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	12/05/2024

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 35474 Based on observation, record review, and interview, the facility failed to ensure privacy was provided during urinary catheter care for one (#2) of two sampled residents who were reviewed for urinary catheters. The staff engagement coordinator identified six residents who had urinary catheters. Findings: The Catheter Care, Urinary policy, dated August 2022, read in part, Provide privacy. Resident #2 had diagnoses which included obstructive and reflux uropathy. A physician's order, dated 09/06/24, documented the resident had an indwelling urinary catheter and staff were to provide catheter care every shift. On 12/04/24 at 10:13 a.m., CNA #1 and LPN #1 were observed to provide catheter care to Resident #2 with the resident's roommate in the room in their bed. The privacy curtain was observed to be open and not closed between Resident #2 and their roommate during the catheter care. On 12/04/24 at 2:07 p.m., CNA #1 stated they were to close the privacy curtains during personal care, but had not noticed Resident #2's roommate was in the room. On 12/04/24 at 2:18 p.m., LPN #1 stated they were to close the privacy curtains during care, but was in a rush and had not closed it during the catheter care for Resident #2. On 12/04/24 at 3:32 p.m., the DON stated staff were to close privacy curtains during personal care.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 41220 Based on observation, record review, and interview, the facility failed to ensure medications were secured in locked medication carts for two (#1 and #2) of seven medication carts observed. The administrator identified 72 residents resided in the facility. Findings: A Storage of Medications policy, dated 10/2024, documented drugs and biologicals used in the facility were stored in locked compartments. On 12/03/24 at 3:08 p.m., medication cart #1 on bluebird hall, outside of room [ROOM NUMBER], was observed to be unlocked. No staff were in view of the cart . On 12/03/24 at 3:17 p.m., medication cart #2, located in the hallway outside of room [ROOM NUMBER], was observed to be unlocked. On 12/03/24 at 3:18 p.m., RN #1 removed a medication from medication cart #1 and went into room [ROOM NUMBER]. The cart remained unlocked. On 12/03/24 at 3:20 p.m., RN #2 was observed to move medication cart #2 to several different rooms, remove medication and enter the room, leaving the cart in the hallway unlocked and unattended each time. On 12/03/24 at 3:32 p.m., RN #1 returned to the unlocked cart to chart. When asked about the unlocked cart, RN #1 locked the cart and stated the medication cart should be locked when not in use. On 12/03/24 at 3:35 p.m., the DON stated medication carts should be locked when unattended. On 12/03/24 at 3:42 p.m., the DON locked medication cart #2.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35474 41809 Based on observation, record review, and interview, the facility failed to ensure meals were palatable for three (#22, 47 and #54) of three residents who were reviewed for food palatability. The staff engagement coordinator identified 71 residents who received nourishment from the kitchen. Findings: A Food and Nutrition Services policy, revised October 2017, read in part, Food and nutrition services staff will inspect food trays to ensure that the .food appears palatable and attractive, and it is served at a safe and appetizing temperature. On 12/02/24 at 11:05 a.m., a hotbox arrived to the satellite kitchen for the [NAME] hall. Food was removed from the hotbox and placed on the steam table. On 12/02/24 at 11:11 a.m., DA #1 was observed to obtain temperatures of the food. The carrots and green beans were observed to be under holding temperature at 128 degrees Fahrenheit. The food temperatures were not obtained again prior to plating at 11:30 a.m. On 12/02/24 at 11:49 a.m., Resident #22 stated lunch was cold. On 12/02/24 at 2:17 p.m., Resident #54 stated the food was not hot in dining room. On 12/02/24 at 3:29 p.m., Resident #47 stated the food was good, but sometimes it was not hot. On 12/03/24 at 3:50 p.m., DA #2 was observed to plate food. The DA was not observed to obtain temperatures of the food. DA #2 stated they were plating the hall trays to serve them first. They stated food temperatures were taken in the kitchen. On 12/04/24 at 2:42 p.m., a test tray was received from the hall cart. The food was observed to be without flavor and not served at a palatable temperature. On 12/04/24 at 3:53 p.m., the DM stated temperatures of the food were taken once the food was cooked. They stated food was then panned and placed in the hotbox before taken to the satellite kitchens, where the temperatures should be obtained again prior to serving.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41809 Based on observation, record review, and interview, the facility failed to ensure foods were served in a sanitary manner in two of two dining areas. The staff engagement coordinator identified 65 resident who ate food in the dining rooms. Findings: A Food Handling policy statement, revised July 2014, read in part, Food will be .served so that the risk of foodborne illness is minimized. On 12/02/24 at 11:17 a.m., in the satellite kitchen on [NAME] hall, DA #1 was observed to pour ice from a large scoop into multiple glasses and used their gloved hand to guide the ice into the cups. DA #1 was observed to have touched multiple objects prior to guiding the ice with their gloved hand without doffing and sanitizing between. On 12/02/24 at 11:32 a.m., DA #3 was observed to deliver meals to two residents without changing their gloves or sanitizing their hands. DA #3 was observed to touch the counter, residents, and themselves between meals. They placed the drinks on the table by handling the top rim of the cup. On 12/02/24 at 12:05 p.m., a family member of a resident eating in the dining room on [NAME] hall requested the resident's food be heated in the microwave. On 12/02/24 at 12:05 p.m., DA #3 doffed their gloves, left the dining room and entered the satellite kitchen, while not wearing a hair net, rinsed their hands in the sink, dried their hands, and re-entered the dining room and donned gloves. On 12/03/24 at 4:41 p.m., CNA #2 and CNA #3 repositioned a female resident in their geri-chair. On 12/03/24 at 4:42 p.m., CNA #2 handed a drink to a resident. They were not observed to sanitize their hands after repositioning the female resident in their chair. CNA #2 was observed to leave the dining room to find the other aide. On 12/03/24 at 4:46 p.m., CNA #3 passed a tray without being observed to sanitize their hands between. On 12/03/24 at 4:50 p.m., CNA #4 entered the dining room and they did not sanitize their hands before delivering a tray to a male resident. CNA #4 was then observed to serve another resident a meal plate and had not sanitized their hands. On 12/03/24 at 4:52 p.m., CNA #4 was observed to cut the food for a resident and did not sanitize their hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/04/24 at 2:27 p.m., CNA #5 stated they sanitized before and after but not in-between passing meal trays. They stated they wore gloves to make sure they are not touching food. CNA #5 stated the cups were placed by the top of the cup due to ease of handling. On 12/04/24 at 4:20 p.m., the DON stated staff were to pick cups up from the side. They stated staff do wear gloves for passing meal trays, but were to change the gloves if they touched residents or anything.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35474 Based on record review and interview, the facility failed to ensure records were accurate for one (#21) of five sampled residents who were reviewed for unnecessary medications. The administrator identified 74 residents who resided in the facility. Findings: Resident #21 had diagnoses which included anxiety, depression, and atrial fibrillation. A physician's order, dated 02/19/24, documented staff were to monitor Resident #21 for side effects related to antidepressant medication and to chart in the progress notes if they documented yes that the resident had side effects. A physician's order, dated 02/19/24, documented staff were to monitor Resident #21 for side effects related to anticoagulant medication and to chart in the progress notes if they documented yes that the resident had side effects. A physician's order, dated 10/14/24, documented staff were to monitor Resident #21 for side effects related to antianxiety medication and to chart in the progress notes if they documented yes that the resident had side effects. The October 2024 TAR documented the following side effect monitoring results: a. from 10/14/24 through 10/31/24, Resident #21 had side effects related to antianxiety medication use 22 times out of 53 opportunities; b. from 10/01/24 through 10/31/24, Resident #21 had side effects related to anticoagulant medication use 23 times out of 93 opportunities; and c. from 10/01/24 through 10/31/24, Resident #21 had side effects related to antidepressant medication use 25 times out of 93 opportunities. The November 20104 TAR documented the following side effect monitoring results: a. from 11/01/24 through 11/30/24, Resident #21 had side effects related to antianxiety medication use 24 times out of 90 opportunities; b. from 11/01/24 through 11/30/24, Resident #21 had side effects related to anticoagulant medication use 18 times out of 90 opportunities; and c. from 11/01/24 through 11/30/24, Resident #21 had side effects related to antidepressant medication use 20 times out of 90 opportunities. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2024 TAR documented the following side effect monitoring results: a. from 12/01/24 through 12/04/24, Resident #21 had side effects related to antianxiety medication use three times out of ten opportunities; b. from 12/01/24 through 12/04/24, Resident #21 had side effects related to anticoagulant medication use two times out of ten opportunities; and c. from 12/01/24 through 12/04/24, Resident #21 had side effects related to antidepressant medication use two times out of ten opportunities. Review of the progress notes did not reveal documentation the resident had experienced side effects related to antianxiety, anticoagulant, or antidepressant medication use. On 12/04/24 at 12:24 p.m., LPN #1 stated the charge nurses monitored for medication side effects. They stated they documented on the TAR and if they documented yes to the question about side effects, they were to document in a progress note. LPN #1 stated Resident #21 had not experienced any medication side effects. They reviewed the electronic clinical record and stated they had documented yes to indicate they had monitored for side effects not to indicate the resident had experienced medication side effects. On 12/04/24 at 3:28 p.m., the DON stated the TARs were monitored for medication side effects by the ADON, consultant nurse, pharmacist, and themselves. They stated Resident #21 had not experienced any medication side effects. On 12/04/24 at 4:03 p.m., the DON stated they had reviewed the TARs for Resident #21 and stated they had noticed the documented side effects for antianxiety, anticoagulant, and antidepressant medications. They stated they needed to provide education to ensure accurate documentation of medication side effect monitoring.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 35474 Based on record review and interview, the facility failed to ensure arbitration agreements contained language residents and/or resident representatives could rescind the agreement within 30 days of signing and signing the agreement was not a condition of admission for three (#20, 38, and #120) of three sampled residents who were reviewed for arbitration agreements. The administrator identified 56 residents who had signed an arbitration agreement. Findings: 1. Resident #20 had diagnoses which included congestive heart failure. Review of the Health Center Long Term Care or Respite Care Agreement revealed the resident signed an arbitration agreement on 02/13/24. 2. Resident #38 had diagnoses which included congestive heart failure. Review of the Health Center Long Term Care or Respite Care Agreement revealed the resident's representative signed an arbitration agreement on 05/28/24. 3. Resident #120 had diagnoses which included unspecified dementia. Review of the Skilled Nursing Facility Agreement revealed the resident signed an arbitration agreement on 12/02/24. Review of the admission packet revealed an arbitration agreement. The arbitration agreement was not observed to contain language granting the resident and/or the resident representative the right to rescind the agreement within 30 days of signing it. The arbitration agreement did not contain language the resident and/or the resident representative was not required to sign the arbitration agreement as a condition of admission to the facility or as a requirement to continue to receive care at the facility. On 12/04/24 at 5:09 p.m., the administrator stated they were relatively new to the facility and would need to consult with a staff member who had been employed longer to gather information about the arbitration agreement. On 12/05/24 at 10:05 a.m., the administrator stated they did not know why the arbitration agreement did not include language the resident and/or resident representative could rescind the agreement within 30 days of signing or why the arbitration agreement did not inform the resident and/or the resident representative of their right not to sign the agreement as condition of admission to the facility.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 35474 Based on record review and interview, the facility failed to ensure arbitration agreements contained language which indicated a neutral arbitrator would be utilized and the arbitration would take place at a venue convenient to both parties for three (#20, 38, and #120) of three sampled residents who were reviewed for arbitration agreements. The administrator identified 56 residents who had signed an arbitration agreement. Findings: The admission packet contained the following document which read in part, 8. Arbitration .such Dispute be settled by arbitration, which shall be conducted in Tulsa County, OK in accordance with [company name withheld] Rules of Procedure for Arbitration. The arbitration agreement did not indicate a neutral arbitrator would be utilized. 1. Resident #20 had diagnoses which included congestive heart failure. Review of the Health Center Long Term Care or Respite Care Agreement revealed the resident signed an arbitration agreement on 02/13/24. 2. Resident #38 had diagnoses which included congestive heart failure. Review of the Health Center Long Term Care or Respite Care Agreement revealed the resident's representative signed an arbitration agreement on 05/28/24. 3. Resident #120 had diagnoses which included unspecified dementia. Review of the Skilled Nursing Facility Agreement revealed the resident signed an arbitration agreement on 12/02/24. On 12/04/24 at 5:09 p.m., the administrator stated they were relatively new to the facility and would need to consult with a staff member who had been employed longer to gather information about the arbitration agreement. On 12/05/24 at 10:05 a.m., the administrator stated they did not know why the arbitration agreement did not include language that a neutral arbitrator would be utilized or that the selection of a venue would be convenient to both parties.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35474 41809 Based on observation, record review, and interview, the facility failed to ensure catheter tubing was maintained to prevent infection for two (#2 and #27) of two residents who were reviewed for catheter infection prevention. The staff engagement coordinator identified six residents who had catheters. Findings: The Catheter Care, Urinary policy, dated August 2022, read in part, Be sure catheter tubing and drainage bag are kept off the floor. 1. Resident #2 had diagnoses which included obstructive bladder. On 12/02/24 at 3:22 p.m., Resident #2 was observed to be in bed with their catheter tubing on the fall mat. On 12/03/24 at 8:52 a.m., Resident #2 was observed in their wheelchair in their room with their catheter tubing on the floor. On 12/04/25 at 10:13 a.m., Resident #2 was observed in their bed with their catheter bag and tubing on the floor. On 12/04/24 at 10:27 a.m., CNA #1 covered Resident #2, lowered the bed, and placed the fall mat. The resident's catheter tubing was observed to touch the fall mat. 2. Resident #27 had diagnoses which included neurogenic bladder. A Physician's Order, dated 08/19/24, documented to maintain and monitor suprapubic catheter with bedside drainage bag and cover with dignity bag. A Care Plan, revised 11/13/24, documented Resident #27 was at risk for urinary tract infection related to a history of UTIs and suprapubic catheter. On 12/02/24 at 3:35 p.m., the catheter tubing was observed to hang below the wheelchair of Resident #27 and touch the floor. On 12/04/24 at 4:18 p.m., CNA #1 stated the catheter bag and tubing were always below the bladder and they placed it on the side of the bed. They stated the catheter bag and tubing should not be on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at 4:20 p.m., the DON stated the catheter bag should be placed on the bed frame and below the bladder to maintain infection control. They stated staff were educated to not lay the catheter bag on the floor and they would need to implement a way to keep the tubing off the floor.