OKLAHOMA
State Department
of Health

Delivery via email to: zach.henson@legendseniorliving.com

June 13, 2024

License Number: AL7241

Mr. Zachary Henson, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event ID: C61W11

Dear Mr. Henson:

Enclosed is a report of the Relicensure Survey with complaint inspection conducted at your Assisted Living Center on **June 11, 2024.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 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.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: **Prairie House Assisted Living and Memory Care**
Address: **2450 North Stone Ridge Drive**
City, State, Zip: **Broken Arrow, OK, 74012, Tulsa**
Provider #: **AL7241**
Complaint #: **OK00065083**
Investigation Dates: **6/6/24, 6/7/24, 6/10/24, and 6/11/24**

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to ensure care and treatment was provided according to the physicians' orders, the contract, the plan of care and the standard of care.
The center failed to complete accurate assessments to ensure the center provided the level of care the residents required.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 06/06/2024 at 1:15 p.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 Summary of Complaint Investigation:

Throughout the survey, the facility was observed for staff and resident interaction, assistance with resident care needs, presence of pervasive odors, and presence of staff.

Residents and staff were interviewed regarding staff and resident interactions, responsiveness to needs, food alternative choices, timing of staff response to call lights, and respect and dignity. Staff were interviewed regarding abuse policies, ability to complete tasks in a timely manner, and knowledge of abuse.

Record review included contracts, assessments, physician orders, medication administration records, grievance reports, facility staffing records, and state reportable incidents.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/12/2024

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
	AL7241	A. BUILDING: _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HOUSE ASSISTED LIVING & MEMOR'	2450 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012

(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 06/06/24 through 06/11/24. A complaint investigation (#OK00065083) was conducted in conjunction with the survey. No deficiencies were cited Facility Census: 111	C 000		

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