/18/25, included mirtazapine oral tablet 15 mg: Give 15 mg by mouth at bedtime for depression. R2's provider orders dated 8/19/25, included risperidone oral tablet 0.5 mg: Give 1 tablet by mouth two times a day for mood disorder.R2's Informed Consent for Required Medications dated 2/5/24, for risperidone 2.5 mg two times a day for bipolar, was signed by R2.R2's medical record had no Informed Consent for Required Medications for mirtazapine.During interview on 6/26/26 at 9:06 a.m., director of nursing (DON) stated consents for psychotropic medications were obtained by a resident's physician, and nursing staff should ensure the consents were in the medical record. DON stated the physician should be updating the consents when prescribing new medications. DON confirmed R2 had no consent for mirtazapine in their medical record, and stated concern for lacking informed consent from R2.Antipsychotic Medication Use policy dated 4/26/2025, instructed that the resident record must include provider diagnosis, indication for use and documentation that the resident acknowledged consent to receive prescribed psychotropic medications.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that a resident who was assessed to be unable to self-administer medications did not self-administer nebulizer treatments. This affected 1 of 1 resident (R8) reviewed for self-administration of medication.Findings include: R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 as cognitively intact. Diagnosis included chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis (RA). R8's MDS further indicated that she was assessed as unable to self-administer medications. R8's current orders, reviewed 6/24/26, included Albuterol Sulfate Inhalation Nebulization Solution 2.5 milligrams (mg), inhale orally three times a day. Current orders failed to indicate R8 was able to self-administer medications. During observation on 6/24/26 at 11:00 a.m., R8's nebulizer sat atop her bedside table with noted droplets in the nebulizer chamber. During interview on 6/24/26 at 11:47 a.m., R8 stated that she uses her nebulizer three times daily. Staff sets it up and I turn it on. They don't come back to clean it. During interview on 6/24/26 at 12:24 p.m., registered nurse (RN)-F stated that she can't say the last time she passed meds on R8's unit, but if they can self-administer medications it should show on the medication administration record (MAR) or in their orders. During interview on 6/24/26 at 1:12 p.m., trained medication aide (TMA)-A stated that she sets up R8's nebulizer, R8 completes the treatment, and she later goes back to clean the nebulizer. There are currently three people on this unit that can self-administer oral medications once set up, and R8 is not one of them. Residents usually have a separate order to self-administer nebulizers themselves. On 6/25/26 at 12:38 p.m., the director of nursing (DON) confirmed that R8 was assessed as unable to self-administer medications and there was not a current order for R8 to self-administer medications. The DON stated the expectation would be that a resident would have a SAM assessment indicating that they can self-administer an albuterol nebulizer. Facility policy, Self-Administration of Medications, undated, identified If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facilty failed to honor shaving preferences and needed assistance for 1 of 1 residents (R112) who required minimal assistance with shaving and oral care. Findings include:R112's admission Minimum Data Set (MDS) dated [DATE], status: ready for export, indicated R112 was cognitively intact with the diagnoses of encounter for orthopedic after care, kidney disease, diabetes, congestive heart failure and muscle weakness. Section GG indicated R112 required setup or clean-up assistance for personal hygiene including shaving and oral hygiene. R112's care plan last updated dated 6/23/26, did not include R112's general preferences or activities of living (ADL) preferences. The Focus area Functional Discharge Goals included: hygiene goal: set up or clean up assistance with personal hygiene. The oral hygiene goal identified was to be independent with oral hygiene. On 6/22/26 at 2:04 p.m., R112 stated staff had not offered to help them get set up to brush their teeth, they had to ask them to help, or it wouldn't get done. R112 touched their face and said they hadn't been able to shave since they got to the facility. They had asked multiple staff but so far nobody had helped them. R112 explained at home they only kept a goatee, and they didn't want all the new whiskers as they were itchy. R112 wanted to be cleaned shaved just like they were at home. It was noted R112 had significant whisker stubble on their face and under their chin. During an interview on 6/24/26 at 9:09 a.m., R112 was noted to have significant whisker growth on the face and neck outside of their goatee. R112 stated they had not been able to shave yet, they had now been waiting three days for help. R112 stated they had asked for help once today, three times yesterday, and multiple times the day before that. R112 thought they had asked at least three or four different staff for assistance. Today, staff had said they were working on it, but nothing had happened yet. During an interview on 6/24/26 at 1:19 p.m., nursing assistant (NA-A) stated the facility had disposable razors that could be used to shave a resident if they didn't have their own shaver or razors. NA-A stated if a resident asked to be shaved staff should do it. During an interview on 6/24/26 at 1:45 p.m., registered nurse manager (RN-D) stated resident preferences were looked at during admission by the charge nurse. In addition, RN-D indicated they and the social worker did a meet and greet with the resident and reviewed their preferences which included shaving and oral care. RN-D stated they would expect shaving to get done when a resident asked.During an interview on 6/25/26 at 9:20 a.m., NA-D stated as NA's they did shave residents. We ask residents if they want to be shaved and then we do it if that is what they wanted. Stock supply razors would be used if a resident did not have their own razor or shaver.During an interview on 6/25/26 at 9:23 a.m., R112 continued to have whisker growth on their face and neck. R112 stated staff had not offered to assist them with brushing their teeth or with getting shaved yesterday or today even after they had asked to shave yesterday. They really needed to shave because they were sick of their face constantly being itchy.During an interview on 6/25/26 at 2:12 p.m., RN-D, stated staff should be setting up and offering assistance with ADLs to residents who have triggered for some level of assistance on the MDS. During an interview on 6/25/26 at 3:03 p.m., the director of nursing (DON) stated when a resident requested to shave, they expected staff to assist the resident to shave as soon as able the same day. They also expected staff to go in and offer assistance and or set up residents so they could shave/brush their teeth themselves. If residents were not doing those things for themselves, the DON expected staff to complete those cares without having to be asked by residents.The facility policy Activities of Daily Living (ADLs), Supporting dated 6/25/26, instructed residents will be provided with care, treatment and services as appropriate, to maintain or improve their ability to carry out activities of daily living. Services identified included bathing, dressing, grooming, and oral care. The facility policy Resident Rights dated 7/14/21, identified that residents had the right to self-determination.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident could smoke safely for 1 of 1 resident (R10) reviewed for safe smoking.Findings include:R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 was cognitively intact and had no rejections of care. In addition, R10's MDS identified he required set up for eating and was dependent on staff for activities of daily living.R10's Diagnosis Report dated 6/26/26, identified R10 had diagnoses which included heart failure (a condition where the heart muscle is too weak or too stiff to pump blood efficiently), lymphedema (a chronic condition characterized by the abnormal buildup of protein-rich lymph fluid, which causes swelling [edema] in the body's soft tissues), cellulitis of left finger, acquired absence of left finger(s), burn of unspecified degree of multiple sites of left and right wrist and hand, diabetes mellitus, open wound of left middle finger, open wound of left ring finger.R10's Medication Review Report dated 6/26/26, identified R10 had orders for dressing changes to left hand wounds twice daily and as needed for nonadherence/soilage. Cleanse left hand wounds with wound cleanser. Then apply collagen and gauze, secure with Coban.R10's care plan dated 1/7/26, identified R10 as using tobacco. Interventions included to determine if he had a desire to quit smoking, to educate on the risks and health effects of tobacco use, to provide education regarding the adverse effects of smoking, to provide resources on smoking cessation, and to provide with a cigarette holder to use while smoking. In addition, R10's care plan identified current functional performance as follows: Resident uses soft touch call light due to limited dexterity in both hands, dated 5/28/26 Dressing - Total assist dated 3/18/25 Eating - Independent/ set-up help only dated 3/14/25R10's smoking assessment dated [DATE], identified he smoked 6-10 cigarettes daily, had medical contraindications to smoking, and was able to safely hold, light, smoke, extinguish the cigarette and secure lighter in a safe manner without assistance. Question six related to prior to the start of the observation, does the resident have existing burn holes in clothing, it was answered no. Question seven related to burns or holes in clothing from falling ashes was answered as no. The conclusion included the following interventions, smoking apron, smoking materials kept at the nurse's station.R10's smoking assessment dated [DATE], identified he smoked 10-20 cigarettes daily, had medical contraindications to smoking, and was able to safely hold, light, smoke, extinguish the cigarette and secure lighter in a safe manner without assistance. Question six related to prior to the start of the observation, does the resident have existing burn holes in clothing, it was answered yes. Question seven related to burns or holes in clothing from falling ashes was yes. The conclusion included the following interventions, adaptive equipment and smoking apron. It also included he had been provided with a cigarette holder and smoking apron for use during smoking.R10's smoking assessment dated [DATE], identified he smoked 5-10 cigarettes daily. Question two related to any medical contraindications to smoking was answered as no. Question six related to prior to the start of the observation, does the resident have existing burn holes in clothing, it was answered yes. Question seven related to burns or holes in clothing from falling ashes was yes. Question nine related to an accident related to smoking was answered yes. Interventions included adaptive equipment, smoking apron, smoking materials kept at nurse's station and violated smoking policy - will reassess per plan. Included he would not use a smoking apron. He signed a risk versus benefit, on 4/11/26, identifying he understood the risks associated with smoking and not using a smoking apron.The facility provided a list of residents who were approved current smokers on 6/22/26, R10's name was not included on the list.During an observation on 6/22/26 at 12:46 p.m., R10's clothing appeared soiled with white spots on shirt and pants and small holes in shirt (across abdomen) and in his pants in the thigh area.During an interview on 6/22/26 at 12:54 R10 stated he smoked independently.During an observation on 6/23/26 at 2:21 p.m., R10 was seated in his wheelchair in his room, he was wearing clean clothes. Both the shirt and (continued on next page)

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	245227	A. Building B. Wing	06/26/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pants had several small holes.During an observation on 6/24/26 at 2:09 p.m., R10 was headed outside, he had a pack of cigarettes in his breast pocket. His clothing was clean but had small holes in the shirt and pants. He declined to have anyone accompany him to the smoking area.During an observation on 6/24/26 at 2:17 p.m., there were food crumbs on the floor under the overbed table where R10 ate in his room.During an interview on 6/24/26 at 2:18 p.m., nursing assistant (NA)-A verified there were crumbs on the floor and what he stated looked like spilled milk on the overbed table. NA-A stated they had to wait for him to leave the room as he would not let them clean up after each meal.During an interview on 6/24/26 at 2:26 p.m., licensed practical nurse (LPN)-A verified there were food crumbs on the floor and the overbed table was wet from a beverage that had been spilled. LPN-A stated he would sometimes use adaptive eating utensils but would also eat using his hands. LPN-A stated he would not use the cigarette holder and stated the wounds on his hands were from burns from smoking. LPN-A verified the holes in his clothing were from burn holes from cigarette smoking but stated he would say they were not.During an interview on 6/24/26 at 2:28 p.m., registered nurse (RN)-A stated she had tried different options to have R10 hold a cigarette (related to his lack of fine motor coordination), but he was not receptive. RN-A verified R10's care plan identified he needed to use a cigarette holder to smoke. RN-A verified the holes in his clothing were from burn holes from cigarette smoking. During an interview on 6/26/26 at 8:04 a.m., the director of nursing (DON) verified R10 would not use a smoking apron and that RN-A and now occupational therapy were working with him for a safe option to hold a cigarette (related to his lack of fine motor coordination and safety with smoking). Smoking Policy - Residents dated 3/2/26, identified the facility would establish and maintain safe resident smoking practices. A resident's ability to smoke safely would be evaluated upon admission/readmission, quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) would be noted in the care plan, and all personnel caring for the resident would be alerted to these issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure Enhanced Barrier Precautions (EBP) protocols were followed for 1 of 1 resident (R103) reviewed for infection control.Findings include:R103's quarterly Minimum Data Set (MDS) dated [DATE], identified R103 was cognitively intact.R103's diagnoses included diabetes mellitus, renal insufficiency, neurogenic bladder, hypertension, anemia, arthritis, anxiety, and depression.R103's care plan dated 6/17/26, identified the resident was on EBP related to a suprapubic (SP) catheter and chronic wounds, and directed care staff to follow EBP and to utilize gowns and gloves for all personal care. R103's provider orders dated 12/11/25, included SP catheter cleansing and maintenance for neuromuscular dysfunction of bladder.During an observation on 6/24/26 at 12:58 p.m., R103's door had a sign indicating R103 was on EBP. The sign instructed staff to wear a gown and gloves for high-contact resident care activities, including dressing and transferring. Nursing assistant (NA)-C was observed in R103's room, without wearing a gown, squatting at R103's feet at bedside.During an interview on 6/24/26 at 1:33 p.m., NA-C confirmed they had not gowned when entering R103's room. NA-C stated they prepared R103 for an appointment, assisted with dressing, and transferred R103 from bed to wheelchair. NA-C stated they were squatting at bedside to put R103's compression socks on. NA-C stated they only needed to gown for EBP if taking care of an open wound. NA-C reviewed the EBP sign on R103's door and stated even though the sign indicated to wear a gown with dressing, they did not need to gown since they were not in contact with R103's wound. NA-C stated gowning for EBP was important to prevent transferring an infection to staff or other residents.During an interview on 6/24/26 at 3:01 p.m., registered nurse (RN)-C stated staff wear gown and gloves when providing cares to residents on EBP. RN-C expected staff to wear gown and gloves when assisting R103 with getting dressed and stated a concern for spreading infection if EBP was not followed.During an interview on 6/26/26 at 8:25 a.m., director of nursing (DON) stated staff were expected to read the EBP sign when entering a resident's room and apply the appropriate personal protective equipment (PPE). DON confirmed that staff needed to wear gown and gloves when assisting with dressing a resident on EBP and stated a concern for cross contamination of infection to staff if a gown was not worn.Facility provided Enhanced Barrier Precautions sign received 6/26/26, instructed providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and wound care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure residents did not have to share a living space with a resident (R72) who would not shower or change clothing. This deficient practice affected 3 of 3 residents (R52, R65, R44) reviewed for environment.Findings include:R72's quarterly Minimum Data Set (MDS) dated [DATE], identified he had diagnoses which included anemia, heart disease, hypertension, arthritis, depression, panlobular emphysema (an irreversible type of chronic obstructive pulmonary disease [progressive, incurable lung disease that blocks airflow and makes breathing difficult]), hypomagnesemia (a low level of magnesium in the blood), cannabis use, and gastroesophageal reflux disease (when stomach acid flows back up into the esophagus and causes heartburn). In addition, R72's MDS identified he was cognitively intact, had no rejections of care and was independent with activities of daily living (ADLS) including personal hygiene.R72's Medication Review Report dated 6/26/26, identified he had an order for a weekly bath audit on shower day every evening shift on Tuesdays.R72's care plan dated 2/4/26, identified R72 had a risk for self-care deficit related to bathing and dressing. Interventions included to evaluate his ability to perform ADLS, to maintain a consistent schedule, minimize environmental stimuli, to provide assistance with ADLs as needed, and to complete a risk versus benefit for bathing refusals. A review of R72's Weekly Bath Audits from January 2026 through June 2026, identified he had refused bath/showers every week for the past six months.A review of risk versus benefit on refusing showers and skin checks dated 2/4/26, identified two staff signed the document but there was no signature for R72.R72's provider notes identified the following:-12/26/25, identified he was declining any help with personal hygiene. He is illkept, matted hair.-1/30/26, identified he declined any help with showers. He is illkept, matted hair.-2/11/26, Refuses any bathing or hygiene care frequently and appears disheveled. Not interested in decreasing ETOH (alcohol), tobacco, or marijuana at this time. is in bed still at 11:00 today and disheveled appearing.-5/15/26, Refuses any bathing or hygiene care frequently and is quite disheveled. Disheveled and unkempt.R52's comprehensive MDS dated [DATE], identified R52 was moderately cognitively intact.During an interview on 6/24/26 at 11:38 a.m., R52 stated he shared a room with R72 and didn't want to be in the same room with him. R52 stated that he coughed all the time. R52 stated sometimes the bathroom would be dirty (the toilet) but he didn't have to clean it up staff would. R52 stated he had asked for a different room about five times.R65's quarterly MDS dated [DATE], identified R65 was cognitively intact.During an interview on 6/24/26 at 10:46 a.m., R65 stated he shared a bathroom with R72 and sometimes there would be poop on the toilet. R65 stated when that happened, he would tell nursing and they would come and clean it up.R44's quarterly MDS dated [DATE], identified R44 was cognitively intact.During an interview on 6/25/26 at 1:18 p.m. R44 stated sometimes the shared bathroom would be dirty with stool on the toilet, but he would tell nursing and they would clean it up. During the course of the survey 6/22/26-6/26/26, a staff member who wished to remain anonymous reported R72 had not showered in over a year, didn't change his clothing, didn't wash his hair (stated his hair was matted), and shared a bathroom with three other residents. The anonymous staff member stated the resident drank alcohol and messes his pants, they stated the other three residents would complain about the bathroom being dirty.During an interview on 6/25/26 at 11:42 a.m., housekeeper (H)-A stated R72's room was odorous and R72's use of alcohol made it hard to keep the room and bathroom clean. H-A stated R72 didn't always make it to the bathroom in time when he needed to use it. H-A stated sometimes there would be stool on the floor, walls, toilet, and on his bed linen. H-A stated they believed he had not bathed, washed his hair, or changed his clothes for eight months. H-A stated housekeeping would use a deodorant spray when he was out of his room, check his bed to see if his bed linen needed to be changed (said it was often stained with stool) and would alert nursing to (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change the bed linens. H-A stated bed linens were typically changed on shower days but R72 would refuse his shower. H-A stated R52 has told her in the past that nothing happens if he complained about the room and the bathroom. H-A stated R65 has also complained to her about how dirty the bathroom would be after R72 used it. H-A stated the bathroom accidents usually occurred overnight, and she would find dried stool in the bathroom when she arrived in the morning about three times a week. H-A stated R52 and R65 would use the main bathroom/shower room when the bathroom would get too bad.During an interview on 6/25/26 at 12:00 p.m., nursing assistant (NA)-B stated she was aware of R72 refusing to shower and stated she didn't think he changed his clothes daily.During an interview on 6/25/26 at 12:04 p.m., licensed practical nurse (LPN)-B stated he was aware R72 refused to shower. LPN-B verified R52, R65, and R44 would come out and tell nursing staff when the bathroom was dirty and stated in fact R65 had told him that morning that the toilet seat had stool on it. LPN-B verified the room could be odorous.During an interview on 6/25/26 at 12:08 p.m., registered nurse (RN)-B stated R72 had not showered for the past six months, maybe longer. RN-B stated he was somehow able to obtain alcohol, and wouldn't change his clothes or wash his hair. RN-B stated she was not aware that R52, R65, and R44 would sometimes use the shower room bathroom because the shared bathroom was so dirty. RN-B verified a reasonable person would not want to share a room or a bathroom with someone who refused to shower or change their clothing.During an interview on 6/26/26 at 7:58 a.m., the director of nursing (DON) stated it had been a very, very, long time since R72 had showered. The DON verified she has had to clean the shared bathroom of stool. The DON verified a reasonable person would not want to share a room or a bathroom with someone who refused to shower or change their clothes. Weekly Skin Care Policy and Procedure dated 4/10/26, Residents will have weekly scheduled showers/baths. The policy identified skin care would enhance the quality of life for all residents residing in the facility. The policy did not address refusals to bathe or shower.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that mail was delivered to residents on Saturdays. This had the ability to affect all residents who received mail to the facility.Findings include: R101's annual Minimum Data Set (MDS) dated , 5/21/26, identified R101 as cognitively intact. R85's annual MDS dated [DATE], identified R85 as cognitively intact. During interview on 6/25/26 at 9:57 a.m., R101 stated that if mail comes on Saturday, it is not being delivered until Monday. R85 confirmed that mail gets delivered to the front desk on Saturday and is sorted and delivered on Monday. During interview on 6/25/26 10:54 a.m., the front desk receptionist and business office manager (BOM)-A stated they deliver to residents during the week. On Saturday if they are expecting something for mail, they can come and grab it, otherwise we go though it on Monday and deliver it out through the facility. Facility policy, Mail and Electronic Communication, undated, indicated mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).