Oklahoma State Department of Health
Creating a State of Health

October 21, 2019

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Bouldvard
Grove, OK 74344

Survey Event ID: 8LRQ11

Dear Ms. Fanning:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **September 24, 2019**. 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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Grandwood Assisted Living**
Address: **2001 Sunrise Boulevard**
City, State, Zip: **Grove, OK, 74344**
Provider #: **AL2103**
Complaint #: **OK00054343**
Investigation Date(s): **09/23/19 and 09/24/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to protect and ensure the safety of the residents.	**US**

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

An unannounced on-site investigation was initiated on 09/23/2019 at 3:10 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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.

An investigation specific to residents' safety was conducted.

The assisted living had three exits available to exit or enter the building with a coded key pad and door alarms at each exit. The focus care area had three exits available to exit or enter the building with a coded key pad and door alarms at each exit. The memory care had two exits available to exit or enter the building with a coded key pad and door alarms at each exit. A sign in/out book was placed at the main entrance in the assisted living entry.

The administrator stated one of the residents was oriented to person and place, confused to time, and had tried to find her husband who had been deceased for at least ten years. She stated the resident was placed in the

memory care unit during waking hours and allowed to sleep in her focus care apartment with documented visual checks every 15 minutes. The administrator stated another resident was oriented to person and was forgetful. During an outing the resident exited the event building with an unknown male. The resident is not permitted to participate in group outings unless her family was in attendance or the family provided a sitter for her. The administrator stated a different resident was alert to person, place, time, and situation, and had the ability to drive her own car. She spent the night away from the center and had not notified the staff. The resident has been required to sign in and out as she exited and returned to the center and she communicated verbally with the staff the time she planned on returning to the center.

The center had submitted the required missing person incident report for three different incidents. At night while the resident was in her focus care apartment every 15 minute visual checks were documented. Another resident has not participated in any outings. A different resident communicated with the staff her expected time to return to the center and she signed the log when she exited and returned to the center.

At the time of the investigation, there was no deficient practice related to resident's safety.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. 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 state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Lisa McWhorter, BSN, RN for

Denise Owen, RN

Date report completed: 09/25/2019

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
	AL2103	A. BUILDING: _____ B. WING _____	C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

(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 An abbreviated survey was conducted on 09/23/19 and 09/24/19 to investigate complaint #OK00054343. Current census was 79. No deficient practice was cited.	C 000		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2103	GRANDWOOD ASSISTED LIVING, LC

Type of Survey (select all that apply)

3				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 35195	09/23/2019	09/24/2019	0.75	0.00	5.50	0.00	4.50	3.50
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3.								
4.								
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6.								
7.								
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9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

OCT 2 2 2019 jm