STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of University Park	2420 Pemberton Rd Richmond, VA 23233

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence professional standards for one of six residents in the survey sample, Resident #2 (R2).The findings include:The facility staff failed to meet professional standards by clarifying the oxycodone orders for R2. R2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ESRD (end stage renal disease), dialysis, diabetes mellitus and congestive heart failure. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 3/3/25, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and supervision for eating. A review of the comprehensive care plan dated 2/27/25 revealed, FOCUS: Resident is at risk for fall related injury and falls related to: left lower extremity fracture. INTERVENTIONS: Keep the resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position. Orient to surroundings as needed.A review of the physician orders dated 2/28/25 revealed, Oxycodone-Acetaminophen Tablet 5-325 MG (Milligrams) Give 1 tablet by mouth every 8 hours as needed for Pain 4-6 Pain. Non-Pharmacological Interventions: Document non-pharmacological interventions used: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4)Ice/cold pack. 5) Diversional Activity. 6)Guided Imagery. 7) Rest. 8)Social Interaction. 9)Other ___ -Start Date 02/28/2025 1045 (10:45 AM) -D/C (discontinue) Date 03/18/2025 2137 (9:27 PM).A review of the physician orders dated 3/17/25 revealed, Oxycodone HCl (hydrochloride) ER (extended release) Tablet ER 12 Hour Abuse-Deterrent 10 MG Give 1 tablet by mouth every 12 hours for moderate to severe pain -Start Date 03/17/2025 2100 (9:00 PM) -D/C Date 03/18/2025 1520 (3:20 PM). On 3/17/25 at 10:14 PM, physician, ASM(administrative staff member) #3 progress note revealed, Patient seen in follow up post dialysis treatment feeling weak poor appetite seen in collaboration with wound care nurse patient continues to suffer from a large unstageable sacral wound reviewed pictures with wound care nurse patient earlier screaming in dialysis session secondary to pain after careful review discussion with patient and wife over the phone plan is to administer scheduled long acting oxycodone extended release also patient with assistance and said since the symptoms he is crying he is tearful family requesting antidepressant treatment psychiatric NP(nurse practitioner) consult placed will start patient on Lexapro (2) 10 mg plan of care reviewed at length with patient and wife over the phone.On 3/18/25 at 12:16 PM MAR (medication administration record) administration note revealed, Oxycodone-Acetaminophen Tablet (1) 5-325 MG, Give 1 tablet by mouth every 8 hours as needed for Pain 4-6 Pain-Non-Pharmacological Interventions: Document Non-Pharmacological interventions used: 1) Massage. 2)Meditation/Relaxation. 3)Positioning. 4)Ice/cold pack. 5)Diversional Activity. 6)Guided Imagery. 7) Rest. 8)Social Interaction. 9)Other. Complaint of pain in left leg, rates at a 6.On 3/18/25 2:17 PM LPN (licensed practical nurse) #1, MAR administration note revealed, Oxycodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 8 hours as needed for Pain 4-6 Pain-Non-Pharmacological Interventions: Document Non-Pharmacological interventions used: 1) Massage. 2)Meditation/Relaxation. 3)Positioning. 4)Ice/cold pack. 5)Diversional Activity. 6)Guided Imagery. 7) Rest. 8)Social Interaction. 9)Other. PRN (as needed) Administration was: Effective Follow-up Pain Scale was: 3.On 3/18/25 at 3:22 PM LPN #1's progress note revealed, Wife in room, concerned for guest condition. Guest is easy to arouse but is not answering staff questions or talking back. Guest able to grip staff hands with equal strength. Guest asked if he is okay and nods his head yes. Wife asked what she would like to be done, if she feels like guest needs to be sent to the ER, wife states she does not want him to go to the hospital unless necessary medically. Wife informed that the lethargy could be from the new pain medication he started, explained that guest was screaming out in pain from his left leg with ADLS (activities of daily living), therapy and wound care. Vitals obtained and WNL (within normal limits) for guest. BS (blood sugar) 219. MD (medical doctor) notified of guest condition and wife concern, ordered to discontinue scheduled ER oxycodone. RP (responsible party) made aware.On 3/18/25 at 4:41 PM, LPN #1's progress note revealed, Easily aroused by name for medication administration. Guest took Renvela (3) whole with water. Guest thanked nurse after taking the medication. Denies pain at this time and denies needing anything additional On 3/18/25 at 8:41 PM, RN