OKLAHOMA
State Department
of Health

Delivery via email to: jim@zarrowpointe.org

October 18, 2023

License Number: CC7203AL

Mr. James 'Jim' Jakubovitz, Administrator
Zarrow Pointe
2025 East 71st Street
Tulsa, OK 74136

RE: Survey Event ID: KUMM11

Dear Mr. Jakubovitz:

On **October 6, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 6, 2023**.

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 (attached). 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 and monitoring will be completed for each violation;
(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 not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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
	CC7203AL	A. BUILDING: _____ B. WING _____	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZARROW POINTE	2025 EAST 71ST STREET TULSA, OK 74136

(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 relicensure survey was conducted from 10/04/23 through 10/06/23. Listed below are abbreviations that will be used throughout this document. DON - Director of Nursing RN - Registered Nurse	C 000		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were reviewed monthly by an RN or pharmacist for six (#1, 2, 3, 4, 5, and #6) of six sampled residents whose medications were reviewed. The DON identified 15 residents who received medications in the facility. Findings: 1. Resident #1 had diagnoses which included hypertension.	C 921		

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C 921	Continued From page 1 Review of the clinical record did not reveal an RN or pharmacist had reviewed the resident's medications monthly. 2. Resident #2 had diagnoses which included Parkinson's disease. Review of the clinical record did not reveal an RN or pharmacist had reviewed the resident's medications monthly. 3. Resident #3 had diagnoses which included congestive heart failure. Review of the clinical record did not reveal an RN or pharmacist had reviewed the resident's medications monthly. 4. Resident #4 had diagnoses which included pain. Review of the clinical record did not reveal an RN or pharmacist had reviewed the resident's medications monthly. 5. Resident #5 had diagnoses which included osteoporosis. Review of the clinical record did not reveal an RN or pharmacist had reviewed the resident's medications monthly. 6. Resident #6 had diagnoses which included osteoarthritis. Review of the clinical record did not reveal an RN or pharmacist had reviewed the resident's medications monthly. On 10/05/23 at 3:16 p.m., the DON stated they	C 921		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZARROW POINTE	2025 EAST 71ST STREET TULSA, OK 74136

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C 921	Continued From page 2 did not have any documentation residents' medications had been reviewed by an RN or pharmacist monthly. The DON stated the pharmacist reviewed medications quarterly. They stated they were unaware medications were to be reviewed monthly by an RN or pharmacist.	C 921		

OKLAHOMA
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Delivery via email to: jim@zarrowpointe.org

November 15, 2023

License Number: CC7203AL

Mr. Jim Jakubovitz, Administrator
Zarrow Pointe
2025 East 71st Street
Tulsa, OK 74136

RE: Survey Event KUMM11

Dear Mr. Jakubovitz:

On **October 6, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. 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 have been corrected and you were in substantial compliance by **November 6, 2023**.

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.

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | 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: 10/23/2023** **Facility Name:** zarrow pointe **License Number:** CC7203AL **Survey Event ID:** KUMM11 **Date Survey Completed: 10/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921	Based on: Based on record review and interview, the facility failed to ensure medications were reviewed monthly by an RN or pharmacist for 6 of 6 sampled residents whose medications were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Facility will address any concerns timely and suffiently to ensure compliance with all regulations.

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?	Facility will implement a monthly medication review tracking form for all residents. RN or pharmacist will complete medication review on all residents monthly and record review on Monthy Review Form.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	This tracking system will be implemented for ALL residents monthly.
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?	The monthly medication review process will be added to the Directors monthly review tasks to ensure timely compliance of practice.
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.	This process will be added to the facility quality assurance program and included in the quarerly review by the QA committee. The Director will be responsible to ensure the forms are reviewed in committee and stored in the QA manual. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/6/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **James M. Jakubovitz** OAC 310:663-25-4(F)	**Date 10/24/2023**

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.

Monthly Medication Review

Date: _____

1.) Resident: _____

Recommendation: _____

2.) Resident: _____

Recommendation: _____

3.) Resident: _____

Recommendation: _____

4.) Resident: _____

Recommendation: _____

5.) Resident: _____

Recommendation: _____

6.) Resident: _____

Recommendation: _____

7.) Resident: _____

Recommendation: _____

8.) Resident: _____

Recommendation: _____

9.) Resident: _____

Recommendation: _____

10.) Resident: _____

Recommendation: _____

Reviewed By: _____ (Printed Name)

_____ (Title)

_____ (Signature)

OKLAHOMA
State Department of Health

Delivery via email to: rubenb@zarrowpointe.org

December 29, 2023

License Number: CC7203AL

Mr. Ruben Bearer, Administrator
Zarrow Pointe
2025 East 71st Street
Tulsa, OK 74136

RE: Survey Event KUMM12

Dear Mr. Bearer:

On **December 27, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 6, 2023,** have now been corrected effective **November 6, 2023.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CC7203AL	A. BUILDING: _____ B. WING _____	R 12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZARROW POINTE	2025 EAST 71ST STREET TULSA, OK 74136

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 12/27/23. 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