STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105228	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurellwood Post- Acute and Rehabilitation Center	3127 57th Ave N Saint Petersburg, FL 33714

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility did not ensure food service safety standards were followed in the kitchen and in one of one nourishment rooms.Findings included: On 8/18/25 at 10:04 a.m., a tour of the kitchen was conducted with the Certified Dietary Manager. An observation of the window, above the three-compartment sink, revealed kitchen items were hanging to include pans, pots, and a long grater with a handle. Further observations of the top part of the window, where the kitchen items were hanging, had multiple black particles and debris throughout the surfaces. Another observation of that area revealed a circular kitchen item that had sharp, metal pieces inside and appeared to be for chopping food, which had dust particles throughout the surface. The CDM said it had never been used. The CDM was observed telling Staff G, Dietary Assistant (DA) to clean that area. On 8/18/25 at 10:06 a.m., an observation of the walk-in refrigerator revealed a 20-ounce Gatorade bottle, on the top shelf, behind a box of bananas. The CDM confirmed the bottle should not be there and was observed asking the dietary staff if it belonged to them. The CDM stated personal items should not be stored in there. On 8/18/25 at 10:10 a.m., an observation of inside the walk-in freezer revealed ice buildup along the top and sides of the door, as well as on top of boxes containing food items. A small mound of ice buildup was observed on the floor next to the door. The CDM said she put a work order in and has told the maintenance staff about the issue. She said the work order placed in the work order system can determine when she identified the issue. The CDM said she thinks the door does not close properly. An observation of the top part of the walk-in freezer door revealed the latch was off center compared to the walk-in refrigerator door. On 8/18/25 at 10:21 a.m., an observation of the refrigerator in the nourishment rooms revealed a 12-ounce plant-based protein shake which did not have a resident’s name or date labeled. An observation of the freezer revealed a pint of vanilla ice cream, a frozen plastic water bottle, and a 20-ounce Gatorade bottle. The CDM said she checked the refrigerator and freezer in the nourishment room on 8/15/25, and those items were not there. She said the Certified Nursing Assistants (CNAs) should have labeled the items with the resident’s name. The CDM was observed asking Staff B, Licensed Practical Nurse (LPN) who the items belonged to. Staff B, LPN answered she didn’t know and was instructed to discard the items. On 8/20/25 at 11:15 a.m., an observation of the lunch tray line was conducted. Staff G, DA was observed washing her hands in the handwashing sink area. After washing her hands, Staff G, DA was observed lifting the lid of the garbage can then went to a storage rack with clean items to retrieve a cup. At 11:25 a.m., Staff I, DA was observed touching the lid of a garbage can then putting on gloves. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	He was not observed performing hand hygiene before putting on gloves. Staff I, DA was observed going to the dry storage area and came back with another box of gloves that he put into the glove holder by the kitchen door. Staff I, DA was observed putting a new pair of gloves on, then went to the tray line to put beverages on the meal trays. He was not observed performing hand hygiene before placing the beverages on the meal trays. Staff I, DA was observed touching his right check while he was completing the task of putting individual bottles of milk on the meal trays. At 11:29 a.m., Staff I, DA was observed washing his hands in the handwashing sink. He was observed touching his forehand, shortly after washing his hands, and while putting items on the meal trays. At 11:36 a.m., Staff I, DA washed his hands and left the kitchen area after having touched the trays. A review of completed work orders revealed documentation for the walk-in freezer door created on 7/31/25. The notes on the work order documentation revealed the following, “Walk-in Freezer door is not closing properly … Door not closing properly and leading to ice buildup around door frame.” 2. On 8/18/2025 at 10:02 a.m., an observation of the kitchen stove revealed food was caked on the sides of the stove and on the floor of the stove. On 8/18/2025 at 10:09 a.m., an observation of the dry storage revealed an opened, half-full lemon juice bottle with no open date written on it and an expiration date of 6/27/25. The CDM confirmed that it was opened and not labeled. She said she’s not sure why the lemon-juice bottle was not stored in the refrigerator, but it should have been. On 8/20/2025 at 11:17 a.m., an observation of Staff H, [NAME] revealed she was wearing two dangling bracelets, with multiple charms on them, hanging outside of her gloved hand. Further observations of Staff H, [NAME] revealed she was stacking plates on a cart, away from the tray line, with gloves on. She was observed going to the food tray line, with the cart and plates, without completing hand hygiene and a glove change in between changing tasks. On 8/21/25 at 9:06 a.m., an interview was conducted with the Regional Director of Maintenance (DOM). He said he learned about the issue with the walk-in freezer door on Monday, 8/18/25, and has the part to fix it. He said the former maintenance staff did not make him aware of the issue. The Regional DOM said he did not expect the previous maintenance staff to notify him as he may have tried to fix the door himself and didn’t require replacement of a door, or something of that nature. On 8/21/25 at 10:08 a.m., a follow-up interview was conducted with the CDM. The CDM said when audits are conducted food item expiration dates are to be checked. Regarding the bottle of lemon juice observed in the dry storage on 8/18/25, she said if anything is expired it should be thrown out, or if an item is opened it needed to be refrigerated after use. The CDM explained the dietary staff are responsible for stocking and storing items, while the cooks check the storage areas daily. She stated she checked the stored food when she is completing orders and kitchen checks which are conducted, “About once a week.” When asked about glove and hand hygiene, the CDM explained that hands are to be washed in-between tasks and when there is a change of tasks. The CDM explained when there is a change of task, current gloves are to be disposed, hands need to be washed, then new gloves can be put on for the start of a new task. Regarding storage of staff’s personal items, the CDM said the dietary staff can have a cup with a lid and can store them in an area they are not working in. The CDM said dietary staff cannot store personal beverages in the kitchen refrigerator or freezer, as they contain items for the residents. She said staff have an area to store personal food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and beverages. Regarding the freezer work order from 7/31/25, the CDM stated, “Nothing was done, to my knowledge.” She said she had been removing the ice buildup with a hammer and checking the temperature to make sure the walk-in freezer was cooling properly. The CDM stated, “When I put something in [work order system], that’s the extent of my knowledge.” She said she does not know what happens with the work order after she puts it in the work order system. For storage of resident’s food and beverage items in the nourishment room, she said the CNA or nurse should have labeled with the date and resident’s name. She said if it’s not labeled or dated, the item should be discarded. The CDM said she does not know who reviewed the nourishment refrigerator and freezer when she is not present. In regard to the food build-up on the stove and surrounding floor area, the CDM stated the cooking area is to be wiped up and cleaned daily. She said major equipment like the stove are cleaned weekly. The CDM stated that staff are to wear minimal jewelry while on shift, and “I don’t believe that hand jewelry is permitted.” On 8/21/25 at 10:29 a.m., an interview was conducted with the Director of Nursing (DON). She said the expectation for storage of resident’s items is to make sure they are in a proper container, as well as dated and labeled. She said any staff member can accept the food or beverage and put it in refrigerator/freezer. The DON said staff have been provided education on the storage of resident’s food and beverages; and it is something they reiterate. She said the kitchen manager, the night shift nurse, and CNAs should be checking the nourishment room refrigerator and freezer for proper storage to include labeling and dating of resident items. A review of the facilities Food Safety Requirements revealed the following, “Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. “Contamination” means the unintended presence of potentially harmful substances including, but not limited to microorganisms, chemicals, or physical objects. “Food service safety” refers to handling, preparing, and storing food in ways that prevent foodborne illness. 1. Food safety practices shall be followed throughout the facility’s entire food handling process. This process begins when food is received from the vendor and ends with the delivery of the food to the resident. Elements of the process include the following: . B. Storage of food in a manner that helps prevent deterioration or contamination of the food, including growth of microorganisms. C. Preparation of food, including thawing, cooking, cooling, holding, and reheating. E. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food. F. Employee hygienic practices. 3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon deliver/receipt and ensure timely and proper storage. Refrigerated storage – foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include: . IV. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (Where applicable)/discarded . 5. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include but are not limited to: . C. Washing hands properly before distributing trays. 7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. A. Staff shall wash hands in according to facility procedures. G. Staff shall keep jewelry to a minimum and cover hand or wrist jewelry with gloves when handling food.” A review of the facilities Handwashing Guidelines for Dietary Employees revealed the following, “Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. Dietary employees shall clean their hands in a handwashing sink or approved automatic (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	handwashing facility . Dietary employees shall keep their hands and exposed portions of their arms clean. Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations: . B. After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc. C. After hands have touched bare human body parts other than clean hands (such as face, nose, hair, etc.) . F. While preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. J. After engaging in any activity that may contaminate the hands.” A review of the facility’s Dietary Employee Personal Hygiene Policy revealed the following, “Gloves are to be worn and changed appropriately to reduce the spread of infection. Employees are to keep jewelry to a minimum. Hand or wrist jewelry must be covered with gloves while handling food.” (Photographic Evidence Obtained)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability following qualifying mental health diagnoses for one resident (#4) of two residents reviewed for PASARRs. Findings included: A review of Resident #4?s admission Record revealed an original admission date of 9/13/2018, and a re-admission date of 8/10/2025 with diagnoses to include psychoactive substance abuse, primary insomnia, post-traumatic stress disorder (PTSD) - 2/7/2024, major depressive disorder, and generalized anxiety disorder. A review of Resident #4?s Active Orders revealed the following: Antianxiety Medication-every shift. Start date 3/13/2025. Antidepressant Medication-every shift. Start date 3/13/2025. Sedative/Hypnotic Medication-every shift. Start date 3/13/2025. Zolpidem Tartrate Tablet 10 mg (milligrams) give 1 tablet by mouth at bedtime for difficulty sleeping. Start date 8/18/2025 A Review of Resident #4?s Level I PASRR, dated 6/22/2020, under Section I-Part A MI (Mental Illness) or suspected MI, indicated anxiety disorder and depressive disorder. A review of Section IV: PASRR Screen Completion revealed the following was marked, No diagnosis or suspicion of Serious Mental Illness or intellectual Disability indicated. Level II PASRR evaluation not required. A review of Resident #4's Quarterly Minimum Data Set (MDS), dated [DATE], Section N - Medications, revealed the following to include: antianxiety, hypnotic and opioid. Further review of the Quarterly MDS, dated [DATE], Section C - Cognitive Patterns, revealed a Brief Interview Mental Status (BIMS) score of 15, cognitively intact.^^ A review of Resident #4's current care plan included the following,^ [Resident name] uses anti-anxiety medications r/t (related to) Her diagnosis of anxiety & muscle spasms. [Resident name] has experienced trauma R/T (related to) adjustment issues affecting the following (specify areas) Feeling tense all the time, Anxiety attacks - Having trouble breathing, flash backs, spacing out, Feeling that things are unreal, Memory problems, bad car accidents, bad accident at work, natural disasters, physical abuse as a child/spousal abuse, forced sexual contact as a child/husband, attacked by gun by husband, sudden death of a family member, sudden loss of home/possessions, death of a close friend. 2/19/25 current triggers for physical abuse is arguing, loud noises, nightmares' due to being awakened out of deep sleep 2/19/25 Care plan reviewed and is current. Psycho-social Well Being Care Plan revealed [Resident name] has the Potential for alteration in psycho-social well being related to major depressive disorder and anxiety disorder On 8/20/2025 at 2:36 p.m., an interview with the DON (Director of Nursing) revealed that it is the her responsibility to check resident's diagnoses to compare the PASARR's with the medical records. She said the Admissions Director will ensure that the PASARR's are in the system. The DON explained that her process involves checking the resident's medications, and the type of diagnoses to determine if a Level II is needed. The DON revealed the previous administrator took on the role of checking PASARR's when an admission came in. The DON stated a resident review is completed when the resident has a change of condition. She stated a, New schizophrenia or PTSD diagnosis, qualifies a resident for a Level II PASRR. The DON revealed that she would have submitted for a Level II PASRR for Resident #4's specific diagnoses. The DON confirmed that Resident #4 does not have a Level II PASRR. She said Resident #4 needed one and she never thought about or recognized that PTSD was not on Resident #4?s PASARR. A review of the facility's policy titled, Resident Assessment-Coordination with PASARR Program, dated 9/1/2023, revealed the following, The facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include:a. A resident who exhibits (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to implement care plan interventions related to falls/accidents for one resident (#14) of three residents sampled.Findings included: On 08/18/2025 at 09:47 A. M., an interview was conducted with Resident #14. During the interview, the resident explained having experienced a fall in the cafeteria on 08/16/2025. The resident reported going out for a smoke break and fell backwards on their walker.Review of a progress note dated 08/18/2025 with a time stamp of 08:20 A. M., showed: staff observed resident sitting on the floor on buttock in front of the sink. [NAME] was behind Resident unlocked. Resident had on slide on thong sandal shoes.A progress note dated 08/16/2025 with a time stamp of 06:50 P. M., revealed: staff heard a noise. Upon checking, Resident was sitting on the floor in the dining room on buttock between a dining table & the wall. Resident's back was against the wall. [NAME] was about two feet away, unlocked. Slide on thong sandals on Resident's feet.Review of the admission record for Resident #14 revealed the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar type medical, major depressive disorder, muscle weakness, unsteadiness on feet, and essential (primary) hypertension. Review of an annual Minimum Data Set (MDS), with a target date of 07/24/2024, revealed in section C - the resident had a Brief Interview Mental Status (BIMS) of 12, which meant the resident's cognition was intact. Section GG of the MDS showed the resident had the capability to walk at least 150 feet independently. Review of the resident's physician orders dated 8/20/2025 revealed mood stabilizing medication Depakote, trazodone, and furosemide for edema. Review of an undated fall risk evaluation showed last dates of falls to include 08/16, 08/05, and 03/12 of 2025, with a fall risk score of 15, which indicated a fall risk.Review of Resident #14's care plan, revealed a focus of fall prevention initiated on 08/05/2022 and revised on 03/26/2025. It showed Resident #14 is at risk for falls. Resident #14 is on anti-psychotropic medications daily. The care plan showed the resident had falls as follows: 08/05/24, 03/12/2025, and 03/25/2025. The goal showed the resident will not experience injury from falls through the next review date. Interventions included: Resident to wear prior footwear, initiated 03/25/2025 and Educate Resident #14 to have proper shoes on when ambulating, initiated on 08/05/2024.On 08/21/2025 at 10:25 A. M., an interview was conducted with Staff A Registered Nurse (RN). Staff A,RN stated the resident was observed with legs in the air on 08/15. Staff A, RN stated the resident was wearing thong shoes. Staff A, RN stated the resident mentioned some back pain. On 08/20/2025 at 03:40 P. M., an interview was conducted with Staff B Licensed Practical Nurse (LPN). Staff B, LPN stated on 08/16 the resident was found in the cafeteria on the floor between a wall and table. Staff B, LPN stated the resident had thong sandals on. Staff B LPN stated Staff B LPN was unaware of the resident's care plan regarding shoes.On 08/20/2025 at 03:23 P. M., an interview was conducted with the Director of Therapy (DOT) and Staff C, Physical Therapist (PT). The DOT stated proper shoes are closed toed shoes like sneakers. The DOT stated thong sandals would not be appropriate for Resident #14. The DOT stated having attended a meeting on 08/15/2025, related to Resident #14, and the resident's shoes was not a topic of the meeting. The DOT and Staff C, PT were not aware of Resident #14's fall on 08/16.On 08/20/2025 at 02:36 P. M., an interview was conducted with the Director of Nursing (DON). The DON stated the resident had two falls, one on 08/15 and one on 08/16 of 2025. The DON stated the fall on 08/15 was unwitnessed and the resident was observed sitting on the floor. The DON stated the resident was educated to lock walker and to sit while washing hands. The DON Stated the resident had lower back pain. The DON stated the resident had on thong slide on shoes and a change of condition was not completed for the fall on 08/15. The DON stated the fall on 08/16 was unwitnessed and the resident was found sitting on the floor of the cafeteria with thong shoes on. The DON stated an IDT meeting was not completed for the resident and the care plan interventions were not reviewed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or updated after the resident's falls. The DON stated thong shoes are not proper walking shoes for Resident #14.Review of a policy titled Accidents and Supervision, revised 04/01/2024 showed: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Policy Explanation and Compliance Guidelines showed:3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: Communicating the interventions to all relevant staff b. Assigning responsibility C. Providing training as needed. d. Documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident) e. Ensuring that the interventions are put into action. f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. g. Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully. h. Facility-based interventions may include, but are not limited to: i. Educating staff iii. ii. Repairing the device/equipment. Developing or revising policies and procedures i. Resident-directed approaches may include: i. Implementing specific interventions as part of the plan of care ii. Supervising staff and residents, etc. iii. Facility records document the implementation of these interventions. 4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: a. Ensuring that interventions are implemented correctly and consistently. b. Evaluating the effectiveness of interventions d. c. Modifying or replacing interventions as needed. Evaluating the effectiveness of new interventions 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency. b. Based on the individual resident's assessed needs and identified hazards in the resident environment.Review of a facility policy titled Comprehensive Care Plans, revised 01/2025 showed: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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 record review, and interviews, the facility failed to ensure residents received Activities of Daily living (ADL) care related to showers for one resident (#16) of three residents sampled.On 08/18/2025 at 09:48 A. M., an interview was conducted with Resident #16. The resident stated showers were not being provided by the facility staff. The resident stated showers were desired and requested from facility staff and the resident stated the facility staff refused to provide the showers.Review of a Certified Nursing Assistant (CNA) Kardex (a care documentation sheet showing individual resident's care needs), showed question 3 asked the type of bathing preferred. The response to type of bathing, revealed the resident was not provided preferred showers on 07/30, 08/06, 08/10, and 08/13 of 2025.Review of the admission record for Resident #16, revealed the resident was re-admitted to the facility on [DATE] with diagnoses to include muscle weakness, need for assistance with personal care, contracture right hand, and unspecified sequelae of cerebral infarctions acute neurologic.Review of a quarterly Minimum Data Set (MDS), with a target date of 06/12/2025, revealed in section C the resident had a Brief Interview Mental Status (BIMS) score of 14 out of 15, which meant the resident's cognition was intact. Section GG of the MDS showed the resident required maximal assistance with ADLs, including washing, rinsing, and drying self.Review of the resident's physician orders, dated 07/15/2025 showed skilled occupational therapy eval and treatment for 4 times a week for 60 days with focus on weakness and increased need for assistance towards ADLs.Review of Resident #16's care plan revised 09/09/2024, revealed: a focus of Resident #16 having a self-care deficit with dressing, grooming, bathing and toilet needs related to (r/t): cerebrovascular accident (CVA), Human immunodeficiency Viruses (HIV), impaired vision, generalized weakness & debility. Resident #16 participates in ADLs with cues from staff. Resident #16 chooses to use double brief for incontinence, initiated on 09/28/2020 and revised on 09/09/2024. The interventions included: provide hands on assistance with dressing, grooming, bathing as needed. A focus initiated on 09/28/2020 and revised on 06/13/2025 showed Resident #16 is at risk for complications r/t alteration in health maintenance with a diagnosis (dx), of Anemia. Interventions included: Provide increased assist with ADLs as needed for complaints of (c/o) increased fatigue/weakness, initiated on 01/07/2022.On 08/20/2025 at 11:30 A. M., an interview was conducted with Staff F, Certified Nursing Assistant (CNA). Staff F, CNA explained not knowing what N/A in Resident #16's Kardex chart meant.On 08/20/2025, at 11:59 A. M., an interview was conducted with Staff D, CNA. Staff D, CNA stated residents are scheduled to receive showers two times a week, according to the shower schedule in a book at nursing stations and in resident charts. Staff D, CNA stated residents can receive more showers than the scheduled showers and they can receive showers on different days than scheduled. Staff D, CNA reviewed the shower logs at each nursing station and stated shower sheets for dates 07/30, 08/06, 08/10, and 08/13 of 2025 could not be found for Resident #16. For the same dates, the CNA Kardex chart for Resident #16 showed N/A. Staff D, CNA stated N/A, in the resident's chart, meant the showers did not happen. On 08/20/2025 at 02:36 P. M., an interview was conducted with the Director of Nursing (DON). The DON stated residents are scheduled to receive showers on two or more days a week and residents can request more showers. The DON stated if a resident received a shower, it should be documented in the resident's chart and the shower log book. The DON stated if a shower isn't documented anywhere, it can't be stated the shower took place. The DON stated Resident #16 should receive showers on Sundays and Wednesdays. The DON stated not applicable means the resident did not receive a shower.Review of a policy titled Activities of Daily Living (ADL), implemented on 09/01/2023 showed: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care.Policy Explanation and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105228	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurellwood Post- Acute and Rehabilitation Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance Guidelines: 2. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.