OKLAHOMA
State Department
of Health

Delivery via email to: jim@zarrowpointe.org; FCeesay@zarrowpointe.org

March 18, 2025

License Number: CC7203AL

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

RE: Survey Event ID: 7P0711

Dear Mr. Jakubovitz:

On **March 6, 2025**, 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 **March 6, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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: IDRCoordinator@health.ok.gov

or mail 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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 _____	03/06/2025

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 03/05/25 through 03/06/25. Facility Census: 17	C 000		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual fire inspection was complete in 2024. The director of nursing identified 17 residents resided in the center. Findings: There was no documentation a fire marshall inspection had been completed in 2024. The last fire marshall inspection completed was 10/06/23.	C 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 711	Continued From page 1 On 03/06/25 at 1:20 p.m. the maintance supervisor was asked if a fire marshall inspection had been completed in 2024. They stated an inspection report was not available for 2024 to show it had been completed.	C 711		

OKLAHOMA
State Department
of Health

Delivery via email to: jim@zarrowpointe.org; FCeesay@zarrowpointe.org

April 1, 2025

License Number: CC7203AL

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

RE: Survey Event 7P0711

Dear Mr. Jakubovitz:

On **March 6, 2025**, 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 in a timely manner. 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 **March 13, 2025**.

We will conduct a revisit 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, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/21/2025** **Facility Name:** Zarrow Pointe **License Number:** CC7203AL **Survey Event ID:** 7P0711 **Date Survey Completed: 3/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711 310:663-7-1(a)	Based on: record review and interview, the center failed to ensure an annual fire inspection was completed in 2024

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Although Center cannot perform its own Fire Inspection, Center will call Fire Marshall regularly requested Inspection be conducted timely.

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?	Maintenance Director will begin calls monthly beginning in October of each year.
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 fire protection systems will be checked by internal staff in the absence of the Fire Marshall to ensure proper working order.
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?	Campus Director will go to Fire Marshalls office if Fire Marshall does not respond to phone calls and insist on timely inspections.
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.	The annual Fire Marshall inspection report will be included in the facility Quality Assurance Program. This report will be incorporated into the October meeting. If the Fire Marshall does not complete inspection timely. The Mainenace Director will begin calling monthly until Inspection is complete. If inspection is not complete by December, Campus Director will request inspection in person. Maintenance Director will be responsible to monitor compliance of the Fire Marshall. 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?	3/13/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **James M Jakubovitz** OAC 310:663-25-4(F)	**Date 3/21/2025**

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	3/21/2025	Submitted by	James Jakubovitz
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.			

TULSA FIRE DEPARTMENT

INSPECTION REPORT

ZARROW POINTE (JEWISH RETIREMENT CENTER), 2025 E 71ST ST S, BLDG UNNAMED, TULSA OK 74136

DETAILS

Inspection Date: 03/13/2025 | Inspection Type: Licensing Inspection | Inspection Number: 112409 |
Shift: Hourly Shift (40 hour shift) | Station: Fire Headquarters | Unit: C714 | Lead Inspector: TROY FRANKLIN | Other Inspectors: N/A

VIOLATIONS AND COMPLIANCES

No Violations or Compliances selected to show for this inspection. Please reach out to the lead inspector for more details.
Resolved Violations: 0 | Passed Codes: 0 | Violations: 0 | N/A Codes: 8

NEXT INSPECTION DATE

No Inspection Scheduled

FEE

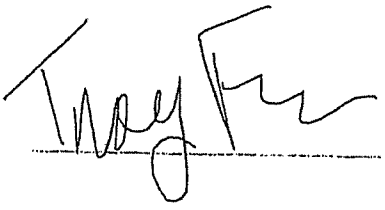
Invoice Date: N/A | Inspection Fee: N/A | Date Paid: N/A | Amount Paid: N/A | Invoice Number: N/A | Check Number: N/A |
Transaction Number: N/A

CONTACT SIGNATURE

Bobby Patterson
Signed on: 03/13/2025 @ 11:38

INSPECTOR SIGNATURE

TROY FRANKLIN
Signed on: 03/13/2025 @ 11:39



QUESTIONS ABOUT YOUR INSPECTION?

TROY FRANKLIN
troy.franklin@cityoftulsa.org
No phone number available

OKLAHOMA
State Department of Health

Delivery via email to: jim@zarrowpointe.org

April 21, 2025

License Number: CC7203AL

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

RE: Survey Event 7P0712

Dear Mr. Jakubovitz:

On **April 18, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your Relicensure survey on **March 6, 2025,** have now been corrected effective **March 13, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, 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 _____	R 04/18/2025

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 An offsite/paper revisit was conducted on 04/18/25. 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