DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2022 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD) DATE SURVEY COMPLETED		
		1100	7. 5010	1110		С		
		495109	B. WING			08/15/2022	06/15/2022	
NAME OF P	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF UNIVERSITY PA	PK		;	2420 PEMBERTON RD			
1112 (510)				١	RICHMOND, VA 23233			
(X4) ID		RTEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(XS)	M	
PREFIX TAG		Must be preceded by full sc identifying information)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY)	DATE		
E 000		ergency Preparedness 6/13/22 through 6/15/22. stantial compliance with 42	E	000	The statements made in this plan of correction not an admission of, or constitute an agreemen with, the deficiencies alleged herein. To remain compliance with all Federal and State regulation the facility will take the actions described in the plan of correction. The following plan of corrections.	nt π in ons, is ction		
		ulrement for Long-Term			constitutes the facility's allegation of complian			
	Care Facilities	mement for cong- term			that the alleged deficiencies, as described below will be corrected by the date indicated.	w,		
F 000	INITIAL COMMENTS		F0	00		1		
9 9	survey was conducted Nine complaints were in survey (VA00053043-sideficiency, VA0005424) deficiency, VA0005219 VA00054160 substantia VA00053123 substantia VA00054634 unsubstantiated without desubstantiated with deficursubstantiated).	ubstantiated with 9-substantiated with 7 unsubstantiated, ated with deficiency, ated with deficiency, ntiated, VA00052979 eficiency, VA00053249						
	CFR Part 483 Federal L		j					
	equirements. The Life				· ,			
	urvey/report will follow.							
1: in	The census in this 145 of 33 at the time of the sunctuded 48 current residuated record reviews.	rvey. The survey sample						
(esident Rights/Exercise	e of Rights	F 55	o,	F550			
\$\$=D C	FR(s): 483.10(a)(1)(2)(b) (1)(2)			Preparation and/or execution of this plan of correction does not constitute admission to, nor			
	483.10(a) Resident Rig				agreement with either the existence of the scope and severity of the cited deficiency or the	:		
		to a dignified existence,			conclusions set forth in the statement of deficien	ncy.		
	eit-determination, and c ccess to persons and s	communication with and		1	This plan is prepared and/or executed to ensure	, -		
	scess to persons and so staide the facility, includ			10	continuing compliance with regulatory			
		TIER REPRESENTATIVE'S SIGNATURE		t	equirements.	(X6) DATE		

Any deficiency statement entring with an asteriak (7 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 disclossible 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 disclossible 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.

FORM CMS-2567(02-89) Previous Versions Obsolete

Event ID: PHHV11

Facility ID: VA0249

If continuation sheet Page 1 of 184

7-8-2022

NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK (A4) ID PREFIX TAG (BEGULATORY OR USC IDENTIFYING INFORMATION) F 550 Continued From page 1 this section. Continued From page 1 this section. S483.10(a)(1) A facility must treat each resident with respect and dignity and cere for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and densuring residents are out of bed based on their		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
THE LAURELS OF UNIVERSITY PARK STREET ADDRESS, CITY, STATE, ZIP CODE				A. BOILDING			С	
THE LAURELS OF UNIVERSITY PARK 2420 PEMBERTON RD RICHMOND, VA 23233 CAN ID SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR USC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			495109	B. WING			06	/16/2022
F 550 Continued From page 1 this section. S483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident promote the rights of the resident. S483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, seventy of condition, or payment source. A facility must establish and maintain identical policies and			RK		2	1420 PEMBERTON RD		
this section. \$483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. \$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, seventy of condition, or payment source. A facility must establish and maintain identical policies and	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFU	((EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA		COMPLÉTION
provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without Interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff.	S from the second secon	this section. §483.10(a)(1) A facility with respect and dignit resident in a manner a promotes maintenance her quality of life, recognity individuality. The facility promote the rights of the §483.10(a)(2) The facility care in severity of condition, or must establish and main practices regarding transprovision of services unresidents regardless of The resident has the rights as a resident of the president of the United \$483.10(b)(1) The facility estdent can exercise his interference, coercion, dirom the facility. 483.10(b)(2) The residence of interference, coercion, dirom the facility in ghts and to be supported to the promote of the or right ubpart. his REQUIREMENT is a seed on observation, referview, facility document cord review, it was determined.	must treat each resident y and care for each and in an environment that or enhancement of his or inizing each resident's y must protect and e resident. Ity must provide equal egardless of diagnosis, payment source. A facility main identical policies and sfer, discharge, and the der the State plan for all payment source. Rights. It to exercise his or her efacility and as a citizen States. It must ensure that the efacility and each reprisal that the state right to be con, discrimination, or reprisal that has the right to be con, discrimination, and a exercising his or her did by the facility in the state as required under this anot met as evidenced esident interview, staff int review and clinical mained the facility staff			Resident #103 suffered no adverse outcom related to wearing a hospital gown and pla out of bed. Upon notification from the survegarding resident #103, staff on the unit we ducated on ensuring residents clothing is after completing ADL care. Criteria 2 All current residents needing assistance with changing clothes and needing assistance go of bed have the potential to be affected by the alloged deficiency. Criteria 3 CNA's will be re-educated on changing clothed ensuring residents are out of bed based preferences. Criteria 4 The DON or designed will conduct audits to esident clothing is changed daily. These and the done 5 days a week for four weeks; then week for four weeks; then the committee will be forwarded to the QAPI committee for review. The committee will etermine the need for further audits and/or a Criteria 5 Date of compliance is 7/26/22.	n to get yeyor yere re- changed th tting out the thing on their ensure ! dits willy one day, month. action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
		496109	B. WING		C 06/15/2022	
	PROVIDER OR SUPPLIER	RK	2	TREET ADDRESS, CITY, STATE, ZIP CO 420 PEMBERTON RD IICHMOND, VA 23233		011012022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(0.5) COMPLETION DATE
h b b b si h p p ju cs yc	falled to honor a reside family's choices for one survey sample, Reside The findings include: On the most recent MD quarterly assessment viceference date) of 05/1: scored 3 out of 15 on the mental status) assessmental status assessment viceference date; assessment viceference date, and totally dependent on two baservation was made of the date, and viceference date of the date	ent and/or a resident a of 59 residents in the ent #103 (R103). PS (minimum data set), a with an ARD (assessment 3/2022, the resident we BIMS (brief interview for ent, which indicated the impaired for making daily ocumented R103 being or more staff members dependent of one person imately 12:15 p.m., an of R103 in their room. He wearing a trospital wed to have their eyes dding yes or no to respond verbally. A served to be written in a stin board beside R103's also on the bulletin y to the room. The note 103] daily (needs total but of the bed so she can es (needs total help), wetness as she will not 1 items are in her V on at night. Thank can speak & saying." When asked or out of bed on "No." When asked if	F 550			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/28/2022 FORM APPROVED

CEIVIE	101 OIL MEDICARE &	MEDICAID SERVICES			UIVID	NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		NTE BURVEY DMPLETED	
		495109	B. WNG_			06/15/2022	
	ROVIDER OR SUPPLIER	ARK		STREET ADDRESS, CITY, STATE, ZIP CO. 2420 PEMBERTON RD RICHMOND, VA 23233	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(XS) COMPLETION DATE	
	and 4:25 p.m. revealed above. On 6/14/2022 observed in a hospital 6/14/2022 at 10:31 a.m bed in a hospital gown bath R103 nodded "Ye wanted to get dressed nodded "Yes." On 6/14 2:45 p.m., R103 was ol hospital gown. The hall observed to remain in ploards in the room. Or and 10:30 a.m., R103 whospital gown on. The comprehensive cardocumented in part, "[R activities of daily living) feficit and requires assimobility r/t (related to): Here is the source of the so	s on 6/13/2022 at 2:12 p.m. If the findings as described at 6:33 a.m., R103 was gown in bed. On in., R103 was observed in in., R103 was observed in in., when asked if they had a structure of the structure of th	F 5	50			
Ci de	NA documentation for tated 6/1/2022-6/30/202/13/2022 was observed ght shift and a "NA" was ocumented in the evening 14/2022, the day and experved to be blank and paerved to contain a "Notation 6/14/2022 at 2:48 p.m. in 6/14/2022 at 2:48 p.m. in 6/14/2022 at 2:48 p.m. in ducted with CNA (cert.)	2 for "Transferring" for I to be blank for day and s observed to be ng shift area. On vening shift areas were I the night shift was A."	,	()6 (5)	23 * s		

		ND HUMAN SERVICES			FO	ED: 06/28/20 RM APPROVE
STATEMENT	RS FOR MEDICARE & TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		496109	B, WING			С
NAME OF	PROVIDER OR SUPPLIER	400,000		EET ADDRESS, CITY, STATE, ZIP CODE		6/15/2022
			ı	PEMBERTON RD		
THE LAU	IRELS OF UNIVERSITY PA	ARK	RIC	HMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	atement of deficiencies y must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	BHOULD BE	(XS) COMPLETION DATE
F 550	Continued From page	4	F 550			
	100-11	5 stated that when they	530			
	worked with R103 the	y asked them what they	1			
		dressed and out of bed				
		ated that all residents should and that the CNA assigned				
		and that the CNA assigned and out clothes on them.				1
		Idents wear hospital gowns				
j	when they don't have a					
J	personal clothes make	them feel more stated that they try their	1 1			
J		y preferences for getting]
		d their choices. CNA #5	1 1			
	stated that R103 was n					1
		eyes and nodding. CNA not been assigned R103				
		old the other CNA to get				
- 1	them up earlier that day	but they had not done it.				
		day shift CNA had already				
1	left for the day.					
- 1	On 6/14/2022 at 3:08 p.	m., an interview was				
	conducted with LPN (lice	ensed practical nurse) #9.	1			
		lents should be dressed				
	•	bed daily. LPN #9 stated he right to be dressed in	1			
		get out of bed each day if			i	
[t	hey wanted to. LPN #9	reviewed the notes in	1			
		R103's family and stated				
		CNA that morning to get py to work with them but	1			
		LPN #9 stated that they].	•		
		d dressed by 10:00 a.m.		9	. ***	
	on 6/15/2022 at 10:54 a.					
	onducted with LPN #3, i				1	
	tated that they had beer seek and were still leami					
		ts had the right to get out				

of bed each day and should be dressed each day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED	
i		495109	B. WING	B. WING			06/15/2022	
	PROVIDER OR SUPPLIER	RK		STREET ADDRESS. CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233				
(X4) IO PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES I' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	c	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
1 d d d d d d d d d d d d d d d d d d d	LPN #3 stated that ear the choice to get out o #3 observed R103 in the observed to be in beding the choice to be in beding the choice from observed the notes from observed the notes from observed the notes from taken down. The facility policy "Gue 9/1/2013 documented in have freedom of choice possible, about how the everyday fives and receiveryday fives and regulated guest/resident conduct governing protection of safety A facility must prights for each guest/resident conduct governing problems and continued to be safety and observed these rights, though determined to be able to assert these right fegree of capability" The facility policy "Routing lated 3/1/2013 documerGuests/residents are conducted in appropriate of dress in appropriate class	ch resident should be given fibed or stay in bed. LPN heir room who was with a hospital gown on, y were unaware of the R103's family and it was in R103's family had been st/Resident Rights" dated in part, " Guests/residents o, to the maximum extent by wish to live their nive care, subject to the ations affecting and those regulations guest/resident health and romote the exercise of sident, including any who communication problems, cognition limits) in the A guest/resident, even a incompetent, should be ta based on his or her the Guest/Resident Care" atted in part, encouraged or assisted othing and footwear daily	F 6	550				
0 (s ac A:	appropriate to season allood repair)" In 8/15/2022 at approxination administrative staff memorial definition and ASM #2, the southaide repordinator and ASM #4, perations were made aw	ber) #1, the le director of nursing, giorial clinical the regional director of	v		F.			

	T OF DEFICIENCIES OF CORRECTION	Inchmon work with Men.		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		DEIVIN IONIION NOMEDNI	A BUILDING	·····		
ĺ		495109	B. WNG		C 06/15/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		_
				2420 PEMBERTON RD		
THE LAU	irels of university pa	ARK		RICHMOND, VA 23233		
W0 ID	VTS VGAMMIS	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(Alla)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETI	KON
F 550	Continued From page	6	F 550			
	No further information	was provided prior to exit.]	
F 558 SS=D	Reasonable Accommo	dations Needs/Preferences	F-558	F558	1	
	§483.10(e)(3) The right services in the facility of accommodation of resistances except when endanger the health or other residents. This REQUIREMENT by: Based on observation, record review and facility	with reasonable dent needs and en to do so would safety of the resident or is not met as evidenced staff interview, clinical ty document review, it was ility staff failed to maintain accessible to the esidents in the survey		Criteria 1 Resident #114 suffered no adverse outcorrelated to call bell allegedly being out of Upon notification from the surveyors regresident #114, the call bell was placed in Criteria 2 All current residents who need to use the for assistance have the potential to be affer this alleged deficiency. Audit of current revas conducted to ensure call bells were we reach. Criteria 3 All staff will be re-educated on ensuring a call bells are within reach.	reach. arding reach. call bell cted by esidents ithin	
	reference date) of 5/23/	Ith an ARD (assessment 2022, the resident scored (brief interview for mental icating the resident is aking daily decisions. R114 having functional		Criteria 4 The DON or designee will conduct audits resident call bells are in reach, these audit done 5 days a week for four weeks; then tweek for four weeks; then twice in the las These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or Criteria 5 Date of compliance is 7/26/22.	s will be one day a I month, PI	•
6 0	The comprehensive care 2/25/2022 documented in for fall related injury and new admit, confusion, ps Date Initiated: 02/25/202 02/26/2022." Under "Inter	n part, "[R114] is at risk falls R/T (related to); sychoactive medication. 2. Revision on:				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A BUILDING			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
l			1 2000	AIRG			С	
		495109	B. WNG				08/15/2022	
	PROVIDER OR SUPPLIER JRELS OF UNIVERSITY PA	.RK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD			
	.,			<u>L</u>	RICHMOND, VA 23233			
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F 558	Continued From page	7	F	658	3			
	documented in part, " within reach and encor assistance as needed. 02/26/2022"	•						
	made of R114 in their r lying in bed with a t-shi	o.m., an observation was com. R114 was observed rt on and asleep. R114's a button was observed to						
95	be clipped onto the call	light cord plugged into the room. The call light was						
	room on 6/13/2022 at 3 revealed the call light in described above. On 6: 1:45 p.m. the call light v							
1	#5. CNA #5 stated that clipped to the sheet or s resident. CNA #5 stated was to be within reach for needed something. CN/was able to use their cal	ortified nursing assistant) the call bell should be comething in reach of the I that the purpose of this or them to call when they A #5 stated that R114 I bell and the phone.						
t t s	CNA #5 observed R114 to bell clipped to the cord p the center of the room at stated that it was not in the nave been there because o call if needed.	lugged into the wall at the patient station and heir reach and should not					. 25	
L	On 6/14/2022 at 3:08 p.m conducted with LPN (lice PN #9 stated that the ca vithin reach of the reside	nsed practical nurse) #9.	(#C					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A. BUILD		LE CONSTRUCTION		SURVEY	
						С		
		486109	B. WING	_		06	15/2022	
	provider or supplier J <mark>rels of University P</mark> A	NRK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
	1							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of Deficiencies I must be preceded by full SC Identifying Information)	PREFIL TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA OEFICIENCY)		(XS) COMPLETION DATE	
F 558	delicited i totil page		F 5	558				
		i #9 stated that staff should coment during rounding the room.	2					
}	staff member) #1, the s director of nursing, ASN regional clinical coordin						V.	
- 1					F578			
F 578		vas presented prior to exit. tue Trmnt;Formite Adv Dir (g)(12)(i)-(v)	F 57	١	Criteria 1 Resident #'s 90, #78, #114, #16 and #58 sun adverse outcomes related to allegedly no			
	§483.10(c)(6) The right discontinue treatment, to to participate in experim formulate an advance di	ental research, and to		I	provided written information regarding the formulation of advanced directives at the tir admission or during periodic reviews. Upon notification from the surveyors regarding re 90, 78, 114, 16 and 58 the facility has obtain their advance directive status if applicable.	sidents,		
ti s	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or nappropriate. 483.10(g)(12) The facility must comply with the equirements specified in 42 CFR part 489, ubpart I (Advance Directives).			1	Admissions and Social Services were re-edu on obtaining advance directives and address them during periodic reviews.			
Ş				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Criteria 2 All current residents have the potential to be affected by the alleged deficiency. Audit cor o ensure current residents have an active ad- lirective.	npicted		
in	form and provide writte	n information to all adult right to accept or refuse		S	<u>Criteria 3</u> Social Services, Admissions and nurso leade. Will be re-educated regarding advanced direct and addressing them during periodic reviews	tives		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495109	B. WNG			C 06/15/2022		
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAYE, ZIP CODE 2420 PEMBERTON RD	<u> </u>	0/15/2022	
INE CAU	NECS OF UNIVERSITY PA		- 1	ı	RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	9E	(KI) COMPLETION DATE	
in for the ass	(ii) This includes a write facility's policies to impand applicable State is (iii) Facilities are permited in a policies to furnish this is legally responsible for requirements of this set (iv) If an adult individual time of admission and is information or articulate has executed an advance directly individual's resident repwith State Law. (v) The facility is not relipprovide this information or articulate provide this information or ahe is able to receive Follow-up procedures may propose time. This REQUIREMENT is presentative) were provided acility document review, eview, the facility staff fire presentative) were proiformation and provided ormulate advance direct dmission and/or conducte residents and/or their mulate one, or, if applieir existing advance direct existing advance direct existing advance direct existing advance direct existing advance directly advance directly advance directly in the provided ormulate one, or, if applieir existing advance directly advance direct	ulate an advance directive. ten description of the element advance directives liv. Itted to contract with other fromation but are still ensuring that the ction are met. It is incapacitated at the sunable to receive whether or not he or she ce directive, the facility dive information to the resentative in accordance eved of its obligation to to the individual once he such information, sust be in place to provide dividual directly at the inot met as evidenced view, staff interview, and clinical record ailed to evidence that it (resident vided with written if the opportunity to lives at the time of it a periodic review with RRs If they wish to cable, make changes to estives or maintain them	F5	76	Criteria 4 The Administrator or designee will concon all new admissions monitoring advandirectives. These audits will be done 5 d for four weeks; then twice in the last month. The weeks; then twice in the last month. The will be forwarded to the QAPI committee review. The QAPI committee will determine the formal audits and action. Criteria 5 Date of compliance is 7/26/22.	ice ays a we four so results s for	ck	

	THE POST MEDICALE	INCOIGNID OFILAIOFO			OMIDIN	<u>O. 0930-038</u>
	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION		E SURVEY
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		495109	B. MNG	<u> </u>	06	/15/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	IRELS OF UNIVERSITY PA	ARK	- 1	2420 PEMBERTON RD		
	т-			RICHMOND, VA 23233		J.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	REMENT OF DEFICIENCIES MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 578	Continued From page	40				
1 5/0			F 578	³		
	(R90) or the RR writter	ed to provide Resident #90				-
		n nationation and the 18 advance directives (1)		}		
		alled to conduct a periodic				
		ctives in 2021 and 2022				
		WYWW III ZOZI I GIIG ZOZZ.	1	1		
	R90 was admitted to th	e facility on 5/25/18. On	1	1		
ľ	the most recent MDS (i	minimum data set), an	1			
}	annual assessment with		1			
ĺ		/22, the resident scored 3	1	İ		
1		brief interview for mental			ľ	
í	status), Indicating the re				ľ	
}	cognitively impaired for	making daily declaions.	1		J	7.3
- 1	A review of R90's clinical	al record falled to reveal				
		was provided with written	1 1			
	information and provide	d the opportunity to	J		ł	
	formulate advance direc				ĺ	
		aw of R90's clinical record	1			
		es notes, evaluations and	1 1		j	1
	care conference minutes		1		j	- 1
	failed to reveal evidence		1 1			ı
	conducted a periodic rev		1 1		1	
		R90 or the RR (excluding	1 1		1	
- 1	resuscitation status) duri	ng 2021 or 2022,	1 1			
10	On 6/15/22 et 12:21 p.m.	an Interview was	1 1			
		ner staff member) #1, the	1 1		1	- 1
		tated advance directives] [1	- 1
,	re reviewed with resider		1			
- tř	ne admissions departme	ent upon admission to		•	.	- 1
l tr	ne facility. OSM #1 state	ed a review of residents'		•		,
	ode (resuscitation) statu					
	onducted during care pla]	
	ometimes other aspects					1
	re reviewed. OSM #1 st				1	
	dvance directives might		J]	
	an meeting minutes but					1
re	view could be evidence	d if it was not	ĺ			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE BURVEY COMPLETED		
1			1 200				С	
1		495109	B. WNG	_	<u></u>	08/15/2022		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		· A	
TUELAL	IDELO AF LIMBIFORITY NA	DV.		:	2426 PEMBERTON RD			
INE LAC	JRELS OF UNIVERSITY PA	arr.		ļį	RICHMOND, VA 23233			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		p(4) COMPLETION DATE	
	documented or checked on 6/15/22 at approximate interview was conducted member) #10, the admitted residents are advance directive notification and the admission contract is set then sent to the medicate the admissions departmented. OSM #10 state were looking for request notification/acknowledge on 6/15/22 at 2:32 p.m. staff member) #1 (the set (the director of nursing), clinical coordinator) and director of operations) was above concern. The facility policy titled, "Guest/Resident Rights & documented, "12. Advantacility must comply with specified in 42 CFR (coderat 489, subpart I (Advantacility must comply with specified in 42 CFR (coderat 489, subpart I (Advantacility must include proprovide written information of the set of	nately 2:00 p.m., an ed with OSM (other staff iselons coordinator. OSM ind/or their RRs fill out an cation/acknowledgment and this form is included in OSM #10 stated the ent to the business office. If records department after their is done with the led administrative staff ted advance directive ment forms. ASM (administrative directive ment forms. ASM (administrative directive ment forms. ASM #2 (the regional ASM #2 ASM #3 (the regional ASM #4 (the regional are made aware of the recility Responsibilities" ce Directives. The the requirements e of federal regulations) ince Directives)I. These visions to inform and in to all adult ing the right to accept or I treatment and, at the formulate an advance dividual is incapacitated and is unable to receive	F	578				
	as executed an advance lay give advance directiv							

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1	TIPLE CONSTRUCTION		E SURVEY IPLETED
		495109	B. WING _		O.	C 5/15/2022
117	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2420 PEMBERTON RD RIGHMOND, VA 22233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	atement of deficiencies / Must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
	with State law" The facility policy titled documented, "7. Revie Advance Directives. I. Code Status shall be nor the Patient Advocate Representative (if prop	I, "Code Status" ew and Discussion of Advance Directives and eviewed with the resident, e/Health Care erty invoked), or the or the patient surrogate (if ity ill/permanently	F 5	78		
A B B B III	Reference: (1) "What kind of medic you were too lit or hurt to Advance directives are allow you to spell out your of-life care ahead oway to tell your wishes the aith care professional ater on. A living will tells which trure dying or permanently occept or refuse medical nature of dialysis and	our decisions about if time. They give you a o family, friends, and is and to avoid confusion eatments you want if you y unconscious. You can if care. You might want to breathing machines citated if your breathing or in ney for health care is a ur health care proxy.				

	OF DEFICIENCIES OF CORRECTION	POENTICICATION MUMPED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			V. BOILD	A politimo			c	
		495109	B. WING	NG			08/15/2022	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LALL	RELS OF UNIVERSITY PA	IBK			2420 PEMBERTON RD			
1116 640	NEED OF ORITERSHIP FA	94/		L	RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI. TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	DBE	(X8) COMPLETION DATE	
F 578	Continued From page	12	-	578				
. 0.0	information was obtain			7			ĺ	
		https://medlineplus.gov/advancedirectives.html						
	The facility staff failed to conduct a periodic review of advance directives with Resident #78							
							i	
1		(R78) or the RR (resident representative) in 2021						
	and 2022.				}			
1	Resident #78 was adm	ultrad to the facility on						
1		ecent MDS (minimum data	1					
		in status essesment						
	with an ARD (assessmi							
		pred 15 out of 15 on the		ĺ				
		or mental status), indicating					1	
	the resident was not co			- [·		
]	making daily decisions.			1				
1.	A review of R78's clinic	al record (including social	}	-				
		ons and care conference					Ì	
	minutes for 2021 and 20		1	- [
- 1	evidence that the facility							
	periodic review of all as directives with R78 or th			- [
	esuscitation status) dur		1	1			1)	
1	Openovitation diagnot, doi:	ing Eval of Evel.		-				
	On 6/15/22 at 10:20 a.m	., an interview was						
1 -	conducted with R78. Th]	
1	ad not discussed advar	nce directives with the						
, n	esident.			1			} [
	on 6/15/22 at 12:21 p.m.	an interview was						
		her staff member) #1 (the						
	ocial worker). OSM #1							
		vith residents and/or their]					
	Rs by the admissions d							
		OSM #1 stated a review	}			ſ		
	f residents' code (resus	citation) status is uring care plan meetings					i	
	anodically conducted di no sometimes other asp						ĺ	
1 61	th abritioning and add	MAN AL BOADLING		,				

CENTE	10 1 OIL WEDIOUILE OF	MEDICAID SERVICES			01401	IO 0830-038
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION		E SURVEY APLETED
		495109	B. WING			C B/15/2022
NAME OF F	PROMOER OR SUPPLIER	450.00		REET ADDRESS, CITY, STATE, ZIP CODE	1 0	W 10/24/22
THE LAU	RELS OF UNIVERSITY PA	NBK	243	20 PEMBERTON RD		
	THE STATE OF	1111	RIC	CHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	nement of deficiencies (Must be preceded by full sc identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	COMPLETION CATE
	of advance directives in care plan meeting minimover a review could be documented or checked. On 6/15/22 at 2:32 p.m. staff member) #1 (the staff member) #1 (the staff member) and director of operations) with above concern. No further information with a staff failed.	d. OSM #1 stated a review might be checked off on utes but she wasn't sure evidenced if it was not id off. I., ASM (administrative administrator), ASM #2 , ASM #3 (the regional were made aware of the vas presented prior to exit. Id to provide Resident representative information	F 578			
F e n p R 2 of R da	quarterly assessment waterence date) of 5/23/3 out of 15 on the BIMS status) assessment, indiseverally impaired for material evidence documentation evidence to the responsitivided to the responsitivities of the care plant	f record failed to of advanced directive advanced directives ole party. neeting minutes dated failed to evidence review ice history evaluation			-	,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		TE SURVEY MPLETED
) c daile in			С
		495109	B. WING		01	6/15/2022
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	:	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION CATE
i di	On 6/14/2022 at approrequest was made to / member) #1, the admi information provided of formulate an advanced. On 6/15/22 at 12:21 p. conducted with OSM (isocial worker. OSM # are reviewed with residence and admission to the review of resident's conducted during care sometimes other aspectance reviewed. OSM #1 advance directives may plan meeting minutes be review could be evident advance directive may plan meeting minutes be review as conducted admissions coordinator, esidents and/or their residvance directive notification and the admission contract, admissio	eximately 8:00 a.m., a ASM (administrative staff nistrator for evidence of an apportunity to a difference of an apportunity to a difference for R114. m., an interview was other staff member) #1, a stated advance directives dents and/or their admissions department facility. OSM #1 stated a de status was periodically plan meetings and stated a review of a de checked off on care at the was not sure how a ced if it was not did off. ately 2:00 p.m., an add with OSM #10, the OSM #10 stated presentatives fill out an ation/acknowledgment ation/acknowledgment did this form is included in OSM #10 stated the sent to the business are medical records missions department was OSM #10 stated looking for the titive nent forms.	F 57	8		
(a	n 6/15/2022 et approxir dministrative staff mem iministrator, was made	ber) #1, the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495109	B. WING			C 06/15/2022	
151	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CO 2420 PEMBERTON RD RICHMOND, VA 23233	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XII) COMPLETION DATE	
F Control of the Cont	ADM #1 stated that the evidence of advance of provided or reviewed fill No further information. 4. The facility staff falls (R16) information on of formulate an advanced. On the most recent MD admission assessment reference date) of 3/14. 15 out of 15 on the BIM mental status) assessment resident is not cognitive daily decisions. On 6/13/2022 at approximately decisions. On 6/13/2022 at approximately decisions, R16 stated receiving any information advanced directives whe facility about 3 months feeliew of R16's clinical documentation of advanced directives who feeling any information of advanced directives who feeling	ey did not have any lirective information for R114 to provide. was presented prior to exit. ed to offer Resident #16 or an opportunity to a directive. It directive. It is a RRD (assessment resident scored is (brief interview for nent, indicating the or an exit in their room. Indicating the or making the or an exit in their room. Indicating the or an exit in their room. Indicating the or an exit in their room. Indicating the or an exit in their room. Indicative their room. Indicative their room of the exit in their room. Indicative their room of the exit in their room of the exit in their room. Indicative their room of the exit in their room of the exit in their room. Indicative admitted to evidence cod directive review or a directives provided. In the exit in their room of a directives of advanced of advanced of advanced of advanced of advanced of a directive review of a	F 578				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTI	PLE CONSTRUCTION	(NJ) DATE SURVEY COMPLETED		
		495109	B, WING		C 06/15/2022		
10.	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) iD PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST 86 PRECEDED BY FULL 8C IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	N	
	request was made to a member) #1, the admit information provided of formulate an advanced. On 6/15/22 at 12:21 p. conducted with OSM (in social worker. OSM #1 are reviewed with resident presentatives by the upon admission to the review of resident's conducted during care sometimes other aspectant reviewed. OSM #1 advance directives may plan meeting minutes be review could be evident documented or checked. On 6/15/22 at approximate interview was conducted admissions coordinator, residents and/or their readvance directive notific form upon admission and the admission contract was office and then sent to the contract and interview was conducted admission contract.	ASM (administrative staff inistrator for evidence of an opportunity to a directive for R16. Im., an interview was other staff member) #1, a stated advance directives denta and/or their admissions department facility. OSM #1 stated a le status was periodically plan meetings and ats of advance directives stated a review of the checked off on care at she was not sure how a sed if it was not off. ately 2:00 p.m., and with OSM #10 stated presentatives fill out an atton/acknowledgment do this form is included in OSM #10 stated the sent to the business as medical records inssions department was DSM #10 stated looking for the tive tive the findings.	F 57				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11.7	CONSTRUCTION		E SURVEY PLETED
		496109	B. WING		0.	C 5/15/2022
	PROVIDER OR SUPPLIER		24	TREET ADDRESS, CITY, STATE, ZIP CODE 420 PEMBERTON RD ICHMOND, VA 23233		I TOTZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULO BE	(XS) COMPLETION DATE
	5. The facility staff fall advance directive upor 58 (R58). On the most recent Mill admission assessment reference date) of 04/1 scored 15 out of 15 on for mental status), indiccognitively intact for materials and the cognitive of (R58's) clinicals.	firective information R16 to provide. was presented prior to exit. ed to obtain or discuss an admission for Resident # DS (minimum data set), an ewith an ARD (assessment 7/2022, the resident the BIMS (brief interview eating the resident is alking delity decisions.	F 578			
1 2 F	an advance directive. The current physician's 2022 documented, "Cod Resuscitate."	dence documentation of order sheet dated April le Status: Do Not				
CC SC SC SC SC SC SC SC SC SC SC SC SC S	re reviewed with reside apresentatives by the exponentatives by the exponents to the faction to the faction of residents' code anducted during care plantetimes other aspects reviewed. OSM #1 s	her staff member) #1, stated advance directives ints and/or their dimissions department cility. OSM #1 stated a status is periodically an meetings and sof advance directives tated a review of be checked off on care				

		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1111	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495109	B. WING			C 06/15/2022		
	OF PROVIDER OR SUPPLIER AURELS OF UNIVERSITY PA				STREET ADDRESS, CITY, STATE, 2IP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		716/2022	
(X4) PREF	IX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 584 \$8=D	review could be evided documented or checked occumented or checked. On 6/15/22 at approximate interview was conducted admissions coordinate residents and/or their madvance directive notification contract is a then sent to the medicate admission contract is a then sent to the medicate admissions departmented to the medicate of the admissions departmented to the medicate of the admission departmented with (R58). It is a staff discussed or obtain with them (R58) stated to own admission paperwood her about an advance of the administrative staff mendid not have (R58's) advantification/acknowledge No further Information with Safe/Clean/Comfortable/	nately 2:00 p.m., an od with OSM #10, OSM #10 stated apresentatives fill out an cation/acknowledgment and this form is included in OSM #10 stated the ent to the business office if records department after each is done with the ted administrative staff advance directive ment forms. In, an interview was When asked if the facility red an advance directive hat they completed their rick and that no one asked rective. Instely 4:48 p.m. ASM inber) #1 stated that they ance directive each form. Its presented prior to exit. Homelike Environment ent. In a safe, clean, a environment, including a treatment and	F 584		F584 Criteria 1 Resident #134 suffered no adverse outcome related to the bathroom allegedly not being Upon notification from the surveyor regard resident #134's dirty bathroom, it was immedeen cleaned. Housekeeping staff re-educations are sident #134's bathroom is clean.	clean. ing ediately ed on		

	OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·	E CONSTRUCTION		E SURVEY PLETED
		498109	B. WING		06	C /16/2022
THE LAU	PROVIDER OR SUPPLIER			BTREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	9E	(XS) COMPLETION DATE
Section 1	homelike environme use his or her person possible. (I) This includes ensured are and serphysical layout of the independence and difference and difference are and services recessary to and comfortable interior services recessary to and comfortable in good condition; §483.10(i)(3) Clean be are sident room, as specification as a services in all areas; §483.10(i)(5) Adequate sevels in all areas; §483.10(i)(6) Comfortable interior sevels. Facilities initially sevels.	vide- clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for resident's property from loss eeping and maintenence maintain a sanitary, orderly, for; ed and bath linens that are closet space in each cified in §483.90 (e)(2)(iv); e and comfortable lighting able and safe temperature y certified after October 1, temperature range of 71 to taintenance of comfortable de not met as evidenced resident interview, staff acord review, the facility		Criteria 2 All current residents have the potential of affected by this alleged deficient practice current resident bathrooms were completensure they were clean and homelike. Criteria 3 Housekeeping staff will be re-educated of residents bathrooms are safe/clean/comforthomelike. Criteria 4 The Administrator or designee will conducted and manuality to ensure resident bathrooms afe/clean/comfortable and homelike, the will be done 5 days a week for four weeks; then twice ast month. These results will be forwarded API committee for review. The QAPI covill determine the needs for further audits ction. Criteria 5 Date of compliance is 7/26/22.	e. Audit of ted to n ensuring ortable and oct (5) ns are se audits s; then in the d to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AS IMPER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
1			T BOILD			c		
l		495109	B. WING			1 (06/15/2022	
NAME OF	PROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF UNIVERSITY PA	ARK .			2420 PEMBERTON RD			
				\Box	RICHMOND, VA 23233			
(X4) IO PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 584	F 584 Continued From page 21		F !	584				
	homelike environment the survey sample, Re	for one of 59 residents in sident #134,						
	The facility staff failed #134's (R134) bathroomenner.	to maintain Resident m in a clean and homelike						
	The findings include:							
	quarterly assessment w reference date) of 5/27/ out of 15 on the BIMS (DS (minimum data set), a vith an ARD (assessment /22, the resident scored 14 brief interview for mental esident was not cognitively by decisions.						
1	resident stated the bath facility staff do not clean	interview with R134, the room was dirty and the the floor in the bathroom. tion of R134's bathroom prown particles were the right corner behind ers under the sink; hair						
R	On 6/14/22 at 3:05 p.m., t134's bathroom was co articles and hair remain						D)	
on he he he be	on 8/14/22 at 3:49 p.m., onducted with OSM (ottousekeeper). OSM #6: nould be swept and mojore than once if needed busekeeper responsible athroom had left for the 134's bathroom was obs SM #6 stated the bathroom	ner staff member) #8 (a stated bathroom floors oped once every day and d. OSM #6 stated the ofor cleaning R134's day. At that time, served with OSM #6.	j.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	111	PLE CONSTRUCTION		E BURVEY PLETED
1			A. Boilean			C
İ		496109	a. WING	 -	06	/15/2022
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	<u>5</u> 2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	atement of deficiencies / Must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(XI) COMPLETION DATE
F 584	cleaned and was not of On 6/15/22 at 11:35 a. staff member) #1 (the (the director of nursing clinical coordinator) and director of operations) above concern.	clean or homelike. m., ASM (administrative administrator), ASM #2 i), ASM #3 (the regional ad ASM #4 (the regional were made aware of the	F 58	34	•	
F 607 SS=D	S=D CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,		F 607	staff have the potential to be affected by deficiency. An audit was completed by director and all licensed staff have curlicenses. Criteria 3 HR director was reeducated to verify by	/ licensed by the allege the HR ent verified	1
	neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and in the course of a complaint investigation, the facility staff failed to implement the facility abuse policy for 4 of 11 employee record reviews.		when Job offer is extended. Criteria 4 The HR director/designees will conduct audits on all new hires to assure license verified in is in personnel file. These at done 5 days a week for four weeks; the week for four weeks; then twice in the The results will be forwarded to the Q/committee for review. The committee of determine the need for further audits and Criteria 5 Date of compliance is 7/26/22.		t weekly has been dits will be n one day a ast month. PI	,

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION AT BARED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		485109	8. WNG				C	
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA		0.74110	2420	ET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD MOND, VA 23233] 06	3/18/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XII) COMPLETION DATE	
di di di di di di di di di di di di di d	nursing license verifications (NAs)certified nursing two LPNs (licensed preserved to LPNs (licensed problem) and documented, "A. S. Guests/Residents: 1. The potential new employees reglect, exploitation, more mistreatment by a consistency of the exception, all potential is candidates must have to the appropriate boards (license/certification and has been taken against certification." CNA #3 was hired on 8/18/2 a.m., a review of certification ember) #9 (the account coordinator). OSM #9 contact a license verification in the consistency was proposed to the conduction of the condu	to conduct certification and ations upon hire for two assistant) #3 and #4, and actical nurse) #10 and #11. Ibition policy was reviewed creening Employees and he facility will screen as for a history of abuse, sappropriation of property aurt of law2. Without icensed and certified heir status confirmed with to verify to determine if any action the license or 25/21. CNA #4 was hired a hired on 8/18/21. LPN 1. On 6/15/22 at 11:04 ation and license ted with OSM (other staff ts payable payroll build not provide evidence was conducted upon LPN #10 or LPN #11. Ing department was g license verifications were hired. OSM #9 sible for conducting M #9 stated she ions through the Virginia as soon as she receives	F	307				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING A, BUILDING			(X3) DATE BURVEY COMPLETED C		
		495109	B. WNG_		08/16/2022
23	PROVIDER OR SUPPLIER	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	
(%) ID PREFIX TAG	(EACH DEFICIENC)	atement of deficiencies y must be preceded by full sc identifying information)	iD PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
	staff member) #1 (the (the director of nursing clinical coordinator) and director of operations) above concern. No further information: Transfer and Discharge CFR(s): 483.15(c)(1)(i) \$483.15(c)(1) Facility in \$483.15(c)(1) Facility in (i) The facility must penremain in the facility, ard discharge the resident (A) The transfer or discipantal because the resident's learned because the resident's laufficiently so the resident's provided by the (C) The safety of individendangered due to the distance of the resident; D) The health of Individuation of the resident has fall appropriate notice, to painder Medicare or Medicion ayment applies if the content of the propries of the safety of individuation of the resident has fall appropriate notice, to painder Medicare or Medicion applies if the content of the propries of the safety of individuations are sident as fall appropriate notice, to painder Medicare or Medicion applies if the content applies if the cont	m., ASM (administrative administrator), ASM #2 1), ASM #3 (the regional ad ASM #4 (the regional were made aware of the was presented prior to exit. a Requirements (ii)(2)(i)-(iii) d discharge-equirements-mit each resident to ad not transfer or from the facility unless-harge is necessary for the he resident's needs chitry; harge is appropriate needs the ofacility; hals in the facility is dinical or behavioral uals in the facility would d; ed, after reasonable and y for (or to have paid cald) a stay at the facility. He resident does not	F 622	F622 Criteria 1 Resident #128 was discharged from the 5/17/22. Criteria 2 All current residents who are discharged hospital have the potential affected by the deficiency. Criteria 3 Nursing staff will be reeducated on the cette hospital policy and the required doct that is to be sent with resident when discette hospital. Criteria 4 The DON or designee will conduct audit morning clinical operations meeting regaresident discharge, these audits will be do a week for four weeks; then one day a we four weeks; then twice in the last month, results will be forwarded to the QAPI confor review. The committee will determine for further audits and/or action.	to the is alleged lischarge to imentation harged to later riding one 5 days lek for limited limited.
P M re re	ubmit the necessary pa ayment or after the third ledicare or Medicaid, de esident refuses to pay for esident who becomes el dmission to a facility, the	party, Including enies the claim and the or his or her stay. For a igible for Medicaid after		Criteria 5 Date of compliance is 7/26/22.	

	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILO		LE CONSTRUCTION		TE SURVEY	
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		495109	a. WING	_		00	8/16/2022	
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK		;	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XII) COMPLETION DATE	
(i) (i) (i) (i) (i) (i) (i) (i) (i) (i)	or (F) The facility ceases (II) The facility may not resident while the apprehance of this chapter at the facility may not resident while the apprehance of this chapter at the facility of the resident facility. The facility must facility. The facility must facility at the facility must facility at the facility transfer of the facility must president under any of the paragraphs (c)(1)(i)(A section, the facility must or discharge is document and approximation or provider. i) Documentation in the must include: A) The basis for the train of this section. B) In the case of paragrection, the specific resident, and the service a scility to meet the need(city to meet the need(ci	to operate. It transfer or discharge the seal is pending, pursuant to ter, when a resident that to appeal a transfer or the facility pursuant to \$ tapter, unless the fallure to ould endanger the health to other individuals in the st document the danger or discharge would pose. Intation. It is or discharges a telectromatances apecified to the resident's reprinted in the resident's ropriate information is ceiving health care resident's medical record that the resident to meet the resident to meet the resident valiable at the receiving solutions.	F	322				

NAME OF PROVIDER OR BUPPLIER THE LAURELS OF UNIVERSITY PARK (A) D REPRIX TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG CONTINUED FOR PROPRIATE TAG F 622 CONTINUED FOR PROPRIATE TAG CONTINUED FOR TAG		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		COMPLETED		
THE LAURELS OF UNIVERSITY PARK THE LAURELS OF UNIVERSITY PARK THE LAURELS OF UNIVERSITY PARK REGULATORY OR LISC IDENTIFYING INFORMATION) FREEXIX TAG FREEXIX	1		495109	B. WING					C 8/4 <i>5/2</i> 022	
PREFIX TAG REGULATORY OR LSG (REMTPYING INFORMATION) F 622 Continued From page 28 necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Readdent representative information including contact information or precautions for organizer care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with \$483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REGUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff falled to evidence that all required documentation was provided to the receiving facility for a hospital transfer for 1 of 53 readdents in the survey sample, Realdent #128. The findings include: Resident #128 was transferred to the hospital on \$1/17/22. There was no evidence that the compensation representation ist, relevant progress notes or labs were provided to the hospital. Resident #128 was admitted to the facility on \$1/10/21. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Data) of \$50/222, the			ARK		2420	PEMBERTON RD	Ē	V	OFTOTAGE	
necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact Information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact Information (C) Advance Directive Information (D) All special Instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals. (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as explicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff falled to evidence that all required documentation was provided to the receiving facility for a hospital transfer for 1 of 55 realdants in the survey sample; Resident #128 was transferred to the hospital on \$/17/22. There was no evidence that the comprehensive care plan goals, medication list, relevant progress notes or labs were provided to the hospital. Resident #128 was admitted to the facility on \$/10/21. On the most recent MDS (Minimum Data Set), a quarterly assessment MOS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 5/30/22, the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFD		(EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A	SHOULD BE		COMPLETION	
resident scored an 11 out of a possible 15 on the		necessary under para this section. (iii) Information provid must include a minimu. (A) Contact information responsible for the car (B) Resident represent contact information. (C) Advance Directive. (D) All special instruction ongoing care, as approvided in the recessary copy of the resident's of consistent with §483.2 any other documentation as afe and effective training the review it was determined failed to evidence that a was provided to the rectransfer for 1 of 59 resident #128. The findings include: Resident #128 was transfer for 1 of 59 resident #128. Resident #128 was transfer for 1 of 59 resident #128. Resident #128 was transfer for 1 of 59 resident #128. Resident #128 was transfer for 1 of 59 resident #128. Resident #128 was admit #128.	graph (c)(1)(i)(C) or (D) of ed to the receiving provider am of the following: n of the practitioner re of the resident. tative information including Information ons or precautions for opriate. re plan goals; y information, including a lischarge summary, 1(c)(2) as applicable, and on, as applicable, to ensure nation of care. Is not met as evidenced w and clinical record of that the facility staff full required documentation eiving facility for a hospital fents in the survey sferred to the hospital on evidence that the n goals, medication list, or labs were provided to itted to the facility on cent MDS (Minimum sessment with an ARD Date) of 5/30/22, the	F 6	22					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CO	(X3) DATE SURVEY COMPLETED		
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		495109	B. WING			0	6/15/2022
	PROVIDER OR SUPPLIER PRELS OF UNIVERSITY PA	ARK		2420	EET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD HMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	RTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEPICIENCY)		COMPLETION DATE
	BIMS (Brief Interviews the resident was mode in ability to make daily resident was coded as assistance for eating a areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of de areas of activities of areas of activities of areas of activities of	for Mental Status) indicating brately impaired cognitively life decisions. The requiring extensive and total care for all other ally living. record revealed a nurse's to documented, "Nurse between the resident not at earlight facial droop and to follow directions. Vitals sure), P-96 (pulse), T-97.4 spirations), 02-97% RA boom air). Resident has me of hospitally via mergency medical uation. Report called into by N.P. (nurse practitioner) RP (responsible party). The dated 5/17/22 by (patient) has been updated." The dated 5/17/22 by (patient) has been updated." The dated 5/17/22 by (patient) has been updated. The patient of speech. No ingrip strength, right disjuring of speech. No ingrip strength, right disjuring of speech. No ingrip strength, right disjuring sent to ER for albie TIA/Stroke/UT1 of (mini stroke), stroke,	F	522			

	TMENT OF HEALTH AN					FOF	ED: 06/28/2023 RM APPROVEI IO. 0938-0391		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED		
1		495109	B. WING			06	C 3/15/2022 *		
NAME OF	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	- 00	7012022		
THE LAU	RELS OF UNIVERSITY PA	AK		} _	1420 PEMBERTON RD RICHMOND, VA 23233				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD S			()(8) COMPLETION DATE		
i i i i i i i i i i i i i i i i i i i	Information, vital signs transfer (a fall, which w 5/17/22) code status, a care needs. Further review of the circveal any evidence with provided to the hospital to comprehensive care list, relevant progress in On 6/14/22 at 3:00 PM conducted with LPN #4 Nurse). She stated that the facility should send face sheet, advance disprogress notes, labs, be On 6/14/22 at approximate (Administrative Staff Mewas provided a list of ite included evidence of whorovided to the hospital. On 6/15/22 at 9:40 AM, Aursing, stated there was focumentation regarding to a document this informatical conditions.	(dated 5/17/22), reason for ras not accurate for and ongoing medical and inical record failed to not documentation was i, including but not limited plan goals, medication otes or labs. an Interview was (Licensed Practical ton a hospital transfer, the hospital transfer form, actives, medication list, id hold and care plan. ately 4:00 PM ASM #1 mber) the Administrator, ms needed, which at documentation was ASM #2, the Director of s no other what was sent to the the staff are supposed tion in the nurse's note. SM #1 was provided with the admission, transfer, er requirements. On	F	322					
	mails with policies attact dmission, transfer, disch								

requirements was provided.

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDPLAN	OF CORRECTION	IDENTIFICATION NOMBER:	A, BUILDII	NG_			
]		495109	B. WNG				C /15/2022
NAME OF	PROVIDER OR SUPPLIER	400100	1 2 2 2	A	ITREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	1012022
10000207	THOUGHT ON OUT FORM				420 PEMBERTON RD		
THE LAI	urela of university pa	ARK		_	RICHMOND, VA 23233		
	DIMMARY STA	NTEMENT OF DEFICIENCIES	I ID		PROVIDER'S PLAN OF CORRECTION		(8)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	PREFIX TAG	,	(EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 622	,		F6	22			
	No further information			- }			
F 623		Before Transfer/Discharge	F 6	23			•
\$\$=D	CFR(s): 483.15(c)(3)-(6)(8)	1	- 1	Criteria 1		
				Ī	Resident # 128 was discharged to the ho.	spital on	
	§483.15(c)(3) Notice b		1	i	5/17/22		*
	Before a facility transfe			- 1	Criteria 2		
	resident, the facility mu				All current residents discharged to the ho	umital kar	
	(i) Notify the resident a	and the residents transfer or discharge and			the potential to be affected by the alleged	shiret tie	YC
	the reasons for the mo			- 1	deficiency,		
	lenguage and manner			-			
	facility must send a con				Criteria 3		
	representative of the O				Licensed nurses will be educated on the p	olicy for	
	Long-Term Care Ombu	daman.			notification of Hospital Transfer to reside responsible party.	nt and or	
	(ii) Record the reasons	for the transfer or		-1	responsible party.		
	discharge in the resider		1		Critoria 4		
		aph (c)(2) of this section;			The DON/Designee will conduct audits m	onitoring	:
	and				resident and RP notification of hospital tra	insfer.	
	(iii) Include in the notice				These audits will be done 5 days a week for	ਸ four	
	paregraph (c)(5) of this	section.		- [weeks; then one day a week for four week twice in the last month. The results will be	s; then	- 1
	§463.15(c)(4) Timing of	the notice		- i i	forwarded to the QAPI committee for review	ou The	- 1
		n paragraphs (c)(4)(ii) and		-18	QAPI committee will determine the needs	for	
	(c)(8) of this section, the		9	_ f	further audits and action.		ļ
ĺ	discharge required under			'			
	made by the facility at le				Citaria 6		j
	resident is transferred of				Criteria 5	1	
	(ii) Notice must be made	es soon as practicable		í	Date of compliance is 7/26/22.		
	before transfer or discha			1			
	(A) The safety of individual						.
	be andangered under pa	eragraph (c)(1)(i)(C) of					
	this section;	- 1 - N - M - M			•		i
	(B) The health of individe					- 1	
	be endangered, under parties section:	aragraph (c)(1)(I)(D) or				1	
	this section; (C) The resident's health	improved aufficiently to					
	(C) The residents health allow a more immediate]				
	allow a more immediate under paragraph (c)(1)(l)		1				
- 1	auses beseRight (a)(1)(i)	(a) or man account.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY
		498109	B. WING	_	1,	C 08/15/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2420 PEMBERTON RD RICHMOND, VA 23233		1517512022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON BHOULD BE IE APPROPRIATE	COMPLETION DATE
the control of the co	(D) An immediate tran required by the resider under paragraph (c)(1) (E) A resident has not days. §483.16(c)(6) Contents notice specified in paramat include the follow (i) The reason for trans (ii) The effective date o (III) The ocation to which transferred or discharge (IV) A statement of the rincluding the name, add and telephone number receives such requests; to obtain an appeal form completing the form and telephone number of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term Care Ombuction of the cong-Term care of the	sfer or discharge is nt's urgent medical needs, l(l)(A) of this section; or resided in the facility for 30 s of the notice. The written ligraph (c)(3) of this section ling: sfer or discharge; f transfer or discharge; ch the resident is ad; resident's appeal rights, dress (mailing and email), of the entity which and assistance in d submitting the appeal (mailing and email) and a Office of the State Isman; seldents with intellectual boilitles or related and email address and a gency responsible for accy of individuals with a established under Part Disabilities Assistance 2000 (Pub. L. 106-402, 201 et seq.); and asidents with a mental lities, the mailing and fore number of the te protection and with a mental disorder	F 623			

	FOF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY
							С
		495109	B. WING			01	8/15/2022
	PROVIDER OR SUPPLIER	RK		2	TREET ADDRESS, CITY, STATE, ZIP CODE 420 PEMBERTON RD LICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREPI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
	for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer or must update the recipital practicable once the becomes available. §483.15(c)(8) Notice in In the case of facility of the administrator of the written notification prior to the State Survey Age State Long-Term Care the facility, and the resident 483.70(l). This REQUIREMENT is by: Based on staff interview review it was determined failed to evidence that whospital transfer was proposed in the property one of 59 residents in the Resident #128.	als Act. Is to the notice. In notice changes prior to redischarge, the facility ents of the notice as soon audated information advance of facility closure osure, the individual who is facility must provide to the impending closure ency, the Office of the Ombudsman, residents of dent representatives, as transfer and adequate his, as required at § Is not met as evidenced at and clinical record of the facility staff written notification of a povided to the resident for a hospital transfer for e survey sample;	F	523			
9	Resident #128 was admi 1/10/21. On the most re- lata Set), a quarterly as	cent MDS (Minimum					

	TMENT OF HEALTH AN					ED: 06/28 <mark>/202</mark> ; RM APPROVE
STATEMENT	RS FOR MEDICARE & FOR DEFICIENCIES OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DAT	IO. 0938-039 [.] TE BURVEY MPLETED
1	i	496109	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	430103	1 B. VIII CO	ADDRESS AND AND ADDRESS AND AD	0	8/15/2022
I TOME OF	PROVIDER OR GOPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF UNIVERSITY PA	RK		2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) IO PRÉFIX TAG	(SACH DEFICIENCY	Tement of Deficiencies Must be preceded by Full SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D 8E	(M) COMPLETION DATE
	BIMS (Brief Interview in the resident was mode in ability to make daily resident was coded as assistance for eating all areas of activities of da A review of the clinical anote dated 5/17/22 that practitioner in facility ob [their] baseline, observe slow to respond. Able to BP-128/78 (blood press (temperature), R-17 (resident compensation on rebeen transported to [neastretcher with EMT's (embechnicians) for an evaluation of the compensation o	per Date) of 5/30/22, the put of a possible 15 on the put of a possible 15 on the put of a possible 15 on the put of a possible 16 on the put of a possible 16 on the requiring extensive and total care for all other lily living. The record revealed a nurse's documented, "Nurse served resident not at adright facial droop and of follow directions. Vitals ure), P-98 (pulse), T-97.4 apirations), 02-97% RA form air). Resident has the of hospitally via the precipital via the properties of the put of the provided into the put of the provided into the put of the provided into the put of the provided into the put of the provided into the put of the provided into the put of the put of the provided into the put of th	F 62	3		

urinary tract infection.)"

minimal right facial droop, pt being sent to ER for further evaluation of possible TIA/Stroke/UTI (transient ischemic attack (mini stroke), stroke,

A review of the clinical record revealed a Hospital

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

PRINTE	0: 08/28/2022
FORM	APPROVED
OMB NO	1028-0301

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(XZ) MULT	TIPLE CONSTRUCTION			E SURVEY IPLETED
		496109	B. WNG_				C 5/15/2022
	PROVIDER OR SUPPLIER URELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, Z 2420 PEMBERTON RD RICHMOND, VA 23233	IP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED TO DEFICIT	ACTION SHOULD BI TO THE APPROPRIA		(X5) COMPLETION DATE
	Transfer form complet some reason dated 2/ resident demographic (dated 5/17/22), reason was not accurate for 5/ ongoing medical and composite particles and expensive providence of hospital transfer being and/or reasonsible particles and conducted with LPN #4 Nurse). She stated that written notification of a limit of the included evidence of a whospital transfer being pland/or responsible party. On 6/15/22 at 9:40 AM, Nursing, stated there was written notification of a hiprovided.	ed on 5/17/22 (but for 11/22) that documented information, vital signs of for transfer (a fall, which (17/22) code status, and are needs. Iinical record falled to a written notification of a provided to the resident by. an Interview was (Licensed Practical to the was not sure about a hospital transfer. ately 4:00 PM ASM #1 (amber) the Administrator, are needed, which (avritten notification of a provided to the resident for a provided to the resident for a provided to the resident for a provided to the resident for a provided with displaying transfer was sold which included a provided to the facility sent for requirements. On is 39 PM the facility sent field. None for marge, hospital transfer ad.	F 63	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		TIPLE CONSTRUCTION		(X3) DATE BURVEY COMPLETED	
	3		\$2	A. BUILDING			C		
			495100	B. WING			06/15/2022		
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE, ZIP CODE			
Ι.	CLUT L ATA	DEL 0 00 (IND/500/5) 24	Pole	2	2420 PEMBERTON RD				
THE LAURELS OF UNIVERSITY PARK					F	RICHMOND, VA 23233			
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		O(5) COMPLETION DATE		
	\$6=0	ME OF PROVIDER OR SUPPLIER HE LAURELS OF UNIVERSITY PARK K4) ID SUMMARY STATEMENT OF DEFICIENCIES REFLX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		. F 6	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		ne y this od hold to o ensure een given l be ee day a month.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		407400 E 147N					С	
495109			B. WING			06/16/2022		
NAME OF	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE			
THELA	IIDEI 9 OF IINNEDSITY DA	DK	ĺ	2	420 PEMBERTON RD			
THE LAURELS OF UNIVERSITY PARK				R	RICHMOND, VA 23233			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(PU) COMPLETION DATE	
F 625	F 625 Continued From page 35		Fe	25				
	The findings include: 1. Resident #128 was on 5/17/22. There was bed hold notice was prand/or responsible part. Resident #128 was add 9/10/21. On the most in Data Set), a quarterly a (Assessment Referencesident scored an 11 of BIMS (Brief Interview for the resident was moder in ability to make daily like in the resident was moder in ability to make daily like in the resident was moder in ability to make daily like in the resident was moder in ability to make daily like in ability to make daily like in the practitioner in facility ob [their] baseline, observe slow to respond. Able to BP-128/78 (blood press (temperature), R-17 (resident with EMT's (entechnicians) for an evaluation of a stretcher with EMT's (entechnicians) for an evaluation of the stretcher with EMT's (entechnicians) for an evalu	transferred to the hospital on ovided to the resident by. mitted to the facility on recent MDS (Minimum issessment with an ARD of 5/30/22, the out of a possible 16 on the or Mental Status) indicating rately impaired cognitively life decisions. Decord revealed a nurse 's documented, "Nurse served resident not at dright facial droop and of follow directions. Vitals ure), P-96 (pulse), T-97.4 spirations), 02-97% RA om air). Resident has ne of hospitalj via nergency medical lation. Report called into y N.P. (nurse practitioner) P (responsible party). The proposible party). The proposible party in the proposition of the possible party in the proposition of the party in the pa						
	was not accurate for 5/17 ongoing medical and can							

PRINTED: 06/28/2022

		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10, 0938-03	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495109	6. WNG_			C 8/1 <i>6</i> /2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF UNIVERSITY F	PARK		RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORU (EACH CORRECTIVE ACTION 8 CROSS-REFERENCED TO THE AL DEFICIENCY)	SHOULD DE	COMPLETIO DATE	
F 625	Continued From pag	e 36	F 62	5			
]	clinical record failed to				1	
		of a written bed hold notice resident and/or responsible					
	#4. She stated that a facility should send the	Licensed Practical Nurse) on a hospital transfer, the se hospital transfer form, directives, medication list,					
i k	(Administrative Staff & was provided a list of included evidence of a	mately 4:00 PM ASM #1 fember) the Administrator, items needed, which a written bed hold notice resident and/or responsible					
- 1		I, ASM #2, the Director of was no evidence that a was provided.					
	e list of policies reques request for one regardi discharge, hospital trar	ASM #1 was provided with sted, which included a lng admission, transfer, nafer requirements. On the facility sent					

emails with policies attached. None for admission, transfer, discharge, hospital transfer

No further information was provided.

2. The facility staff failed to evidence a bed hold was provided when Resident #76 was transferred to the hospital on 4/20/22. The facility's "Acute Care Transfer Document Checklist" did not evidence bed hold on the check list.

requirements was provided.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLI IDENTIFICATION NUMBER

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495109	B, WING_			C 06/18/2022	
1000	PROVIDER OR SUPPLIER URELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		001 1G/2G22	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SMC CROSS-REFERENCED TO THE APPL DEFICIENCY)	OVLD BE	(XB) COMPLETION DATE	
F 625	Continued From page	37	F 6:	25			
	were not limited to: Es disease), COPD (chror disease, diabetes melli Resident #76's most reset) assessment, an arrassessment reference resident as scoring 9 or interview for mental statesident was moderated. A review of the eINTER Reduce Acute Care Trad/20/22 at 4:28 PM, rev "Mental confusion, weal pressure-22/112, pulse temperature-97.7, oxygiroom air. Emergency as transported resident to it party) and NP (nurse producted with LPN (lick When asked what bed his resident is transferred to stated, There is a form to been sent with the resident	It's diagnoses included but SRD (end stage renal nic obstructive pulmonary itus and dementia. It cant MDS (minimum data musi assessment, with an date of 3/19/22, coded the ut of 15 on the BIMS (brief itus) score, indicating the y cognitively impaired. ACT (INTerventions to insfera) form dated ealed the following, kness. Vital signs blood e-76, respirations-21, en saturation-98% on slatance arrived and nospital. RP (responsible actitioner) notified." an interview was ensed practical nurse) #1, old is provided when a the hospital, LPN #1 ocheck off, of what has ent, there is a big papers in. I do not know thely 4:00 PM a request os of the bed hold policy transferred to the					
10	On 6/14/22 at approximal	tely 9:00 AM, SBAR					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.71.111	IPLE CONSTRUCTION	(XS) DAT	E \$URVEY PLETED
		495108	B, WING			C
	Provider or Supplier JRELS OF UNIVERSITY PA			STREET ADDRESS, CITY, STATE, 2IP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		3/15/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Must be preceded by full BC (Dentifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D 86	COMPLETION DATE
	(situation background a recommendation) form provided. On 6/14/22 at 4:00 PM bed hold for Resident & On 6/15/22 at 1:40 PM, member) #1, the admin not have the bed hold for When ASM #1, the admin the director of nursing whe bed holds for residents, does that but she is on the control of the director of nursing when Asm #2, the regional clin ASM #3, the regional clin ASM #4, the regional director of the above of the ab	assessment for Resident #76 was request made again for #76. ASM (administrative staff istrator, stated, "We do or this resident." sinistrator and ASM #2, were asked who provides they stated, admissions vacation. ASM #1, the he director of nursing, nical coordinator and ector of operations were encern. 8/15/22 on 3:30 PM for	F 6:	25		
Į e	any policy related to bed No further information wa	holds.		É		
F 641 A	Accuracy of Assessments CFR(s): 483.20(g)		F 641	F641		
re Ti by	483.20(g) Accuracy of A he assessment must accessiont's status. his REQUIREMENT is a y: lased on staff interview, and in the course of a control of the state of	curately reflect the not met as evidenced clinical record review		Criteria J. Residents #'s 46, 114, and 701 suffered no outcomes related to the alleged inaccurate of their MDS assessments. Residents #46 had their MDS's corrected and resident #7 longer in the facility so social services staff re-educated on ensuring assessments are coand coded accurately.	coding and #114 Of is no Twere	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

prior assessment was an End of PPS Part A Stay with an ARD of 4/21/2022 and a quarterly MDS

Review of the clinical record for R46 revealed documented falls on 5/5/2022 and 5/21/2022.

"5/5/2022 10:03 (10:03 a.m.) Resident was found on the floor at 0025 (12:25 a.m.) in her room facing the door by her aid, her bed was behind her and wheelchair within 5 ft (feet) to her left. Resident stated that she was going to get some fish. Neuro (neurological) assessment conducted and her vital signs were within normal limits, alert

The progress notes documented in part:

with an ARD of 4/11/2022.

PRINTED: 06/28/2022

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495109 a. wing 06/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RO THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY Continued From page 39 F 641 Criteria 2 was determined that the facility staff failed to All current residents have the potential to be accurately code the MDS (minimum data set) affected by the alleged deficient practice. Audit resident assessment for 3 of 59 residents in the completed to ensure current residents MDS's were coded correctly for falls and social services sections survey sample, Resident #46, #114 and #701. were coded accurately. The findings include: Criteria 3 Social Services MDS coordinators will be re- The facility staff failed to accurately code educated on ensuring all MDS assessments are Resident #46's (R46) quarterly MDS with an ARD coded accurately. (assessment reference date) of 8/4/2022 for falls sustained at the facility since the previous Criteria 4 assessment. MDS Director or designee will randomly audit five (5) MDS assessments to ensure assessments are On the most recent MDS, a quarterly assessment coded accurately. These audits will be done 5 days with an ARD of 6/4/2022, the resident scored 3 a week for four weeks; then one day a week for out of 15 on the BIMS (brief interview for mental four weeks, then twice in the last month. These status) assessment, indicating the resident is results will be forwarded to the QAPI committee severely impaired for making daily decisions. for review. The committee will determine the need Section J1800 documented R46 not having any for further audits and/or action. falls since admission/entry or reentry or prior assessment. Criteria 5 Date of compliance is 7/26/22. Review of the clinical record revealed a list of R46's MDS assessments. The list revealed the

		ND HUMAN SERVICES				ITED: 06/28/202 ORM APPROVE
CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X)	DATE SURVEY COMPLETED
		496109	B. WING_			C 06/15/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	VO 10/2022
			- 1	2420 PEMBERTON RD		
THE LAU	IRELS OF UNIVERSITY P	ARK		RICHMOND, VA 23233		
(X4) ID	BUMMARY ST	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN	OF CORRECTION	OVID
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	,	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION
F 641	Continued From page	40	F 64	41		
	, -	name speech clear and	"	**		-
	Moicel PERRIA (our	ils, equal, round, reactive to				}
		tion) and able to move all	ļ	1		1
		. No injuries or complaints				
	of pain or discomfort	n	ſ	}		1
		3 a.m.) Resident had an	1			1
		5 pm, resident was self	1			
	propelling wheelchair i	n hallway and alld out of	1			
		rith shoes Intact. Resident	1			Ì
	was assessed with no		-			
	On 6/15/2022 at 9:44 a	T. on intendeuture				
- 1		glatered nurse) #1, MDS	1	ĺ		
	nurse. RN #1 stated th		1			1
ľ	manual for guidence in		1	J		1
- 1	assessments. RN #1 s	itated that they reviewed				J
	the look-back period for]		
		sessments. RN#1 stated	1	1		1
		dinical record for falls. RN	1			1 1
	#1 stated that they wou	ld review R46's quarterly	ſ	1		1 1
- 1	MDS with the ARD of 6/	/4/2022 and see if it	1	1		
1	should have been code	d for falls.				
	On 6/15/2022 at 2:03 p.	m DNI#4 sinted that				
	her had seviewed the a	uarterly MDS for R46 and	1	1		
	hat it should have been	coded for fells. ON #1				
	itated that R46 had falls		ľ			1 1
		ted on the quarterly MDS]		1 1
	with the ARD of 6/4/2022]		1
	coording to the RALLIA	nual, Version 1.16, dated	18.5			 .
		1800 documented in the] [
	tops for assessment, "			(2)	•]]
	ssessment/entry or ree:					1
		day after the ARD of the				
	st MDS assessment to					j i
	economont 3 Davieus					i i

any fall since the last assessment, no matter whether it occurred while out in the community, in

	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION MINUSED:		2) MULTIPLE CONSTRUCTION SUILDING			(X3) DATE BURVEY COMPLETED	
								С
		495109	B. WING	_			06	/15/2022
NAME OF I	PROVIDER OR SUPPLIER			ľ	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF UNIVERSITY P	ARK			420 PEMBERTON RD			
					RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of deficiencies Y must be preceded by full LGC identifying information)	PREFII TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 9H CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	<u> </u>	(X5) COMPLETION DATE
F 641	Continued From page	41	F6	341				
		n the nursing home, include rated in any health care						
		p.m., ASM (administrative	1					
1	staff member) #1, the director of nursing, AS	administrator, ASM #2, the					4	
	regional clinical coordi			- 1			- 1	
- (_	rations were made aware		- (- [
1	of the findings.		1					
ļ	No further information	was provided prior to exit.						
	2. The facility staff faile	ed to accurately code) quarterly MDS with an						
		rence date) of 5/23/2022						
- 1		s facility since the previous						
		S, a quarterly assessment						
		22, the resident scored 3 brief interview for mental		1				
	status) assessment, Ind			1			- 1	
įs	leverely impaired for m	aking deliy decisions.		-				
		ited R114 not having any	1				Ì	
,	ells since admission/en Issessment,	try or reentry or prior						
	teview of the clinical red							
		its. The list revealed the						
		n End of PPS Part A Stay 8/2022 and an admission						,
	ssessment with an ARC						Ì	ĺ
1	eview of the clinical rec							
de	ocumented fails on 4/29	9/2022 and 5/15/2022.						1
	ne progress notes docu						1	- 1
*4	/29/2022 18:08 (6:08 n	m) Resident observe						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		496109	B. WING_			C 06/15/2022	
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	RK		STREET ADDRESS, CITY, STATE, ZIP COU 2426 PEMBERTON RD RICHMOND, VA 23233		771	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
tt ct the state of	side lying lateral to bed Resident unable to not fallNo Injuries noticed "5/15/2022 21:00 (9:00 (approximately) 1930 (called to residents roor resident laying on his rist to bed, last observed 1: resting in low bed quiet and bedside table within socks and facility gown unable to explain how hidagnosis, moves upper lower extremities contraineurochecks wni (within injuries noted, no swelling and discomfort" On 6/15/2022 at 9:44 a.conducted with RN (reginurse. RN #1 stated the nanual for guidance in consessments. RN #1 stated the look-back period for completing the MDS assistat they reviewed the closes.	On assessment, patient droom with face down. e events leading up to [sic] at this time" p.m.) Approx. 7:30 p.m.), writer was in by staff, writer observed ght side, on the floor, next 5 minutes prior by writer, fly, eyes closed, call bell in reach, wearing non skid, clean and dry, resident in fell, related to dementia rextremities without pain, acted unable to move, a normal limits), no new ing noted, denies all pain in many many many many many many many man	F 64				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION LIDERTIFICATION NUMBER: (X2) MULTIPLE AND PLAN OF CORRECTION LIDERTIFICATION NUMBER: (X2) MULTIPLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
1			A. BUILD	RNU		ŀ	С
l		495109	B. WING	_			06/15/2022
NAME OF	PROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE		4071012002
				1 ;	2420 PEMBERTON RD		
THE LA	URELS OF UNIVERSITY PA	ARK			RICHMOND, VA 23233		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	lō.	_	PROMDER'S PLAN OF CORRECT	CTION	(248)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETION
F 641	Continued From page	43	F	841			
	On 8/15/2022 at 2:40	p.m., ASM (administrative					
	staff member) #1, the	administrator, ASM #2, the			1		
	director of nursing, AS	M #3, the southside			14		}
	regional clinical coordi]		
		rations were made aware	1				
	of the findings.						1
	No further information	was provided prior to exit.	1				1
		was provided prior to exit.		İ			ł
	3. For Resident #701.	the facility staff falled to					
	accurately complete the		1				
		lews of sections C and D.	1	ı			İ
J	_			[
[Resident #701 was adn			ı			
- 1	8/17/21 and discharged			- [
- 1	facility on 9/25/21. The			- 1			•
- 1	assessment dated 8/18/		1	- 1			
J	On the admission MDS			- [
	an ARD (Assessment R	(Minimum Data Set) with	1	- 1			
	8/21/21, the resident wa				4		
	supervision for eating ar			ĺ			
	for all other areas of act			-			
		,w.					
	On the above MDS, the						
		d Section D "Mood" were		1			
	not attempted nor accura		j		ce		
· · · · · ·	question response was d	locumented with a dash.					
1	On 6/15/22 at 10:00 AM	an interview was	}				
	conducted with RN #1 (R		ŀ		•		- 1 1
	MDS nurse. She stated to			.	III.		
	encouraged and that real			1			
	e attempted, and if they						- -
	hen that should have be						
8	tated that the staff memi	per who was responsible					
	or completing these sect						
	ne facility. When asked						
fe	acility follow for completion	ng the MDS, she stated		1			1

	TO TOTAL MEDIONICE G	MILDIONID SERVICES			Ť	NID 140. 0330-034		
	r of Deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
l						C		
		495109	B. WING			06/15/2022		
	PROVIDER OR SUPPLIER IRELS OF UNIVERSITY PA	ark	242	REET ADDRESS. CITY, STATE, ZIP O PEMBERTON RD CHMOND, VA 28233	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of deficiencies Must be preceded by full SC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO OEFICIENT	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE		
F 641	Continued From page the RAI manual (Resk Instrument).		F 641					
	Section B "Hearing, Sp above MDS was coded	eech, and Vision" of the i as follows:						
	to express ideas and wand non-verbal express Usually understood - disome words or finishing prompted or given time understood - ability is litrequests. 3. Rarely/nex#128 was coded as a "Z-Section B 0800 "Ability (Understanding verbal of (with hearing aid or devi Understands - clear con understands - misses somessage but compreher	fficulty communicating thoughts but is able if a 2. Sometimes mited to making concrete rer understood.) Resident a." to Understand Others" content, however able ice if used). 0. aprehension. 1. Usually ome part/intent of anda most conversation. ids - responds adequately nication only. 3.		25				
n	The coding of Section B Inderstood and understa esident Interviews for ap hould have been attemp	inds indicated that plicable sections below			ű			
	ection C "Cognitive Pati Illows:	ems" was coded as						
-	ection C 0100 Should B tatus (C0200-C0500) be							

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
l			A BOILDIN		_	1	С	
i		495109	a. WING_			0	8/15/2022	
NAME OF	PROVIDER OR SUPPLIER			OTRE	ET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF UNIVERSITY PA	ARK			PEMBERTON RD			
				RICH	IMOND, VA 23233			
(X4) IO PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XI) COMPLETION DATE	
F 641	Continued From page	45	F 64	41				
	to conduct interview w		1					
		ly/never understood) Skip					}	
	to and complete CU/O	0-C1000, Staff Assessment						
		200, Repetition of Three	}					
		responses was filled in response was selected.	1	-			1	
1		ded in Section B as being]	
		and understands, Section						
ĺ		w for cognitive patterns)	
j	should have been atter	npted.]	
	A review of the Long-Te	erm Care Facility Resident		1				
[Assessment Instrument	•						
	Version 1.17.1, dated 0 conducted as follows:	ctober 2019 was						
	Page C-1 documented:					i		
	Most residents are able	•	ĺ	1				
	Interview for Mental Sta	tus (BIMS).						
	A structured cognitive te	at is more accurate and		1				
	reliable than observation		1	1			i	
		(1) Without an attempted	1	1				
,	structured cognitive intel mislabeled based on his	rview, a resident might be		1				
,		Structured interviews will				1		
€	afficiently provide insight	into the resident's			•	1		
· c	current condition that will	enhance good care					23	
A	And on page C-2 was do	ecumented:	l					
	code 0, no: if the intervie							
	onducted because the r			[(
		ond verbally, in writing, or ran interpreter is needed						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		405400					C	
NAME OF	PROVIDER OR SUPPLIER	495109	8, WNG	_	ATTREET ADDRESS SIDE STATE TO CODE		06/15/2022	
	PREUM OF UNIVERSITY PA	ARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP	3 6 D	(X8) COMPLETION DATE	
	because the resident li understood verbally, in method, and if an inter- avallable. Proceed to C Words If the resident interview the look-back period (p the day of) the ARD, ite 1, Yas, and the standar dash "-") entered in the A "Yes" was not coded it by the RAI manual in or interview responses. Ti	to C0700, Staff Status. Inview should be conducted at least sometimes I writing, or using another preter is needed, one is 20200, Repetition of Three If was not conducted within referably the day before or in C0100 must be coded at "no information" code (a resident interview items." If item C0100 as required der to dash out the ne resident interview was C0100 was not accurately coded as follows:	F	84				
R 1		never understood) Skip to 600, Staff Assessment of 0, Resident Mood						
W A SC D	he box for both above noith a dash (-). Neither noise the resident was code ornetimes understood at for a resident interview sen attempted.	esponse was selected. d in Section B as being nd understands, Section						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ITE SURVEY
1			A. BOILD	71110		1	С
l		498109	B. WING			0	6/15/2022
0300	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	NRK .			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E	(XS) COMPLETION CATE
F 641	Continued From page	47	F	841		· · · · · · · · · · · · · · · · · · ·	
	Assessment Instrumer Version 1.17.1, dated (conducted as follows: Page D-1 documented Most residents who are communicating can another feel. Obtaining information a the resident, sometimes resident's voice, is more than observation alone disorder. And on page D-2 was decode 0, no: if the intervict conducted because the inderstood or cannot represent of Resident's voice and the resident of Resident's voice and the inderstood or cannot represent of Resident's voice if the resident of Resident's voice if the resident of Resident and	capable of swer questions about how bout mood directly from a called "hearing the a reliable and accurate for identifying a mood ocumented: ew should not be resident is rarely/never spond verbally, in writing, i, or an interpreter is b. Skip to item D0500, aident Mood. ent interview should be resident is at least erbally, in writing, or and if an interpreter is					
R	nd on page D-3 was do				•		
th		ferably the day before or				Į	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		405400	e, wng			C
	- 000 dodg 00 01 00 (0)	496109	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	/16/2022
NAME OF	PROVIDER OR SUPPLIER		- 1	2420 PEMBERTON RD		
THE LA	URELS OF UNIVERSITY PA	RK	- [RICHMOND, VA 23233		
	1					1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IE	(XII) COMPLETION DATE
F 64	Continued From page	48	F64	s1		
		rd "no Information" code (a resident interview items.				
	by the RAI manual in of interview responses. It not attempted and item completed. On 6/15/22 at approxim (Administrative Staff Mo ASM #2, the Director of Regional Director of Op	The resident interview was D0100 was not accurately actely 4:00 PM, ASM #1 amber), the Administrator, Yoursing, and ASM #4, the erations were made to further information was				
	PASARR Screening for CFR(s): 483.20(k)(1)-(3 §483.20(k) Preadmissio individuals with a menta with Intellectual disability §483.20(k)(1) A nursing	MD & ID) In Screening for I disorder and Individuals /- facility must not admit, on , any new residents with: fined in paragraph (k)(3) the State mental health I, based on an of mental evaluation or entity other than the ority, prior to admission, physical and mental I, the individual requires ided by a nursing facility; rea such level of fyidual requires	F 84	Criteria 1 Resident #19 suffered no adverse outcom to the alleged inaccurate or incomplete le PASARR. Resident #19 has an updated a corrected PASARR. Criteria 2 All current residents needing PASARRs of have the potential to be affected by the all deficient practice. Audit completed to enscurrent residents have an up to date PASACCriteria 3 Social Services will be re-educated on ens PASARR's are completed and accurate.	vel I nd completed leged ure LRR.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE BURVEY COMPLETED		
ľ		496109	B. WING				C /15/2022		
	PROVIDER OR SUPPLIER JRELS OF UNIVERSITY PA			1	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233				
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	(k)(3)(II) of this section intellectual disability or authority has determin (A) That, because of the condition of the individing the level of services phand (B) If the Individual requervices, whether the inspecialized services for \$483.20(k)(2) Exception (I) The preadmission screening paragraph(k)(1) of this informations in the to a nursing facility of an being admitted to the nutransferred for care in a (II) The State may choospreadmission screening paragraph (k)(1) of this into a nursing facility of an (A) Who is admitted to the hospital after receiving a hospital after receiving a hospital, (B) Who requires nursing condition for which the inthe hospital, and (C) Whose attending physical after authority in the hospital, and (C) Whose attending physical after authority in the hospital, and (C) Whose attending physical after authority in the hospital, and	, unless the State developmental disability ed prior to admission- ee physical and mental ual, the individual requires ovided by a nursing facility; ulires such level of adividual requires intallectual disability. The purposes of this reening program under section need not provide a case of the readmission an individual who, after ursing facility, was hospital. The not to apply the program under section to the admission a individual- the facility directly from a faculte inpatient care at the dividual received care in facility that the individual an 30 days of nursing For purposes of this ered to have a mental	F6		Criteria 4 Administrator or designee will complete frandom audits of current resident's charts PASARR's are completed and accurate. The audits will be done 5 days a week for four then one day a week for four the last month. The results will be forward QAPI committee for review. The committed determine the need for further audits and/or Criteria 5 Date of compliance is 7/26/22.	to ensure hese weeks; wice in ed to the	ı		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
l			100	1~1010	W10		1	С
l			495109	B. WING			0	6/15/2022
		ROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	RK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
	(X4) LD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFU TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)		COMPLETION DATE
	T C C Find In red did R book did P / D C S & C in	or is a person with a redescribed in 435.1010. This REQUIREMENT by: Based on staff interview review, the facility staff complete and accurate (preadmission screening determine if a level 2 Phone of 59 residents in the Resident #19.	sidered to have an the individual has an defined in §483.102(b)(3) lated condition as of this chapter. In order the condition as of this chapter. In order the condition as evidenced where and clinical record falled to ensure a level I PASRR grand resident review) to ASRR was required for the survey sample, the entirely complete section (a) PASRR and do the resident as not illness. If (minimum data set), a sment with an ARD late) of 4/18/22, the first on the BIMS (brief is), which indicated the ely impaired for making in bipolar disorder (1), order (2) and der (3). R19's level 1 14/21 documented, "2. HAVE A CURRENT ESS (MI)? "No" was mental disorder	. F 6	945			

	PROVIDER OR SUPPLIER URELS OF UNIVERSITY PA	495109	B. WING		<u> </u>		С
		495109	B. WNG	_		- 1	C
							6/16/2022
				T	STREET ADDRESS, CITY, STATE, ZIP CODE		10/ 10/2022
THE LA	URELS OF UNIVERSITY PA			1	2420 PEMBERTON RD		
1		ARK		1	RICHMOND, VA 23233		
(X4) ID	RIMMADV STA	TEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECT	ÓN	(94)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD			COMPLETION
F 645	Continued From page	51	F	645	5		
	Statistical Manual of M	lental Disorders) (e.g.			1		l
		paranold, panic, or other	1		1		
	serious anxiety disorde	er, somatoform disorder,	1				1
	personality disorder; of	ther psychotic disorder; or	1		1		1
		hat may lead to a chronic					
	disability)? Neither "yes	s" nor "no" was circled.	1				
	The employees who see	npleted R19's PASRR was					
	not available for Intervie	•					
]				
	On 6/14/22 at 9:03 a.m		1				1
		ther staff member) #1 (the					J
	social worker). OSM #						1
	department completes (1		
		familiar with the process.	1		1		}
- (s are completed based on	i		1		Į
	residents' medical recor		ļ		1		
- 1	knew R19 had some ps including bipolar disords		ľ				
ĺ	personality disorder. Of				1		ĺ,
1		PASRR was not accurate		J	J		
	and one wouldn't know i						i
	needed if the level 1 is n			-			
	On 8/15/22 at 11:35 a.m						
	staff member) #1 (the ac						[]
	(the director of nursing),						1
	clinical coordinator) and director of operations) we						
		/22 at 6:20 p.m., ASM #1					
	and ASM #2 stated the fa						1.5
	policy regarding PASRRs		•				
	No further information wa	s presented prior to exit.				j	
	D. d						
	References:			}			
l d	 "Bipolar disorder is a secure intense mood swin was obtained from the we 	gs." This information					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ĺ							C
		496109	B. WING_			0	6/15/2022
NAME OF	F PROVIDER OR SUPPLIER		- 1	STREET ADD	DRESS, CITY, STATE, ZIP CODE		
THE LA	URELS OF UNIVERSITY PA	RK	- 1	2420 PEMBI	erton RD		
				RICHMONI	D, VA 23288		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Must be preceded by Full BC Identifying Information)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XB) COMPLETION DATE
F 64	https://medlineplus.go		F6	15			
-	mental condition in wh patterns of unstable or inner experiences oftel and chaotic relationship information was obtain https://medlineplus.gov. (3) "Dissociative identity known as multiple persolisorder is characterize alternate identities. You two or more people talk head, and you may feel possessed by other identities://www.mayoclinic.	ch a person has long-term turbulent emotions. These in result in impulsive actions is with other people." This sed from the website: lency/article/000935.htm y disorder. Formerly brightly disorder, this is done by 'switching' to may feel the presence of ing or living Inside your as though you're notities." This information website: brightly diseases-conditions/diaptoms-causes/syc-2035 Imprehensive Care Plan ive Care Plans y must develop and sive person-centered int, consistent with the int \$483.10(c)(2) and les measurable is to meet a resident's intal and psychosocial in the comprehensive energian must be be furnished to attain highest practicable	F 650	related to care plan in physician medication received. Resident # liters and (O2 was ind #58 did no intervention medication deficient p. from not his were place. Pressure ul orders. Resident #7 reimplement send commo Dialysis care effects from	#'s 14,96,701 had no adverse ou the alleged implementation of res for medication administration. The and RP were notified of alleged in errors by the nurse. No new orders to 3L as per MD order. Resident was remained within normal licerased to 3L as per MD order. Resident was reins prior to administering pain in She had no ill effects from allegoratice. Resident #87 had no ill edwing hand splint in place. Hand sid on guest and added to C.N.A talcer treatment was reinstituted per 76 dialysis communication sheets in the dimmediately. Dialysis contact immediately. Dialysis contact in the catheter /dialysis. Resident in the catheter /dialysis. Resident is secorrected at the time it was not	ers 1.5. imits. asident ged ffect splints sk list. mD were cted to ity. e no ill	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) OATE SURVEY COMPLETED C	
		495109	B. WING		0	18/15/2022	
THE LAU	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 22233 PROVIDER'S PLAN OF CORRE		(29)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION 8HC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETION	
(f) for the control of the control o	(ii) Any services that we under §483.24, §483.2 provided due to the result of §483.10, including treatment under §483. (iii) Any specialized serehabilitative services to provide as a result of Precommendations. If a findings of the PASARI rationale in the resident (iv) in consultation with resident's representative (A) The resident's prefer future discharge. Facilitive the resident's prefer future discharge. Facilitive the the resident's desired outcomes. (B) The resident's prefer future discharge. Facilitive the resident's desired outcomes. (B) The resident's prefer future discharge plans in the facilities, for this purpose C) Discharge plans in the colon. This REQUIREMENT is complement set forth in action. This REQUIREMENT is complement the colon of a complaint investment of a complaint investment of a complaint in the diministration observation of \$96); and for 6 of 59	14, §483.25 or §483.40; and rould otherwise be required at \$25 or §483.40 but are not sident's exercise of rights ing the right to refuse 10(c)(8). Invices or specialized the nursing facility will PASARR facility disagrees with the R. It must indicate its it's medical record. The resident and the re(s)— Is for admission and rence and potential for ites must document lesire to return to the ed and any referrals to and/or other appropriate of the comprehensive care accordance with the aparagraph (c) of this is not met as evidenced resident interview, staff and the restigation, it was the staff failed to develop imprehensive care plan medication.		Criteria 2 All current residents have the potential affected by the alleged deficient practimplementation of Care Plans. Criteria 3 Licensed nurses will be reeducated of orders, medication administration, defined and implementation of resident care the O2 concentrators and validating communication sheets, non-pharmacointerventions for pain management, and doffing medication pass, and Meadministration. Criteria 4 DON/Designee will randomly audit firm medication administration, following following MD orders, dialysis communications, O2 documentation, and follow residents care plan for splinting. These becompleted 5 days a week for four woone day a week for four weeks; then two one day a week for four weeks; then two one day a week for four weeks; then the committee for review. The committee determine the need for further audits a Criteria 5 Date of compliance is 7/26/22.	n Physician velopment plan, Reading order, dialysis plogical plint donning dication We Nurses for MD orders, nication ing the audits will vecks; Then vice in the QAPI will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:		(X2) MUI		LE CONSTRUCTION	(X3) DATE SURVEY - COMPLETED		
]			7.00,00	1110		1	С
		496109	B. WNG			06	8/18/2022
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAI	JRELS OF UNIVERSITY PA	RK			2420 PEMBERTON RO		
					RICHMOND, VA 23233		
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F 656		54	F	656			
	The findings include:				1		
	For Resident #14, to implement the comprese administering medications. Resident #14 was administering administering medications. Resident #14 was administering medications.	on as ordered. itted to the facility on					
	Set) assessment with a	•					
	a 15 out of a possible 1		1				!
	interview for mental status) Indicating the resident was cognitively intact in ability to make daily life						
	decisions.		1				
- 1	at risk for constipation F mobility, medications sk plan included the interve "Administer medications	3/21 for "[Resident #14] is R/T (related to): decreased de effects." This care ention, dated 3/23/21 for as sordered and observe effects. Report abnormal					
	On 6/14/22 at 8:17 AM, Practical Nurse) was ob- administer the following #14:						
	Methimazole 5 mg (millig Buspar 10 mg, 1 tab Aspirin 81 mg, 1 tab Magnesium Oxide 400 m					•	
r k ii	On 6/14/22 at 11:16 AM, medications was conductohysician's orders. An oldocalne 4% patch (1) to noming was noted. It was	ted compared with the rder dated 9/8/21 for a the left knee every					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, .,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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1		496109	8. WING			06/16/2022		
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
THE LAL	IRELS OF UNIVERSITY PA	ARK .		l '	2420 PEMBERTON RD			
					RICHMOND, VA 28233		(XII) COMPLETION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTÉMÈNT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ACTION SHOULD BE O TO THE APPROPRIATE		
F 656	Continued From page	56	F	856				
	signed out for a lidocaine patch to left knee as being administered when it had not been administered.		<u> </u>					
	On 6/14/22 at 12:40 Pl conducted with Reside they received their pair morning, they stated th	nt #14. When asked if n patch on their knee this						
	On 6/14/22 at 12:45 PN reported to ASM #1 (Ad Member) the Administra Regional Director of Op	ator and ASM #4, the						
	stated that if a resident medications and there v	(Licensed Practical ation administration. She was not administered was no parameters to hold administer medications as						
1	On 6/15/22 at 9:03 AM, purpose of care plans w #6. LPN #6 stated that it plan was so that staff kn doing and what staff necessident.	the purpose of the care ow what the resident is				8.4		
C	conducted. The policy d	have a person-centered						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IPLE CONSTRUCTION NG		COMPLETED		
			496109	B, WING_			C 6/15/2022		
		ROUDER OR SUPPLIER RELS OF UNIVERSITY PA	RK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(NB) COMPLETION DATE		
	F (linh thr 22 inn ac R 2/Si of po	comprehensive assess measurable objectives residents medical, nurs psychosocial needs ide comprehensive assess interdisciplinary team was to; attending physician, responsible for the resident representative, and any other ancillary will also be utilized to eneeds or risk areas are On 6/15/22 at approxima (Administrative Staff Measing and Director of Openware of the findings. No provided by the end of the ferences: 1) Lidocaine - is used to formation obtained from	dent rights, based on the ment that includes and time frames to meet a ing, and mental and intified in the ments and prepared by an includes but not limited a registered nurse who is dent, a nurse aide, a in services, the resident or therapy staff as required staff. Additional resources insure that any additional identified" ately 4:00 PM, ASM #1 mber), the Administrator, Nursing, and ASM #4, the erations were made to further information was ne survey. It reat pain in facility staff failed to naive care plan for as ordered. ed to the facility on a MDS (Minimum Data ament Reference Date) accored a 13 out of a (brief interview for	Fes	58				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND MARCO.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495109	B. WING	5. WNG		C 06/15/2022		-	
	PROVIDER OR SUPPLIER IRELS OF UNIVERSITY PA			2420	EET ADDRESS, CITY, STATE. ZIP CO PEMBERTON RD IMOND, VA 23233	ODE		1132022	
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X8) COMPLETION DATE	
A COURT OF SA	cognitively intact in at decisions. The reside supervision for eating for other areas of active. A review of the compressed one dated 5/1 at risk for abnormal bit to): medication use" Intervention dated 5/12 medications as ordere ineffectiveness and sid findings to the physicial dated 7/22/21 was for for constipation R/T: dediminished appetite, the medications side effect included the intervention for ineffectiveness/side findings to the physicial Con 6/14/22 at 8:28 AM, Practicel Nurse) was obadminister the following 496: Dulera 100 mcg (micro Aspirin 325 mg (milligra /Itamin D3 25 mg, 1 tab-Silipizide 5 mg, 1 tab-Silipizide 5 mg, 1 tab-	sility to make daily life int was coded as and extensive to total care ities of daily living. shensive care plan 12/21 for "[Resident #96] is seding/bruising R/T (related The care plan included an 2/21 for "Administer d. Observe for le effects, report abnormal in." Another care plan, "[Resident #96] is at risk ecreased mobility, it (history) of constipation, is." This care plan in, dated 7/22/21 for a sa ordered and observe effects. Report abnormal in." LPN #5 (Licensed in the care plan in the care of the care and in medications for Resident in the care of the c	F 6	558					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
A BUILDING	С
496109 B. WING	08/15/2022
NAME OF PROVIDER OR SUPPLIER 87REET ADDRESS, CITY. STATE, ZIP CODE 2420 PEMBERTON RD	
THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERE	ULD BE COMPLETION
On 6/14/22 at 11:15 AM, reconciliation of the medications was conducted compared with the physician's orders. An order dated 6/30/21 for Alaway (1) eye drops and an order dated 1/18/21 for Pepcid (2) were noted. It was noted that LPN #5 signed out these medications as being administered when they had not been administered. On 6/14/22 at 12:40 PM an interview was attempted with LPN #5 regarding the missed medication. He refused to answer any questions, denied doing enything wrong and walked away from the surveyor. On 6/14/22 at 12:45 PM the above concern was reported to ASM #1 (Administrative Staff Member) the Administrator and ASM #4, the Regional Director of Operations. On 6/14/22 at 3:00 PM, an interview was conducted with LPN #4 (Licensed Practical Nurse) regarding medication administration. She stated that if a resident was not administration. She stated that if a resident was not administration as ordered was not being followed. On 6/15/22 at 9:03 AM, an interview regarding the purpose of care plan to administer medications as ordered was not being followed. On 6/15/22 at 9:03 AM, an interview regarding the purpose of care plans was conducted with LPN #8. LPN #6 stated that the purpose of the care plan was so that staff know what the resident is doing and what staff need to do to care for the resident. A review of the facility policy, "Care Planning" was conducted. This policy documented, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						C	
NAME OF B	ROMDER OR SUPPLIER	495109	8. WING	OTREET ADDRESS, CITY. STATE, ZIP CODE	[08	3/15/2022	
	RELS OF UNIVERSITY PA	ARK	2	420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION CATE	
	comprehensive assess measurable objectives residents medical, nur psychosocial needs id comprehensive assess interdisciplinary team is to; attending physician responsible for the resimember of food/nutritic resident representative and any other ancillary will also be utilized to eneeds or risk areas are On 6/15/22 at approxim(Administrative Staff McASM #2, the Director of Opaware of the findings. It provided by the end of the symptoms of the eyes information obtained from tops://medlineplus.gov/end	sident rights, based on the sment that includes and time frames to meet a sing, and mental and entified in the sments and prepared by an who includes but not limited, a registered nurse who is ident, a nurse aide, a on services, the resident or o, therapy staff as required staff. Additional resources insure that any additional identified" Inately 4:00 PM, ASM #1 amber), the Administrator, if Nursing, and ASM #4, the cerations were made to further information was the survey. The treatment of allergy and druginfo/meds/a604033.h The treatment of reflux and and any druginfo/meds/a687011.ht	F 656				
	plement the comprehe		}				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(XX) DATE SURVEY COMPLETED		
1			A DOIGH			J	C	
		495109	B. WNG_		<u> </u>	١,	6/15/2022	
NAME OF	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,	10/2022	
			- 1	24	420 PEMBERTON RD			
THE LAU	RELS OF UNIVERSITY PA	ARK	- 1	A	ICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD S CROSS-REFERENCED TO THE APPROPRI DEPICIENCY)	ORRECTIVE ACTION SHOULD SE FERENCED TO THE APPROPRIATE				
E ACO	Cantinuad From man		7.0					
F 656	Continued From page		F 65	56			1	
	administering medicati	on as ordered.		-				
	Resident #701 was ad	mitted to the facility on					1	
	8/17/21 and discharge			- 1			1	
	facility on 9/25/21. The							
	assessment dated 8/18		1	- 1			[
		oriented to person only.]	- 1			1	
		(Minimum Data Set) with		- [
ĺ	an ARD (Assessment F			-			1	
ĺ	8/21/21, the resident w							
[for all other areas of ac	ind extensive assistance		-				
ĺ	IOI dil Otiloi diego (il de	uvides of daily living.	ĺ	1			1	
i	A review of the comprel	hensive care plan for	1	-			1	
- 1	Resident #701 revealed	one dated 9/2/21 for					Ì	
	"[Resident #701] is at ri							
	bleeding/bruising R/T; n		İ	-			1	
	Interventions included o							
	"Administer medications	r as ordered"	1					
- 1,	A review of the clinical re	scord revealed a nurse's	1				J I	
()	note dated 9/20/21 at 7:	20 AM (note actually	ĺ	1				
		05 PM) that documented,	-	1				
		other resident was put to	[1			[
	ped in the wrong beds. o			1			i 1	
	701] received the medi		1				i I	
	who bed (they) was put I They) received Levothy:]	1				
	nonitored and (their) bro							
	he medication error. [Re		ĺ					
		back when being talked			r	9	1	
to	o. No S/S (signs or sym) eaction noted,"				•		,	
	nurse's note dated 9/23							
T I	notified brother of med e							
	otified np (nurse practitie							
	octor) of med event n.n. me will cont (continue) to	o (no new orders) at this o monitor."						

14:39

	TMENT OF HEALTH AN					FO	FED: 06/26/2027 PRM APPROVED NO, 0936-0391
STATEMENT	RS FOR MEDICARE & TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU		LE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495108	B. WING				C 06/16/2022
NAME OF	PROVIDER OR SUPPLIER			- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
THETAI	IRELS OF UNIVERSITY PA	, ov		1	2420 PEMBERTON RD		
THE LAU	IKELS OF GRIVERSITI FA			1	RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 656	Continued From page	61	F6	356			
	that made the medication of the computer and calling of the picture and calling of the picture and calling of clearly identify the MD. That she placed [Resident #701] we approximately seven in to the computer and, identify the MD. That she placed [Reside room around approximation around approximation were taken and not be computed and record of cognitive level."	d 9/20/21, included a d 9/21/21 from the nurse con error, documented, "On to [Resident #701] two cld (same as 1); When I t #701] (their) medication I e, I looked at (their) picture and thought it was the d. I was asked by the aide asn't in (their) bed the morning. I then went entified in the computer out the guest name to the aide (name) stated on t#701] in the wrong stelly three A.M. Vital or distress noted - same					
r s s f n ic b	dentified no criteria for v	chysician Verify the ithe medication ithe guest/resident and routeNever supplied for one if guest/resident" sed steps for preparing it the medication cart but erifying the resident inedication at the bedelde (i.e. ask their name,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY	
i			7.50.13			1	¢
ſ		495109	B. WING			08	/15/2022
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	.RK		STREET ADDRESS, CITY, STATE, ZIP (2420 PEMBERTON RD RICHMOND, VA 23233	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRI	e Ate	(X9) COMPLETION DATE
	The nurse who made to longer at the facility and conducted with LPN #4 Nurse) regarding medications and there it, then the care plan to ordered was not being On 6/15/22 at 9:03 AM purpose of care plans with the care plans with the staff of the conducted. This policy resident in the facility producted. This policy resident in the facility with the resident in the facility with the resident measurable objectives a residents medical, nursi psychosocial needs ider comprehensive assessmenterdisciplinary team with the resident medical, nursi psychosocial needs ider comprehensive assessmenterdisciplinary team with the resident medical, nursi psychosocial needs ider comprehensive assessmenterdisciplinary team with the resident representative, and any other ancillary a will also be utilized to entered or risk areas are in the facility of the facility will also be utilized to entered or risk areas are in the facility and any other ancillary a will also be utilized to entered or risk areas are in the facility and any other ancillary a will also be utilized to entered or risk areas are in the facility and any other ancillary a will also be utilized to entered or risk areas are in the facility and any other ancillary a will also be utilized to entered or risk areas are in the facility and any other ancillary a will also be utilized to entered or risk areas are in the facility and any other ancillary and any othe	the medication error was not ad could not be interviewed. I, an Interview was I (Licensed Practical cation administration. She twas not administered was no parameters to hold administer medications as followed. I an Interview regarding the was conducted with LPN in the purpose of the care now what the resident is seed to do to care for the colicy, "Care Planning" was documented, "Every ill have a person-centered and implemented that is fent rights, based on the ment that includes and time frames to meet a rig, and mental and intified in the menta and prepared by an an includes but not limited a registered nurse who is ent, a nurse aide, a services, the resident or therapy staff as required taff. Additional resources sure that any additional dentified"	F	656			

PRIN	TED:	06/28	V2022
FC	DRM.	APPR	OVED
OHAD	NIO	0000	0204

I	AND PLAN O	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	<u> </u>		(X3) DATE SURVEY COMPLETED		
			495109	B, WNG_				C		
	**********	ROWDER OR SUPPLIER RELS OF UNIVERSITY PA			STREET ADORESS, 2420 PEMBERTON RICHMOND, VA			<u>08/15/2022</u>	_	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPERIOR DEFICIENCY)	38 0	COMPLETION DATE		
	A direction of the second of t	Regional Director of Opaware of the findings. provided by the end of References: (1) Levothyroxine - is unhypothyroidism Information obtained from the standard of the standa	of Nursing, and ASM #4, the perations were made No further information was the survey. Sed to treat om or of the survey. Sed to treat om or of the survey. Sed to treat om or of the survey. Sed to treat om or of the survey. Sed to treat om or of the survey. Sed to treat om or of the survey. Sed to treat or of the su	F 6	56					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	PLE CONSTRUCTION		TE BURVEY
				G		С
NAME OF I	PROVIDER OR SUPPLIER	495109	B. WNG_	STREET ADDRESS, CITY, STATE, ZIP CODE	01	8/15/2022
	RELS OF UNIVERSITY PA	ARK	1	2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Atement of Deficiencies / Must be preceded by full sc (Dentifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULDBE	(X6) COMPLETION DATE
	liters per minute continuation in the composition of the composition included the intervention included the included the included	shensive care plan 1/10/20 for "[Resident #94] culty breathing and risk for 1/10/20 for "[Resident #94] culty breathing and risk for 1/10/20 for "[Resident #94] 1/10/20 for "[Resident	F 65			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB N	O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		PLE CONSTRUCTION		'E BURVEY APLETED
l							C
6.		495109	B. WNG	_		06	3/15/2022
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF UNIVERSITY PA	ARK			24Z0 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ae.	(XII) COMPLETION PATE
F 656	measurable objectives residents medical, nur psychosocial needs ld comprehensive assess interdisciplinary team to; attending physician responsible for the resmember of food/nutritions and any other ancillary will also be utilized to eneeds or risk areas are	and time frames to meet a sing, and mental and entified in the sments and prepared by an who includes but not limited in a registered nurse who is ident, a nurse aide, a on services, the resident or one, therapy staff as required estaff. Additional resources insure that any additional identified"	F	850	6		
	(Administrative Staff M. ASM #2, the Director of Regional Director of Oraware of the findings. If provided by the end of 6. Facility staff falled to #58's (R58's) comprehented the provided pron-pharma	No further information was the survey. Implement Resident ensive care plan for cological interventions on of a PRN (as needed)				į	
Ji	(R58) was admitted to t that included by not limi arthritis.	he facility with a diagnosis ted to: rheumatoid			z-		
6 6 6 6	admission assessment verterence date) of 04/17	he BIMS (brief interview atting the resident is king daily decisions. as a series coded (R58) as the past 5 (five) days.			÷	·	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			HETRUCTION	ļo	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	46 —			c	
l		496109	B. WNO_			- 1	06/15/2022	
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, 2IP CODE		VW 100×V22	
			ľ	2420 P	EMBERTON RD			
THE LAU	RELS OF UNIVERSITY PA	ARK	- 1		MOND, VA 23233			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	Т	PROVIDER'S PLAN OF CORRE	CTION	(XS) COMPLETION	
PREFIX TAG	(EACH DEFICIENCY	/ Must be preceded by full 8C identifying information)	PREFIX		(EACH CORRECTIVE ACTION 8H CROSS-REFERENCED TO THE APP DEFICIENCY)		D.100	
F 656	Continued From page	66	F 6	56			2	
	being the worse pain.		}			83		
	The physician's order part, "Tramadol HCI (h (milligram). Give 1 tab hours as needed for part, non-pharmacological in Order date: 4/18/2022. The eMAR (electronic record) for (R58) dated the physician's order as "Pain-Non-Pharmacologocument Non Pharma used: 1)Massage. 2) M 3)Positioning. 4) Ice/col Activity. 6) Guided Imaginteraction, as needed (NonPharmacological Interaction).	medication administration June2022 documented s stated above and gical Interventions editation/Relaxation. Id pack. 5)Diversional gery. 7) Rest. 8)Social Document terventions using the Start Date04/12/2022." Ied to evidence tharmacological above from 08/01/2022 the eMAR revealed that of tramadol on the			400 .0			
	non-pharmacological int	•						
	attempted on: 06/01/202		2.					
	06/02/2022 at 10:48 a.m		[ĺ				
	06/03/2022 at 11:07 a.m p.m., 06/06/2022 at 8:24		%		7 .		4.	
	0;19 a.m. and at 9:59 p		706					
	.m. and at 9:43 p.m., 06							
	ind at 8:25 p.m., 06/10/2			1				
	6/11/2022 at 9:38 p.m.			}				
4	:32 a.m. and at 9:33 p.n	π.						
Т	he comprehensive care	plan for (R58)						

DEPARTMENT OF HEALTH AND HUMAN	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(XX		SURVEY LETED
			A BOILD	טאווי	' 	- 1		c
		495109	a, WNG					15/2022
NAME OF P	PROVIDER OR SUPPLIER	<u></u>		Г	STREET ADDRESS, CITY, STATE. ZIP CODE			144444
	V. 22 22 22 2				2420 PEMBERTON RD			
THE LAU	RELS OF UNIVERSITY PA	ARK			RICHMOND, VA 23233			
OLA IB	\$1 IMMADY ETA	TEMENT OF DEFICIENCIES	IP)	_	PROVIDER'S PLAN OF CORRECT	TION	1	(%)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		COMPLETION DATE
F 656	Continued From page	67	E	656			l	
	, •	ocus, (R58) is at risk for	'`		1			
		chronic pain r/t (related to)]		- 1	
	-	eumatold arthritis), DJD						
ľ	(degenerative joint disc		1					
		ux disease). Date initiated:					- 1	
	04/13/2022." Under "II						- 1	
	documented in part, "E	valuate the effectiveness	ĺ					
	of pain interventions as	given, Review for	1					
	compliance, alleviating of symptoms, dosing				1		- 1	
		t satisfaction with results,					-	
	impact on functional ability and impact on		1					
- 1	cognition as needed, D	ate Initiated: 04/13/2022."					- }	
	Review of the facility's a							
	evidence non-pharmaci	_	ĺ				- 1	
	being attempted on the							1
1	above.							
10	On 08/15/22 at 8:00 a.m	ı., en interview was						
,		ensed practical nurse) #7.	1				- 1	
(\	When asked to describe	the procedure when						
		d pain medication LPN #7	1					-
1		sesses the resident's pain						
		of the resident's pain on		1			- 1	
	scale of zero to ten, w			1				
		pain and the type of pain		-				- 1
	uch as throbbing or sta			- [ŀ
	nat the nurse would the		J	-				
	on-pharmacological inte			1	•			18
	positioning, ice pack, o							
	ot alleviate the resident dminister the prescribe		{					
	sked how often non-pha						(ł
	terventions LPN #7 sta			1				
	tempted each time before		(- 1
	edication is administere	•						
		that the location of pain,						
	pe of pain and non-pha							

DEPARTMENT OF HEALTH AND HUMAN	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED				
		495109	8. WING			00	C 5/15/2022
	PROVIDER OR SUPPLIER URELS OF UNIVERSITY PA	ARK		2420	EET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD HMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X8) COMPLETION DATE
	interventions were after it would be documented the eMAR. After review non-pharmacological it asked about the missing stated that they could it non-pharmacological it attempted because it were reviewing (R58's) complete with the intervention implementing non-pharmasked if (R58's) care wouse and documenting of LPN #7 stated no. On 06/15/2022 at approximation with the intervention in the intervention in the intervention in the intervention in the intervention in the intervention in the intervention in the intervention with	empted LPN #7 stated that and in the nurse's notes or w of the eMAR for interventions LPN #7 was ag documentation. LPN #7 not say interventions were was not documented. After brehensive care plan, LPN in the intervention for as stated above. LPN #7 tion referred to m interventions. When as implemented for the of non-pharm interventions with a simplemented for the of non-pharm interventions. The sing and ASM # 3, ator, ASM# 4, regional was presented prior to exit. Trainadol is and capsules are only expected to need in around-the-clock. This is from the website: irruginfo/meds/a695011.ht Ito implement the infor Resident #87 (R87)	F	356			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	or conduction on	DEWARDON MONDER	A BUILD	ING		С	
1		495109	B. WING			٥	8/15/2022
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		-	STREET ADDRESS, CITY, STATE, ZIP CODE		
		. Pu		;	2420 PEMBERYON RD		
IRELAU	IRELS OF UNIVERSITY PA			H	RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 656		69 DS (minimum data set), a	F	956	3		
		with an ARD (assessment					
		2/2022, the resident scored					
	15 out of 15 on the Biff mental status) assess				1		
	resident is not cognitive				!		
	daily decisions. Section	n M documented R87					
		sure ulcer and 1 Stage 3					1
	pressure utoer.		ĺ				
	A. On 6/14/2022 at 8:2	25 a.m., an interview was					
	conducted with R87 in						
ļ		en in earlier that morning					
	to change their wound a better about doing the v	dressing and had gotten		-			
ľ	R87 stated that they ha						
	with getting the wound	dressing changed and					
ľ	their family had compla	ined to the nurses about it.		-			
ł	The comprehensive car	na plan for R87					}
		(in #2: [R87] has pressure		- {			1
1	ulcers to sacrum and rig						
	followed by wound doct			-			
- 1	07/17/2019. Revision o "Interventions" it docum	1		- 1			j
	"Treatments as ordere			-			í I
1							
	The eTAR (electronic tre record) for R87 dated 1/						
1	record) for Nor dated in to evidence documentati						()
1.	provided to the sacral we			1	•		(4)
1	1/17/2022.				·	· ·	
-	The progress notes docu	imented in part.					
		8 p.m.) Note Text: Sacral					
Jv	wound care provided du	ring shift. Yellow/reddish					
	discherge noted. Foul od						
		oviding wound care. Pain					
0	neds offered, declined p	er resident"					

(FAX)

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED		
			A BUILDI	43			C 06/15/2022	
		496109	B. WNG	13				
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK				2420 PI	T ADDRESS, CITY, STATE, ZIP CODE EMBERTON RD IOND, VA 23233			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION		BE	(XS) COMPLETION CATE	
F 656	Continued From page 70		F6	56				
P s d (o	The progress notes failed to evidence documentation of treatment to the sacral wound 1/7/2022-1/9/2022 and 1/11/2022-1/17/2022. The physician orders reviewed from 1/1/2022 through 1/31/2022 documented in part, "Wound care: Sacral wound- clean with 1/4 Dakins solution- pack with Silver Calcium Alginate QD (every day) and PRN (as needed)- cover with dry dressing. Order Date: 01/07/2022, End Date: 01/17/2022" The order failed to evidence a start date. The wound evaluation & management summary dated 1/7/2022 documented in part, "Stage 4 pressure wound sacrum full thickness Wound progress: deteriorated, Additional wound detail: larger, d/c dakins packing, start Silver Alginate, dressing treatment plan, primary dressing(s). Sodium hypochlorite solution (dakins) apply once daily for 30 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 30 days" The wound evaluation & management summary dated 1/14/2022 documented in part, "Stage 4 pressure wound sacrum full thickness Wound progress: improved, Additional wound detail: smaller, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 23 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 23 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 23 days. econdary dressing(s), gauze island (w/bdr) apply once daily for 23 days"							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 06/15/2022	
		498109 B. WING					
NAME OF P	PROVIDER OR SUPPLIER			धा	REET ADDRESS, CITY, STATE, ZIP CODE		
		I Polic	i	24	20 PEMBERTON RD		
I HE LAU	REL3 OF UNIVERSITY PA	KK		RI	CHMOND, VA 23233		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		86	(US) COMPLETION DATE
	pressure wound sacru progress; improved, Al shorter, no longer with treatment plan, primary hypochlorite solution (c. 9 days; clean with 1/4 calcium w/silver apply secondary dressing(s), once daily for 9 days On 6/14/2022 at 3:08 p conducted with LPN (ik LPN #9 stated that the staff on how to care for stated that the staff use what to do for the residimplementing the care; following the intervention of 6/15/2022 at 9:56 a. was conducted with ASI member) #7, the wound attated that R87 had a sceen following for 950 d R87's wound was slow to cornorbidities and nonce	mented in part, "Stage 4 m full thickness Wound dditional wound detail: exposed bone, dressing y dressing(s), Sodlum dakins) apply once daily for dakins solution; Alginate once daily for 9 days. gauze island (w/bdr) apply	F6	556			
tr	reatment for the pressur nat there should be a co	re ulcer. ASM #7 stated					
(X) #X (X)	3 stated that treatments completed by documents	the unit manager. LPN were evidenced as					

PRINTED: 06/28/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE BURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495109 B. WING 06/15/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 PROVIDER'S PLAN OF CORRECTION (76) COMPLETION DATE **BLIMMARY STATEMENT OF DEFICIENCIES** (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG TAG DEFICIENCY) F 656 Continued From page 72 F 656 there was no evidence to support that anything was done. LPN #3 they were always taught that if it was not documented it was not done. LPN #3 reviewed the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence that there was a treatment in place for the sacral pressure ulcer between 1/7/2022-1/17/2022. On 6/15/2022 at 1:29 p.m., an interview was conducted with LPN #2, wound nurse. LPN #2 stated that they were new to the wound nurse position. LPN #2 stated that R87's pressure ulcer was slow to heal due to non-compliance with offloading and turning and positioning off of the wound. LPN #2 stated that they round with the wound doctor and make any changes to treatment orders as needed when the physician rounds. LPN #2 reviewed the physician orders and the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence of a treatment in place for the pressure ulcer from 1/7/2022-1/17/2022. On 6/15/2022 at approximately 4:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing.

Complaint deficiency

ASM #3, the southside regional clinical

coordinator and ASM #4, the regional director of operations were notified of the findings.

No further information was provided prior to exit.

B. On 6/14/2022 at 8:25 a.m., an interview was conducted with R87 in their room. R87 stated that they used to wear hand splints to keep their hands from getting stiff but had not worn them in

07/11/2022 14:40

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION MINDED.		MULTIPLE CONSTRUCTION UILDING			COMPLETED		
127		495109	B. WING			1 .	06/15/2022		
_	ROYDER OR SUPPLIER	ark .		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(7(8) COMPLETION DATE		
# C C # R A	hand splints and had a nurses had told them if for them. R87 stated to staff knew where they ever offered to apply the Additional observations 2:45 p.m. and 4:30 p.m. a.m., revealed them not a.m., revealed them not a.m., revealed them not adocumented in part, "[F. Contracture development of the comprehensive candocumented in part, "[F. Contracture development of the contracture mgmt (man morning ADL (activities remove in the evening of Date Initiated: 04/05/20 p.m. Pt. (patient) to we plints daily, on after AD art, "Pt. (patient) to we plints daily, on after AD after lunch/before dinned hour wear and is able when she wants splints in ide trained in splint propassive range of motion xtremities) and hands	net they wanted to wear the seked about them but the hat therapy had to evaluate het they did not know if the were or not and no one sem anymore. Is of R87 on 6/13/2022 at n. and 6/14/2022 at 10:50 at wearing hand spilints. The plan for R87 (887) is at risk for ent, Date Initiated: n. 04/05/2022" Under sented in part, "Pt (patient) both hands daily for agement). Apply after of daily living) care and or as requested by pt. 22" They OT discharge 12/7/2021 documented in ear B (bilateral) hand off r. Pt has been tolerating to communicate to staff removedRestorative gram and PROM (a) to BUE (bilateral upper m., an interview was stiffed nursing assistant) they perform passive is on residents during did that they were not	F	866					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ACCOUNT) multiple construction Building			(X3) DATE SURVEY COMPLETED C	
ļ		496109	B. WNG_			06/16/2022		
NAME OF F	PROVIDER OR SUPPLIER			8TR	EET ADDRESS, CITY, STATE, ZIP CODE			
THELAI	RELS OF UNIVERSITY PA	APK		2420	PEMBERTON RD			
INE LAU	KELO OF DAIVEROIT FA	ann.		RIC	HMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROLIDERICS)	DBE	(XI) COMPLÉTION DATE	
F 656		ed that they thought the	F6	56				
	nurses or the therepis	t applied the splints					[
	because the CNAs did	1 not.						
	LPN #9 stated that the recommended splint ustated that the nurses sure the splint is being the nurse. LPN #9 stated to guide the staff on he LPN #9 stated that the know what to do for the implementing the care applying the splints as LPN #9 stated that the remembered R87 having the CNAs should apply LPN #9 went to R87's resplints in the drawer of stated to LPN #9, "Oh, because no one knew approceeded to apply the	icensed practical nurse) #9. Irapy evaluated and se for residents. LPN #9 would follow up and make applied by the CNAs or ted that the care plan was two care for the resident. It is the care plan to the residents and were not plan if they were not directed in the care plan. If they were not the they thought they them after morning care. The residents and that them after morning care. The residents and that them after morning care. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents and that the nightstand. The residents are the residents and that the nightstand. The residents are the residents and that the nightstand. The residents are the residents are the residents and that the nightstand. The residents are the resid						
		timately 4:05 p.m., ASM	1					
	administrative staff me							
	administrator, ASM #2, ASM #3, the southside i							
		t, the regional director of	1		10			
	perations were notified							
		ras provided prior to exit.		-	,			
c	. The facility staff failed comprehensive care pla tesident #76.							
F	tesident #76 was admit	ted to the facility on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IN CAPACITO ATTOMA AN ALACE CO.			(2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			B. WNG				١	C	
NAME OF I	PROVIDER OR SUPPLIER	496109	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE		1 00	5/16/2022	
	RELS OF UNIVERSITY PA	ARK		;	2420 PEMBERTON RD RICHMOND, VA 23233				
] SUBMIADV ST	ATEMENT OF DEFICIENCIES	ID	'	PROVIDER'S PLAN OF COR	RECTION		(24)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		COMPLETION	
F 656	Continued From page	75	Fe	856					
	7/19/21. Resident #7/ were not limited to, ES disease) and dementing							s	
	Resident #76's most recent MDS (minimum data								
	set) assessment, an annual assessment, with an assessment reference date of 3/19/22, coded the								
	resident as scoring 9 out of 15 on the BIMS (brief				X				
	interview for mental st	atus) score, indicating the						i	
	resident was moderate	ely cognitively impaired.						1	
J	A review of Resident #	78's comprehensive care							
ļ	plan revised 9/9/21, revealed the following,							ĺ	
	"NEED: Resident is at							1	
		alyais due to: End Stage						ļ	
	Renal Disease, dialysi Hemodialysis Tuesday		1					Ĺ	
J		eerve for signs/symptoms							
	of infection to access s			ď					
		eding and other signs of		Į					
		ilzed malaise, complaints							
		s. Document and report							
	abnormal findings to the Hemodialysis: Facility v		1	-				ľ	
	memodialysis: racility v		-	-					
		e dialysis communication	1						
	book to the dialysis cen								
		rn from the dialysis center)	- 1					
	review the communicati						ĺ		
	progress notes and pro-								
	physicien and eny staff needed.	member/disciplines as			•				
	A review of the physicia								
	renewed 5/2/22, reveale		1						
	Hemodialysis Tuesday,								
	Monitor dialysis catheter signs/symptoms of infec								
	tressing if needed. Mor								

		ND HUMAN SERVICES			FOR	D: 06/28/202 RM APPROVÉ O, 0938-038
STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SLIA	(X2) MULTIF	PLE CONSTRUCTION	(K3) DAT	E SURVEY
AND PLAN C	of Correction	IDENTIFICATION NUMBER:	A. BUILDING	·	СОМ	PLETED
		498109	B. WING _		ne	C /15/2022
NAME OF	PROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
THE LAU	RELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC identifying information)	iD PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	B€	COMPLETION DATE
F 656	Continued From page	76	F 65	6		
	on 6/14/22, revealed to "Hemodialysis Commo completed on the folio 4/22/22, 4/7/22, 3/29/2 The facility falled to prodictly a facility for 10 of the missing dates in M	wing dates, 6/14/22, 22, 3/26/22 and 3/24/22. ovlde communication to the if 14 visits in March 2022, arch 2022 wers: 3/1, 3/3,				
1 c c c c c c c c c c c c c c c c c c c	The facility failed to produce of the facility failed to produce of the facility for 11 or missing dates in April 2	17, 3/19, 3/22 and 3/31. byide communication to the f 13 visits in April 2022, the f022 were: 4/2, 4/5, 4/9, 4/23, 4/28, 4/28 and 4/30.			ļ	
	The facility falled to provide communication to the dialysis facility for 13 of 13 visits in May 2022, the missing dates in May 2022 were: 5/3, 5/5, 5/7, 5/10 5/12, 5/14, 5/17, 5/19, 5/21, 5/24, 5/28, 5/28 and 5/31.					
r	lialysis facility for 5 of 5	vide communication to the visits in June 2022, the 022 were: 6/2, 6/4, 6/7,				
1.	A review of the TAR (tre ecord) for March 2022,					

"Monitor dialysis catheter Right Chest for signs/symptoms of infection. May reinforce dressing if needed. Monitor every shift." The reviewed evidenced that 25 out of 93

shifts/opportunities were missing documentation. Missing dates were day shift: 3/1, 3/2, 3/4, 3/5, 3/8, 3/7, 3/12, and 3/15; evening shift 3/3, 3/6, 3/8, 3/9, 3/24 and 3/26 and night shift 3/1, 3/4, 3/6, 3/7, 3/9, 3/10, 3/11, 3/14, 3/15, 3/22 and

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION		NTE SURVEY
			,		-		c	
į			496109	B. WING_	_		<u> </u>	06/16/2022
		ROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	RK		24	REET AODRESS, CITY, STATE, ZIP CODE 20 PEMBERTON RD CHMOND, VA 23233		
	(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	;	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
-	A find the f	following, "Monitor dialy for signs/symptoms of indressing if needed. Monitor dialy shifts/opportunities were day 4/21; evening shift 4/8 at A review of the TAR for following, "Monitor dialy for signs/symptoms of indressing if needed. Monitor dialy several shifts/opportunities were day evening shift: 5/23, 5/25 shift 5/11. A review of the TAR for collowing, "Monitor dialys or signs/symptoms of indressing if needed. Monitor dialys in education. Missing 1/5, 6/8, 6/10 and 6/11; educated with Resident and a dialysis binder, Resident in the property of the prop	April 2022, revealed the yes catheter Right Chest infection. May reinforce printer every shift." The se out of 61 or missing documentation. If shift: 4/1, 4/9, 4/10 and and night shift 4/4. May 2022, revealed the sis catheter Right Chest infection. May reinforce inter every shift." The out of 90 or missing documentation. In shift: 5/8, 5/17 and 5/23; 5, 5/26 and 5/28 and night. June 2022, revealed the sis catheter Right Chest fection. May reinforce liter every shift." The of 42 shifts were missing dates were day shift: evening shift: 6/10 and in interview was #76. When asked if she sident #76 stated, I have ne dialysis center. When alysis catheter site	F 6	56			
	Ar	n interview was conduct	•					
_	اوم	A MIGHT FLA (Recursed bu	actical nurse) #3. When		\Box			

498109 8. WING 06/15/2	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DEFICIENCY M
F 656 Continued From page 78 asked the purpose of the care plan, LPN #3 stated, the purpose of the care plan is to identify the needs of each resident and what actions need to be taken for those needs. When asked if not having the dialysis communication sheets sent with the resident indicated the care plan was being followed, LPN #3 stated, no, it would not be followed in that case. When asked if there were branks on the TAR, what that Indicated, LPN #3 stated, if there are blanks, then I have always been taught, if it was not documented it was not done. When asked if dielysis catheter care was not documented, was the care plan being followed, LPN #3 stated, no, it was not. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Care Planning" policy dated 6/21, which reveals, "in addition to care plans based on admission orders, goals for admission and desired outcomes, interdisciplinary tearn assessments, physicien orders. No further information was provided prior to exit. 8. The facility staff failed to implement the comprehensive care plan for oxygen therapy for Resident #61. Resident #61 was admitted to the facility on 4/23/21 with diagnoses that included, but not limited to, COPD (chronic obstructive pulmonary disease). Resident #61's most recent MDS (minimum data set)) assessment, a quarterly assessment, with an	ed the purpose of the ed, the purpose of the ed, the purpose of the ed, the purpose of the ed, the purpose of the ed, the purpose of the ed, the purpose of the ed the ed, the dialysis committee resident indicate g followed, LPN #3 swed in that case. Whick on the TAR, what is the ed, if there are blanks in taught, if it was not in the ed, if there are blanks in taught, if it was not in the ed, the ed, LPN #3 stated, if there are blanks in taught, if it was not incommented, was the wed, LPN #3 stated, in the ed, th

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER		TIPLE ((X3) DATE SURVEY COMPLETED		
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		496109	B. WNG	,		0	8/15/2022
	PROVIDER OR BUPPLIER IRELS OF UNIVERSITY PA	ARK		243	REET ADDRESS, CITY, STATE, ZIP CODE NO PEMBERTON RD CHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFL TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X8) COMPLETION DATE
F CO F T T F A A R P I	resident as scoring 7 of interview for mental stresident was severely resident was coded as assistance in bed mobitotal dependence with personal hygiene and a Resident #81's care plarevision date, revealed Resident has a potential and risk for respiratory. COPD. Interventions: encourage cough & desordered via nasal cannul (shortness of breath), CA review of the physicial revealed the following, "cannula for SOB." Resident #61 was observanula at 3 liters per manula at 3 liters	date of 4/22/22, coded the but of 15 on the BIMS (brief atus score), indicating the cognitively impaired. The requiring extensive lity, transfers, dressing; toileting, bathing and supervision with eating. In dated 4/24/21 with no the following, "Need; at for difficulty breathing complications related to: Elevate head of bed, ap breathing, Oxygen as ale every shift for SOB OPD oxygen per order." In's orders dated 4/4/22, Oxygen 2l/min via nasal inute on 6/13/22 at 1:09 and 6/14/22 at 2:50 PM. Is the Invacare to be conducted with initive impairment. PN (licensed practical absence the oxygen ited on 6/14/22 at 3:00 actical nurse) #3. When	F	856			

07/11/2022 14:41

	RTMENT OF HEALTH AN				PRINTED: 06/26/2022 FORM APPROVED OMB NO. 0938-0391		
STATEME	ERS FOR MEDICARE & NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		498109	B. WNG_		C 06/15/2022		
NAME O	F PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LA	URELS OF UNIVERSITY PA	RK		2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PRÉFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE		
F 65	stated, the purpose of the needs of each resi to be taken for those noxygen setting observe on 3 liters need cannuloxygen being set at 3 lindicated that the care LPN #3 stated, "No, it is Con 6/14/22 at 4:20 PM administrator, ASM #2, and ASM #3, the region were informed of the all According to the instruct Invacare Perfecto2 oxyproperly read the flown flowrate line on the flow know until the ball rises the ball on the liters per The facility's "Physician 6/24/21, revealed the forendered to a guest/real accordance with the specific part of the set of the s	the care plan is to identify dent and what actions need eeds. When asked the ed, LPN #3 stated, It is set its. When asked if the liters nasal cannula, plan was being followed, a not." ASM #1, the the director of nursing, hal clinical coordinator cove concern. Ation manual for the gen concentrator, "To leter, locate the prescribed meter. Next, turn the flow to the line. Now canter minute line prescribed." orders" policy dated llowing, "Treatment dent must be in locific standing, written, er of a physician or other conal ordering within their	F6	F657			
F 667 \$3=E	No further information w Care Plan Timing and R CFR(s): 483.21(b)(2)(l)-(§483.21(b) Comprehens §483.21(b)(2) A comprel be-	evision III) Ive Care Plans	F 65	Criteria I Resident # 114 had her care plan updated v Splint to RU arm splint and use of fall mat was applied to resident # 114. Fall mats we planned and put in place for resident #114. Resident # 87 and Resident 25's care plans updated to reflect the altercation and preve further confrontations.	s. Splint ere care		
	(i) Developed within 7 de	ys after completion of		Resident # 336 was discharged from the fa	cility on		

the comprehensive assessment.

10/21/21.

		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		496109	B. WNG_		06	C i/15/2022	
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	1 00	710/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	VEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE	
	includes but is not limit (A) The attending physical (B) A registered nurse resident. (C) A nurse aide with medical. (D) A member of food at the resident and the resident and the resident record if the personal their resident represent practicable for the cresident's care plan. (F) Other appropriate addisciplines as determined as requested by the accomprehensive and quasies as the same after each assess comprehensive and quasies as the same after each assessments. This REQUIREMENT is but and in the course investigation it was determined as a survey and in the course investigation it was determined as a survey sample, Resident and incomprehensive care plant or the findings include: The facility staff falled comprehensive care plant or the care plant of the course investigation and the	erdisciplinary team, that ted to-sician. with responsibility for the esponsibility espons	F 65	Criteria 2 All current residents have the potential affected by the alleged deficient practice. Criteria 3 Licensed nurses will be re-educated of updating plan of care for the use of de (brace/splint), resident-to-resident incitater a fall. Criteria 4 DON/Designee will randomly audit fit care plan updates related to falls. They be completed 5 days a week for four words, then the last month. The results will be forward QAPI committee for review. The complete for eview the need for further audits at Criteria 5 Date of compliance is 7/26/22	on fall policy, vices idents, and ve Nurses for se audits will weeks; Then wice in the ded to the smittee will	r	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA (DENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	V y	(X3) DATE SURVEY COMPLETED	
			A Boileon		ĺ	С	
		495109	B. WING_		01	8/15/2022	
75 14	PROVIDER OR BUPPLIER RELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RIGHMOND, VA 22233			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	atement of deficiencies y must be preceded by full .gc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE	
F 657	Continued From page	82	F 6	57			
To bit au thr	with an ARD of 5/23/2: out of 15 on the BIMS status) assessment, in severely impaired for r Section J1800 docume falls alnoe admission/e assessment. A. On 6/13/2022 at 1:5 made of R114 in their r lying in bed with a t-shi was observed not wear upper arm. Additional observations 8/13/2022 at 3:41 p.m. 8/14/2022 at 8:45 a.m. R114 not wearing a spli The comprehensive car focumented in part, "[R contracture development extremities. Date initial tevision on: 03/10/2022 vidence an intervention extension brace. The physician orders for art, "Pt (patient) to wear R (race RUE (right upper es tolerated. Perform sk me a day. Order Date: The clinical record failed	ented R114 not having any entry or reentry or prior 9 p.m., an observation was oom. R114 was observed at on and asleep. R114 ring a splint on the right of R114 in their room on and 4:24 p.m. and and 1:30 p.m. revealed and 1:30 p.m. revealed and on the right upper arm. e plan for R114 114) is at risk for at. Has contractures to all ated: 03/10/2022. The care plan failed to a for the right wrist R114 documented in extremity) during the day in inspections daily, one 04/02/2022."					
		6/13/2022 or 6/14/2022.			ĺ		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA	11.	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION CONTRACTOR	A BUILDII	··G		C		
		498109	e. WNO_			06/15/2022		
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STA		0/10/2022		
				2410 PEMBERTON RD				
THE LAU	RELS OF UNIVERSITY PA	ARK	- 1	RICHMOND, VA 23233				
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full BC identifying information)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION TIVE ACTION SHOULD SE LED TO THE APPROPRIATE FICIENCY)	COMPLETION DATE		
F 657	Continued From page	83	F6	57				
t shift find a Control R pi	#5. CNA #5 stated the range of motion exercically care. CNA #5 states aware of any residents hallway. CNA #5 states nurses or the therapist because the CNAs did On 6/14/2022 at 3:08 p conducted with LPN (lin LPN #9 stated that the recommended splint us stated that the nurse. LPN #9 stated that the splint is being the nurse. LPN #9 stated that the staff on how LPN #9 stated that they thought having a splint on their astated that they thought having a splint on their astated that they thought he other unit. LPN #9 to ound a splint in the closupply the splint to R114 on 6/15/2022 at 9:44 e.f. onducted with RN (regions. RN #1 stated that anythic R1 stated that stated that anythic R1 stated that stated that anythic R1 stated that stated that anythic R1 stated that stated that anythic R1 stated that stated that anythic R1 stated that sta	certified nursing assistant) at they perform passive ises on residents during at that they were not at that they thought the sepplied the splints on their applied the splints ont. A.m., an interview was consed practical nurse) #9. The second practical nurse of the second practical nurse of the second practical nurse of the second practical nurse of the second practical nurse of the second passive to care for the resident. In the second plan was the second passive to care for the second passive to care plan to residents and were not color if they were applying the care plan. LPN #9 they remembered R 114 arm when they were on went to R114's room and second plan if the care plan was stered nurse) #1, MDS at the care plan was used to care for the patient. The placed on the care plan. RN replaced on the care plan.						
0	n 6/15/2022 at 11:31 a.	m., RN #1 stated that						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		DEIGH TORROUT HOMBER	A. BUILO	ING			_	
i						1	C	
		495109	8. WNG				06/16/2022	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	IDEL À OF LINE FRANCE DE	DIV.		1	2420 PEMBERTON RO			
THE LA	urels of University Pa	KK			RICHMOND, VA 23233			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		OCE	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION	
<u> </u>					(DEPICIENCY)	_		
					Ess			
F 657	Continued From page	84	F6	357			1	
	they had reviewed R1	14's care plan and the splint						
	was not included but s	hould have been. RN #1					ſ	
	stated that they had co	prected the care plan.	}		1		İ	
			1		1		1	
		re Planning" dated 9/1/2011	1				1	
	documented in part, "		1		1			
	specific, resident cente						1	
	unique to each residen	-	1				1	
		ard preventing avoidable	1		J		1 .	
	declines. How to mana							
		nt strengths. Utilize current	1		J			
		The care plan and resident]	
		on Admission, Quarterly,	l				1	
	Annually and with signi						1	
	Includes adding new for						1	
i	interventions and resolu		1				1	
	longer applicable as ne	eded,.,"	}					
ĺ	The facility policy, "Brad	e and Salist Program ^d					1 1	
ı	• •	nted in part, "a. A care	1	- /				
- 1	plan will be developed to	•						
}	objectives and Intervent		ĺ	- 1			} [
	following: b. Applying the]	- 1			1 1	
	applies the brace with at			J]	
		nd direction that teaches						
	the resident how to apply							
	for the appliance. c. Sta							
	program of applying and			- [
		led hours to be worn and		-			1 1	
	when skin will be inspect						1 1	
	symptoms of pressure ar				•			
	atc. and will be reported				•	•	[
	attending physician. e. C						}	
	ndividualized Interventio			-				
	providers. Provide specif			1			}	
	as needed (e.g., correct :							
	of motion tech, skin integ							
	nd Kardex. 6. Documen							
	esident daily participation							

I		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		ATE SURVEY OMPLETED
l								С
Į.			496109	B. WNG		06/15/2022		
		PROVIDER OR SUPPLIER IRELS OF UNIVERSITY PA	IRK		;	STREET ADDRESS, CITY, STATE, 2IP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LEC (DENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION (PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X6) COMPLETION DATE
	F 657	Continued From page number of minutes par Care"		F	357			
	fin O T - or si R fa	On 6/15/2022 at appro- (administrative staff me administrator, ASM #2, ASM #3, the southside coordinator and ASM # operations were notified No further information v B. On 6/13/2022 at 1:5 was made of R114 in the observed lying in bed w R114's bed was observe the wall in the room with floor to the right side of the	the director of nursing, regional clinical defined the regional director of dof the findings. Was provided prior to exit. 9 p.m., an observation self room. R114 was ith a t-shirt on and asleep, and to be pushed against a fall mat placed on the the bed. of R114 in their room on and 4:24 p.m. and and 1:30 p.m. revealed are right side of the bed. R114 documented in mack placement and afety. Order Date: Immented in part: p.m.) Resident observe assessment, patient om with face down. events leading up to collect this time"					
		ipproximately) 1930 (7:3 atled to residents room b						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, -,		LE CONSTRUCTION		re survey Apleted
			A, BUILD	ING		C	
l		496109	B. WING		06/16/2022		
NAME OF	PROVIDER OR SUPPLIER	430,02	Tot miles		STREET ADDRESS, CITY, STATE, ZIP CODE] 0	0/10/2022
PHAME OF I	LUCAIDEU OU SOLLCIEN				2420 PEMBERTON RD		
THE LAU	IRELS OF UNIVERSITY PA	RK		1			
	·		,		RICHMOND, VA 23233		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		E	(XII) COMPLETION DATE			
F 657	Continued From page	86	F	357	,		
	resident laying on his a	ight side, on the floor, next]
		5 minutes prior by writer,	ĺ				1
		tly, eyes closed, call belt					
	and bedside table with	in reach, wearing non skid					1
	socks and facility gowr	i, clean and dry, resident					
		he fell, related to dementia					
		r extremities without pain,					1
ĺ	lower extremities contri				<u> </u>		
		n normal limits), no new					
1		ing noted, denies all pain					
ĺ	and discomfortnsg (n bedside mat"	ursing) intervention					1
	Deuside Illat	}					1
ĺ	On 6/14/2022 at 3:08 p	m an interview was					l
1		ensed practical nurse) #9.		ĺ			J
	LPN #9 stated that fall r			Į			
	plans for residents. LPI	V #9 stated that the care					
	. •	aff on how to care for the		- [
- 1	resident. LPN #9 stated			- {			
	care plan to know what	The state of the s		- 1			
	The second secon	hould be reviewed after a		-]			
	fall. LPN #9 stated that			J			
	reviewed to determine if						
		rrent plan was adequate		- 1			
	fall. LPN #9 stated that			ì			
- 1	updated so that all staff			-			J
	needed to be in place.			J			
1		}					
	On 6/15/2022 at 9:44 a.r	n., an interview was					
0	conducted with RN (regis	stered nurse) #1, MDS			•	ĺ	
		t the care plan was used	•		ži.	Ĩ	
	o guide the staff on how					1	1
	RN #1 stated that the uni						
		meetings and they would					
	pdate the care plans the					- 1	
	fter a fall the care plan v						
1 ***	*** ***********************************	ere added. RN#1 stated				- 1	
th	nat anything that require	d a physician order was		\perp	<u>, </u>		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
					-		
		495109	B. WNG_		_	06/15/2022	
	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 8	STATE, ZIP CODE	•	
THE LAU	RELS OF UNIVERSITY PA	ARK		RICHMOND, VA 23233			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRI	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(7.5) COMPLETION DATE
F 657	Continued From page	87	F 65	7			
		n. RN #1 stated that fall he care plan so the staff m.					
	they had reviewed R11	a.m., RN #1 stated that 4's care plan and the fall I but should have been, had corrected the care					
	staff member) #1, the a director of nursing, ASI regional clinical coordin						
ļı	No further information w	as provided prior to exit.					
16	 The facility staff failed the comprehensive care (R87) after a resident to their roommate on 11/10 	resident incident with					
q re 1 rr		th an ARD (assessment 1022, the resident scored 5 (brief interview for ant, indicating the		1980			
or we	in 6/14/2022 at 8:25 a.m onducted with R87 in the bout any incident with the 11/10/2021, R87 state ell with their current roo ey had hallucinations at member any problems	eir room. When asked leir previous roommats d that they got along mmate. R87 stated that times and did not		•			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		495109	B, WING	_		0	06/15/2022	
	PROVIDER OR SUPPLIER IRELS OF UNIVERSITY PA	ARK		24	TREET ADDRESS, CITY, STATE, ZIP CODE 120 PEMBERTON RD ICHMOND, VA. 22233		.,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	atement of deficiencies y must be preceded by full sc identifying information)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
F 657	Continued From page	88	F	357				
	roommate. R87 stated facility.	I that they felt safe at the						
th in the case of awares	for R87 was reviewed. summary dated 11/17/2 "This is a follow-up and Reported Incident in wire Resident [R25] got out. 2021 and placed a pillot [R87]'s head A little aff 10, 2021 [R87] was heat who immediately respond [R87]'s bedside with a particular and placed (R25) back to be nursing assistant [Name the room to monitor [R26] [CNA] provided comfort that she was fine [R25] for psychiatric evaluation and the nurse practitioner, [Name the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room [Room number the room number the room [Room number the room number the room [Room number the ro	2021 documented in part, is summary to Facility which it was reported that of bed on November 10, ow over her roommates ter midnight on November and calling out for nurse anded and found [R25] at willow over [R87]'s face, removed the pillow and ed and placed certified of CNA] at the door of 5) for the rest of the night, to [R87] who reported was sent to the hospital on November 10, whe was transferred to a was seen by same of NP] upon to seen by psychiatric of NP] who agreed with atton. [R87] continues to and continues to state on and findings: The series of the night, made up the night, made up the night, made up the night, made up the night, made up the night, made up the night, made with the gress, writer spoke with						

PRINTED: 08/28/2022 FORM APPROVED

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION		E SURVEY APLETED
			1				С
1		496109	8. WNG	_		Of	3/15/2022
NAME OF	PROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
		· maa		l	2420 PEMBERTON RD		
THE LAU	RELS OF UNIVERSITY PA	ARK			RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
	noted will cont (continu-"11/10/2021 10:08 (1) Guest noted talking to Guest stating, "stop sti before I call my son". It time. Writer was stand observing guest. Guest ready yet Jesus"." - "11/10/2021 10:30 (10 Practitioner note: CC (of smothered by roommate recent altercation with it that her roommate atter a pillow last night, when on her face for long become in and rein roommate. She states is (difficulty) breathing, no stable), oxygen stable. It scared to sleep sec (sec sis (signs or symptoms) up in her wheelchair, following and the pre- placing a pillow over her course: Resident, staff, it severely frightened and collowing assault previous the states the roommate ame to her bedside and ace, She was able to put	see) to monitor." 0:08 a.m.) Note Text: people who are not there, cking me with needles to one is in the room at this ling in the doorway t observed saying, "I'm not 0:30 a.m.) Nurse chief complaint): te, Seeing patient for commate, patient states impted to amother her with states the pillow was not cause she moved the moved the pillow from the she feels fine, no Diff pain, VSS (vital signs She does state that she is condary) to incident. No of acute distress, patient lowing commandsPlan with) staff on the floor: ych consult" 3 p.m.) Psychiatric Nurse hock from being vious night by roommate face. Information secords Interval History: currently anxious s night by her roommate. I totd her to be quiet then placed a pillow over her sh against it with her uting "Jesus help me! I'm	F	8557			
	escue. States that this re er before, and is relieve	oommate has shouted at distributed distrib					

77 17 2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		LE CONSTRUCTION		DATE SURVEY COMPLETED	
			1			¢		
		496109	B. WING			06/15/2022		
NAME OF	PROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	2420 PEMBERTON RD			
THE LAU	RELS OF UNIVERSITY PA	ARK			RICHMOND, VA 23233			
(X4) IO	BUMMARY STA	TEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECT	TION	(20)	
PREFIX TAG		' must be preceded by full BC identifying information)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLÉTION	
F 657	Continued From page	90	F	857				
	permanently removed	from being her roommate	1				ĺ	
		had a scare which her faith			1			
	is helping her resolve		1					
		propriate at this time as					- 1	
		on was promptly dealt with					1	
	to her satisfaction. Pla						ì	
	signs and symptoms of	er) for which medication			1		ĺ	
	would be appropriate		1		ļ		ļ	
- 1	- "11/17/2021 13:56 (1:							
1	worker) check with gue						1	
	doing since the inciden						}	
	Guest voiced she was t		1					
	roommate and she is e							
ſ	Guest volced she does this time."	not have any issues at	1				İ	
	ti iis tii iie.		1	1			- 1	
ĺ	The comprehensive car	e plan for R87 failed to						
		or revision regarding the	1					
1	realdent to realdent inci-	dent on 11/10/2021.		ĺ				
	On 6/15/2022 at 12:20 p			1				
	conducted with OSM (of							
	n the building when the	stated that they were not	ļ					
	petween R87 and R25 b			-			1	
	fterwards. OSM #1 sta	,		- 1				
	eviewed and updated R	-					1 1	
it	ncident but had not upd	ated R87's care plan.	ĺ	-				
	OSM #1 stated that they		ļ	-				
	eview the care plan of the		}	-}	•	•		
re	esident to resident incid	ent.					12.5%	
	n 6/16/2022 at 2:07 p.n							
		nsed practical nurse) #7.					I	
		are plan was used to tell						
	e staff how to care for t							
	erson centered care dire							
i in	uno raciinty. LPN #/ 808	ated that any altercation					1	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		ITE SURVEY MPLETED
			A. BUILDIN	16	С	
1		498109	B. WING			•
NAME OF I	PROVIDER OR SUPPLIER		D. 711110_	STREET ADDRESS, CITY, STATE, ZIP CODE		6/16/2022
POSSIG OF P	-KONDER OK SOPPLIER		- 1			
THE LAU	RELS OF UNIVERSITY PA	ARK	- 1	2420 PEMBERTON RD		
				RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 657	Continued From page	91	F 65	57		
	between two guests re	equired both care plans to				1
j .	be updated. LPN #7 s	stated that both residents		1		1
	should have their care	plan updated and reviewed	}	i		1
	even if only one was th	ne aggressor.				
			}	1		1 .
		o.m., a follow up interview				
j	was conducted with OS					{
		purpose of the care plan nursing could follow what	1			
ĺ		guest, OSM #1 stated that				1
ĺ	nursing would need to		}			
- 1		lent altercation, OSM #1				1 1
	stated that R87 should			1		1 1
[changes after an incide	ent like the one on		1		
	11/10/2021 and the care	e plan probably should	J			1 1
	have been updated to r	reflect that.				
	On 6/15/2022 at approx	dmately 4:05 p.m., ASM	1	1)
	(administrative staff me		ĺ	1		}
	administrator, ASM #2,					1
- 14	ASM #3, the southside i	regional clinical				
		1, the regional director of		}		1 1
	operations were notified	of the findings.				
1	No further information w	as provided prior to exit.				
0	Complaint deficiency		}]
] 3	. The facility staff falled	d to review and/or revise		1		
		plan in a timely manner			1	1
fe	or Resident #25 (R25) a	after a resident to resident				. !
ir	ncident with their roomn	nate on 11/10/2021.	•	•	,3	
	on the most recent MDS					
		th an ARD (assessment				
		022, the resident scored				
		(brief interview for mental		1	J	
	atus) assessment, Indic					
80	everely impaired for mai	king daily decisions.	!			

	OF DEFICIENCIES OF CORRECTION	(X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			LTIPLE CONSTRUCTION DING			(XI) DATE SURVEY COMPLETED C	
		496109	8. WING			06/15/2022			
	PROVIDER OR SUPPLIER		6TREET ADORESS, CITY, STATE, ZIF CODE 2420 PEMBERTON RD RICHMOND, VA 23233					071072022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI	COMPLETION DATE		
F 657	Continued From page	92	Fe	57					
	made of R25 in their in their private room sittle was not observed displayed behaviors during the displayed for R26 was reviewed. A FRI (facility reported for R26 was reviewed. aummery dated 11/17/ "This is a follow-up and Reported Incident in w. Resident (R25) got out 2021 and placed a pill [R87]'s head A little at 10, 2021 [R87] was heaving in the responsibility of the rorn to monitor [R26] is bedside with a provided comfort that she was fine [R25] or psychiatric evaluation (D21 Upon her return strivate room [Room numer nume practitioner, [Namese changes in medical provided comfort in the rorn factor of [R25] in the rorn facto	Incident) dated 11/10/2021 The follow up and 2021 documented in part, if summary to Facility hich it was reported that of bed on November 10, ow over her roommates for midnight on November and calling out for nurse nded and found [R25] at oillow over [R87]'s face. removed the pillow and bed and placed cartified a of CNA] at the door of (S) for the rest of the night. Ito [R87] who reported 1 was sent to the hospital in on November 10, she was transferred to a niber]. [R25] was seen by Name of NP] upon so seen by psychiatric e of NP] who agreed with ation. (R87) continues to and continues to state							
Te	'11/10/2021 00:30 (12: ext: Noted that resident	125 documented in part; 30 a.m.) Late Entry: Note got up and placed a shead. She kept getting							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		11111	7. 55.6			С	
		495109	B, WING	·	06/15/2022		
NAME OF	NAME OF PROVIDER OR SUPPLIER			BTI	REET ADDRESS, CITY, STATE, ZIP CODE		
THE LAW	THE LAURELS OF UNIVERSITY PARK			247	20 PEMBERTON RD		
INC LAU	RELS OF UNIVERSITY PA	IKK		RK	CHMOND, VA 23233		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(XS) COMPLETION DATE
in de	head, Agency CNA (ca had to sit in the door was from [R87] the entire is responsibility until next approximately approximately Ambulance. She appear signs of distress" - "11/10/2021 08:03 (8:03	and place a plliow over [R87] pertified nursing assistant) yay to keep [R25] away hift. Nurse assumed is hift." 2:48 a.m.) Late Entry: Note dimitted To [Name and hital]. She was transported acility] this evening shift at) 2130 (9:30 p.m.) via hired to be rested and no 0.03 a.m.) Note Text: Guest umber] from [Room ings." 54 a.m.) Note Text: spoke sible party) r/t (related to) during the night, notified ioner) was made aware blaced in a different room anent room can be ware that resident has noted at this time, will cont of transfer to psych (psychiatric) evaluation of transfer to psych (psychiatric) evaluation to go pee, she doesn't No s/s te distress, RP daughter tient today. Plan of care fron the floor: now in	F	857			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		LE CONSTRUCTION		JE SURVEY MPLETED
1			7. 8010	HAG			С
1		495109	E. WNG			06/15/2022	
NAME OF	PROVIDER OR SUPPLIER			Т	STREET ADDRESS, CITY, STATE, ZIP CODE		
					2420 PEMBERTON RD		
THE LAU	URELS OF UNIVERSITY PA	ARK			RICHMOND, VA 23233		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(XB)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION
F 657	Continued From page	94	F	957	,		
		2:07 p.m.) Note Text: Cell					İ
	placed to [name and n		1		ĺ		
		te with dispatcher who took	1		Į.		
	Information. Per dispat		}		1		
	1	cility to speak with DON					i .
	(director of nursing) in	reference to incident. And	1				
		ne is to return call to facility					
	with how guest is going		1				1
	[Name of hospital]. Wa	iting to be notified."	{				
	The comprehensive ca	re nien for R25	İ				
ĺ		(25) has a actual behavior	1				
ľ	problem R/T (related to						1 1
- 1	roommate with a pillow.		1				ļ
İ	yelling/screaming out, p	hysical behavioral		ĺ			l i
}	symptoms directed town		1	-			1 1
		levision on: 04/06/2022."		-			1
1	The care plan failed to		ļ				
- (revision prior to 3/17/20	22.	ĺ				
- 1	On 6/15/2022 at 12:20 p	o.m., an interview was					
	conducted with OSM (of			-1] [
[3	social worker. OSM #1	stated that they were not					1
	in the building when the			- [l !
	between R87 and R25 b						}
	efterwards. OSM #1 sta						
	behaviors of yelling out a						
	any aggressive behavior			1			1
	OSM #1 stated that R25 aggressive behaviors to	- 1					
	eggressive benaviors too remained in a private roc	•			14		
	they thought they had re-			1			' I
	R25's care plan after the						
	stated that they normally						
	care plan of the aggresso						
		11 reviewed the cere plan					ı
	or R25 dated 3/17/2022					1	1
		red/revised right after the				- 1	
ir	ncident on 11/10/2021 ar	nd was not sure where		Ì			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
TO TO				C		
	496109	a. wing			06/16/2022	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PA	ARK	1	STREET ADORESS, CITY, STATE, 2IP CO 1420 PEMBERTON RD RICHMOND, VA 23233	até, 219 code		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		(XII) COMPLETION DATE	
that they would ask an review and see if they OSM #1 stated that the been reviewed prior to On 6/15/2022 at 2:07 producted with LPN (like LPN #7 stated that the the staff how to care for person centered care of in the facility. LPN #7 stated that the facility. LPN #7 stated that the person centered care of in the facility. LPN #7 stated that the staff how to care for person centered care of in the facility. LPN #7 stated that the staff how to guests received as soon as On 6/15/2022 at approximation (administrative staff meadministrator, ASM #2, ASM #3, the southside coordinator and ASM #4 operations were notified to further information with the facility staff failed that the complaint deficiency.	me from. OSM #1 stated bother staff member to could pull the history on it. a care plan should have 13/17/2022. D.m., an interview was censed practical nurse) #7. care plan was used to tell or the resident and was a lirective for each resident stated that any aftercation quired both care plans to possible. It will be the director of nursing, regional clinical 4, the regional director of it of the findings. It to review or revise comprehensive care plan tained on 8/16/21 and Comprehensive care plan tained on 8/16/21 and Comprehensive care plan tained on 8/16/21 and	F 657				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		DATE BURVEY
		495109	B. WNG		}	C 06/16/2022
	Provider or supplier RELS OF UNIVERSITY PA	ark	8TR 2420 RIC	CODÉ	OU 10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
	and 9/16/21. A review dated 8/16/21 and 9/16 beside the words, "Car The check box was no R336's comprehensive 3/16/21 falled to reveal resident's care plan wa regarding those falls. On 6/15/22 at 8:02 a.m conducted with RN (regregarding the purpose stated the care plan is a kind of gives staff the gwith the resident and with the resident and with the resident and with the second size of the second stated the care plan is a kind of gives staff the gwith the resident and with the resident and with the resident and with the second size of th	sustained fails on 8/16/21 of post fall evaluations 3/21 revealed a check box re Plan/Kerdex Updated." It marked. A review of care plan initiated on evidence that the s reviewed or revised, an interview was pistered nurse) #2, of the care plan. RN #2 comething to follow that uideline of what's going on	F 657		·	
in control of the con	resually within 24 hours of the seldent's fall or when a contervention is obtained, the care plan. The care plan to evaluate for proper fit initiation date was 9/11/2 was 9/22/21. RN #1 state ocumented due to a new eview or revisions from	the MDS coordinator). The residents' care plans of being made aware of a new order for an RN #1 reviewed R336's of documented for therapy fing of shoes. The resident this was probably worder and not from a R336's falls. RN #1 review R336's care plants for the 8/16/21 and review R336's care plants for the 8/16/21 and revised for either fall. ASM (administrative				n:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UNMBER:		A BUILDIN	(XS) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER URELS OF UNIVERSITY PA	RK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RO RICHMOND, VA 23233	
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	(the director of nursing clinical coordinator) ard director of operations) above concern. The facility policy titled documented, "3. When nurse will evaluate the injury4. The licensed Review and for revise guest/resident kardex No further information of the company of the services provided Mee CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehense outlined by the company of the services provided of the services pro	and ASM #3 (the regional and ASM #4 (the regional were made aware of the were made aware of the were made aware of the procession of the aware of the west freshold for nurse will complete: care plan and "" West presented prior to exit. WCY It Professional Standards The arranged by the facility, rehensive care plan, and ards of quality. In not met as evidenced resident interview, staff review, and facility determined that the exprofessional standards dents in the Medication on task, Residents #14 residents in the survey and #113.	F 65		Provide All MD were the ity to f at the e the I on d that the

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MVL		E CONSTRUCTION		TE SURVEY MPLETED
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		495109	B. WING			0	6/15/2022
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		6	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LA	URELS OF UNIVERSITY PA	ARK	ĺ		420 PEMBERTON RD		
				F	RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Atement of Deficiencies I must be preceded by full SC identifying information)	PREFID TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION COMPLETION
- (c) the n	LPN #5 signed out for was not administered, Resident #14 was adm 3/12/21. On the annual Set) assessment with a Reference Date) of 3/1 a 15 out of a possible to interview for mental state was cognitively intact in decisions. On 6/14/22 at 8:17 AM, Practical Nurse) was obtained the following #14: Methimazole 5 mg (milli Buspar 10 mg, 1 tab Aspirin 81 mg, 1 tab Magnesium Oxide 400 mm of 1/14/22 at 11:16 AM medications was conductive.	medication as given that alted to the facility on al MDS (Minimum Data an ARD (Assessment 1/22, Resident #14 scored 15 on the BIMS (brief atus) indicating the resident a shility to make daily life LPN #5 (Licensed beerved to prepare and a medications for Resident and prepare and a medication of the beted and compared with An order dated 9/8/21 for to the left knee every as noted that LPN #5 a patch to left knee as a it had not been an interview was #14. When asked if astch on their knee this they did not. an interview was	F 6		Criteria 4 DON and/or designee will complete five (random audits of licensed nursing staff for physician's orders and following the stand practice for medication administration. The and/or designee will also complete med per on licensed nurses. Five random med pass will be conducted. These audits will be convectly x four (4) weeks and monthly x two months. These results will be forwarded to QAPI committee for review. The committee determine the need for further audits and/or Criteria 5 Date of compliance is 7/26/22.	llowing lards of c DON is audits impleted to (2) the ce will	
a		gerding the missed					Ж

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DAT	E SURVEY
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	PROVIDER OR SUPPLIER		\$ 2	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 PEMBERTON RD RICHMOND, VA 23233		3/15/2022
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o e e e e e e e e e e e e e e e e e e e	and denied doing anyl away from the surveyor away from the surveyor on 6/14/22 at 12:45 Preported to ASM #1 (A Member) the Administration Regional Director of Open 6/14/22 at 3:00 PM conducted with LPN #4 Nurse) and medication discussed. She stated out for medications that A review of the compresevealed one dated 3/2 at risk for constipation Frobility, medications siplan included the interved A review of the physician for ineffectiveness/side findings to the physician A review of the facility physician. Record the demolication on the Maministration Record. Invest/resident refused." Indress not signing out for given.	thing wrong and walked or. M the above concern was dministrative Staff rator and ASM #4, the perations. , an interview was l (Licensed Practical administration was that staff should not sign t were not given. hensive care plan 3/21 for "[Resident #14] is 3/T (related to): decreased de effects." This care antion, dated 3/23/21 for a se ordered and observe effects. Report abnormal h." policy, "Medication ducted. This policy may are administered in orders of the attending ose, route, and time of edication/Treatment Document if the The policy did not for medications that were als of Nursing, 5th ms & Wilkins, page 577, ication errors include	F 658			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	TIPLE CONSTRUCTION			TÉ BURVEY MPLETED	1
		495109	B. WING				C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 2430 PEMBERTON RD RICHMOND, VA 23233	ZIP CODE	<u>v</u>	6/15/2022	-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Must be preceded by full BC Identifying Information)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED			(XB) COMPLETION DATE	
F 2 2 5 0 0 pp m c c d O P e e e e e e e e e e e e e e e e e e	(Administrative Staff M ASM #2, the Director of Regional Director of Ogaware of the findings. provided by the end of References: (1) Lidocaine - Is used to Information obtained from https://medlineplus.gov/tml 2. For Resident #96, the follow professional standard from was not administered. Resident #96 was admit £/15/20. On the quarter foet) with an ARD (Assessional status) indicating ognitively Intact in ability ecisions. In 6/14/22 at 8:28 AM, Laractical Nurse) was observed.	nately 4:00 PM, ASM #1 ember), the Administrator, if Nursing, and ASM #4, the perations were made No further Information was the survey. To treat pain and druginfo/meds/a603026.h e facility staff failed to dards of practice when nedication as given that ted to the facility on ly MDS (Minimum Data asment Reference Date) ascored a 13 out of a (brief Interview for the resident was by to make daily life PN #5 (Licensed erved to prepare and medications for Resident ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler ams) / 5 mcg Inhaler	Fe	358				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(XS) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER JRELS OF UNIVERSITY PA	ARK		2	STREET ADDRESS, CITY, STATE, 2IP CODE 2420 PEMBERTON RD RICHMOND, VA 23233				
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F 658	Genvoya 150 mg/150 Risperdone 0.5 mg, 1 Prednisone 10 mg, 1 to Senna 8.6 mg, 1 tob Acetaminophen 325 m Spiriva 18 mcg On 6/14/22 at 11:15 Al medications was conditine physician's orders, for Alaway (1) eye drop 1/18/21 for Pepcid (2) that LPN #5 signed out being administered who administered. On 6/14/22 at 12:40 PN attempted with LPN #5 medication. He refused and denied doing anyth	mg/200 mg/10 mg, 1 tab tab ab g, 1 tab M, reconciliation of the ucted and compared with An order dated 6/30/21 as and an order dated were noted. It was noted these medications as an they had not been If an interview was regarding the missed I to answer any questions	F	358					
	reported to ASM #1 (Ad Member) the Administra Regional Director of Open On 6/14/22 at 3:00 PM, conducted with LPN #4 Nurse). She stated that for medications that were A review of the compreheavealed one dated 5/12 at risk for abnormal blee.	tor and ASM #4, the erations. an Interview was (Licensed Practical staff should not sign out a not given. ensive care plan //21 for "(Resident #96) is ding/bruising R/T (related his care plan included an infor "Administer			1477				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULT A. BUILDI	TIPLE CONSTRUCTION NG		NTE SURVEY IMPLETED
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	RELS OF UNIVERSITY P	ARK		2420 PEMBERTON RD RICHMOND, VA 23233	, 511 0002	
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	findings to the physicil dated 7/22/21 was for for constipation R/T: of diminished appetite, is medications side effectional side effections side effections side effectional for ineffectiveness/side findings to the physicist. A review of the facility is Administration" was conducted the medication on the Jacondance with written physician Record the the medication on the Jacondant signing out not given. According to Fundament addition, Lippincott, William The most common medicumentation errors	de effects, report abnormal an." Another care plan, "[Resident #96] is at risk ecreased mobility, ix (history) of constipation, its." This care plan on, dated 7/22/21 for as as ordered and observe e effects. Report abnormal an." policy, "Medication inducted. This policy ions are administered in a orders of the attending dose, route, and time of Medication/Treatment Document if the "The policy did not for medications that were atals of Nursing, 5th ams & Wilkins, page 577, dication errors include charting medication that ately 4:00 PM, ASM #1 inber), the Administrator, Nursing, and ASM #4, the erations were made o further information was	F6	58		
R	eferences;					
(1) Aleway is used for the	treatment of allergy			.]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION		DATE SURVEY OMPLETED	
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7905 11414	DEL O OF LIMBICONTY NA	DIV.		2	2420 PEMBERTON RD			
I THE LAU	KELS OF UNIVERSITY PA	irce	- 1	ı	RICHMOND, VA 23233			
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PREFIX TAG	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI:				COMPLÉTION	
F 658	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK O(4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Contlinued From page 103 symptoms of the eyes Information obtained from https://medlineplus.gov/druginfo/meds/a604033.h tml (2) Pepcid is used for the treatment of reflux and ulcers Information obtained from https://medlineplus.gov/druginfo/meds/a687011.ht ml 3. The facility staff failed to follow medication administration standards of practice during medication administration to Resident #87 (R87). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 16 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. On 6/14/2022 at 10:55 a.m., an interview was conducted with R87 in their room. During the interview with R87, at 10:59 a.m., an observation was made of LPN (licensed practical nurse) #5 entering R87's room. LPN #5 entered the room with two medication cups, one in the right hand and one in the left hand. LPN #5 proceeded to R87's roommate's (Resident 113) side of the room and placed the cup on the overbed table and stated, "Here are your meds" to Resident		F 6	358				
	symptoms of the eyes	£17						l
		om						Ì
	https://medlineplus.gov	/druginfo/meds/s604033.h						l
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1	medication administration	on to Resident #87 (R87).		- [**	- 1	- 1	
· .	On the most recent MD:	(minimum date set) s		1		- 1	i	
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10	resident is not cognitive	y Impaired for making		-			1	
	faily decisions.	1				- 1	- 1	
1.	>+ 8/4 4/2022 -4 40:55 -							
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#	113 (R113) who was in I	he bed. LPN #5						
		to R67 and stated, "Here					1	
	e your meds" handing e					1	ŀ	
	87. LPN #5 assisted Re]		
	eir mouth and then left i							
le	aving R113 with the cup	of pills still sitting on	15					

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ŀ	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	IRK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFE TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X8) COMPLETION DATE
in the second se	Interview was attempted stated that the medical "morning meds" and the residents medications never made a mistake stated that they put A to hand and B bed medical LPN #5 stated that they normally and had alread surveyor that morning attalk. On 6/14/2022 at approximaterview was conducted attaled that medications residents at the same the infection control concentrated on't do that." During the entrance comproximately 1:30 p.m. staff member) #1, the actions in the control concentrated in the entrance comproximately 1:30 p.m. staff member) #1, the actions in the control concentrated in the entrance comproximately 1:30 p.m. staff member) #1, the actions in the control concentrated in the entrance control concentrated in the entrance control concentrated in the entrance control control concentrated in the entrance control control concentrated in the entrance control co	eximately 11:08 a.m., an ed with LPN #5. LPN #5 tions were the residents not they always gave two at the same time and had doing it this way. LPN #5 ed medications in the left ations in the right hand. If y did not work at the facility dy been followed by a and did not have time to dimately 3:08 p.m., an d with LPN #9. LPN #9 were administered to one If y stated that errors instairing to multiple me and there were also not. LPN #9 stated, "You ference on 6/13/2022 at , ASM (administrative tiministrator stated the sitheir nursing standard cation Administration" need in part, ations are administered	F	858			
N	filkins 5th edition; page	j, Lippincott, Williams & 557 under the section lurses are also expected					

(FAX)

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROMDER OR SUPPLIER RELS OF UNIVERSITY PA	IRK			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(A) COMPLETION DATE
	to practice in a safe are the nurse's legal doma medications in a safe at 568, "Procedure 29-1; Medications". Procedu Arrange MAR next to in Prepare medications for 4. Remove ordered medications and the correct drug of selected medications and directly to client's room unattended" On 6/14/2022 at 4:15 p. administrator, ASM #2, ASM #3, the southside coordinator and ASM #2 operations were made at the facility staff faller administration standards medication administration R113). On the most recent MDS quarterly assessment will be administration of 15/21/25 out of 15 on the BIMS mental status) assessment saident is not cognitively ally decisions.	and prudent manner	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
ł			1,000				C		
		496109	B. WING			06/15/2022			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
THOUALL	RELS OF UNIVERSITY PA	PV		;	2420 PEMBERTON RD		!		
INE DAO	KELO OF ONINGKOLLI PA	inn.			RICHMOND, VA 23233				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(2(5)		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD 9 CROSS-REFERENCED TO THE APPROPRIS DEFICIENCY)		COMPLETION		
F 658	Continued From page	106	F	358			}		
	right hand and one in t			,,,,			i 1		
		ide of the room and placed	1						
j	the cup on the overbed						1 1		
		no was in the bed. LPN #5					[]		
ſ		er to R87 and stated here							
-		g a cup of medication to				-			
ſ	R87. LPN #5 assisted						1		
	their mouth and then le			- 1					
1	leaving R113 with the c	up of pills etilf sitting on					1		
	the overbed table. At the						1		
	observed to get out of b	ed and get in the	ĺ						
		the nurse forgot their pain	ì				1		
		og bns moor ent fixe of be]				- 1		
		ation cart to request pain							
	medication. R113 retur			- 1		- {	- 1		
1	second medication cup	with two tablets inside.		ĺ					
- 10	On 6/14/2022 at approxi	imately 11:08 a.m., an		1					
i	nterview was attempted	with LPN #5. LPN #6	1				- 1		
8	stated that the medication	one were the residents]	- 1					
"	morning meds" and that	t they always gave two	1						
į r	esidents medications at	the same time and had		-		i	ſ		
		oing it this way. LPN#5				- 1	1		
		d medications in the left							
	and and B bed medicat			-		1			
		did not work at the facility	}						
	ormally and had aiready						1		
	urveyor that moming an					ĺ	- 1		
	alk. LPN #5 stated that						1		
	atched both residents a					J			
	the room, stated that the								
	redications at the bedsic			1		- 1	. [
ļ fro	om the surveyor into a n	esidents room.							
	n 6/14/2022 et approxin								
	terview was conducted					1			
		ere administered to one]	- 1		
	sident at a time. LPN #								
co	uid be made by adminis	atering to multiple					1		

	T OF DEFICIENCIES OF CORRECTION	IOGNITICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE BURVEY COMPLETED	
1			11233			С	
		495109	B. WNG.			06	/18/2022
NAME OF	PROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAD	JRELS OF UNIVERSITY PA	RK			2430 PEMBERTON RD		
					RICHMOND, VA 23233	_	
(X4) ID PREF(X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(XII) COMPLETION DATE
F 658	Continued From page	107	Fé	358	3		
	residents at the same infection control conce just don't do that." LPI medications were not I the nurse stayed to me swallowed the medicat anyone could come in they could get lost. On 6/13/2022 at approxentrance ASM (administrator stated Lippincott as their nursi	time and there were also irns. LPN #9 stated, "You N #9 stated that eff at the bedside and that like sure the resident ion. LPN #9 stated that and take the medication or dimately 1:30 p.m., during strative staff member) #1, If the facility used ing standard of practice. Ilication Administration" inted in part, " Observe swallows the oral are medications with the					₩.
- 1	•	red for self-administration					
	operations were made a	he director of nursing, egional clinical , the regional director of		Į	F677 Criteria 1 R40 in the facility was noted to have long fingernails and without palm protectors. Rewere trimmed, and protectors placed on gu	lO nails egt,	
F 677 /	ADL Care Provided for D CFR(s): 483.24(a)(2) 5483.24(a)(2) A resident	ependent Residents	F 677		R10 in the facility was noted as failed to he resident preference for showers instead of a bath. R10 has received showers as per gues preference.	bed	,
s p T	out activities of daily living	g receives the necessary i nutrition, grooming, and e;		1	R87 in the facility was noted as failed to probathing/showers, incontinence care, persone hygiene and ADL care. R87 has received th ADL care to include incontinence care, personglene and bathing/showering as per guest preferences.	ii orough onal	

DEPAR	TMENT OF HEALTH AN	ID HUMAN SERVICES					D: 06/28/2022 MAPPROVED	_
CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			(OMB NO	0. 0938-0391	1
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE BURVEY COMPLETED		Ī
		485109	B, WING		_		C 15/2022	ı
NAME OF E	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE ZIP CODE	V 01	TOLEVEE	1
12302 31 1					ALLIER OODG			ı
THE LAU	RELS OF UNIVERSITY PA	RK		2420 PEMBERTON RD				ľ
				RICHMOND, VA 23233				Į
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		(X6) COMPLETION DATE	
i i i i i i i i i i i i i i i i i i i	Interview, facility docur course of a complaint is staff falled to provide A care for 3 of 59 resider Residents #40, #10 and The findings include: 1.a. The facility staff fair (R40) fingernalls. On the most recent MD quarterly assessment was reference date) of 4/6/2 out of 15 on the BIMS (to status), indicating the relimpaired for making dail coded R40 as being total staff with personal hygies on 6/14/22 at 3:10 p.m., ingernalls was conducted and bent in to palms; however, LPN #8 resident's fingers out from the servation. R40's right peroximately one forth it 40's left hand, excluding peroximately one half in	n, resident Interview, staffment review and in the nvestigation, the facility. DL (activities of daily living) at in the survey sample, d#87. Ided to trim Resident #40's S (minimum data set), a sith an ARD (assessment 2, the resident scored 15 orief interview for mental seldent was not cognitively by decisions. Section Gally dependent on one one. an observation of R40's and with LPN (licensed its fingers were owards the resident's a was able to move the month one. All nails on gothe pinky finger, were		Criteria 2 All residents who are the potential to be affed deficiency. Criteria 3 Nursing staff will be read to include an bathing/shower prefers the criteria 4 DON/designee or designandom audits of document dependent for ADL completed 5 days a week for four we month. The results will committee for review. Intering 5 Date of compliance is	e-educated on providing all trimming, orthotic ences. In the series of	ng and e (5) s who ill be en one last)API		
4/ W	40's comprehensive car (15/22 documented, "(Ri th adi's r/t (related to) in agnosis of quadripledis.	npaired mobility						

chronic pain. Guest will state that he needs his

NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD 2420 PEMBERTON RD RICHMOND, VA 23223	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233 ID PROVIDER'S PLAN OF CORRECTIVE ACTION 6HC CROSS-REFERENCED TO THE APPL DEFICIENCY)	Bf	PPLIER PERSITY PARK LIMMARY STATEMENT OF DEFICIENCIES LIDEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) From page 109 Id and then decline when offered by ING: Check nail length and trim and the day and as necessary" However, R40's clinical record (Including nurses DL records for March 2022 through ailed to reveal documentation that bred a fingernali trim and refused. It 8:02 a.m., an interview was th CNA (certified nursing assistant) agistered nurse) #2 (a CNA and	(X4) ID SUMMARY \$7/ PREFIX (EACH DEFICIENCY REGULATORY OR LETTING) F 677 Continued From page nails trimmed and their staff. BATHING: Checken on bath day and a review of R40's clinic notes and ADL records June 2022) failed to re R40 was offered a fing On 6/15/22 at 8:02 a.m.	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Thued From page 109 Immed and then decline when offered by BATHING: Check nail length and trim and on bath day and as necessary" However, sw of R40's clinical record (Including nurses' and ADL records for March 2022 through 2022) failed to reveal documentation that as offered a fingernall trim and refused. 5/22 at 8:02 a.m., an interview was
THE LAURELS OF UNIVERSITY PARK THE LAURELS OF UNIVERSITY PARK C(4) ID PREFIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) F 877 Continued From page 109 nalls trimmed and then decline when offered by staff. BATHING: Check hail length and trim and clean on bath day and as necessary" However, a review of R40's clinical record (including nurses' notes and ADL records for March 2022 through June 2022) failed to reveal documentation that R40 was offered a fingernall trim and refused. On 6/15/22 at 8:02 a.m., an interview was conducted with CNA (certified nursing assistant) #2 and RN (registered nurse) #2 (a CNA and nurse who has cared for R40). CNA #2 stated she recently wanted to cut R40's fingernalls but it was difficult to get the clippers under the resident's nalls and she didn't know how to do so. CNA #2 stated she had not reported this to any other facility employee. CNA #2 stated she was going to ask the podiatrist tif there was enaything that could be done but the podiatrist was busy during the last visit. RN #2 stated she had recognized R40's fingernalls and how his hands were formed (contracted fingers). RN #2 stated she had not attempted to trim R40's fingernalls because she wasn't comfortable doing so. RN #2 stated had not found out what could be done to	STREET ADDRESS, CITY, STATE, ZIP GODE 2420 PEMBERTON RD RICHMOND, VA 23223 ID PROVIDER'S PLAN OF CORRECTIVE ACTION 6HC CROSS-REFERENCED TO THE APPL DEFICIENCY)	er,	PPLIER PERSITY PARK LIMMARY STATEMENT OF DEFICIENCIES LIDEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) From page 109 Id and then decline when offered by ING: Check nail length and trim and the day and as necessary" However, R40's clinical record (Including nurses DL records for March 2022 through ailed to reveal documentation that bred a fingernali trim and refused. It 8:02 a.m., an interview was th CNA (certified nursing assistant) agistered nurse) #2 (a CNA and	(X4) ID SUMMARY \$7/ PREFIX (EACH DEFICIENCY REGULATORY OR LETTING) F 677 Continued From page nails trimmed and their staff. BATHING: Checken on bath day and a review of R40's clinic notes and ADL records June 2022) failed to re R40 was offered a fing On 6/15/22 at 8:02 a.m.	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Thued From page 109 Immed and then decline when offered by BATHING: Check nail length and trim and on bath day and as necessary" However, sw of R40's clinical record (Including nurses' and ADL records for March 2022 through 2022) failed to reveal documentation that as offered a fingernall trim and refused. 5/22 at 8:02 a.m., an interview was
THE LAURELS OF UNIVERSITY PARK 2420 PEMBERTON RD RICHMOND, VA 23233 10 PROVIDERS PLAN OF CORRECT TAG 31 MAMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IMFORMATION) F 677 Confinued From page 109 nalls trimmed and then decline when offered by staff. BATHING: Check nail length and trim and clean on bath day and as necessary" However, a review of R40's clinical record (including nurses' notes and ADL records for March 2022 through June 2022) failed to reveal documentation that R40 was offered a fingernell trim and refused. On 6/15/22 at 8:02 a.m., an interview was conducted with CNA (certified nursing assistant) #2 and RN (registered nurse) #2 (a CNA and nurse who has cared for R40). CNA #2 stated she recently wented to cut R40's fingermalis but it was difficult to get the cippers under the resident's nails and ahe didn't know how to do so. CNA #2 stated she had not reported this to any other facility employee. CNA #2 stated she was going to ask the podiatrist if there was anything that could be done but the podiatrist was busy during the last visit. RN #2 stated she had not altempted to trim R40's fingermalis because she wasn't comfortable doing so. RN #2 stated had not found out what could be done to	2420 PEMBERTON RD RICHMOND, VA 23223 ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	3f, 8f	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) from page 109 d and then decline when offered by ING: Check nail length and trim and h day and as necessary" However, R40's clinical record (including nurses DL records for March 2022 through ailed to reveal documentation that bred a fingernall trim and refused. t 8:02 a.m., an interview was th CNA (certified nursing assistant) egistered nurse) #2 (a CNA and	(X4) ID SUMMARY \$7/ PREFIX (EACH DEFICIENCY REGULATORY OR LETTING) F 677 Continued From page nails trimmed and their staff. BATHING: Checken on bath day and a review of R40's clinic notes and ADL records June 2022) failed to re R40 was offered a fing On 6/15/22 at 8:02 a.m.	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Thued From page 109 Immed and then decline when offered by BATHING: Check nail length and trim and on bath day and as necessary" However, sw of R40's clinical record (Including nurses' and ADL records for March 2022 through 2022) failed to reveal documentation that as offered a fingernall trim and refused. 5/22 at 8:02 a.m., an interview was
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On 6/15/22 at 8:54 a.m., an interview was conducted with LPN #6 (a unit manager). LPN #6 stated she observed R40's fingernalis Wednesday or Thursday of the previous week. LPN #6 stated R40's fingers were hard to open. LPN #6 stated she was now trying to see how R40's nalls could be trimmed and maybe a hand towel could be rolled into the resident's hands. LPN #6 stated she spoke with someone from the therapy department regarding this two weeks ago but she could not remember who she spoke to.			wanted to cut R40's fingernalis but it to get the clippers under the is and she didn't know how to do so, d she had not reported this to any employee. CNA #2 stated she was he podiatrist if there was anything done but the podiatrist was busy tivisit. RN #2 stated she had 10's fingernalis and how his hands contracted fingers). RN #2 stated tempted to trim R40's fingernalis wasn't comfortable doing so. RN #2 found out what could be done to nits nails. 9:54 a.m., an interview was a LPN #6 (a unit manager). LPN #6 erved R40's fingernalis Thursday of the previous week. R40's fingers were hard to open, she was now trying to see how all de trimmed and maybe a hand rolled into the resident's hands.	#2 and RN (registered nurse who has cared for she recently wanted to was difficult to get the considerity and she called the resident's nails and she con #2 stated she had other facility employee, going to ask the podiatr that could be done but to during the last visit. RN recognized R40's finger were formed (contracted she had not attempted to because she wasn't compated had not found out the resident's nails. On 6/15/22 at 8:54 a.m., conducted with LPN #8 stated she observed R40 Wednesday or Thursday LPN #6 stated she was not recovered to the resident of the reside	to the the	RN (registered nurse) #2 (a CNA and who has cared for R40). CNA #2 stated cently wanted to cut R40's fingernalis but it ificult to get the clippers under the it's nails and she didn't know how to do so. It stated she had not reported this to any utility employee. CNA #2 stated she was as ask the podiatrist if there was anything all be done but the podiatrist was busy he last visit. RN #2 stated she had sed R40's fingernalis and how his hands med (contracted fingers). RN #2 stated inot attempted to trim R40's fingernalis as he wasn't comfortable doing so. RN #2 ad not found out what could be done to resident's nails. In the contracted fingers was sed with LPN #6 (a unit manager). LPN #6 he observed R40's fingernalis day or Thursday of the previous week. It is stated she was now trying to see how all a could be trimmed and maybe a hand all did be rolled into the resident's hands.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES	<u>.</u>		OMB N	IO. 0938-039
STATEMENT	f of deficiencies Of correction	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
						C
		495109	B, WNG_		06	6/16/2022
	provider or supplier IRELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X6) COMPLETION DATE
in a b	lying in bed. A palm p realdent's right hand. R40's hands were trim therapist, nurse and C and trimmed the reside on 6/15/22 at 10:44 all conducted with OSM (a rehab therapy director) employee had come to regarding R40's finger when the unit manager the resident. On 6/15/22 at 11:35 a.m. staff member) #1 (the a (the director of nursing) clinical coordinator) and director of operations) was above concern. The facility policy titled, Care'' documented, "Gunecessary assistance to and personal/oral hygier hygiene minimally includencouraging guests/resident and/or providing denture in reported to the nurse. It of further information was complaint Deficiency.	m., R40 was observed protector was on the The fingernails on both of med. R40 stated a NA had been in the rooment's nails. m., an interview was other staff member) #8 (the context of the staff member) #8 (the context of the staff member) #8 (the context of the staff member) #8 (the context of the staff member) #8 (the context of the	F 67			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 '		ONSTRUCTION		E SURVEY
						С	
NAME OF	PROVIDER OR SUPPLIER	496109	B. WING			06	3/16/2022
	AURELS OF UNIVERSITY PARK		TREET ADDRESS, CITY, STATE, ZIP CODE 420 FEMBERTON RD ICHMOND, VA 23233				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	atement of Depiciencies of Must be preceded by Full sc identifying information)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page 8/31/21,	111	F	377			
	quarterly assessment reference date) of 4/6/. out of 15 on the BIMS status), indicating the r impaired for making da	DS (minimum data set), a with an ARD (assessment 22, the resident scored 15 (brief interview for mental resident was not cognitively ally decisions. Section Ging extensive assistance of					
	R40's comprehensive care plan last reviewed on 4/15/22 documented, "(R40) requires assistance with adl's r/t (related to) impaired mobility diagnosis of quadriplegia, muscle weakness, chronic pain. EATING: Resident requires extensive set-up one staff assistance to eat."		2.				
i c	on 9/9/21 documented of assisted with eating on A review of R40's point of daily living) records for a coreveal documentation	o the SA (state agency) concern that R40 was not either 8/30/21 or 8/31/21. of care ADL (activities of 8/30/21 and 8/31/21 failed of R40's meal intake or resident was assisted with ch on those dates.					
c w R tr	then the resident does in the state the state the state keep tays on the cart and feet to other meal trays. R4	O stated there are times not receive a meal tray. It is the "feeders" meal did them after they pass O stated the facility and sometimes they forget		-			
CC CC	n 6/15/22 at 8:02 a.m., onducted with CNA (cer 2 (a CNA who has cared	tified nursing assistant)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2022

OMB NO. 0938-0391

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
		495109	B. WNG		С	
		493108	0. mms_			5/15/2022
NAME OF	PROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	IRELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RO		
		_		RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	atement of deficiencies / Must be preceded by full sc identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 8H CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD SE	(XS) COMPLETION DATE
F 677	Continued From page	112	F6	77		
	assistance and intake CNA #2 stated R40 miconcems about not be meal trays for the resk assistance stay on the can be fed. CNA #2 st	tray cart until the residents rated sometimes R40 gets is fed and then states he				
	records and nurses' no	documentation that R40				
	On 6/15/22 at 11:35 a.n	n., ASM (administrative				

Complaint Deficiency.

assistance with feeding.

above concern.

2. The facility staff falled to provide showers per the resident's preference for Resident #10 (R19).

staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional clinical coordinator) and ASM #4 (the regional director of operations) were made aware of the

The facility policy titled, "Routine Guest/Resident Care" failed to reveal documentation regarding

No further information was presented prior to exit.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/8/2022, the resident scored 14 out of 15 on the BIMS (brief Interview for mental status) indicating the resident is not cognitively impaired for making daily decisions.

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA		PLE CONSTRUCTION		E GURVEY
			A. BUILDIN		1	¢
1		495109	A. WING _		06	3/15/2022
	ROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RO RICHMOND, VA 23233		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full BC identifying information)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
	Section G documente dependent on one per and totally dependent On 6/13/2022 at 3:44 conducted with R10 In that they were suppose Tuesdays and Thursday one every 3 weeks. Repreferred to have at least because it made them bath. R10 stated that baths on their shower shower. R10 stated that that they were short stawhy they could not give On 6/15/2022 at 12:00	d R10 being totally aon for personal hyglens on one person for bathing. p.m., an interview was their room. R10 stated ed to get showers on ays but were lucky to get 10 stated that they ast one shower a week feel cleaner than a bed the staff often gave bed days and never offered a at the staff often told them affed or gave no reason e the shower. p.m., a follow up interview	F 67	77		
	was conducted with R1 did not receive their shischeduled. R10 stated and was not offered a sthe CNA (certified nursiand gave them a bed b. The physician orders for "If patient refuses show daughter to calm patien to not let pt (patient) middle: 3/25/2022." The progress notes date alled to evidence docurs howers. The "Shower/Bath" documents of the "Shower/Bath" documents of the shower of th	O, R10 stated that they ower on 6/14/2022 as that they did not refuse it shower. R10 stated that ing assistant) just came in ath. If R10 documented in part, are or is agitated call at and encourage patient is shower days. Order and 4/1/2022-6/15/2022 mentation of R10 refusing armentation for umented a				
8	hower/bath/bed bath gi	ven on 4/15/2022. The		2		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	LE CONSTRUCTION	3	TE SURVEY
						С
NAME OF F	PROVIDER OR SUPPLIER	495109	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	0	6/15/2022
THE LAU	RELS OF UNIVERSITY PA	UNIVERSITY PARK 2420 PEMBERTON RD RICHMOND, VA 23233				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 6HC CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION CATE
	shower/bath/bed bath 4/8/2022, 4/22/2022, 4/22/2022, 4/22/2022, 4/The document contain the shower/bath/bed bath 4/12/2022 and 4/19/202 and 4/19/202 and 4/19/202 as shower/bath/bed bath 5/13/2022, 5/24/2022 adocument failed to evice shower/bath/bed bath 5/10/2022, and 5/17/2020 contained an "NA" in the shower/bath/bed bath adocument contained evice shower/bath/bed bath adocument contained evice shower/bath/bed bath as shower/bath/bed bath gath/2022-6/30/2022 document/bath/bed bath gath/2022-6/30/2022 document contained evice shower/bath/bed bath gath/2022-6/30/2022 and 6/10/2022-8/30/2022 and 6/10/2022-8/30/2022 and 6/10/2022-8/30/2022 and 6/10/2022-8/30/2022 and 6/10/2022-8/30/2022 and 6/10/2022-8/30/2022 and 6/10/2022-8/30/2022 at approximated mobility and weal inf/16/2020. Revision of the care performance desistance with ADL's and mitted mobility and weal inf/16/2020. Revision of the care performance desistance with ADL's and mitted mobility and weal inf/16/2020. Revision of the care performance desistance with ADL's and mitted mobility and weal inf/16/2020. Revision of the care performance desistance with ADL's and mitted mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022 at approximated mobility and weal inf/16/2022	given on 4/5/2022, 1/26/2022 and 4/29/2022. 1/26/2022 and 4/29/2022. 1/26/2022 and 4/29/2022, 1/26/202, 1/26/202, 1/26/2022, 1/26/20	F 677			
	ਸ 6/15/2022 at approxit 2, the director of nursing					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X\$) DATE BURVEY COMPLETED		
[200	A 801LD	A BUILDING		l	С	
		498109	B. WING			08/15/2022		
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY F	ARK		2420	EET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD HMOND, VA 23233	E		7.793430
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(KI) COMPLETION DATE
	dated 6/14/2022 which bath given" On 6/14/2022 at 2:48 conducted with CNA (#5. CNA #5 stated the week. CNA #5 stated they followed with certification of the resident refute in urse showers on at CNA #5 stated if the retres documented the refused did not have any probles showers completed dustated that resident prospected of the week. CNA #5 stated that resident prospected or refused. On 6/14/2022 at 3:08 producted with LPN (IkLPN #9 stated that resident completed or refused. On 6/14/2022 at 3:08 producted with LPN (IkLPN #9 stated that resident refused their shower sheets in a boot asident refused their shower and they spoke to convince them. LPN #8	p.m., an interview was (certified nursing assistant) at showers were given twice at that they had a schedule tain room numbers to ertain days. CNA #5 stated used their shower they let tempted later in the day, exident continued to refuse d a bed bath or al. CNA #5 stated that they ems getting their scheduled uring their shift. CNA #5 aferances regarding should be honored and at they wanted on their stated that showers/bed d in the computer as censed practical nurse) #9. dent showers were given stated that the CNA's rs in the computer and on k. LPN #9 stated that if a nower the CNA notified the or the resident to try to a stated that if they still a responsible party and edical record.	F	377				
	onducted with CNA #2 howers/bed baths were							

14:46

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495109	e. WING_		C 08/15/2022	
	PROVIDER OR SUPPLIER	RK		STREET ADDRESS, CITY, STATE, ZII 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	GONPLETION DATE
S S S S S S S S S S S S S S S S S S S	that there should not be shower/bath/bed bath you could not say whe if there was an "NA" it is did not happen. On 6/16/2022 at 10:54 conducted with LPN #3 showers were given two documented in the showers were given the shower it was refused the shower it was not documented it was say that showers were given the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation to support the facility policy "Routid dated 3/1/2013 documentation and facility at 2:40 p.r. and indicator and ASM #4, perations were made and further information were the facility staff failed athing/showers, inconting the properties of the facility staff failed athing/showers, inconting the facility staff failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing/showers, inconting the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed athing the failed at failed athing the failed athing the failed athing the failed athing t	rer sheets. CNA #2 stated e any blank areas in the documentation because ther it was done or not and meant not applicable so it. a.m., an interview was a like a week and wer book and in the ed that if a resident as documented in the family was notified. LPN by learned that if it was not done and could not given if there was no art it. The Guest/Resident Care and in the grant it. Showers, not are scheduled the part, " Showers, not are scheduled the part of the provided in the regional director of vare of the findings. The provided prior to exit. The provided prior to exit.	F6	777		

A95109 A95109 A95109 A95109 A9510P	l		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
THE LAURELS OF UNIVERSITY PARK STREET ADDRESS, CITY, STATE, ZIP CODE 2430 PREMERTION BY PARK 2430 PREMERTION BY PARK	I							C		С
THE LAURELS OF UNIVERSITY PARK PROVIDERS PLAN OF CORRECTION FOR PRECISION OF PRE	Į	-,		495109	B. WING	B. WING			0	6/15/2022
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 677 Continued From page 117 Con the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident accred 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intect for making daily decisions. Section E documented no rejections of care observed. Section 6 documented R87 requiring extensive assistance from one staff member for bed mobility, transfers, personal hygiene and tollet use and totally dependent on one person for bathing. On 8/14/2022 at 10:50 a.m., an interview was conducted with R87. R87 stated that there were times when there was a clearly getting their brief changed when solled but they knew the staff were busy with other residents. R87 stated that there were days when they did not get their bath until after lunch and they preferred to get washed up in the morning so they could get out of bed between 10:00 a.m. and 12:00 p.m. R87 stated that there were days when they did not get washed up at all but the staff did come in and change their brief. The complaint allegations related to 12/2021-1/2022 timeframe, clinical records and ADL records for those dates were reviewed. The "Documentation survey report" for R87 dated				RK			2420 PEMBERTON RD			· · ·
On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident accred 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section E documented no rejections of care observed. Section G documented R87 requiring extensive assistance from one staff member for bed mobility, transfers, personal hygiene and toilet use and totally dependent on one person for bathing. On 6/14/2022 at 10:50 a.m., an interview was conducted with R87. R87 stated that there were times when there was a delay getting their brief changed when solled but they knew the staff were busy with other residents. R87 stated that there were days when they did not get their bath until after lunch and they preferred to get washed up in the morning so they could get out of bed between 10:00 a.m. and 12:00 p.m. R87 stated that there were days when they did not get washed up at all but the staff did come in and change their brief. The complaint allegations related to 12/2021-1/2022 timeframe, clinical records and ADL records for those dates were reviewed. The "Documentation survey report" for R87 dated		PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFL	PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API		HOULD BE		COMPLETION
quarterly assessment with an ARD (assessment reference date) of 5/12/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section E documented no rejections of care observed. Section G documented R87 requiring extensive assistance from one staff member for bed mobility, transfers, personal hygiene and tollet use and totally dependent on one person for bathing. On 6/14/2022 at 10:50 a.m., an interview was conducted with R87. R87 stated that there were times when there was a delay getting their brief changed when solled but they knew the staff were busy with other residents. R87 stated that there were days when they did not get their bath until after lunch and they preferred to get washed up in the morning so they could get out of bed between 10:00 a.m. and 12:00 p.m. R87 stated that there were days when they did not get washed up at all but the staff did come in and change their brief. The complaint allegations related to 12/2021-1/2022 timeframe, clinical records and ADL records for those dates were reviewed. The "Documentation survey report" for R87 dated		F 677	Continued From page	117	F	377				
and incontinence care for R87 on day shift on 12/5/2021, 12/6/2021, 12/10/2021, 12/11/2021, 12/18/2021, 12/20/2021-12/24/2021, and 12/26/2021-12/31/2021. The report failed to evidence toilet use and incontinence care for R87 on evening shift on 12/5/2021, 12/6/2021,		1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	quarterly assessment of reference date) of 5/12 15 out of 15 on the Billy mental status) assessment of the second control of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed. Section E do of care observed with R87. Retimes when there was a changed when solled be observed when there was a changed when solled be observed to the resident were days when they did after lunch and they predict the staff did come in the complaint allegation 2/2021-1/2022 timefrand. Di. records for those define "Documentation sun 2/1/2021-1/2021, 12/20/2021, 1	with an ARD (assessment //2022, the resident accred //5 (brief interview for ment, indicating the y intact for making daily ocumented no rejections ilon G documented R87 letance from one staff y, transfers, personal and totally dependent on a.m., an interview was 87 stated that there were delay getting their brief at they knew the staff were s. R87 stated that there d not get their bath until ferred to get washed up in it get out of bed between m. R87 stated that there if not get washed up at all and change their brief. Is related to be reviewed. Yey report for R87 dated led to evidence tollet use R87 on day shift on //10/2021, 12/11/2021, 12/24/2021, and The report failed to continence care for R87						

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES				FOR	ED: 08/28/20 RM APPROVI
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(XS) DAT	10, <u>0</u> 938-03 TE SURVEY MPLETED
		496109	B. WING _			C 9/15/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		01 1012022
THE LAU	RELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RO		
				RICHMOND, VA 23233	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETIO DATE
1 1 1 1 1 1 1 1 1	report failed to evidence incontinence care for F 12/7/2021-12/12/2021 12/15/2021-12/31/2021 12/15/2021-12/31/2021 12/10/2021, 12/14/2021 12/28/2021, 12/6/2021, 12/5/2021, 12/13/2021, 12/13/2021, 12/14/2021 12/20/2021-12/24/2021 The report failed to evidence shift on 12/5/2021 12/26/2021, 12/30/2021 report failed to evidence hight shift on 12/7/2021 12/16/2021, 12/31/2021 12/26/2021, 12/31/2021 12/26/2021, 12/31/2021 12/26/2021, 12/31/2021 12/26/2021, 12/31/2021 12/26/2021, 12/31/2021, 12/26/2021, 12/31/2021, 12/26/2021, 12/31/2021, 12/26/2021, 12/23/2	21 and 12/31/2021. The be toilet use and 287 on night shift on and 1. dence a shower or bath on 1, 12/21/2021, 12/24/2021, 2021. The report failed to R87 on day shift on 12/10/2021, 12/11/2021, 12/18/2021, 12/18/2021, 12/26/2021-12/31/2021, 12/26/2021, 12/24/2021, 12/23/2021, 12/24/2021, 12/23/2021, 12/24/2021, 12/24/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, and 12/31/2021, 12/3/2021	F 67	7		

12/31/2021.

The "Documentation survey report" for R87 dated 1/1/2022-1/31/2022 falled to evidence toilet use and incontinence care for R87 on day shift on 1/2/2022 and 1/3/2022, 1/8/2022, 1/8/2022, 1/11/2022-1/13/2022, 1/15/2022-1/23/2022,

PRINTED: 06/28/2022 FORM APPROVED

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X8) DATE BURVEY COMPLETED
		496109	B. WING		C 06/15/2022
100	PROVIDER OR SUPPLIER PRELS OF UNIVERSITY PA	ARK	24	REET ADDRESS, CITY, STATE, ZIP CODE 120 PEMBERTON RD CHMOND, VA 23233	1 00110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ntement of deficiencies I must be preceded by full SC Identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
7 FR 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	1/25/2022-1/27/2022 a failed to evidence tolle care for R87 on evening 1/2/2022-1/6/2022, 1/6 1/14/2022 and 1/15/20 1/19/2022, 1/21/2022-1/31/2022-1/31/2022-1/31/2022-1/31/2022-1/31/2022-1/31/2022-1/31/2022-1/31/2022-1/31/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/3/3/2022-1/2/2022-1/3/2022-1/2/2022-1/3/2022-1/2/202-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/2/2022-1/	and 1/30/2022. The report to use and incontinence by shift on 1/2022-1/11/2022, 22, 1/18/2022 and failed to evidence toilet are for R87 on night shift, 1/14/2022-1/25/2022 and 1/25/2022 and 1/25/2022 and 1/25/2022 and 1/25/2022, 1/6/2022, 1/6/2022, 1/6/2022, 1/6/2022, 1/6/2022, 1/18/2022 and 24/2022, 1/28/2022	F 677		

	ARTMENT OF HEALTH AI				FO	ED: 06/28/202 RM APPROVE IO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DA1	re aurvey MPLETED	
		495109	B. WING		06/16/2022		
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2IP CODE			
THE	LAURELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RD RICHMOND, VA 23233			
PRE	(X4) ID PREFIX TAG 8UMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(MB) COMPLETION OATE	
FE	777 Continued From page 1/28/2022-1/31/2022.		F 67	7			
	and underlying comorifoley r/t neurogenic bis 07/17/2019. Revision plan further documents Self Care Performance assistance with ADL's (diagnoses) of MS (mu (gastro-esophageal ref (hypertension), ame (alperaplegic, and blindne 07/17/2019. Revision of "Interventions" it docum MOBILITY: Resident reassistance of one staff bed. Date Initiated: 08/0 further documented, "[For treatment regimen R/T; removed. Declines to be Date Initiated: 05/19/2020.05/19/2022." On 6/14/2022 at 2:48 p. conducted with CNA (cells a week. CNA #5 stated that a week. CNA #5 stated they followed with certain	ncontinence: [R87] is Needa assistance in lated to) functional deficit bidity. Use of indwelling adder. Date initiated: on: 08/19/2021." The care ed, "Adi: [R87] has an ADL a Deficit and requires and mobility r/t dx litiple sclerosis), gerd flux disease), htn litered mental status), ess. Date initiated: on: 08/19/2021" Under mented in part, "BED requires extensive to reposition and turn in 02/2019" The care plan 08/7] chooses not to follow declines to have wedge ave to of the bed to be repositioned in the bed. 22, Revision on: m., an interview was intified nursing assistant) showers were given twice that they had a schedule in room numbers to ain days. CNA #5 stated ad their shower they let					
	CNA #5 stated if the resi the shower they offered a documented the refusal.	s bed bath or					

DEPAR'	TMENT OF HEALTH A	ND HUMAN SERVICES					ED: 08/28/202 RMAPPROVE	
		MEDICAID SERVICES			,		10. 0938-039	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		496109	8. WNG			04	C N15/2022	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS. CIT	Y STATE ZIP CODE	- 00	W 1312022	
	A. 171 E. 111 - 171 - 181		}	2420 PEMBERTON RD				
THE LAU	RELS OF UNIVERSITY PA	ARK		RICHMOND, VA 232				
(X4) ID	SUBSTRADV ST	TELIEUT OF DECICIONAIS	ID.		ER'S PLAN OF CORRECTION			
PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH COI	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION COMPLETION DATE	
F 677	Continued From page	121	F 6	77				
	showers/bed baths we			"				
-	computer as complete			}				
]		e care was provided every		1				
	2 hours and as needed	and personal hygiene was					1	
1	completed every shift.	CNA #5 stated that all						
		bed bath each day in the					ĺ	
		ady for the day. CNA #5					l	
		h included the full body. se were documented in the	1				ļ	
	computer. CNA#5 state		- [1				
		led the catheter bag each						
	shift. CNA #5 stated th							
	repositioned R87 every							
	wedge to help position			1				
	incontinence care at the			 		Í		
	that R87 liked to stay or			}		- 1		
	time and often refused t					ĺ		
	and use the wedge for p		1					
		#5 stated that R87 got out]		
		d there were days when					- 1	
	hey refused to get out o	urse when R87 refused	}	1		- 1	- 1	
,	uming and positioning a		1				- 1	
1"		gorang out or book		i			ı	
10	on 6/15/2022 at 8:15 a.r	π., an interview was		1				
	onducted with CNA #2,							
	howers/bed baths were			Į				
		sheets. CNA #2 stated		1			- 1	
	at there should not be		ĺ				1	
	nower/bath/bed bath do				_			
		er it was done or not and					- 1	
		eant not applicable so it stated that all residents					. 1	
	o not nappen. CNA#2 era given a bed bath es					-		
	ior to getting up and dre			}				
l Pi	or to Botteria ab and an	reverd.				[
Or	n 6/15/2022 at 10:54 a.i	m., an interview was					1	
co	nducted with LPN (lices	nsed practical nurse) #3.	:]	ľ	

LPN #3 stated that showers were given twice a

A BUILDING 498109 B WING NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK A BUILDING 2420 PEMBERTON RD	C 06/15/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE LAURELS OF UNIVERSITY PARK 2420 PEMBERTON RD	06/15/2022
THE LAURELS OF UNIVERSITY PARK	
RICHMOND, VA 22233	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)	
F 677 Continued From page 122 week and documented in the shower book and in the computer. LPN #3 stated that if a resident refused the shower it was documented in the medical record and the family was notified. LPN #3 stated that they always learned that if it was not documented it was not done and could not say that the care was provided if there was no documentation to support it. On 6/15/2022 at 4:05 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional director of operations were made aware of the findings. No further information was provided prior to exit. Complaint deficiency. F 684 Quality of Care Quality of Care as a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a realdent, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to maintain residents' highest level of well-being for 4 of 59 residents in the survey sample, Residents #19,	the ments. g to god on re- iments and verse a error. cation ducated ac re- dre- dre- dre- dre- dre- dre- dre- d

PRINTED: 08/28/2022

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 496109 B. WING 06/15/2022 NAME OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) 10 (766) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Critoria 2 F 684 Continued From page 123 F 684 All current residents who rely on the facility to schedule their medical appointments and receive #15, #436, #701. medication from the licensed staff at the facility have the potential to be affected be the alleged The findings include: deficiency. <u>Criteria 3</u> 1. The facility staff failed to schedule a Licensed Nursing staff will be re-educated on mammogram per Resident #19's (R19) plan of ensuring physician orders are followed and that the care. standards of practice for medication administration are upheld. Ward Clerk will be re-educated on On the most recent MDS (minimum data set), a scheduling medical appointments per resident's five day Medicare assessment with an ARD physician orders and plan of care. (assessment reference date) of 4/18/22, the resident scored 15 out of 15 on the BIMS (brief Criteria 4 interview for mental status), indicating the DON and/or designee will complete five (5)

On 6/13/22 at 1:21 p.m., an interview was conducted with R19. R19 stated that about a year ago, the resident's sister was diagnosed with breast cancer and the resident had not had a mammogram in approximately 15 years so R19 requested to have a mammogram scheduled at that time. R19 stated she spoke to two nurse practitioners and still had not had a mammogram.

resident was not cognitively impaired for making

daily decisions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

A note signed by a nurse practitioner on 5/27/21 documented, "Patient concerned about her sister being dx (diagnosed) with breast cancer and would like to schedule a mammogram..."ASSESSMENT/PLAN OF CARE/MEDICAL DECISION-MAKING: Family hx (history) of breast cancer- will schedule mammogram..." A review of R19's clinical record falled to reveal a physician's order for a mammogram at this time. Further review of R19's clinical record revealed a physician's order signed by another nurse practitioner and dated 5/12/22 for a mammogram but failed to reveal a mammogram had ever been scheduled or

audits and/or action.

Criteria 5

Date of compliance is 7/26/22.

random audits of licensed nursing staff following

physician's orders and following the standards of practice for medication administration. The DON and/or designee will also complete five (5) random

audits of resident's medical appointments to ensure

the physician orders and plan of care are followed.

These audits will be done 5 days a week for four

weeks; then one day a week for four weeks; then

forwarded to the QAPI committee for review. The

twice in the last month. These results will be

committee will determine the need for further

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE BURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495109 B. WNG 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XUI) MPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DAT CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 684 Continued From page 124 F 684 completed. The nurse practitioner who signed the 5/27/21 note and the nurse practitioner who signed the 5/12/22 physician's order were no longer employed at the facility and were not available for interview. On 6/14/22 at 8:47 a.m., an interview was conducted with CNA (certified nursing assistant) #1 (the ward clark responsible for scheduling appointments). CNA #1 stated she keeps a book on all three units and the nurses and nurse practitioners are supposed to communicate needed appointments via those books. CNA #1 stated that sometimes, nurses and the nurse practitioners will email her with appointment needs but sometimes she lan't notified of needed appointments at all (vie the communication book or email). CNA #1 stated R19 makes her own appointments most of the time then writes them down along with a confirmation number and gives the paper to CNA #1. CNA #1 stated she could not provide any documentation to evidence why R19 had not received the mammogram.

On 6/14/22 at 9:41 a.m., another interview was conducted with R19. R19 stated that sometimes she does schedule appointments but she asked

mammogram appointment because R19 did not know who to contact to make the appointment.

On 6/15/22 at 9:13 a.m., another interview was conducted with CNA #1. CNA #1 stated R19 has a lot of appointments and she was not aware of the nurse practitioner's documentation on 5/27/21 or the physician's order on 5/11/22. CNA#1 stated one of the nurse practitioners used to

the nurse practitioners to schedule the

		TO TOTA MEDIONINE OF	MILDIOAID SERVICES				CIAID IA	O. 0330-038	
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION			e survey IPLETED	
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			496109	B. WING	B. WING				
		PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	IRK		STREET ADDRESS, CITY, STATE, Z 2420 PEMBERTON RD RICHMOND, VA 23233	ip code		Ç.	
P	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Provider's Plan (Bach Corrective / Cross-Referenced 1 Deficie	ACTION SHOULD BE TO THE APPROPRIA		COMPLETION DATE	
	F 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	make the statement the appointments so she's CNA #1 could not prove On 6/15/22 at 11:35 au staff member) #1 (the second coordinator) and director of operations) was above concern. The facility policy titled, documented, "Physiciar provide a clear direction guest/resident." On 6/15/22 at 8:20 p.m. stated the facility did not mammograms or scheding the facility staff falled orders for a mammogram was admitted to: COPD (chronicles ase), diabetes meliticles are fallure) and demendent fallure) and demendent fallure) and demendent fallure are fallure as account for resident as account for the resident as accounts for the resident was accounted the resident as accounted the resident as accounted the resident as accounted the resident as accounted the resident was apaired.	at R19 "makes her own going to let her do it." ide any further information. I. ASM (administrative administrator), ASM #2 I. ASM #3 (the regional down and aware of the were made aware of the "Physician's Order" orders are obtained to in the care of the in the care of the large appointments. I. ASM #1 and ASM #2 It have a policy for utiling appointments. I. As presented prior to exit. To follow physician in for Resident #15. I. As the facility on the included but were not ic obstructive pulmonary us, CHF (congestive tia. Inimimum data set) assessment, with an ince date) of 3/14/22, oring a 4 out of 15 on the mental status) score, is severely cognitively	F 684					
	A	review of the comprehe	nsive care plan dated						

PRINTED: 06/28/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 498109 B. WING 06/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 (X4) ID **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (XII) IPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LOC IDENTIFYING INFORMATION DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 684 Continued From page 126 F 684 12/1/21 documented in part, "NEED: Resident is at risk for impaired skin integrity/pressure injury. Resident is at risk for decline in condition. INTERVENTIONS: Observe and report to physician any changes in condition. Conduct weekly head to toe skin assessments." A review of the nurse practitioner's orders dated 10/12/21, revealed the following, "Set up ASAP (as soon as possible) appointment with Breast cancer center one time only for hx (history) of left breast cancer, new mass to right breast for 2 Days. A review of the nurse practitioner's orders dated 10/18/21, revealed the following, "Set up ASAP (as soon as possible) appointment for memmogram right breast mass/lump hx (history) of breast cencer. Call daughter and notify and see if able to set up and take to appointment one time only for right lump for 3 Day. A review of the nurse practitioner's orders dated 10/27/21, revealed the following, "If not already done set up appointment for ASAP (as soon as possible) MAMMOGRAM FOR MASS TO RIGHT BREAST WITH HX (history) OF BREAST CANCER -NEED DONE ASAP one time only for MAMMOGRAM ASAP for 2 Days. A review of the nurse practitioner's orders dated 11/3/21, revealed the following, "If not already done set up ASAP (as soon as possible) APPOINTMENT FOR MAMMOGRAM, RIGHT **BREAST HARD MASS ORDER PLACED** MULTIPLE TIMES IN OCC one time only for HX (history) BREAST CANCER, RIGHT BREAST

MASS for 2 Days.

PRINTED: 06/28/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> (X1) PROVIDER/GUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING C 495109 B. WNG 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 **BLIMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION ()(d) COMPLETION DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 884 Continued From page 127 F 884 A review of the nurse practitioner's orders dated 11/8/21, revealed the following, "If not already done set up ASAP (as soon as possible) APPOINTMENT FOR MAMMOGRAM, RIGHT **BREAST HARD MASS ORDER PLACED** MULTIPLE TIMES IN OCC one time only for HX (history) BREAST CANCER, RIGHT BREAST MASS for 2 Days. A review of the nurse practitioner's orders dated 1/4/22, revealed the following, "Please schedule patient to see surgeon ASAP (as soon as possible) for right breast mass, hx (history) left breast cancer s/p (status/post) mastectomy. Try

A review of the nurse practitioner's orders dated 2/4/22, revealed the following, "Referral to Breast surgeon for right breast mass/ hx (history) of breast cancer."

to schedule appointment on Wed, Thu, or Fri. Patient will need transport provided as daughter unable to transport. Notify daughter of date/time

of appointment for her to be present.

A review of the nursing progress note dated 10/13/21 at 4:30 PM, revealed the following, "Dynamic mobile notified of US ultrasound to right breast. Lump noted to right breast. Guest denied pain/discomfort. Order/face sheet/and paper work has been completed. Someone is to call facility from Dynamic mobile with date and time of US. MD/RP aware."

A review of the nursing progress note dated 10/14/21 at 3:29 PM, revealed the following. "Dynamic mobile notified facility that they would not be able to obtain US ultrasound to right breast, due 2 lumps. NP in facility and made aware."

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495109	8. WING			C	
	PROVIDER OR SUPPLIER REL8 OF UNIVERSITY PA		5 2	TREET ADDRESS, CITY, STATE, ZIP CODE 420 PEMBERTON RD RICHMOND, VA. 23233	1 06	3/15/2022	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD S CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	GOMPLETION DATE	
F 684	A review of the nurse practitioner's note dated 11/3/21 at 10:50 AM, revealed the following,						
		aced twice for appointment ogram ,patient denies pain			1		
	10:15 AM, revealed the breast mass, history let documents on 10/14/21 able to obtain ultrasour lumps. Nurse practition	an's note dated 1/4/22 at office following, "Follow up right to the stancer. Nursing if that Dynamic mobile not office to right breast due to 2 or recertification 11/3 wice for appointment to be					
	set up for mammogram miscellaneous or result click care). Spoke to de was unaware of situatio not she wishes to proce	." No result found in a section in PCC (point aughter on phone, she n. Discussed whether or					
1	be able to stand for mar want to pursue evaluate and indicated for prefere lospital system and pre unable to provide name loctors for her left breas	ence to stay within vious doctor. She was of patient's treating					
1 n	1:59 AM, revealed the financial oct/	. .			\$\delta\		
bi le		led the following, "Right d Oct/Nov 2021. History astectomy 2017. No					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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		495109	B. WING			01	6/16/2022
NAME OF	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF UNIVERSITY P	ARK		_	420 PEMBERTON RD		
				R	ICHMOND, VA 28298		
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F 684	Continued From page	129	Fe	384			
	party) who would like	further evaluation. Will					
		n, daughter aware she will					
!		appointment for decision		- [
	making/consent.		ĺ	- 1			
	A review of the nurse	practitioner's note dated		- 1			
	3/11/22 at 12:20 PM, i						
ĺ		ast cancer surgeon- patient					
ľ		cencer with possible mets	- [- [
- 1		have PET scan on 3/24 at ced in book for secretary."					1
1	outil -appointment plac	cad in book for secretary.	İ				ì
]	A review of the nurse p	practitioner's note deted	1				1
	3/22/22 at 8:52 PM, re						ļ
		ist biopsy 3/1, patient has					}
	breast cancer with Mei scan 3/24."	s she is scheduled for pet					
	A review of the nurse p						l
		vealed the following, "Post + mets. Was scheduled	1				
		led due to Blood sugar on					
	high side."						
		in note on dated 5/11/22 at					
		following, "Discussed PET graphy) scan result stage				- 1	
	B CA (cancer), chemo v						
		to age/dementia. Due to					
8	bove patient will not be	a candidate for any					
	ardiac procedure as w		1				
	heart fallure) in the factorognosis 6-18 months.				•		-
	omfort/hospice once at		1			1	
	ecline."						
τ	he nurse practitioners	and nurses who					
		o longer employed at the	45				
fa	icility.		I	J			

	nt of Deficiencies I of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
1.0		495109	a. wng	8. WNG		C 06/15/2022	
NAME O	F PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD	1 0	0/10/2022
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F 684	684 Continued From page 130		F6	384			
		lucted on 6/14/22 at 8:58					
		d nursing assistant) #1. cheduling appointments for	}				
	the residents, CNA #1	stated, i make hole house except some					
	residents might make t						1
		und twice a day at 9:00 AM	1	Ì			
	and 2:00 PM. I may get pulled to the floor to do AM care. I have an appointment book on all 3						Ì.,
	units. On one side of th	e book, I have the					
	appointment papers.						
		name, date and time, who doctors address. In that		-			
		occors address. In that					
	from PCC and put on th		1	1			1 1
	The nurses let me know		ŀ	-]
		of the order. I go around	}				1 1
	every morning and chec						} <u> </u>
		o not make me aware of					[
	appointments, I have a			- 1			1 1
	practitioners sometimes practitioners will come u			Ţ			} !
	give me appointments to			-}			!]
ľ	schedule mammograms						
ł	get in. The nume practit			- 1		i	
i	call, sometimes they have	e the number. I do not					1
	document the follow up,					- 1	
- 1	not know if they write a r			1			· .
	transportation does not a				94	1	80
	we try to find out what he	* * * * * * * * * * * * * * * * * * * *	•			- 1	
	take the resident to the d	ure they are coming, I will			·		1
	transportation does not s			1			
j	CNA #1 was asked for ev	vidence of the				1	
	appointments being mad						
	for Resident #15, CNA#	¥ 1					
	edministrator and DON (d						
(to shred all the Information	n monthly. I do not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) OATE SURVEY COMPLETED		
			Tre boiled in	<u></u>	c			
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(X4) (D PREFIX TAG	(EACH DEFICIENC)	atement of deficiencies y must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION CATE		
i i i i i i i i i i i i i i i i i i i	asked if she had discurent administrator (director of nursing (stated, no, I have not.) An interview was cond. An interview was cond. An, with ASM (administ the physician. When a mammogram situation #5 stated, "Yes I do. Why or ceas, so that the physician with the long term care about the delay in implemanmograms, ASM #5 procedure like a mammin and let the nurses know. We try to let the sometimes gets lost with CNA (CNA #1) schedule is unique. Some procedure, and forth. The fambannot make decisions, Family involved and some resident, or to make procedure." When aske the mammogram for Resident, "I cannot say for that the prognosis was plar dementia, comorbid tatus would all impact the interview was conductive."	comented evidence. When issed this process with the started April 2022) or and May 2022), CNA #1 ucted on 6/14/22 at 11:20 strative staff member) #5, aked if she knew the with Resident #15, ASM We have changed our ysician spends more time residents." When asked ementation of orders for 5 stated, "If it's an outside rogram, we put the order ow and the agency nurses unit manager know. It is the agency nurse. The est he test, each situation dure are multiple calls mily is notified, if patients we let them know. The statement will go for the diff the delay in obtaining sident #15 could have for the resident, ASM #5 100%. I honestly believe robably not impacted. conditions and functional me prognosis." Ited on 6/14/22 at 3:00 ractical nurse) #3. When for appointments or its ordered, has the stained, LPN #3 stated,	F 66					

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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l I		ROVIDER OR SUPPLIER	RK		2420	EET ADDRESS, CITY, STATE, ZIP CODE PEMBERTON RD HMOND, VA 23233		
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				Provider's Plan of Correction (Each Corrective action should b Cross-Reperenced to the appropri Deficiency)	_	(X8) COMPLETION DATE
	R 44 limitid	member) #1, the admin director of nursing, ASM coordinator and ASM # operations were informed. According to the facility policy dated 6/24/21, wis following, "Treatment reguest/resident must be impecific standing, written order of a physician or operational ordering witer and clinical private and clinical private and clinical private for a physician with a property and the facility staff falled anders for a physician apurgeon for Resident #436 was admit/15/21 with diagnosis the mitted to: dementia, falls, idney disease. The most recent MDS (missessment, a Medicare in the sessment, with an ARD atte) of 5/19/21, coded the out of 15 on the BIMS (to the sessment).	ality of care. ASM (administrative staff instrator, ASM #2, the regional clinical #4, the regional director of sed of the above concern. Se "Physician Orders" inich revealed the indered to a lin accordance with the indered to a lin accordance with the indered to a lin accordance of illeges." as provided prior to exit. Ito follow physician inpointment with the ass. Itted to the facility on at included but were not at included but were not at atrial fibrillation, chronic linimum data set) So day admission of assessment reference in resident as scoring a prief interview for mental the resident was severely	F 6	84			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB N	O. 0938-0391	
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING			
495109 B. WING	C 06/15/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RO RICHMOND, VA 23233			
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Continued From page 134 practitioner tells me where to call, sometimes they have the number. I do not document the follow up, I tell the nurses and I do not know if they write a note or not. Sometimes transportation does not show up at all and then we try to find out what happens. I call a day ahead of time to make sure they are coming, I will take the resident to the door myself and the transportation does not show up at times. When CNA #1 was asked for evidence of the transportation being made for the surgeon appointment on 5/18/21 for Resident #436, CNA #1 stated, the previous administrator and DON (director of nursing) sald to shred all the Information monthly. I do not have any written or documented evidence. When asked if she had discussed this process with the current administrator (started April 2022) or director of nursing (started May 2022), CNA #1 stated, no, I have not. An interview was conducted on 6/14/22 at 11:20 AM, with ASM (administrative staff member) #5, the physician. When asked if she remembered Resident #436, ASM #5 stated, "I believe my partner cared for him" When asked if they knew he had missed his follow up surgical appointment, ASM #5 stated, "I do not see any documentation of that." An interview was conducted on 6/14/22 at 3:00 PM with LPN (licensed practical nurse) #3. When- asked if physician orders for appointments or tests are not completed as ordered, has the quality of care been maintained, LPN #3 stated, no, if we have not followed physician orders, we			

On 6/15/22 at 3:45 PM, ASM (administrative staff

PRINTED: 06/28/2022 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495109 B. WING 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIF CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XII) COMPLETION DATE: (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LEC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 684 Continued From page 135 F 684 member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional clinical coordinator and ASM #4, the regional director of operations were informed of the above concern. According to the facility's "Physician Orders" policy dated 6/24/21, which revealed the following, "Treatment rendered to a guest/resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges." No further information was provided prior to exit. Complaint Deficiency. 4. For Resident #701 the facility staff failed to follow physician's orders and standards of practice for medication administration, by administering another resident's medications to Resident #701. Resident #701 was admitted to the facility on 8/17/21 and discharged to an assisted living facility on 9/26/21. The admission nursing assessment dated 8/18/21 documented the resident was alert and oriented to person only. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/21/21, the resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living. A review of the facility policy, "Medication Administration" was conducted. This policy

documented, "Medications are administered in accordance with written orders of the attending

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PRINTED: 06/28/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING C 495109 B. WING 06/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2410 PEMBERTON RO THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE ()(4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD SE PREFIX PREFIX REGULATORY OR LBC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 684 Continued From page 137 F 684 administered [Resident #701] (their) medication I did not ask (their) name, i looked at (their) picture in the electronic record and thought it was the person laying in the bed. I was asked by the aide why [Resident #701] wasn't in (their) bed approximately seven in the morning. I then went to the computer and, identified in the computer the picture and calling out the guest name to clearly identify the MD. the aide (name) stated that she placed [Resident #701] in the wrong room around approximately three A.M. Vital signs were taken and no distress noted - same level of cognitive level." The nurse who made the medication error was no longer at the facility and could not be interviewed. On 6/14/22 at 3:00 PM, an Interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that the rights of medication administration were right resident, right medication, right dose, right route and right time. She stated that staff should not administer medications for one resident to another resident.

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References:

hypothyroldism

On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was

https://medlineplus.gov/druglnfo/meds/a682461.h

provided by the end of the survey.

(1) Levothyroxine - is used to treat

information obtained from

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE BURVEY COMPLETED	
i		495109	B. WNG_	B. WNG			/18/2022
NAME OF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			- 1		420 PEMBERTON RD		
THE LAURELS OF UNIVERSITY PARK			j		RICHMOND, VA 23233		
			1				
(X4) ID PREFIX TAG				(X8) COMPLETION DATE			
F 684	4 Continued From page	138	F 6	84		1	
	Information obtained fr	treat mild to moderate pain om //druginfo/meds/a681004.h				ell	
	Complaint Deficiency.		1	- 1			
F 686	, , , , , ,	ent/Heal Pressure Ulcer	F 68	3.5			
88=D			'		F686		
00-0	0111(0): 400:20(0)(1)(1)	(")			Criteria 1 R87 in the facility was noted to have impr		
	§483.25(b) Skin Integrity				In pressure injury per wound physician	ovement	
	§483.25(b)(1) Pressure ulcers.				documentation.		
	Based on the comprehe	ensive assessment of a	ł	ļ			
	resident, the facility mus				Criteria 2		
	(i) A resident receives o	are, consistent with			All residents who have pressure injuries he	ve the	
	professional standards			-	potential to be affected by the alleged defic	iency.	
	pressure ulcers and doc	, ,	'		At the second		
	ulcers unless the individual's clinical condition				Criteria 3 Numina staffunilli ka sa aduana 3 fattan		
	demonstrates that they were unavoidable; and		!	-13	Nursing staff will be re-educated on follow physician's orders and documentation of the	ing	
	(ii) A resident with pressure ulcers receives				and interventions.	caiments	
	necessary treatment and					1	
	with professional stands				riterio 4		
	promote healing, prevent new ulcers from develop				ON/designee or designee will complete five		
	This REQUIREMENT is				andom audits of documentation for resident		- 1
ľ	by:	Tiot that as avidanced			ave pressure injury treatment orders. These ill be done 5 days a week for four weeks; t		- 1
		esident interview staff		nr nr	ne day a week for four weeks; then twice in	the	
ļ	Based on observation, resident interview, staff interview, clinical record review, facility document			la	st month. The results will be forwarded to	the	
ı	review and in the course of a complaint				API committee for review. The committee		
1	investigation it was deter				termine the need for further audits and/or		
	staff failed to provide car		•				
	promote healing of a pre-				riteria 5	- 1	ſ
	residents in the survey a			, D	Pate of compliance is 7/26/22.		
	The findings include:						
	The facility staff failed to	evidence a treatment to				1	
- 1	the Stage 4 pressure ulco	er between					
				L			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING			(XX) DATE SURVEY COMPLETED	
		405400				С	
NAME OF PROVIDER OR SUPPLIER			B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		06/15/2022	
	URELS OF UNIVERSITY PA	RK	2420 PEMBERTON RD RICHMOND, VA 23233				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		BHOULD BE	(XS) COMPLETION DATE	
	1/7/2022-1/9/2022 and Resident #87 (R67). On the most recent Mit quarterly assessment vareference date) of 5/12 15 out of 15 on the Billy mental status) assessment exident was not cognit daily decisions. Section having 1 Stage 4 press pressure ulcer. On 6/14/2022 at 8:25 at conducted with R67 in that the nurses had been to change their wound deter about doing the warm of their family had complaint. A request was made to member) #2, the director wound care for R87 on 6 approximately 9:30 a.m., R87's wound care had beday and they would arrainted as a second care had beday and they would arrainted.	OS (minimum data set), a with an ARD (assessment /2022, the resident scored IS (brief interview for nent, indicating the lively impaired for making in M documented R87 ure ulcer and 1 Stage 3 m., an interview was their room. R87 stated in in earlier that morning liressing and had gotten wound care as ordered. It problems in the past irressing changed and ned to the nurses about it. ASM (administrative staff of nursing, to observe 1/14/2022 at On 8/14/2022 at On 8/14/2022 at ASM #2 stated that seen completed for the nige the observation for 2 at approximately 10:15 tical nurse) #2, the ed performing wound LPN #2 stated that the ad already completed thing and it could not be	F	886			
	rough 1/31/2022 docum					155	

DEPARTMENT OF HEALTH AND HUMAN	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		C	(X3) DATE SURVEY COMPLETED	
I							С	
l		495109 B. WNG			06	/15/2022		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK			æ	STREET ADDRESS, CITY, STATE, ZIP C 2420 PEMBERTON RD RICHMOND, VA 23233	CODE			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI) TAG		TION SHOULD BE THE APPROPRIATE	Ę	(XII) COMPLETION DATE
	Ting to the state of the state	Dakins moistened gauze PRN (as needed) - apper evening shift for wound of sacral region unspect 12/14/2021. Start Date 01/07/2022." - "Wound care; Sacral word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word of pack word pack word pack word pack word pack word of pack word	wound- clean with NS flagyl and pack with 1/4 ze QD (every day) and bly dry dressing every if related to pressure ulcer clified stage. Order date; c: 12/14/2021. End Date; wound- clean with 1/4 with Silver Calcium Alginate in (as needed)- cover with te: 01/07/2022, End Date; or falled to evidence a wound- clean with 1/4 lth Silver Calcium alginate in Dry dressing in the in Order Date; 01/18/2022. End Date; eatment administration 1/2022-1/31/2022 failed fon of a treatment bund 1/7/2022 through imented in part, ing shift. Yellow/reddish for noted. No c/o viding wound care. Pain far resident."	F6	686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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(XX) ABOVADED/RIVER LEAD.

	(X3) DATE SURVEY COMPLETED	
498109 B. WING 06/-	/15/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XI) COMPLETION DATE	
Continued From page 141 dated 1/7/2022 documented in part, "Stage 4 pressure wound sacrum full thicknessWound progress: deteriorated, Additional wound detail: larger, dic dekins packing, start Silver Alginate, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 30 days: clean with 1/4 dakins solution; Alginate calcium w/silver apply once daily for 30 days: ascondary dressing(s), gauze sistand (wbdr) (with border) apply once daily for 30 days" The wound evaluation & management summary dated 1/14/2022 documented in part, "Stage 4 pressure wound secrum full thickness Wound progress: improved, Additional wound detail: smaller, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 23 days: clean with 1/4 dakins solution; Alginate calcium w/silver spiply once daily for 23 days. secondary dressing(s), gauze island (w/bdr) apply once daily for 23 days" The wound evaluation & management summary dated 1/28/2022 documented in part, "Stage 4 pressure wound sacrum full thicknessWound progress: improved, Additional wound detail: shorter, no longer with exposed bone, dressing treatment plan, primary dressing(s), Sodium hypochlorite solution (dakins) apply once daily for 9 days: clean with 1/4 dakins solution; Alginete calcium w/silver apply once daily for 9 days. secondary dressing(s), gauze island (w/bdr) apply once daily for 9 days" The comprehensive care plan for R87 documented in part, "Skin #2; [R87] has pressure uloes to sacrum and right thigh; Stage 4, Being		

PRINTED: 06/28/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE BURVEY (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 496109 B. WING 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) (D (XII) MPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR LBC IDENTIFYING INFORMATION) TAG DEFICIENCY F 688 Continued From page 142 F 686 07/17/2019. Revision on: 06/14/2022..." On 6/15/2022 at 9:56 a.m., a telephone interview was conducted with ASM (administrative staff member) #7, the wound physician. ASM #7 stated that R87 had a secral wound they had been following for 956 days. ASM #7 stated that R87's wound was slow to heal due to medical comorbidities and noncompliance with offloading and turning and positioning. ASM #7 stated that there was a zinc barrier cream ordered for the skin around the wound but was not the primary treatment for the pressure ulcer. ASM #7 stated that there should be a continuous treatment in place for the Stage 4 pressure wound treatment. On 6/16/2022 at 10:54 a.m., an interview was conducted with LPN (licensed practical nurse) #3, unit manager. LPN #3 stated that treatments were evidenced as completed by documenting them on the eTAR. LPN #3 stated that if there was no documentation there was no evidence to support that anything was done. LPN #3 they were always taught that if it was not documented it was not done. LPN #3 raviewed the eTAR for R87 dated 1/1/2022-1/31/2022 and stated that they did not see any evidence that there was a treatment in place for the sacral pressure ulcer between 1/7/2022-1/17/2022. On 6/15/2022 at 1:29 p.m., an interview was : conducted with LPN #2, the wound nurse. LPN #2 stated that they were new to the wound nurse position. LPN #2 stated that R87's pressure ulcer

was slow to heat due to non-compliance with offloading and turning and positioning off of the wound. LPN #2 stated that they round with the wound doctor and make any changes to treatment orders as needed when the physician

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		(X3) DATE SURVEY COMPLETED			
45		495108	B. WING		06/15/2022	
	F PROVIDER OR SUPPLIER AURELS OF UNIVERSITY PA			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RO RICHMOND, VA 23233	00/10/202	14
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F690 \$S⊅E	rounds. LPN #2 revies and the eTAR for R87 and stated that they distreatment in place for the 1/7/2022-1/17/2022. It is pressure ulcer during should have been a tree. The facility policy, "Skin 5/1/2010 documented like with wounds and/or preside for skin compromis and provided appropriate prevention and healing. On 6/15/2022 at approximation and healing. ASM #3, the southside coordinator and ASM #4 operations were notified to further information with the complaint deficiency. Bowel/Bladder Incontine	wed the physician orders dated 1/1/2022-1/31/2022 d not see any evidence of a he pressure ulcer from PN #2 stated that R87 had no that time and there ratment in place. In Management" dated in part, " Guests/residents insure injury and those at e are identified, evaluated the treatment to promote" Idmately 4:05 p.m., ASM imber) #1, the the director of nursing, regional clinical if, the regional director of of the findings. It is provided prior to exit. In must ensure that it of bladder and bowel on ces and assistance to each his or her clinical such that continence is each with urinary.	F 690		hanges. dent ed to :illity rders for	

OF MEDICAKE BI	MEDIONID BEKVICES			Olan Li	0.0000-000
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1,37.5	LE CONSTRUCTION		E BURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PA	RK		8TREET ADDRESS, CITY, 8TATE, ZIP CODE 2420 PEMBERTON RD RIGHMOND, VA 23233		
PREFIX (EACH DEFICIENCY	rement of deficiencies MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BĘ	(X6) COMPLETION DATE
resident's clinical condit catheterization was nec (ii) A resident who enter Indwelling catheter or si is assessed for removal	s the facility without an ot catheterized unless the tion demonstrates that ressary; at the facility with an obsequently receives one of the catheter as soon esident's clinical condition eterization is necessary; continent of bladder atment and services to octions and to restore possible. Ident with fecal fine resident's tent, the facility must no is incontinent of bowel atment and services to bowel function as not met as evidenced lew, staff interview I in the course of a ne facility staff failed to care and services per rone of 59 residents in ent #40.		Criteria 3 Licensed nurses will be re-educated on the care of condom catheters to meet nursing of practice. Criteria 4 DON and/or designee will audits of condicatheters. These audits will be done 5 day for four weeks; then one day a week for feweeks; then twice in the last month The will be forwarded to the QAPI committee review. The committee will determine the further audits and/or action. Criteria 5 Date of compliance is 7/26/22.	standards om s a week our se results	

DEPARTMENT OF HEALTH AND HUMAN	SERVICES
CENTERS FOR MEDICARE & MEDICAID	SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULI A. BUILDII	RPLE CONSTRUCTION	V	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK			STREET ADDRESS, 2420 PEMBERTON RICHMOND, VA	•	1 0	<u>8/16/2022</u>
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F 690	condom-like device. Ti placed around the pen condom catheter. A dri	often consist of a pouch or his device is securely is. This is often called a sinage tube is attached at	Fe	90			IS.
	empties into a storage directly into the toilet. I most effective when ap You may need to trim the area for better grip of the change the device at le protect the skin and pre infections." This inform the website:	plied to a clean, dry penis. ne hair around the pubic ne device. You must aat every other day to				5	
1	reference date) of 4/8/2; out of 15 on the BIMS (t	Ith an ARD (assessment 2, the resident scored 15 prief interview for mental sident was not cognitively					
c b 1 ci	ut nurses are currently	O stated the condom pe changed "right much" changing it about every nurses say they forgot to low to change it so the			TI.		
ph co 6/. co ph	review of R40's clinical hysician's order to routing andom catheter. A physician's order to clandom catheter as need hysician's order dated 3/hange the resident's con	dicien's order dated hange the resident's ed and another 31/22 documented to		,	·		

f		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			495109	B. WING_		(C 06/15/2022	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF UNIVERSITY PARK			RK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
	(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OULD BE COMPLE		
	CO W pi si th pri st as As or to rec	needed. R40's compressive weed on 4/15/22 do risk for urinary tract infestrauma: has Condom Control paraplegia. Change cas facility policy" A review of TARs (treatmeter and the following dates: 8/5/1/24/22, 2/6/22, 2/13/22 4/29/22, 5/9/22, 5/15/22 and 6/14/22. There was evidence the catheter wild dates. On 6/15/22 at 12:11 p.m. conducted with ASM (admember) #6 (the nurse paractice to change a control to the catheter change was only as conducted with ASM (admember) #6 stated she was a latheter change was only the skin for irritation/pressive to the could not explicated she could not ex	chensive care plan lest cournented, "(R40) is at cournented, "(R40) is at cournented, "(R40) is at cournented, "(R40) is at cournented catheter r/t (related to) other and tubing per ment administration of the result of the res	Fes				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION	O(3) DATE SURVEY COMPLETED		
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MANIE OF	PROVIDER OR SUPPLIER	498109	B. WING _	CANALA VIDENCE CIAN CALLE AND CODE		6/15/2022	
	URELS OF UNIVERSITY PA	RK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency must be preceded by full regulatory or lsc identifying information)		IÓ PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XII) COMPLETION DATE	
	Further review of R40' antiblotic medication to UTIs on 9/16/21 and 6 On 6/15/22 at 3:35 a.m administrator), ASM #2 ASM #3 (the regional of ASM #4 (th	s clinical record revealed eatment was initiated for /15/22. In, ASM #1 (the coordinator) and coordinator) and coordinator) and coordinator a	F 69	P695 Criteria 1 Resident #289,#94, #61. Resident bagged after identification. Reside was adjusted to to 3L as per MD o	ent#94 O2 rate order. The rate of 2L/min the potential to cy. O2 orders and ste. The rate of 2L/min the potential to cy. O2 orders and ste. The rate of 2L/min the potential to cy.		

CENT	RTMENT OF HEALTH AN ERS FOR MEDICARE &	MEDICAID SERVICES					FOR OMB N	ED: 06/28/2022 RM APPROVED IO, 0938-0391	
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			-	(X3) DATE SURVEY COMPLETED		
		495109	8. WING			_	06	C 3/18/2022	
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THE LA	URELS OF UNIVERSITY PA	RK			2420 PEMBERTON RD RICHMOND, VA 23233				
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F 695	Continued From page The findings include:	148	F	69:	5				
	The facility staff falk (R289) nasal car manner.								
	admission assessment reference date) of 06/09 scored 13 out of 15 on for mental status), indic cognitively intact for ma	the BIMS (brief interview ating the resident was king daily decisions. tments, Procedures and							
	On 08/13/22 at approxin observation of (R289's) observed hanging over to of the bedside dresser u	nasal cannula was he partially open drawer ncovered.							
	On 06/14/22 at approximobservation of (R269's) robserved hanging over the bedside dresser un	nasal cannule wes ne partially open drewer							
	The physician's order for part, "Oxygen 2l/min (two (by) nasal cannula as new of breath). Order Date: 5 08/03/2022."	liters per minute) via eded for SOB (shortness							
r F	On 06/15/22 at approximation of the conducted practical nurse) #7. When procedure for storing a rewhen it was not in use LP vrapped up and placed in portrol purposes. When it	with LPN (licensed in asked to describe the sident's nasal cannula in the stated it should be side a bag for infection							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ADENTICA AND AN ANAMAN.		2) MULTIPLE CONSTRUCTION BUILDING			(XS) DATE SURVEY COMPLETED	
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ľ		495109	B. WING			1 -		3/16/2022
NAME OF	PROVIDER OR SUPPLIER			\$1	FREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAU	RELS OF UNIVERSITY PA	ARK		24	20 PEMBERTON RD			
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OX4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		OULD B		(X6) COMPLETION DATE		
F 695	Continued From page	149	Fe	395				
		d above LPN #7 stated that uld not have been stored						
	in part, "III. The O2 car	e of Oxygen" documented nnula or mask, when not in n a clean bag. Bag should						
	(administrative staff me ASM #2, director of nur	oximately 11:35 a.m., ASM imber) #1, administrator, islng and ASM #3, regional M #4, regional director of						
- 1	No further information v	as presented prior to exit.						
t c c iii	to 6 Umin. The nesal protected approx. 1 cm into connected to a common connected to the oxygen formation was obtained.	each naris and are tube, which is then a source. This						
	. For Resident #94 the dminister oxygen at the	facility staff failed to physician ordered rate.	T.					
Di (A Ri or in	esident #94 was admitt 130/20. On the most rec ata Set) an annual asse issessment Reference le esident #94 scored an in the BIMS (brief intervious dicating the resident was ability to make daily life aldent was coded as rec	cent MDS (Minimum esament with an ARD Date) of 5/10/22, If out of a possible 15 ew for mental status) s moderately impaired decisions. The			• v			

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		ND HUMAN SERVICES			FOI	ED: 06/28/202 RM APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	10. 0938-039 TE SURVEY MPLETED
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	areas of activities of d which only required at A review of the clinical physician's order date liters per minute continuous on 6/13/22 at 1:13 PM Resident #94 was obsion. The flow meter ref 1.5 liters per minute as the 1.5 liter mark cross the flow meter ball. On 6/14/22 at 3:00 PM, conducted with LPN #4 Nurse). She stated the rate should be 3 liters per rate was set at 1.5 liters per rate was set at 1.5 liters per reference.	ally living, except for eating apervision. record revealed a di 1/25/22 for oxygen at 3 auously. and 6/14/22 at 9:04 AM, erved in bed with oxygen lected an oxygen rate of evidenced by the line for ing through the middle of an interview was (Licensed Practical the resident's oxygen er minute. When asked if	F 695			
n h n n ir vi	as a potential for difficus spiratory complication actuded the intervention administer medication a hysician ordersoxyge he facility policy, "Use of his policy did not docum arifying physician's order oxygen. n 6/15/22 at approxima dministrative Staff Men	10/20 for "[Resident #94] Ity breathing and risk for s" This care plan It, dated 3/15/21 for and treatments per Ith per order" If Oxygen" was reviewed, ment anything about Ithere for the use of and rate				·

Regional Director of Operations were made

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	TE BURVEY MPLETED
		495109	B. WING			C 6/15/2022
	PROVIDER OR SUPPLIER		S1 24	TREET ADDRESS, CITY, STATE, ZIP CODE 120 PEMBERTON RD ICHMOND, VA 23233		6/15/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of Depiciencies Must be preceded by full SC (Dentifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
Find a Control of the	aware of the findings. provided by the end of 3. The facility staff falle therapy as ordered for #61 was observed with at 3 liters per minute or 6/14/22 at 9:00 AM and Resident #61 was admit 4/23/21 with diagnoses limited to: COPD (chronic obstructions) assessment, a qual assessment reference of resident #61's most received assessment; a qual assessment reference of resident was severely of the revision date, revealed the resident has a potential and risk for respiratory of COPD. Interventions: Encourage cough & deep refered via nass! cannulation the following, "Coreview of the physician ovealed the following, "Coreview of the physician ovealed the following," Coreview of SOB, every significant for SOB, every significant was severely as annulation of SOB, every significant for SOB, every signi	No further information was the survey. In the survey. In the survey. In the survey. In the survey. In the survey. In the survey. In the survey. In the survey. In the survey of	F 695			

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DEPARTMENT OF HEALTH AND HUMAN SERV	ICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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		495109	B. WING			0	8/15/2022	
	PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK	-	24	reet address, city, state, zip code 20 pemberton RD ICHMOND, VA 23233			
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F 695	Continued From page	152	F	395				
	Resident #61 wa unable to be interviewed due to cognitive impairment. On 6/14/22 at 2:55 PM, LPN (licensed practical nurse) #3 was asked to observe the oxygen setting on Resident #61.						10	
	An interview was conducted on 6/14/22 at 3:00 PM with LPN #3. When asked the oxygen setting observed, LPN #3 stated, it is set on 3 liters nesal cannula. I need to check the order. When asked how she read the level at 3 liters, LPN #3 stated, you read the number where the center of the ball is located. LPN #3 checked the order in the medical record and stated, the order is for 2 liters nasal cannula. I will go change it now. When asked if the oxygen being set at 3 liters nasal cannula, Indicated that the oxygen was being monitored for correct therapy, LPN #3 stated, "No, it is not."							
8	On 6/14/22 at 4:20 PM, administrator, ASM #2, and ASM #3, the region were informed of the ab	the director of nursing, al clinical coordinator	2:1					
- n	owrate line on the flow now until the ball rises	gen concentrator, "To eter, locate the prescribed meter. Next, turn the flow to the line. Now center minute line prescribed."			· .	e e		
p fo	olicy dated 6/24/21, whollowing, "Treatment reruest/resident must be in bedfic standing, written	ich revealed the ndered to a naccordance with the						

SETTING STATES OF THE STATES OF THE SETTING							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		(C2) MULTIPLE CONSTRUCTION A. BUILDING			ate survey Impleted
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		495109	B. WING	_		06/15/2022	
	provider or supplier URELS OF UNIVERSITY PA	ARK		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	_	
240.10	BI MOMANY STO	TEMENT OF REPIGIPNOIPS	ID ID		PROVIDER'S PLAN OF CORRECTION		AVA
(X4) IO PREFIX TAG				X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)		COMPLETION DATE
F 695	ordar of a physician of professional ordering practice and clinical pr	other licensed health within their scope of lvileges."	Fé	395			
		was provided prior to exit.		(l		1 1
F 697			F6	97	F697		'
	provided to residents we consistent with profess the comprehensive per and the residents' goals. This REQUIREMENT is by: Based on resident into clinical record review as review, it was determine	a that pain management is the require such services, ional atandards of practice, son-centered care plan, and preferences, and preferences, and met as evidenced rylew, staff interview, and facility document and that the facility staff implete pain management asidents in the survey		1	Criteria 1: R#58 was provided as needed pain medical without documented non-pharmacologic interventions. Resident #58 is now receive pharmacological interventions prior to administration of pain medication. Criteria 2 All residents who have as needed medicate pain have the potential to be affected by the deficiency. Criteria 3 Nursing staff will be re-educated on document of NPI (non-pharmacological interventions administering any as needed (PRN) medical	ions for allegeneration	r ed
1 t s	Facility staff failed to conduct complete pain assessments and attempt non-pharmacological interventions prior to the administration of a PRN (as needed) pain medication, tramadol (1). (R58) was admitted to the facility with a diagnosis that included by not limited to: rheumatoid arthritis. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/17/2022, the resident scored 15 out of 15 on the BIMS (brief interview				Criteria 4 DON/designee or designee will complete firandom audits of resident documentation we prescribed As Needed/PRN medications by MD/NP. These audits will be done 5 days a for four weeks; then one day a week for four weeks; then twice in the last month. The reswill be forwarded to the QAPI committee for review. The committee will determine the number audits and/or action. Criteria 5 Date of compliance is 7/26/22.	the are the week ir sufts	*8

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED		
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				RICHMOND, VA 23233			
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F 697	for mental status), indi cognitively intact for m Section J0300 "Pain P	cating the resident Is aking daily decisions. resence" coded (R58) as	F 697				
	having frequent pain in Section J0600 "Pain In having a pain level of f being the worse pain.	tensity" coded (R58) as					
	The physician's order for (R58) documented in part, "Tramadol HCI (hydrochloride) Tablet 50 MG (milligram). Give 1 tablet by mouth every 6 (six)			s			
	hours as needed for pa	in. Complete NPi					
	(non-pharmacological li Order date: 4/18/2022."						
	The eMAR (electronic national) for (R58) dated the physician's order as "Pain-Non-Pharmacological".	stated above and					
[Document Non Pharma used: 1)Massage. 2) Ma	cological interventions editation/Relaxation.					
- 1	3)Positioning, 4) Ice/cok Activity, 6) Guided Imag Interaction, as needed D	ery. 7) Rest. 8)Social					
[NonPharmacological integration corresponding number.	erventions using the					
- 10	Review of the eMAR falls documentation of non-ph	armacological					
- t	nterventions as stated a hrough 06/12/2022. The	eMAR revealed that					
10	R59) received 50 mgs of following dates and times ocation of pain, type of p	s, with no evidence of the		*3			
n	ion-pharmacological inte	rventions being			}		
	ittempted on: 08/01/2022					1	
	16/02/2022 at 10:48 a.m. 16/04/2022 at 12:21 p.m.						
	•	//2022 at 12:21 p.m., 06/06/2022 at 8:24 08/07/2022 at 10:19 a.m. and at 9:59 p.m.,					

PRINTED: 06/28/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495109 B. WNG 08/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DAT REGULATORY OR LEC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 897 Continued From page 155 F 697 08/08/2022 at 5:20 p.m., 08/09/2022 at 8:25 p.m., 06/10/2022 at 5:50 a.m., 06/11/2022 at 9:38 p.m. and on 06/12/2022 at 4:32 a.m. and at 9:33 p.m. Further review of the eMAR failed to evidence non-pharmacological interventions being attempted on: 06/03/2022 at 11:07 a.m., 06/08/2022 at 9:43 p.m. and on 08/09/2022 at 8:46 a.m. The comprehensive care plan for (R58) documented in part, "Focus. (R68) is at risk for pain and/or has acute/chronic pain r/t (related to) DX (diagnoses: RA (rheumatoid arthritis), DJD (degenerative joint disease), GERD (gastroesophageal reflux disease). Date Initiated: 04/13/2022." Under "Interventions" it documented in part, "Evaluate the effectiveness of pain interventions as given. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition as needed. Date Initiated: 04/13/2022," Review of the facility's nurse's notes for (R58) dated 06/01/2022 through 06/12/2022 falled to evidence the location of pain, type of pain and non-pharmacological interventions being attempted on the dates and times listed above and failed to evidence non-pharmacological interventions being attempted on the dates and times listed above. On 06/13/22 at approximately 12:52 p.m., an Interview was conducted with (R58). When asked if they receive as needed pain medication (R58) stated yes. When asked of the nurse attempts to alleviate their pain by other means

before administering their pain medication (R58) stated that nurse just gives them their medication.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		LTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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F 697	Continued From page	158	F 69	97					
	On 06/15/22 at 8:00 a	m. an Intendew was		- [
		icensed practical nurse) #	1				1		
	· ·	cribe the procedure when							
		ed pain medication LPN # 7		-			1		
		ssesses the resident's pain	-				1		
		by obtaining the severity of the resident's pain on					}		
		with ten being the worse	1				1		
[pain and the type of pain							
		abbing. LPN #7 stated					1		
- 1	that the nurse would th		[1					
	non-pharmacological interventions such as repositioning, ice pack, or heat, and if that does		1				1		
			1				1		
	not alleviate the resider administer the prescribe		1	-					
	asked how often non-pi		1	1					
	interventions LPN # 7 s		-	1					
		fore the as needed pain	i						
		red. When asked where	1						
		that the location of pain,	1	1					
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- (1	interventions were atten	npted LPN # 7 stated that	1	ĺ					
- 1	t would be documented	in the nurse's notes or	J	ì			1		
	he eMAR. When asked		}	1					
		gical interventions prior	1	1					
	o the administration of a		1				}		
		ed that it could decrease	1						
		After review of the eMAR	1	1					
1,1	or non-pharmacological	Interventions LPN # /	J						
	vas asked about the mis		· ·				-22		
	.PN #7 stated that they on-pharmacological Inte					-7	-		
		a not documented. After			•				
	eviewing the facility's nu]						
	ated 06/01/2022 through								
		ion of Tramadol LPN # 7				ł			
		of pain, type of pain and							
	on-pharmacological inte					1			
		listed above, LPN #7	[[ł			

	ARTMENT OF HEALTH AI						FOR	D: 06/28/20: MAPPROVE	
STATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONST	RUCTION		(X3) DATE SURV COMPLETE:		
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	OF PROVIDER OR SUPPLIER AURELS OF UNIVERSITY PA	ırk		2420 PEN	ADDRESS, CITY, STATE, ZIP COD MBERTON RD DND, VA 23233	DE		116/2022	
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	IO PRÉFII TAG	c	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(XB) COMPLETION DATE	
1	stated, "No." The facility's policy "Padocumented in part, "8 and observe to determ Mild pain - If a guest/repain is "mild". Moderate indicates his or her pain Pain- If a guest/resident indicates asvere". Very severe guest/resident indicates asvere or horrible". 7. A observe to determine the The staff will implement the guest/resident, and interventions for pain, if On 08/15/2022 at approximation of pain, if On 08/15/2022 at approximation of numerical coordination of operations. No further information we References: (1) Tramadol is used to remoderately severe pain. extended-release tablets used by people who are emedication to relieve pain information was obtained https://medlineplus.gov/dr	din Management* Ask the guest/resident ine the intensity of pain: sident indicates his or her a pain - if a guest/resident in a "moderate". Severe tindicates his or her pain or Homble - if a his or her pain is "very sk the guest/resident and e location of pain14. the care plan, monitor administer therapeutic ordered." Administrator, administrator, sing and ASM # 3, ator, ASM# 4, regional as presented prior to exit. Believe moderate to Tremedol and capsules are only expected to need around-the-clock. This from the website:	F6	97					
F 698	ml. Dialysis CFR(s): 483.25(l)		F 698						

§483.25(I) Dialysis.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DATE BURVEY COMPLETED	
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in the state of th	with professional stand comprehensive person the residents' goals and This REQUIREMENT is Based on staff interview clinical record review, a review, it was determined provide dialysis care an residents in the survey of Resident #116. The findings include: 1. For Resident #76, the communication to the dialysis in March 2022, 11 is of 13 visits in May 20.	e that residents who such services, consistent ards of practice, the centered care plan, and if preferences, is not met as evidenced w, resident interview, and facility document and the facility staff falled to diservices for two of 59 sample, Resident #76 and a facility failed to provide alysis facility for 10 of 14 of 13 visits in April 2022, 22 and 4 of 5 visits in monitor the catheter site bleeding.	Fé	in no CA b A w CN en an	Criteria 1 Resident #76 suffered no adverse outcomes to the alleged failure of the facility to moni resident's catheter site for signs of infection bleeding or provide communication to the of facility where the resident receives treatment Resident #116 suffered no adverse outcome related to the alleged failure of the facility to provide dialysis communication forms for refiled dialysis appointments. Upon notificative allegations, unit staff and ward clerk we educated on providing dialysis communication forms for residents #76 and #116 and the statesponsible for resident #76 were re-educated nonlitoring the catheter site for signs and synthesis in the catheter site for signs and synthesis affected by the alleged deficient practiculate completed on dialysis residents and the with dialysis catheters to ensure compliance. Triteria 2 Turning staff and ward clerk will be re-educated in the catheter sites are monitored for signs and that catheter sites are monitored for signs and that catheter sites are monitored for signs and the catheter sites are monitored for signs and signs and signs are s	tor the n and dialysis nt, as o esident ation of re re- ion aff ad on mptoms ential of ce, ose atted on sed	
as re Ini re	sessment reference da	ral assessment, with an to of 3/19/22, coded the of 15 on the BIMS (brief a) acore, indicating the cognitively impaired.		Do dia dia syn day for res for	riteria 4 on and/or designee will complete audits to cally sis communication forms are utilized and ally sis catheter sites are monitored for signs in the sign of infection. These audits will be done a week for four weeks; then one day a we four weeks; then twice in the last month. I sults will be forwarded to the QAPI commit review. The committee will determine the further audits and/or action.	the and one 5 cck These tee	
'N	EED: Resident is at rislated to needs for dialys	c for complications		Cr	iteria 5 te of compliance is 7/26/22.		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED		
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	Renal Disease. distys Hemodistysis Tuesday INTERVENTIONS: Ob of infection to access a warmth or drainage/bla infection: fever, general of abdominal pain, chil abnormal findings to the Hemodistysis: Facility Communication form to distysis center. Send to book to the distysis center.	is cath replaced 1/6/21. If, Thursday, Saturday. It is ever for signs/symptoms site: Redness, Swelling, seding and other signs of alized malaise, complaints is. Document and report is physician. For will utilize the Dialysis o communicate with the ne dialysis communicate with the net of the communicate with the net of the communicate with the net of the communicate with each urn from the dialysis center the communicate to the	F 698				
- T	renewed 5/2/22, reveals "Hemodialysis Tuesday Monitor dialysis cathete algns/symptoms of Infeddressing If needed. Mo A review of the dialysis on 6/14/22, revealed the "Hemodialysis Communicompleted on the follow 4/22/22, 4/7/22, 3/29/22 The facility falled to providelysis facility for 10 of the missing dates in Mai 1/8, 3/10, 3/12 3/15, 3/1	Thursday, Saturday. TRight Chest for ction. May reinforce nitor every shift." binder for Resident #76 of following, the facility's ideation Form" was ing dates, 6/14/22,					
ď	The facility failed to provide communication to the dialysis facility for 11 of 13 visits in April 2022, the missing dates in April 2022 were: 4/2, 4/5, 4/9,						

	8TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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ĺ			495109	B, WNG			08/15/2022		
		PROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	RK		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23333			
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	a so so so so so so so so so so so so so	The facility falled to prodialysis facility for 13 or missing dates in May 2 5/10, 5/12, 5/14, 5/17, and 5/31. The facility falled to prodialysis facility for 5 of 5 missing dates in June 2 6/9 and 6/11. A review of the TAR (trerecord) for March 2022, Monitor dialysis cathetesigns/symptoms of infectings/symptoms	4/23, 4/26, 4/28 and 4/30. by ide communication to the f 13 visits in May 2022, the 022 were: 5/3, 5/5, 5/7, 5/19, 5/21, 5/24, 5/26, 5/28 vide communication to the identity in June 2022, the 022 were: 6/2, 6/4, 6/7, atment administration revealed the following, or Right Chest for allor every shift" 93 ehifts were missing to dates were day shift: 3/12, and 3/15; evening 24 and 3/26 and night, 3/10 3/11, 3/14, 3/15, pril 2022, revealed the is catheter Right Chest fection. May reinforce itor every shift"	F	398				
	do 4/ nla	ocumentation. Missing of 1, 4/9; 4/10 and 4/21; eight shift 4/4. The review of the TAR for Millowing, "Monitor dialysis."	dates were day shift: vening shift 4/8 and ay 2022, revealed the			· ·			
	for dre	algna/symptoms of infessing if needed. Monit denced that 8 out of 90	ection. May reinforce or every shift"						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TION	(X3) DATE SURVEY COMPLETED	
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L n n d d t t t a a c c c c c v v re c c b i	5/8, 5/17 and 5/23; eviand 5/28 and night shi and 5/28 and night shi and 5/28 and night shi and 5/28 and night shi are signs/symptoms of dressing if needed. Mo evidenced that 6 of 42 documentation. Missin 6/5, 6/8, 6/10 and 6/11; night shift 6/8. On 6/13/222 at 3:25 PM conducted with Resider had a dialysis binder, Rhave one. I believe I leis when asked if they (nuidialysis catheter site eviated, "I do not think so that a dialysis bin extend, "I do not think so that a dialysis bin extend, "I the not esident's room." When allelysis communication is provide information to ne resident's vital signs, dditional important informationary sends us informationary endes or orders." When thanges or orders." When	ng dates were day shift: ening shift: 5/23, 5/25, 5/26 ft 5/11. r June 2022, revealed the yels catheter Right Chest infection. May reinforce onitor every shift" shifts were missing g dates were day shift: evening shift: 6/10 and ft, an interview was at #76. When asked if she esident #76 stated, "I ft lt at the dialysis center." raing staff) check the ery shift, Resident #76 by shift, Resident #76 cted on 6/13/22 at 3:30 bractical nurse) #1. When ader for Resident #76, up here, it may be in the asked the purpose of the form, LPN #1 stated, "It is the dialysis center about weight and any mation. The dialysis ion back about weight en asked the frequency estion form to the dialysis its sent with every visit. It care is provided to a s, LPN #1 stated, "We er or fistula site for here is a fistula, we	F 6	98			

F 898 Continued From page 162 frequency of these checks, LPN #1 stated, it is every shift. When asked where this is documented, LPN #1 stated, it means that it was not done. A request was made on 8/14/22 at 12:15 PM for the dialysis communication forms from 3/1/22 through 6/14/22 for Resident #76. The dialysis binder was provided on 8/14/22 at 2:09 PM. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the sbove concern. A review of the facility's "Hemodialysis" policy dated 10/19, which reveals, "The facility			QUS) APLICTION CATE
THE LAURELS OF UNIVERSITY PARK THE LAURELS OF UNIVERSITY PARK IS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 698 Continued From page 162 frequency of these checks, LPN #1 stated, it is every shift. When asked where this is documented on the TAR. When asked if there are blanks in the TAR, what does that indicate, LPN #1 stated, it means that it was not done. A request was made on 6/14/22 at 12:15 PM for the dialysis communication forms from 3/1/22 through 6/14/22 for Resident #76. The dialysis binder was provided on 6/14/22 at 2:09 PM. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Hemodialysis" policy dated 10/19, which reveals, "The facility	3 PE PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA	E cor	(XS)
THE LAURELS OF UNIVERSITY PARK 2420 PEMBERTON RD RICHMOND, VA 23233 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 698 Continued From page 162 frequency of these checks, LPN #1 stated, it is every shift. When asked where this is documented, LPN #1 stated, it is documented on the TAR. When asked if there are blanks in the TAR, what does that indicate, LPN #1 stated, it means that it was not done. A request was made on 6/14/22 at 12:15 PM for the dialysis communication forms from 3/1/22 through 6/14/22 for Resident #76. The dialysis binder was provided on 6/14/22 at 2:09 PM. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Hermodialysis" policy dated 10/19, which reveals, "The facility	3 PE PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA		PLETION
F 898 Continued From page 162 frequency of these checks, LPN #1 stated, it is every shift. When asked where this is documented on the TAR. When asked if there are blanks in the TAR, what does that indicate, LPN #1 stated, it means that it was not done. A request was made on 6/14/22 at 12:15 PM for the dialysis communication forms from 3/1/22 through 6/14/22 for Resident #76. The dialysis binder was provided on 6/14/22 at 2:09 PM. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Hemodialysis" policy dated 10/19, which reveals, "The facility	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIE		PLETION
frequency of these checks, LPN #1 stated, it is every shift. When asked where this is documented, LPN #1 stated, it is documented on the TAR. When asked if there are blanks in the TAR, what does that indicate, LPN #1 stated, it means that it was not done. A request was made on 6/14/22 at 12:15 PM for the dialysis communication forms from 3/1/22 through 6/14/22 for Resident #76. The dialysis binder was provided on 6/14/22 at 2:09 PM. On 6/14/22 at 4:20 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator were informed of the above concern. A review of the facility's "Hernodialysis" policy dated 10/19, which reveals, "The facility			
completes the appropriate section of the hemodialysis communication form prior to the guest/resident receiving each dialysis session and again when the resident returns. Evaluate the resident daily for dialysis access elte and possible complications, including, but not limited to: bleeding, stenosis, infection, steel syndrome or aneurysms. No further information was provided prior to exit. 2. The facility staff falled to provide dialysis communication forms for (R116's) to the dialysis center on 05/20/2022, 05/23/2022, 06/25/2022, 05/27/2022, 05/30/2022, 08/01/2022, 06/10/2022 and 08/13/2022 and failed to complete dialysis communication forms on 05/13/2022, 05/18/2022, 05/18/2022, 06/03/2022, 06/08/2022 and			

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER		XZ) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
,		407400					¢		
	PROVIDER OR SUPPLIER IRELS OF UNIVERSITY PA	495109	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			06/15/2022			
(X4) (D PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI DEFICIENCY		ION SHOULD BE HEAPPROPRIATE			
F 698	Continued From page	163	F 6:	98		·			
	(R118) was admitted to included but were not failure.	o the facility with diagnoses limited to: acute kidney							
- 1	annual assessment wit reference date) of 05/1 scored 14 out of 15 on for mental status), Indic cognitively intact for ma	the BIMS (brief interview cating the resident is along deily decisions. atments, Procedures and							
	part, "Hemodialysis Moi "[Name of Dialysis Cent	or (R116) documented in Inday, Wednesday, Friday, Independent of the Price of the P							
(F		piration, blood pressure) day, Wednesday, Friday. d, Fri. (Monday,							
O fo d In dk	The comprehensive care 15/12/2022 documented or complications R/T (refue to: ESRD (end stage hitlated: 06/12/2022," Understand In part, "Restonday, Wednesday, Fris/12/2022."	In part, "(R116) is at risk lated to) needs dialysis renal disease). Date inder-"Interventions" it sident receives dialysis							
Fo	he facility's "Hemodialys orms" for (R116) docum COMPLETED BY THE F	ented in part,				_			

DEPA	RTMENT OF HEALTH AN	ND HUMAN SERVICES					ED: 06/28/2022 RM APPROVED
	ERS FOR MEDICARE &						O. 0938-0391
STATEME	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		(X8) DATE SURVEY COMPLETED		
		495109	B. WING	o		06	C 3/15/2022
NAME (F PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
				,	1420 PEMBERTON RD		
THEL	lurels of University Pa	IRK		R	RICHMOND, VA 23233		
(X4) II PREFI TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA		(XG) COMPLETION DATE
					DEFICIENCY)		
F 69	DEPARTURE. VS (vit	DEPARTURE. VS (vital signs): BP: T: P: R:, Mental Status; Medication Dialysis:, Medication		398			
	Changes:, Pertinent La Special Instructions to	abs: Condition of Shunt:, Dialysis Unit:, Nurse	ļ				
	Signature:." Under "Co						1
		JRN" it documented, "VS: atus;, Condition of Access	1	- 1			1
	Site:, Nurse Signature:						
	Review of (R116's) dialysis communication book falled to evidence the facility's "Hemodialysis Communication Forms" for 05/20/2022,			- 1			l Ł
	05/23/2022, 05/25/2022	2, 05/27/2022, 05/30/2022, 2 and 08/13/2022. Further	ļ				
		sis communication book		-		- 1	J
		/S: BP: T: P: R:, Mental				}	J
	Status: Medication Dia		1	- {			
	Changes:, Pertinent Lat and Nurse Signature: o			1		ĺ	
	heading "COMPLETED			-			
	BEFORE DEPARTURE.					i	
	BY THE FACILITY UPO						- 1
	blanks under "VS: BP: 1					- 1	
	Condition of Access Site	:, Nurse Signature:" on . 05/18/2022, 08/03/2022.					ĺ
	06/06/2022 and on 06/08					i	
	OOFOOFECEE BING OIL OUTO	# L VL2.		1			
	On 06/14/2022 at approx	dmately 10:10 a.m., an				ſ	j
	interview was conducted	• • • • • • • • • • • • • • • • • • • •		1			
	practical nurse) #7. Whe					l	- 1
	important to complete the					J	
ſ	forms prior the resident g				•		- 1
	center LPN # 7 stated the and the nurse could comp	* · · · · · · · · · · · · · · · · · · ·					
[medical status before and						
J	dialysis. When asked wh						
- 1	complete the dialysis com						
	the resident comes back						
	dialysis center LPN # 7 st	sted that it directed the					

		TMENT OF HEALTH AN				FOR	D: 08/28/2022 MAPPROVED D: 0938-0391)
		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION	COM	SURVEY PLETED	
			495109	B. WING_		ı	C /15/2022	
I	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ł	THE LAU	RELS OF UNIVERSITY PA	.RK		2420 PEMBERTON RD			ı
ļ	***************************************				RICHMOND, VA 23233			ı
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(XS) COMPLETION DATE	
	Í	well the resident was described in the resident was described in the reviewing the dialysis of dated 05/13/2022, 06/106/03/2022, 06/08/2022 (R116) LPN # 7 stated documented then it was about (R116's) missing sheets for 05/20/2022, 05/27/2022, 05/30/2022	the resident", gauges how loing, see any the dialysis center and alysis access alte. After communications sheets 6/2022, 05/18/2022, 2 and on 06/08/2022 for that if it wasn't sen't done. When asked	F 69	8			
		part, "4. The facility com section of the hemodialy prior to guest/resident re session and again when returns from hemodialys On 06/14/2022 at approx administrative staff men	sis communication form scelving each dialysis the guest/resident is." dimately 4:13 a.m., ASM ober) #1, administrator, ing and ASM #3, regional	***	8			
	R (1 re ki (a of	o further information was eferences: Dialysis treats end-sta moves waste from your dneys can no longer do nd other types of dialys the kidneys when they formation was obtained tps://medlineplus.gov/er	blood when your their job. Hemodialysis s) does some of the job stop working well. This from the website;			j, če		

	RTMENT OF HEALTH AN					FOR	D: 06/28/2022 MAPPROVED O: 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
27		495109	B, WING_				C /16/2022
NAME OF	PROVIDER OR SUPPLIER			91	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAN		PIZ.	- 1	24	120 PEMBERTON RD		
THE LAURELS OF UNIVERSITY PARK				RI	ICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 730 SS#D	\$483.35(d)(7) Regular In-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of \$483.95(g).			i I	F730 Criteria 1 Facility residents suffered no adverse outco related to CNA #7 and CNA #8 allegedly no acciving their performance/competency rev	nt l	
				p th	Nursing leadership re-educated on completi erformance reviews and ensuring CNAs co heir annual competencies.	ng Implete	į
	This REQUIREMENT I by: Based on staff Interview review, it was determine complete annual perfor reviews for two of five C assistant), CNA #7 and	v and employee record od the facility staff falled to nance/competency NA (certified nursing		th cu co de	Il active residents receiving assistance fron icility CNAs have the potential to be affecta e alleged deficiency. Audit completed of all trrent CNAs and performance reviews were impleted to ensure compliance with the alle ficiency.	ed by	
	The findings include: Five CNA employee reco	e/competency reviews.	Critoria 3 Nursing leadership will be re-educated on completing CNA performance reviews and CNA's will be re-educated on completing their annual competencies.				
1 1 2 2	On 6/13/2022 at approximately 5:00 p.m. a request was made for the annual performance/competency reviews completed on CNA #7 and CNA #8. CNA #7 was hired on 9/2/2020 and CNA #8 was hired on 3/17/2021. A second request for the annual performance/competency reviews was made on		Criteria 4 Director of Nursing and/or designee will complete audits of CNAs annual competencies and performance reviews to ensure they have met the regulation. These audits will be done 5 days a week for four weeks; then one day a week for four weeks; then twice in the last month. The results will be forwarded to the QAPI committee for				
A 2 P a a st	3/16/2022 at approximate at the end of the day meet 34 p.m. A third request erformance/competency and CNA #8. At that time that member) #1, the administration did not have the area formance/competency and CNA #8.	oting on 6/15/2022 at was made for the reviews for CNA #7 ASM (administrative ministrator, stated the anual		revie furth <u>Crite</u>	ew. The committee will determine the need ler audits and/or action. erla 5 of compliance is 7/26/22.	for	

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
STATEME	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BURLDING			re survey Apleted		
		495109	B. WING		C 06/15/2022			
	of provider or supplier Aurels of University Pa	ARK	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	, ,			
	(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE			
F 73	Continued From page	167	F 730)				
F 759 SS=D	p.m. with ASM #4, the operations. When asked get their annual performance tracks who is due and adapartment manager. (director of nursing) has for two months as well A policy on annual performance was requested approximately 4:00 p.m. ASM #1, ASM #2, the director of aware of the above comp.m. On 6/15/2022 et 6:20 p.m.	and the process for CNAs to mance/competency of the payroll employee gives the list to the ASM #4 stated the DON is only been in the position as the payroll employee. Tomance/competency on 6/15/2022 at Tirector of nursing, ASM coordinator, and ASM #4, operations, were made cern on 6/15/2022 at 4:18 The ASM #1 and ASM #2, informed the surveyors the licy on annual y reviews.	F 759	F759				
	§483.45(f) Medication Er The facility must ensure (hat its-		Criteria I The medication Brrors for resident not result in any ill affects. MD we both residents and order to monito	as notified on	id ·		
	§483.45(f)(1) Medication percent or greater; This REQUIREMENT is by:			Criteria 2 All residents who have medication		at		

Based on observation, resident interview, staff

the facility have the potential to be affected by the alleged deficiency.

PRINTED: 08/28/2022 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE BURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495109 B. WING 06/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON AD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 SUMMARY STATEMENT OF DEFICIENCIES O(4) ID PROVIDER'S PLAN OF CORRECTION (PUS) COMPLETION OATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 759 F 759 Criteria 3 Continued From page 168 Licensed nurses will be re educated on the Interview, clinical record review and facility Medication Administration policy, Licensed nurses document review, it was determined that the will have a medication pass audit completed facility staff falled to ensure a medication error rate of less than 6%. The facility medication error rate was 10.71%, having made 3 identified medication errors out of 28 opportunities. The Criteria 4 errors were for 2 of 3 residents in the Medication DON/designee or designee will complete five (5) Administration task; Residents #14 and #96. random audits of residents with medications ordered for assurance medications are signed and The findings include: given. Medication pass audits will be reviewed by DON/Designee to assure competency. These audits 1. For Resident #14, the facility staff failed to will be completed 5 days a week for four weeks; ensure the resident was free of medication errors. Then one day a week for four weeks; then twice in the last month. These results will be forwarded to the QAPI committee for review. The committee Resident #14 was admitted to the facility on will determine the need for further audits and/or 3/12/21. On the annual MDS (Minimum Date action. Set) assessment with an ARD (Assessment Reference Date) of 3/11/22, Resident #14 scored Criteria 5 a 15 out of a possible 15 on the BIMS (brief Date of compliance is 7/26/22. Interview for mental status) indicating the resident was cognitively intact in ability to make daily life decisions. A review of the facility policy, "Medication Administration" was conducted. This policy documented, "Medications are administered in accordance with written orders of the attending physician." On 6/14/22 at 8:17 AM, LPN #5 (Licensed Practical Nurse).was observed to prepare and

Buspar (2) 10 mg, 1 tab Aspirin (3) 81 mg, 1 tab

administer the following medications for Resident

Methimazole (1) 5 mg (milligrams), 1 tab.

Magnesium Oxide (4) 400 mg, 1 tab

			ND HUMAN SERVICES			FO	TED: 06/28/202 DRM APPROVE NO: 0938-039
STAT	TEMENT	of deficiencies f correction	MEDICAID SERVICES (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
L			495109	B. WNG			C 06/15/2022
		ROVIDER OR SUPPLIER RELS OF UNIVERSITY PA	ARK	2	treet address, city, state, zip col 420 pemberton RD ICHMOND, VA 23233	E	
PI	(X4) ID REFL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	Provider's Plan of Co (Each Corrective action Cross-Referenced to the Deficiency)	N SHOULD BE APPROPRIATE	COMPLETION DATE	
ı	of the control of the	medications was cond physician's orders. An lidocaine 4% patch (5) morning was noted. It signed out for a lidocai being administered whadministered. On 6/14/22 at 12:40 Pheonducted with Resided they received their pain morning, they stated the promise of the refused to the promise of the surveyor. On 6/14/22 at 12:40 Pheonducted with LPN #5 medication. He refused tended doing anything whom the surveyor. On 6/14/22 at 12:45 PM reported to ASM #1 (Additember) the Administrate egional Director of Open 6/14/22 at 3:00 PM, and a stated that staff and cated with LPN #4 (purse) in regard to medically in regard to medically a stated that staff and cated with LPN #4 (purse) in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically in regard to medically, medicallons side in included the interver	M, reconcillation of the fucted compared with the order dated 9/8/21 for a to the left knee every was noted that LPN #5 ne patch to left knee as en it had not been If an interview was not #14 when asked if a patch on their knee this at they did not. If an interview was regarding the missed it to answer any questions, wrong and walked away If the above concern was ministrative Staff tor and ASM #4, the prations. In interview was Licensed Practical cation administration, should not sign out for the proof of the proof	F 759			

findings to the physician."

for ineffectiveness/side effects. Report abnormal

PRINTED: 06/28/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 495109 B. WING 06/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XII) MPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 759 Continued From page 170 F 759 On 6/15/22 at approximately 4:00 PM, ASM #1 (Administrative Staff Member), the Administrator, ASM #2, the Director of Nursing, and ASM #4, the Regional Director of Operations were made aware of the findings. No further information was provided by the end of the survey. References: (1) Methimazole - is used to treat hyperthyroidism Information obtained from https://medlineplus.gov/druginfo/meds/a682464.h tml (2) Buspar - Is used to treat anxiety Information obtained from https://medlineplus.gov/druginfo/meds/a688005.h tml (3) Aspirin - is used to treat paln, fever, prevent heart attacks and strokes Information obtained from https://medlineplus.gov/druginfo/meds/a682878.h (4) Magnesium Oxide - is used to treat indigestion Information obtained from https://mediineplus.gov/druginfo/meds/a601074.h bol (5) Lidocaine - is used to treat pain Information obtained from https://medlineplus.gov/drugInfo/meds/a603026.h

For Resident #96, the facility staff failed to ensure the resident was free of medication errors.

tml

	ENG FOR MEDICARE &		1		CIMD 14	U. 0830-038	
	ent of deficiencies N of correction	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X8) DATE SURVEY COMPLETED	
	49\$109 B. WING			04	C 06/15/2022		
NAME (OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7 10/2022	
			- 1				
THEL	THE LAURELS OF UNIVERSITY PARK			2420 PEMBERTON RD			
				RICHMOND, VA 23233			
(X4) K PREFI TAG	X (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	9E	(X6) COMPLETION DATE	
			1	DEFICIENCY)	_	1	
F 75	Resident #96 was adn 2/15/20. On the quark Set) with an ARD (Ass of 5/11/22, Resident #1 possible 15 on the BIM mental status) indicatin cognitively intact in abidecisions. The resider supervision for eating a for other areas of activity Administration" was condocumented, "Medicality accordance with written physician." On 6/14/22 at 6:28 AM, Practical Nurse) was obadminister the following #96:	nitted to the facility on erly MDS (Minimum Data essment Reference Date) 96 acored a 13 out of a 15 (brief interview for ag the resident was lity to make daily life at was coded as and extensive to total care ties of dally living. Policy, "Medication and action of the attending orders of the attending to orders of the attending the prepare and medications for Resident arograms) / 5 mcg inhaler grams), 1 tab	F 759				
	Risperdone (7) 0.5 mg, 1 Prednisone (8) 10 mg, 1						
	Senna (9) 8,6 mg, 1 tab	,s &	531	**		·	
	Acetaminophen (10) 325	mg, 1 tab	j		in .	ſ	
	Spiriva (11) 18 mcg						
	On 6/14/22 at 11:16 AM, medications was conduct physician's orders. An or Alaway (12) eye drops an	ed compared with the der dated 6/30/21 for					

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 06/28/20 RM APPROVI NO: 0938-03:
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		498109	8. WNG			C 6/15/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		W TOTALDZZ
THE LAU	RELS OF UNIVERSITY P	ARK		2420 PEMBERTON RD RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEPICIENCY)	IOULD BE	(XS) COMPLETION DATE
A no set to di for di min "A for	1/18/21 for Pepcid (13 that LPN #5 signed or being administered will administered will administered. On 6/14/22 at 12:40 P attempted with LPN #5 medication. He refuse and denied doing anyt away from the surveyor On 6/14/22 at 12:45 Placeported to ASM #1 (Almember) the Administr Regional Director of Open 6/14/22 at 3:00 PM conducted with LPN #4 Nurse) regarding medicated that staff should nedications that were refused one dated 5/12/1 trisk for abnormal blee by: medication use" The tervention dated 5/12/1 redications as ordered, affectiveness and side addings to the physician ated 7/22/21 was for "[I or constipation R/T: deciminished appetite, Hx edications side effects cluded the intervention deminister medications	B) were noted. It was noted at these medications as nen they had not been M an interview was bregarding the missed at to answer any questions hing wrong and walked at. M the above concern was administrative Staff ator and ASM #4, the perations. An interview was (Licensed Practical cation administration. She not sign out for not given. The care plan included an act for "Administer Observe for effects, report abnormal "Another care plan, Resident #96] is at risk reased mobility, (history) of constipation, "This care plan, dated 7/22/21 for as ordered and observe iffects. Report abnormal	F 759			

	RS FOR MEDICARE &				1	NO. 0938-039	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	91.35	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495109	B. WING_			C 6/15/2022	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD			
THE LAU	RELS OF UNIVERSITY PA	ARK		2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 759	(Administrative Staff M ASM #2, the Director of O Regional Director of O	mately 4:00 PM, ASM #1 lember), the Administrator, of Nursing, and ASM #4, the perations were made No further information was	F 7.	69			
	References:	ŧ					
1	(1) Dulera is used to tra Information obtained for https://medlineplus.gov tml						
- 1	and from https://medlineplus.gov/ tml	/druginfo/meda/a608035,h					
	heart attacks and stroke Information obtained fro						
i h	(3) Vitamin D3 is used to deficiency and to improven formation obtained from https://medlineplus.gov/o mi	e absorption of calcium	705				
o Ir	1	•					
(5	5) Giipizide is used for th	ne treatment of diabetes				1	

Information obtained from

https://medlineptus.gov/druginfo/meds/a684060.h

PRINTED: 06/28/2022

DEPARTMENT OF HEALTH AND HUMAN SERV	ICES
CENTERS FOR MEDICARE & MEDICAID SERV	ICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N (DENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		Δ				C	
		495109	8. WNG _		0	6/16/2022	
	PROVIDER OR BUPPLIER URELS OF UNIVERSITY PA	IRK		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX YAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPRICACE TO THE APPRICACE TO THE APPRICACE OFFICIENCY)	JLD BE	(XS) COMPLETION DATE	
. (1	tml (6) Genvoys is used for Information obtained from https://medilneplus.gov/tml (7) Risperdone is used schizophrenia, blpolar, Information obtained from https://mediineplus.gov/tml (8) Prednisone is used redness information obtained from https://mediineplus.gov/mi (9) Senna is used for the constipation information obtained from https://mediineplus.gov/mi (10) Acetaminophen is used information obtained from https://mediineplus.gov/cimi (11) Spiriva is used for the information obtained from https://mediineplus.gov/cimi (12) Alaway is used for the information obtained from https://mediineplus.gov/cimi (13) Alaway is used for the information obtained from https://mediineplus.gov/cimi (14) Alaway is used for the information of the eyes	or the treatment of HIV com //druginfo/meds/a612035.h to treat symptoms of and behavior, com //druginfo/meds/a694015.h to reduce swelling and ediruginfo/meds/a601102.ht eliteratment of m //druginfo/natural/652.html ised to treat mild to m //druginfo/meds/a681004.h eliteratment of COPD in ruginfo/meds/a604018.h eliteratment of allergy	F 75				
	nformation obt <mark>ein</mark> ed from https://medlineplus.gov/di						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			A. Boileant			С	
		495109	8. WNG _		06/15/2022		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAN	RELS OF UNIVERSITY PA	N D W	ĺ	2420 PEMBERTON RO			
THE LAU	NELS OF UNIVERSITY PA	ARR		RICHMOND, VA 23233		_	
(X4) ID		ATEMENT OF DEFICIENCIES	10 PROVIDER'S PLAN OF CORRECTION			(X8)	
PREFIX TAG		y must be preceded by full sc identifying information)	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI OBFICIENCY)		COMPLETION	
F 759	Continued From page	175	F 75	9			
	tml						
	(13) Papcid is used for ulcers Information obtained fr	r the treatment of reflux and					
		//druginfo/meds/a 887011.ht					
F 761	ml Label/Store Drugs and	Pielesissis	F 78	F761			
85=D			F /0	Critoria I]	
1	(0)(1)(1)	,,-,	1	Resident # 96 did receive all his medica	atione		
ŀ	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be			Medication Cart was locked and no me	dications		
			1	were left on top after nurse was relieved	I of duty		
	labeled in accordance oprofessional principles,		}	Criteria 2			
	appropriate accessory			All residents who have medications adm	ninistered et		
1	instructions, and the exapplicable.			the facility have the potential to be affect alleged deficiency.	ted by the		
1:	§483.45(h) Storage of [Drugs and Biologicals	J i	Criteria 3 Licensed nurses will be re-educated on	the		
- !	§483.45(h)(1) In accord	ance with State and	[.	Medication Administration policy, Licen	ised nurses		
		must store all drugs and	1	will have a medication pass audit comple	red		
		npartments under proper		<u>Criteria 4</u> DON/designoe or designee will complete	five (S)		
	personnel to have acces	nd permit only authorized as to the keys.	1	random audits of Medication carts to ens nedications are locked up appropriately	ure all		
5	483.45(h)(2) The facilit	y must provide separately		ind cart is locked. These audits will be c			
	ocked, permanently affi			lays a week for four weeks; Then one da or four weeks; then twice in the last mor			
		gs tisted in Schedule II of		or rour weeks; then twice in the last more sults will be forwarded to the QAPI cor			
	he Comprehensive Drug			or review. The committee will determine			
	Control Act of 1976 and	other drugs subject to. facility uses single unit	f	or further audits or actions.	'		
	ackage drug distribution			Criteria S			
		and a missing dose can	0.0	Criteria 5 Date of compliance is 7/26/22.			
b	e readily detected.			venightenies is traviasi	1		
by	his REQUIREMENT is y:	not met as evidenced				1	
		taff interview, and facility			}		
		j	- 1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			1				¢
		495109	B. MNG			0	6/15/2022
NAME OF	Provider or supplier			ľ	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAL	IRELS OF UNIVERSITY PA	ARK			2420 PEMBERTON RD		
				_	RICHMOND, VA 23233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	REMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	(D PREFL TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 761	Continued From page document review, it we facility staff falled to er	as determined that the	F	761			
		ecure manner on one of 3					
	The findings include:						
	unit, LPN #5 left a bottl	ninistration on the Jefferson e of Folic Acid on top of the in Resident #96's room, of sight.					
1		rly MDS (Minimum Data essment Reference Date) 6 scored a 13 out of a 5 (brief interview for 9 the resident was					
	inhaler. LPN #5 then be medications for Residen resident's Dulera (1) and t was noted that while L Resident #96, a bottle of op of the medication car ine of sight of LPN #6 wiles of room. A staff membass by the cart with the nedication on top.	served preparing erson unit. A CNA ant) came and reported #96 was asking for their gan to prepare t #96, by first pulling the I taking it to the resident. PN #5 was in the room of Folic Acid (2) was left on t, with the cart out of the hille he was in Resident ther was observed to unsupervised			·		÷.
1 -	on 6/14/22 at 12:40 PM i ttempted with LPN #5 re						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/28/2022

	TMENT OF HEALTH AIRS FOR MEDICARE &						MAPPROVED O. 0938-0391
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		(X3) DAT	E BURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			COM	IPLETED
l		496109	B. WNG_				C
NAME OF I	PROVIDER OR SUPPLIER	430103	10:11:10	STREET ADDRESS, CITY, STATE, ZIP	CODE	U	1/16/2022
			- 1	2420 PEMBERTON RD			
THE LAU	IRELS OF UNIVERSITY PA	ARK	-	RICHMOND, VA 23233			_
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN O			(NS) COMPLETION
PREFIX TAG		BC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPRIA		DATE
	ļ			DEFICIEN	NCY)		
F 761	 Continued From page	. 477	F 76				
	, ,	ed to answer any questions,	F 76	21			
		wrong and walked away		1			
	from the surveyor.						Í I
	On 6/14/22 at 12:45 P	M the above concern was					
185	reported to ASM #1 (A		ĺ				
	Member) the Administr]
	Regional Director of O	parations,					
1	On 6/14/22 at 3:00 PM	, an interview was					ŀ
	conducted with LPN #4	•	1				
		at staff should not leave a					
1	of it when the cart is un	ed and medications on top	1				
i		,		}			
	The facility policy, "Med						
	was reviewed. This poleure that the medication	ncy documented, "make n cart is locked at all times					1
1	when it is not in use or i		1				1
	vision, Store the locked						1
	appropriate storage are The policy did not addre	a between med passes."					
		of the cart, unsupervised.				- 1	
			1	}			
	On 6/15/22 at approximate of the Staff Manager of t	ately 4:00 PM, ASM #1 mber), the Administrator,					
, , , , , , , , , , , , , , , , , , ,		Nursing, and ASM #4, the		:			
	Regional Director of Ope		1				
		o further information was	İ				
P	rovided by the end of the	ne survey.				ļ	
R	teferences:				* *		
(1	1) Dulere is used to trea	it asthma and COPD					
	nformation obtained from						
	ttps://medlineplus.gov/d nt	lruginfo/meds/a602023.h					
	nd from]				
1		ruginfo/meds/a608035.h					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
100			A. BUILDIN	NO		C	
		496109	B. WNG_		l of	08/15/2022	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1		
			- 1	2420 PEMBERTON RD			
THE LA	JRELS OF UNIVERSITY PA	RK	- 1	RICHMOND, VA 23233			
(X4) ID	RIBINARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL P		PREFIX TAG		ON SHOULD BE COMPLETE DATE		
F 761	- Contained I tom page	178	F 70	81			
	tmi		1				
	(2) Fotic Acid is used to healthy new cells. Information obtained in https://medlineplus.gov	om		F812			
	CFR(s): 483.60(i)(1)(2)		F 81	Criteria 1 Upon notification from surveyor regularity failing to properly store plast the dry good area, the facility immed	c scoops in		
	§483.60(i) Food safety The facility must -			the scoops correctly. When they surv improper storage of frozen food, the immediately corrected the issue, and	yor identification	ed	
	§483.60(i)(1) - Procure approved or considered state or local authorities	satisfactory by federal,		expired milk was identified by the suiting immediately discarded.		•	
ĺ	and local laws or regula (ii) This provision does r	ibject to applicable State tions. not prohibit or prevent		Criteria 2 All residents who are served meals at have the potential to be affected by the deficiency. Audit completed to ensure	alleged		
	facilities from using proc gardens, subject to com			with the alleged deficiency.			
	safe growing and food-h			Criteria 3			
1	(iii) This provision does r	not preclude residents		Dietary staff will be re-educated on pr	per storage	i	
	from consuming foods n	ot procured by the facility.		of plastic scoops in dry goods areas, p of frozen foods, and ensuring milk is t			
	§483.60(I)(2) - Store, pre			when expired.			
	serve food in accordance standerds for food service			Criteria 4			
	STANDARDS FOR 1000 SERVICE This REQUIREMENT is			Dietary Manager or designee will com		1	
	Dy:	LIST HEE BY GAMELICES		of the kitchen to ensure plastic scoops	re stored		
		taff Interview, and facility		properly in dry goods areas, frozen foo properly and the expiration dates on m			
	focument review it was o			audits will be done 5 days a week for fi		•	
	ailed to store food in one			then one day a week for four weeks; the	n twice in		
	eccordance with profession in the profession in the second section in the second secon	onal standards for food		the last month. The results will be forw QAPI committee for review. The comm	ittee will		
],	he findings include:	}		determine the need for further audits an	nor action.		
Ι,	ne mungs naude.			Criteria 5 Date of compliance is 7/26/22.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A SUILDING		
			C			
495109			B. WING		06/15/2022	
	F PROVIDER OR SUPPLIER AURELS OF UNIVERSITY PA	ARK	24	REET ADDRESS, CITY, STATE, ZIP CODE 20 PEMBERTON RD CHMOND, VA 23233		
(X4) IC PREFU TAG	((EACH DEFICIENC)	Atement of Deficiencies y must be preceded by full sc identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ON
	The facility falled to print the dry good area, pavallable for use froze freezer, and discard min the walk in refrigera. On 6/13/2022 at 10:44 made of the facility kitch member) #11, the dieta the dry goods area revious. One of the plastic and was approximately scoop was located inside the salt. Another plastic the salt. Another plastic milk" was observed to be A plastic gallon sized zich observed laying on top plastic scoop sitting on air. OSM #11 stated the supposed to be stored in ot in use and should not in use and sh	operly store plastic scoops properly store opened, in foods in the walk in floods in the walk in ilk past it's expiration date for. a.m., an observation was then with OSM (other staff ary aide. Observation of saled three 18 quart plastic to bins was labeled "Salt" of 1/2 full. A blue plastic de the bin reating on top of the bin reating on top of the bin labeled "Powdered the approximately 3/4 full, poer closure bag was of the lid to the bin with a top of the bag exposed to at the plastic scoops were in the plastic bags when the bin touching the food at that the plastic scoops to keep them clean. In plastic scoops were not expect to the plastic scoops were not expect them clean. In plastic scoops were not expect the plastic scoops were not expect them clean. In plastic scoops were not expect the plastic scoops were not expect them clean. In refrigerator revealed a roximately 1/4 full with a secontainer of "Jun 08." date meant that it should have been seed that it was available	F 812			
	Observation of the waik is labeled as french petit rol plastic bag in the box was	Is-unbaked. The inner				

P. 182/185

PRINTED: 06/28/2022 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING 405100 B. WING 06/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD THE LAURELS OF UNIVERSITY PARK RICHMOND, VA 23233 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (KS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LOC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY F 812 Continued From page 180 F 812 approximately 3/4 full and open with rolls exposed to air. One 3.5 lb bag of hashbrown patties was observed to be opened with hashbrowns exposed to air. One 3 ounce bag in a 10 pound box of battered pollock wedges was observed to be approximately 1/4 full with pollock wedges exposed to air. OSM #11 stated that products in the freezer should be dated and closed in plastic wrap after opening to keep them fresh. OSM #11 stated that it appeared someone had dated the products but had not closed the bags like they were supposed to. The facility policy "Food purchasing and storage" dated 8/1/2011 documented in part, "...Dry Storage: ... Containers with tight fitting covers or sealed plastic bags will be use for storing foods that have been removed form their original container. Scoops will be provided for items stored in bulk, kept covered near the containers and sanitized at least daily...Perishable Food Storage:...All frozen food will be dated, labeled and wrapped or sealed. Moisture-proof, tight-fitting materials will be used to prevent freezer burn..." On 6/14/2022 at 4:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the southside regional clinical coordinator, and ASM #4, the regional director of operations were made aware. of the findings, No further information was provided prior to exit.

CFR(s): 483,95(g)(1)-(4)

Required in-Service Training for Nurse Aides

§483.95(g) Required in-service training for nurse

F 947

SS=D

F 947

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495109		495109	B. WING			С			
l I		PROVIDER OR SUPPLIER	-		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 PEMBERTON RD RICHMOND, VA 23233	06	/16/2023	
PI	(4) ID REFIX TAG	(EACH DEFICIENCY	Tement of Deficiencies Must be preceded by Full BC identifying information)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ASS COMPLETED C O6/15/2022 Y, STATE, ZIP CODE ASS PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) facility suffered no adverse I to CNA #7 and #8 allegedly set their annual abuse and dementia appleted their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and set their annual abuse and dementia feeted by the alleged deficiency. The complete audits of CNAs dementia training. These audits are aweek for four weeks; then or four weeks; then twice in the results will be forwarded to the for review. The committee will defor further audits and/or action.		
	t tall the state of the state o	\$483.95(g)(2) Include of training and resident ab \$483.95(g)(3) Address a determined in nurse aid and facility assessment address the special need determined by the facility \$483.95(g)(4) For nurse to individuals with cognition address the care of the office and the second staff interview eview, it was determined in sure two of five CNAs in dementia and abuse, (a) the findings include: ive CNA employee reconcurrentation of their and dementia. On 6/13/20, a) the request was reasining in abuse and dementia and demential and abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse and demential abuse abuse and abuse	ient to ensure that of nurse aldes, but must resper year. Idementia management ruse prevention training. Breas of weakness as es' performance reviews at § 483.70(e) and may do of residents as y staff. In aldes providing services rive impairments, also cognitively impaired, and employee record do the facility staff failed to had their annual training CNA #7 and CNA #8. In the complete reviewed for an and employee record do the facility staff failed to had their annual training CNA #7 and CNA #8. In the complete reviewed for an and employee record do the facility staff failed to had their annual training the annual reaining in abuse to the annual reaining for CNA #7 and end on 9/2/2020 and CNA 1.	F		Criteria 1 Residents in the facility suffered no adveroutcomes related to CNA #7 and #8 alleg failing to complete their annual abuse and training. CNA's have completed their annual abuse dementia training. Criteria 2 All residents who are cared for by CNAs potential to be affected by the alleged defix An audit was completed to ensure complist the alleged deficient practice. Criteria 3 CNA's will be re-educated on completing annual abuse and dementia training. Criteria 4 HR and/or designee will complete audits of annual abuse and dementia training. These will be done 5 days a week for four weeks; one day a week for four weeks; then twice last month. These results will be forwarded QAPI committee for review. The committee determine the need for further audits and/or Criteria 5 Date of compliance is 7/26/22.	edly dement and nave the ciency. ance with their f CNAs audits then in the to the e will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		406470				С		
NAME OF PROVIDER OR SUPPLIER			B. WING	\$ TREET ADDRESS, CITY, STATE, ZIP CODE			06/15/2022	
	RELS OF UNIVERSITY PA	ARK	=	,	2420 PEMBERTON RD RICHMOND, VA 23233			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B REGULATORY OR LBC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			COMPLETION DATE				
a se se se se se se se se se se se se se	2:34 p.m. A third requed documentation of army training for CNA #7 and (administrative staff me administrative staff me administrator, stated the evidence of annual traindementia for CNA #7 a An interview was condupractical nurse) #8, the nursing, on 6/15/2022 at the process for ensuring annual required educational dust started two days that the facility goes the staff member just stated calendar for educations, also has an on-line education and the education and the education when the education are assigned education when the core conditions are assigned education on the core and demential that the regional conditions and demential that is the education of the CNAs and discoumentation trainings. SM #1, ASM #2, the diff, the regional clinical core regional director of operations and director of operations and director of operational director of operations and director of operational director of operations.	meeting on 6/15/2022 at set was made for the set was made for the set was made for the set was made for the set was made for the set was made in the ASM ember) #1, the efacility did not have ning in abuse and nd CNA #8. Interest with LPN (licensed assistant director of it 3:20 p.m. When asked it the staff receive their ons, LPN #8 stated she is ago. Her understanding through in-services. Every abuse and dementia she is developing a LPN #8 stated the facility cation program where the stions that are due the abuse and dementia is on-line education or provide documentation is education for abuse of the on-line training for in the on-line tr	FE	347				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
498109			B. WING			C	
141	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COO 2420 PEMBERTON RD RICHMOND, VA 23233		06/15/2022	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION COMPLETION CATE	
F 947	the director of nursing, facility did not have a partrainings.	p.m. ASM #1 and ASM #2, informed the surveyors the policy on annual mandatory	F 94	17			
	No further information (was provided prior to exit.					
\$.			•				