STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375531	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Village Retirement Community	8555 South Lewis Avenue Tulsa, OK 74137

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 34270 Based on record review and interview, the facility failed to inspect a hospice supplied bed for safety prior to use by a resident for one (#1) of three sampled residents reviewed for bed safety. The administrator identified 68 residents resided at the facility. Findings: A facility policy titled Bed Safety and Bed Rails, dated March 2023, read in part, Bed frames, mattresses, and bed rails, are checked for compatibility and size prior to use. Resident #1 had diagnoses which included a history of falling. A progress note, dated 10/21/24 at 10:48 p.m., documented the resident was found on the floor next to the bed. The resident's neck was resting on the bed rails and legs were on the ground. On 10/28/24 at 9:58 a.m., Resident #1's representative stated the incident occurred when the headboard separated from the frame of the bed. On 10/28/24 at 10:26 a.m., Maintenance #1 stated they thought they performed bed inspections quarterly and when something malfunctioned. They stated they did not inspect hospice supplied beds when they were brought into the facility. They stated they did not call call them when they set up the beds. They stated when the incident with Resident #1 occurred they did look at the bed, but it was already in the hallway and was broken. On 10/28/24 at 11:34 a.m., Resident #1 stated they recalled the bed incident. They stated their head was never stuck in the bed rail. The stated the bed broke on one side and they slid from the bed and landed on their knees with their head resting against the mattress and bed rail. They stated they would have gotten up, but they had been too weak. They stated there was no injury from that incident they recalled. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 12:15 a.m., the ADON stated when the bed had broken the resident's neck had been resting on the side rail on the left side of the bed and their legs were on the floor mat. They stated the resident did have small skin tear on their neck where it rested against the side rail. They stated they were not sure when bed inspections were done, but did know they should be done prior to use by a resident. They stated that was policy.