

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Laurellwood Post- Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3127 57th Ave N Saint Petersburg, FL 33714	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility neglected to adequately supervise residents to prevent sexual abuse for two residents (#2 and #3) out of two residents reviewed, resulting in resident-to-resident sexual abuse. Findings included: An interview was conducted on 03/16/2026 at 10:15 AM with Staff A, Certified Nursing Assistant (CNA). Staff A stated on 03/08/2026 she was a witness to abuse in the facility. Staff A, CNA stated during breakfast tray pass, she walked into the room of Resident #3, after noticing that the resident's door was closed which was unusual for that resident. She stated the room was dark and Resident #2 was in their wheelchair at the bedside of Resident #3. Staff A revealed they immediately noticed Resident #3 was lying on their side in a fetal position with their brief pulled down and Resident #2 had their hand in a clenched fist against Resident #3's vagina. Staff A immediately separated the residents. Staff A, CNA noticed Resident #2 had their other hand on their penis which had been pulled out. She stated having pulled Resident #2 out of the room in their wheelchair and moved them out of the room. Staff A stated having worked with both Resident #2 and Resident #3 many times prior to the incident. She said Resident #2 was frequently going into Resident #3's room, was always smiling and seemed very friendly with Resident #3. Staff A, CNA stated she did not know anything about Resident #2 having any behavioral diagnoses until after the incident. She said if she knew about their behaviors they would have kept a closer eye on the resident. Staff A stated there was one previous inappropriate incident between Resident #2 and Resident #3 back in late November of 2025, they could not remember the exact date. Staff C said they witnessed an interaction between the two residents in the dining room. Staff A stated they saw Resident #2 at the table of Resident #3 smiling at them and then when he moved away from the table. Resident #3 turned towards Resident #2, opened their legs wide, and started to open one side of their incontinence brief. Staff A stated at that point they quickly approached the table, telling Resident #3 to close her legs and redirecting her to the meal at the table. Staff A CNA stated she did not report the incident when it occurred because she did not know about Resident #2's diagnosed behaviors. Staff C stated she did not think anything the incident was serious at the time. An interview conducted on 03/16/2026 at 10:34 AM with Staff B, Licensed Practical Nurse (LPN) revealed the LPN came to the facility on the date of the alleged abuse, 03/08/2026 right after the event occurred. Staff B stated their shift started after the residents had been separated so they did not witness the abuse but was told that Resident #2 was found in Resident #3's room with their hand on the other resident's private area and was masturbating with the other hand. Staff B stated that they did not know of Resident #2 having any inappropriate behaviors prior to the incident, however, it was known the resident frequently masturbated in their room which is a shared room with three other residents. An interview was conducted on 03/16/2026 at 3:55 AM with Resident #3 who was observed in the dining room. Resident #3 stated she liked it at this facility stating, Oh very much so. Resident #3 was unaware of the reported incident and stated not knowing who Resident #2 was. The resident said she was doing great and expressed no concerns. A review of the medical record for Resident #3 shows the resident was admitted to the facility in June of 2023 with diagnoses of unspecified sequelae of cerebral (continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>out. The NHA stated that when interviewing the staff after the incident, staff told them Resident #2 liked to go visit other residents and sometimes needed to be redirected. The NHA stated being unaware of the resident's hypersexual behavior diagnosis and was not concerned of any behavioral issues with the resident. The NHA stated both residents were immediately separated, they assessed by their doctors and also seen by psych. There were no outcomes. The NHA said Resident #2 was placed on 1:1 for increased supervision and was moved further from Resident #3's room. The NHA stated they educated all their staff on their policies. On 03/16/2026 at 1:03 PM an interview was conducted with the Nurse Practitioner (NP) for Resident #3. He stated being on-call and being notified of the sexual encounter. He stated he was told there was no penetration and both residents had cognitive decline. He stated both residents were assessed by psych as well as medical assessments. He stated he could not speak of prior behavioral concerns. On 03/16/2026 at 6:43 PM an interview was conducted with the facility's Medical Director (MD). The MD stated he was notified the morning the incident happened. He was then notified the next day to come and assess Resident #3. He stated she was confused, but at baseline and had no signs of distress or not being okay. The MD stated not having any concerns at the time of his visit. He stated the residents are monitored more closely and staff were educated. Review of the facility's policy titled, Abuse, Neglect and exploitation, dated 1/1/2026, revealed: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Sexual Abuse is non-consensual sexual contact of any type with a resident. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement care plan interventions related to hypersexual behaviors for one resident (#2) of two residents reviewed. Findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses of dementia and behavioral disturbances, psychotic disturbance and mood disturbance. Resident #2 was diagnosed with high-risk heterosexual behavior on 09/09/2017. A review of Resident #2 care plan showed a focus of potential for behaviors related to depression, dementia and hypersexual behaviors; date initiated: 01/05/2026. The goal showed Resident #2 will have no evidence of behavior problems by review date. Interventions included: Anticipate and meet the residents needs. Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Can you give us to provide opportunity for positive interaction attention stop and talk with him/he as passing by. Intervene as necessary to protect the rights and safety of others. Remove from situation and to take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider time of day, persons involved, and situations. Document behaviors and potential causes. Review of a primary physician note dated 3/11/2026 revealed . patient seen today for follow -up post behavioral incident with review of consults and new lab results. Per nursing report over the weekend on 3/8/2026, staff entered room and observed patient attempting to touch a female resident. Patient is non-verbal with a history of impulsive behaviors.</p> <p>Review of a psychiatry progress note dated 3/12/26 revealed Patient was seen today for follow up visit. Patient was last evaluated on 3/8/2026. Patient was seen in his room remaining on one-to-one supervision for safety and behavior monitoring. During the encounter the patient appeared calm and comfortable. He responded to questions using a thumbs up gesture and remained pleasant throughout the visit. No sign of distress was observed. Per nursing report behavioral concerns continue involving inappropriate gestures towards staff and other residents. When discussed the patient responded by laughing suggesting limited awareness of their behavior.</p> <p>An interview was conducted on 03/16/2026 at 10:15 AM with Staff A, Certified Nursing Assistant (CNA). Staff A stated on 03/08/2026 she was a witness to abuse in the facility. Staff A, CNA stated during breakfast tray pass, she walked into the room of Resident #3, after noticing that the resident's door was closed which was unusual for that resident. She stated the room was dark and Resident #2 was in their wheelchair at the bedside of Resident #3. Staff A revealed they immediately noticed Resident #3 was lying on their side in a fetal position with their brief pulled down and Resident #2 had their hand in a clenched fist against Resident #3's vagina. Staff A immediately separated the residents. Staff A, CNA noticed Resident #2 had their other hand on their penis which had been pulled out. She stated having pulled Resident #2 out of the room in their wheelchair and moved them out of the room. Staff A stated having worked with both Resident #2 and Resident #3 many times prior to the incident. She said Resident #2 was frequently going into Resident #3's room, was always smiling and seemed very friendly with Resident #3. Staff A, CNA stated she did not know anything about Resident #2 having any behavioral diagnoses until after the incident. She said if she knew about their behaviors they would have kept a closer eye on the resident. Staff A stated there was one previous inappropriate incident between Resident #2 and Resident #3 back in late November of 2025, they could not remember the exact date. Staff C said they witnessed an interaction between the two residents in the dining room. Staff A stated they saw Resident #2 at the table of Resident #3 smiling at them and then when he moved away from the table. Resident #3 turned towards Resident #2, (continued on next page)</p>		

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