OKLAHOMA
State Department
of Health

Delivery via email to: RAlsup@uvrc.com

May 10, 2022

License Number: AL7214

Mr. Ryan Alsup
University Village Retirement Community
8555 South Lewis Avenue
Tulsa, OK 74137

Survey Event ID: VXXZ11

Dear Mr. Alsup:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **April 4, 2022**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.05.10 08:21:00 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **University Village Retirement Community**
Address: **8555 South Lewis Ave.**
City, State, Zip: **Tulsa, OK. 74137**
Provider #: **AL7214**
Complaint #: **OK00058590**
Investigation Date(s): **03/31/22 and 04/04/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered as per physician's orders	**US**
2. The center failed to ensure call lights were answered in a timely manner.	**US**
3. The center failed to ensure residents were treated with dignity and respect.	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, March 31, 2022 at 10:00.

A sample of three residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.
A nursing tour of the facility was conducted upon arrival and throughout the survey.
Facility staff were observed to perform assessments, provide timely assistance, and pass medications.
Residents were observed clean, groomed, well dressed, and generally requiring minimal assistance with activities of daily living.

Residents were interviewed and stated they received their medication as ordered by the physician. The residents stated they were able to purchase medications from their preferred pharmacy. Residents stated a family member would pick up the medication or the pharmacy would deliver the medication to the facility.

Facility staff were interviewed and stated they had some difficulty with timely reordering with their preferred pharmacy provider and had recently changed providers to help resolved the issue. The facility staff stated the residents were responsible for their own medical and pharmaceutical expenses. They stated with the residents able to choose their own physician and their own pharmacy, the facility attempted to refill medications a week before the resident was to be out but had no control over external issues such as prescription renewal or pharmacy payment.

Sampled residents' clinical records were reviewed and documented the residents were offered and received their medications or utilized their right to refuse their medications. There was documentation of delays in receiving medications due to delayed payment to the pharmacy for the medication from resident or family. There was documentation of delays in receiving medication related to resident's personal physician not responding to refill requests in a timely manner.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.
A nursing tour of the facility was conducted upon arrival and throughout the survey.
Facility staff were observed to perform assessments, provide timely assistance, and pass medications.
Residents were observed clean, groomed, well dressed, and generally requiring minimal assistance with activities of daily living.

Resident were interviewed and stated they received timely assistance with activities of daily living. One resident stated she had a concern with timely assistance one weekend several weeks back but verbalized her concern with the administrator and felt the issue was corrected.

Facility staff were interviewed and stated they attempted to provide everyone with timely care. They stated there were occasional delays with a resident's care due to unforeseen circumstances like a resident with injury requiring extended care until transferred to the emergency room.

Administration was interviewed and stated they worked hard to ensure there was enough staff to provide timely care, to include utilizing agency staff to ensure coverage.

The sampled residents' clinical records were reviewed and documented the residents received care based on their contract of service. The records documented any concerns related to timely care brought to the attention of the facility were addressed.

Staffing sheet were reviewed and documented daily coverage of shifts.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.
A nursing tour of the facility was conducted upon arrival and throughout the survey.
Facility staff were observed to perform assessments, provide timely assistance, pass medications, and generally interact with residents in a respectful manner. Residents were observed clean, groomed, well dressed, and generally requiring minimal assistance with activities of daily living.

Residents were interviewed and stated the facility staff treated with dignity and respect.

Facility staff were interviewed and stated they treated all residents with dignity and respect.
The administrative staff were interviewed and stated they monitored and trained to ensure staff treated residents with dignity and respect. They stated any concerns residents or families brought to the attention of the facility was investigated and addressed.

Sampled residents' clinical records were reviewed and documented any concerns brought to the attention of the facility were investigated and addressed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegations one, two, and three. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

B. Garrison, R.N.

B. Garrison, R.N.

Date report completed: 04/11/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7214	A. BUILDING: _____ B. WING _____	04/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY VILLAGE RETIREMENT COMMUNITY	8555 SOUTH LEWIS AVENUE TULSA, OK 74137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00058590) was conducted from 03/31/22 through 04/04/22. No deficiencies were cited.	C 000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE