Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52274501M

Date Concluded: October 22, 2024

Name, Address, and County of Licensee Investigated:
Bayshore Residence & Rehabilitation Center
1601 St. Louis Avenue
Duluth, MN 55802
St. Louis County

Facility Type: Nursing Home

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP), a facility staff member, emotionally abused resident #1, resident #2, resident #3, and resident #4 when she took humiliating videos and photos of the residents and posted them on social media (Snapchat). In addition, the AP physically abused resident #1 when the AP aggressively threw resident #1 onto his bed, removed the resident's shoes and threw the shoes onto his bare chest and head.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP admitted to law enforcement, facility administration, and the federal surveyor she abused resident #1, resident #2, resident #3, and resident #4 by posting humiliating videos and photos of the residents on social media. In addition, the AP admitted to physically abusing resident #1 when the AP threw shoes and food at resident #1.

The investigator interviewed facility leadership and reviewed the federal surveyor's interviews with resident #1, resident #2, resident #3, resident #4, the alleged perpetrator, facility staff, and

resident's family members. The investigator reviewed documents collected by federal surveyor during their onsite investigation at the facility. The investigator contacted law enforcement. The investigation included review of the resident #1, resident #2, resident #3, and resident #4's records, the AP's employee file, the federal surveyor's notes, and documents.

Resident #1 resided in a nursing home. Resident #1's diagnoses included congenital (present at birth) disorder of muscle tone, movement, and posture (cerebral palsy), epilepsy (seizures), post-traumatic stress disorder (PTSD), anxiety and major depression. The resident's plan of care included assistance with personal cares, meals, medication administration, and extensive assistance with transfers and toileting. Resident #1 had difficulty being understood by others. Resident #1 required a sit to stand lift for transfers and a wheelchair for mobility. Resident #1 was a risk for abuse due to his physical, communicative, and cognitive impairments.

Resident #2 resided in a nursing home. Resident #2's diagnoses included a stroke and right-sided paralysis (hemiplegia). Resident #2's plan of care included extensive assistance with personal cares, transfers, toileting, repositioning, assistance with meals, and medication administration. Resident #2 used a sit to stand lift for transfers and a wheelchair for mobility. Resident #2 was at risk for being abused due to her slurred speech and difficulty communicating needs.

Resident #3 resided in a nursing home. Resident #3's diagnoses included a developmental disorder, anxiety, and impaired mobility. Resident #3's plan of care indicated he was independent with mobility, transfers, meals, toileting, and personal cares with staff assistance as needed. Resident #3 received assistance with medication administration. Resident #3 walked independently using a four-wheeled walker. Resident #3's lacked insight and was unlikely to be able to report abuse.

Resident #4 resided in a nursing home. Resident #4's diagnoses included severe (morbid) obesity, major depression, and a right below the knee amputation. Resident #4's plan of care included assistance with personal cares, and medication administration, along with extensive assistance with toileting and transfers. Resident #4 required a mechanical sling lift and assistance from two staff for transfers and a wheelchair for mobility. Resident #4 was vulnerable to being abused due to her history of misconstrued (false understanding) relationships with facility staff.

During an interview with the federal investigator, a former employee stated the AP sent them numerous photos and videos of various residents at the facility. The AP was posting the photos and videos on social media (Snapchat.) The former employee stated the images were upsetting and seemed to be getting worse in nature.

In a recorded video, the AP can be seen setting up her personal cell phone on a table to record an interaction with resident #1. The AP turned and walked towards resident #1 who was seated at the edge of his bed. Resident #1 was naked from the waist up and his pants were pulled

down, exposing his brief. The AP walked up and grabbed resident #1's lower legs, forcefully flinging his body into a face up lying position on his bed. Resident #1 appeared to say, "quit it" to the AP. The AP looked at resident #1 and sternly said, "Hmm!" to resident #1. Next, the AP removed and threw resident #1's left shoe onto resident #1's bare chest, causing resident #1 to say "ow." The AP then removed resident #1's right shoe which landed and hit resident #1's face. The AP lifted her middle finger at resident #1 before she walked away and turned her camera off.

In a second video, resident #1 was seated in his wheelchair in the facility's eating area. Resident #1's body leaned towards his right side, unable to use his right hand due to cerebral palsy. The AP is off camera, but her voice is heard asking resident #1, "Where you are going?" as she scooped and tossed pasta at resident #1, telling resident #1, "Here catch!" Resident #1 was distraught and responded with "No!" opening his mouth to "catch" the pasta. Resident #1 attempted to brush the tossed food off his body with his left hand. The AP asked resident #1, "Do you want to try and catch another one?" Resident #1 was distraught and repeated "no." The AP ignored resident #1's request and told resident #1 "k, ready?" then continued to toss pasta on resident #1's body.

A photo taken by the AP showed resident #1 seated in his wheelchair, smiling, and looking up at the AP. The AP's middle finger can be seen pointing at resident #1 in the foreground of the photo. The photo clearly contained resident #1's face.

Another photo taken by the AP showed resident #2 lying in bed smiling and holding a photo of a man with an erect penis. In a caption with several of the same laughing emoji faces, the AP wrote resident #2 [provided resident's first name] "showing me the dick pics she gets." The photo clearly contained resident #2's face.

Another photo taken by the AP from the bottom to the top of resident #3's bed, resident #3 smiling and lying in his bed with no sheet or blanket wearing only underwear.

Another photo taken by the AP showed resident #4 lying on her left side with her bottom visible to the camera. Resident #4's right hand was holding up the skin of the hip and right buttock exposing most of resident #4's genitalia. Resident #4 had a bandage placed on her tailbone and a soiled brief was behind resident #4's buttocks.

The police report indicated when interviewed, the AP stated over the years a former staff saved the AP's photos in an album to "try and get her in trouble." The AP admitted she took the photos and videos and unlocked her phone for police by using facial recognition. The AP stated the residents were like "family" to her, stating if asked, the residents would say the AP would be their favorite staff member. The AP stated she felt "dumb" and should not have taken the photos and videos. The AP stated she cared for the residents and wished no ill will against them. The AP cried and when police asked the AP how she would feel if she was the residents,

the AP stated she would be upset if someone took photos of her in her underwear without her knowledge. The report was being forwarded for further investigation.

During an interview, facility leadership stated the AP picked up shifts and was a hard worker. Leadership stated they immediately removed the AP off the floor and contacted law enforcement when leadership was shown the residents photos and videos. Leadership stated the AP was unable to answer why she took the photos and videos of the residents but asked leadership if she was in trouble. Leadership stated, “I told her she was in pretty serious trouble.” Leadership stated they were specifically surprised by the AP’s actions stating staff were trained multiple times a year on abuse and the restrictions of posting on social media.

During an interview with the federal investigator, resident #1’s family member stated due to resident #1’s stroke he was unable to recall being abused. Resident #1’s family member stated, “It’s really hard. I keep thinking about this now.”

During an interview with the federal investigator, resident #2 cried stated she felt “embarrassed” other people could see her photo on the internet, stating she trusted the AP.

During an interview with the federal investigator, resident #3’s family member stated the abuse was “awful” and should never have happened.

During an interview with the federal investigator, resident #4 cried and stated she considered the AP her “friend” and felt violated by the AP. Resident #4 often saw the AP on her phone but never believed the AP would do something like that. Resident #4 stated it was a horrible feeling to know a photo of her was on social media stating, “I’m not beautiful, why would she do this?”

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Resident #1 was unable to be interviewed due to cognitive level. The federal investigator interviewed resident #2, resident #3, and resident #4.
Family/Responsible Party interviewed: The federal investigator interviewed resident #1 and resident #3's family members.
Alleged Perpetrator interviewed: No. The AP declined the investigator's request for an interview.

Action taken by facility:
The AP was immediately terminated upon the facility's awareness of the photos and videos.

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.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00589	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE AND REHABILITATION CENTER	1601 ST LOUIS AVENUE DULUTH, MN 55802

(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) COMPLETE DATE
2 000	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 #H52274501M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the	

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2 000	Continued From page 1 #H52274501M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the evaluators findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN, WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from	21850		

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21850	Continued From page 2 non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: The facility failed to ensure four of four residents reviewed (R1, R2,R3, R4) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850	There is no plan of correction required.	