OKLAHOMA
State Department
of Health

Delivery via email to: ed@grovemidtown.com

August 24, 2021

License Number: AL7216

Ms. Jennifer Braun, Administrator
The Grove At Midtown Senior Living
5211 South Lewis Avenue
Tulsa, OK 74105

Survey Event ID: 9M9I11

Dear Ms. Braun:

On **August 16, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance

under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may <u>not</u> use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

OKLAHOMA
State Department
of Health

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Grove at Midtown Senior Living**
Address: **5211 South Lewis Avenue**
City, State, Zip: **Tulsa, Oklahoma 74105**
Provider #: **AL7216**
Complaint #: **OK00057554**
Investigation Date(s): **08/16/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. Center failed to allow residents unrestricted visitation.	S

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

An unannounced on-site investigation was initiated on 08/16/2021 at 10:00 a.m.

A sample of 4 residents including any identified resident(s), 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1507 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Mary Cooper By Edict.

Mary Cooper RN/CHFS

Date report completed: 08/17/2021

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
	AL7216	A. BUILDING: _____ B. WING _____	C 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE AT MIDTOWN SENIOR LIVING	5211 SOUTH LEWIS AVENUE TULSA, OK 74105

(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 completed on 08/16/2021 to investigate complaint #00057554. Deficient practice was cited. Census was 66. The following abbreviations may have been used in the writing of this report. ED (Executive Director) HWD (Health and Wellness Director)	C 000		
C1507 SS=F	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced by:	C1507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7216	A. BUILDING: _____ B. WING _____	C 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE AT MIDTOWN SENIOR LIVING	5211 SOUTH LEWIS AVENUE TULSA, OK 74105

(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
C1507	Continued From page 1 Based on observation, interview and record review it was determined the center failed to ensure in-room visitation was not restricted for four (# 1, 2, 3 and #4) of four residents sampled for visitation. This had the widespread potential for more than minimal harm. Findings: On 08/16/2021 at 10:00 a.m., upon entry to the facility, a sign was observed on the front door that read, "Please stop indoor visitation has been suspended at this time. To schedule a porch visit please call ..." At 10:00 a.m., the ED was asked how visitation was allowed. She replied, the visitors are screened, go around the center and enter the courtyard. She then stated they could visit on the porch or in the activity room, and staff brought the resident down for the visit. The ED then added all Visits were scheduled with the family for thirty minutes to an hour. At 11:19 a.m., resident #1 was asked if visitation was allowed in her room, she replied no. She was asked if visits were held on the porch. Resident #1 replied, yes. She was asked if it bothered her that visitation was not allowed in her room and if she preferred to have visitation in her room. She stated "Yes." The form titled "Visitor Sign-In Sheet" documented resident #1 had visits on 08/11/2021 and 08/12/2021. At 11:30 a.m., resident #2 was asked if he can have visitors in his room. He stated "no we are all quarantined." He was asked if he can have visitation outside on the porch? He replied, yes.	C1507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7216	A. BUILDING: _____ B. WING _____	C 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE AT MIDTOWN SENIOR LIVING	5211 SOUTH LEWIS AVENUE TULSA, OK 74105

(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
C1507	Continued From page 2 At 12:11 p.m., resident #3 was asked if she can have visitors in her room, she replied, no. At 1:32 p.m., the HWD was asked how visitation was allowed. She replied, the patio, or activity room. She was asked when visitation changed, she replied on 08/09/2021 after a staff member reported a positive test result. The HWD then stated all staff and residents were tested on 08/09/2021, 08/13/2021 with no new positives. The facilities "Coronavirus Outbreak Infection Control policy and procedure" was reviewed with the HWD. She stated, "If we have an outbreak here, we have to shut down." The policy documented, " ...vii. Restrict all visitors, volunteers and non-essential health care personnel (e.g., barbers) except for certain compassionate care situations, such as end-of-life situations ..." At 2:03 p.m., the "Oklahoma State Department of Health recommendation grid" was reviewed with the HWD. She was asked if she used that as a guideline for visitation, she stated, "No, I don't think so. I don't think I have ever seen that." At 3:37 p.m., resident #4 was asked if he had visitors? He replied, not too much since being locked down. He was asked when was the last time he had unrestricted visits? He replied, approximately a week ago.	C1507		

OKLAHOMA
State Department
of Health

Delivery via email to: jenniferb@seasonsliving.com

September 7, 2021

License Number: AL7216

Ms. Jennifer Braun, Administrator
The Grove At Midtown Senior Living
5211 South Lewis Avenue
Tulsa, OK 74105

Survey Event ID: 9M9I11

Dear Ms. Braun:

On **August 16, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 2, 2021**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.09.07 14:10:15 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care I Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/2/2021** **Facility Name:** The Grove at Midtown Senior Living **License Number:** AL7216 **Survey Event ID:** 9M9I11 **Date Survey Completed: 8/16/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1507	Based on: observation, interview and record review it was determined the center failed to ensure in-room visitation was not restricted for four (# 1, 2, 3 and #4) of four residents sampled for visitation. This had the widespread potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident's #1,#2,#3 and #4 continues to live at the community. Community has updated the visitation policy to meet state regulated visitation grid.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents receiving visitation have the potential to be affected by the same deficient practice.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Policy and procedure will be updated to incorporate state regulated visitation grid. All staff have been in-serviced over state regulated visitation grid and updated visitation policy. The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for one quarter after compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Executive Director or designee will conduct random audits and interviews with the residents to establish compliance. and will continue to monitor through one quarter of QA meetings to ensure continued compliance. The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for one quarter after compliance. Executive Director or designee will continue to monitor through one quarter of QA meetings to ensure continued compliance. Community will keep a binder with random audits conducted for compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/2/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jennifer Braun-Executive Director**	**Date 9/3/2021**

OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

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Delivery via email to: jenniferb@seasonsliving.com

December 19, 2022

License Number: AL7216

Ms. Jennifer Braun, Administrator
The Grove At Midtown Senior Living
5211 South Lewis Avenue
Tulsa, OK 74105

Survey Event ID: 9M9I12

Dear Ms. Braun:

On **December 16, 2022,** an offsite/paper complaint revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **August 16, 2021,** have now been corrected effective **September 2, 2021.**

If you have any questions concerning the information in this letter, please contact me at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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
	AL7216	A. BUILDING: _____ B. WING _____	R-C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE AT MIDTOWN SENIOR LIVING	5211 SOUTH LEWIS AVENUE TULSA, OK 74105

(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 offsite/paper revisit was conducted on 12/16/22. The facility was in substantial compliance.	{C 000}		

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