OKLAHOMA
State Department
of Health

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

July 24, 2024

License Number: AL7241

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

Survey Event ID: 8ERS11

Dear Mr. Henson:

On **July 3, 2024, 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 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 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 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 a 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:

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,

Clorissa Nubine

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

Enclosure

OKLAHOMA State Department of Health

INVESTIGATIVE REPORT

Facility: **Prairie House Assisted Living and Memory Care**
Address: **2450 North Stone Ridge Drive**
City, State, Zip: **Broken Arrow, OK 74012**
Provider #: **AL7241**
Complaint #: **OK00065232**
Investigation Date(s): **07/01/24 through 07/03/24**

ALLEGATION(S)
The center failed to ensure residents were not restrained.
The center failed to ensure adequate nutrition was provided to prevent significant weight loss/severe weight loss, failed to ensure labs were collected and acted upon in a timely manner and failed to ensure wound treatments were completed according to physician's orders, the contract, the plan of care and the standard of care.
The center failed to adequately assess, monitor, and intervene for residents who fell and failed to report falls to the nurse.
The center failed to ensure medications were administered at the time ordered by the physician and failed to ensure medications were not crushed without an order and/or according to the physicians' order, the plan of care and the standard of care.
The center failed to ensure residents received physician visits according to the physician visits which were billed for.
The center failed to prevent fraudulent billing for physician visits.
The center failed to ensure residents' representatives were notified of a change in condition and failed to ensure the right to privacy.
The center failed to ensure allegations of neglect were reported to the Oklahoma State Department of Health and investigated according to State Law.

An unannounced on-site investigation was initiated 07/01/2024 at 11:45 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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:

Tours of the facility were conducted upon entry and throughout the survey. Resident hallways were observed for staff assistance with resident care needs including activities of daily living, medication administration, and fall prevention measures. Staff were observed answering call lights in a timely manner and assisting residents with care. Nursing staff were observed providing treatments and administering medications. Fall prevention measures were observed.

OKLAHOMA
State Department
of Health

Resident medical records were reviewed including physician orders, medication administration records, progress notes, plans of care, assessments, physician progress notes, activities of daily living records, nutrition notes, and labs. Policies and procedures were reviewed including fall prevention, medications, restraints, and notification of a change in condition. Incident reports, including state reportable incidents were reviewed. In-services including medication administration and fall reporting and prevention were reviewed.

Residents were interviewed regarding their safety and satisfaction with the care they received. Staff were interviewed related to resident health monitoring, notification procedures, and fall reporting and prevention measures.

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: 07/05/2024

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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**
Provider #: **AL7241**
Complaint #: **OK00065562**
Investigation Date(s): **07/01/24 through 07/03/24**

ALLEGATION(S)
The center failed to ensure interventions were implemented for residents at high risk for elopement.
The center failed to ensure adequate staff to meet the needs of the residents.
The center failed to ensure residents' representatives were notified of a change in condition.

An unannounced on-site investigation was initiated 07/01/2024 at 11:45 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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:

Tours of the facility were conducted upon entry and throughout the survey. Resident rooms, hallways, and common areas in the memory care unit were observed for staff assistance with resident care needs including activities of daily living and safety supervision. Staff were observed answering call lights in a timely manner and assisting residents with care. Nursing staff were observed providing treatments and administering medications. Elopement prevention measures were observed.

Resident medical records were reviewed including physician orders, medication administration records, progress notes, plans of care, assessments, physician progress notes, activities of daily living records, and hospital records. Policies and procedures were reviewed including staffing, elopement prevention, and notification of a change in condition. Incident reports, including state reportable incidents were reviewed.

Residents were interviewed related to their safety and satisfaction with the care they received. Staff were interviewed related to resident health monitoring, notification procedures, and elopement prevention measures.

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: 07/05/2024

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 _____	07/03/2024

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 Complaint investigations (#OK00065562 and #OK00065232) were conducted on 07/01/24 through 07/03/24. Facility Census: 116 Listed below are the abbreviations that will be used througout this document. DON - director of nursing lbs - pounds Res - resident	C 000		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative and the person completing the form for two (#1 and #2) of four sampled residents reviewed for comprehensive assessments. The administrator identified 116 residents resided at the center.	C 543		

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C 543	Continued From page 1 Findings: Res #1's comprehensive assessment, dated 03/07/24, was not signed by the resident and/or their representative. Res #2's comprehensive assessment, dated 05/13/24, was not signed by the resident and/or their representative. On 07/02/24 at 11:30 a.m., the healthcare director stated the assessments should have been signed by the resident and/or their representative. They stated not knowing if the residents and/or their representatives had been personally interviewed during the assessment process due to the lack of signatures.	C 543		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a negotiated service agreement/care plan in consultation with the resident and/or their representative for two (#1 and #2) of four sampled residents whose records were reviewed.	C 552		

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C 552	Continued From page 2 The administrator identified 116 residents who resided in the facility. Findings: A "Negotiated Service Agreement" policy, dated 07/01/12, read in parts, " ...The Resident Director and Healthcare Coordinator shall develop a negotiated service agreement in collaboration with the resident, their legal or assigned representative, physician and other appropriate healthcare providers ...Each individual involved in the development of the Negotiated Service Agreement shall sign the agreement ..." 1. Res #1 had diagnoses which included Alzheimer's Disease and epilepsy. A negotiated service plan, dated 04/08/24, had no signature from the resident and/or their representative to reflect consultation in the development. 2. Res #2 had diagnoses which included dementia and hypertension. A negotiated service plan, dated 03/05/24, had no signature from the resident and/or their representative to reflect consultation in the development. A negotiated service plan, dated 05/19/24, had no signature from the resident and/or their representative to reflect consultation in the development. On 07/02/24 at 11:40 a.m., the healthcare director stated the negotiated service agreements were the residents' care plans. They stated the agreements should have been signed by the	C 552		

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C 552	Continued From page 3 resident and/or their representative to reflect consultation in the development process.	C 552		
C1325 SS=D	310:663-13-2(5) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (5) dispute resolution and grievance procedures; This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the resident service contract clearly stated grievance procedures for two (#1 and #3) of four sampled residents whose service contracts were reviewed. The administrator identified 116 residents who resided in the facility. Findings: On 07/03/24 at 9:00 a.m., resident service contracts were reviewed. Res #2's contract, dated 03/31/22, did not contain a clear statement of grievance procedures. Res #3's contract, dated 10/31/22, did not contain a clear statement of grievance procedures. On 07/03/24 at 9:50 a.m., the healthcare director stated the service contracts did not contain grievance procedures. They stated the facility's service contracts had been updated about a year	C1325		

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C1325	Continued From page 4 ago to document the grievance procedures, but the old contracts did not contain this statement.	C1325		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete an internal incident report related to falls for two (#1 and #2) of four residents sampled for falls and address weight loss for one (#2) of four residents whose records were reviewed. The administrator identified 116 residents who resided in the facility. An incident occurrence tracking log documented 49 falls in the last three months. Findings: An "Incidence Occurrence Reporting" policy, dated 07/01/12, read in parts, " ...An Incidence Occurrence Report must be completed in the event that a resident experiences an incidence or occurrence such as witnessed or alleged falls ...The nurse, physician, and resident's legal representative should be notified of events requiring an incidence occurrence report ...All incidents must be recorded on the Incidence Occurrence Tracking Log ..." A "Falls Management" policy, dated 07/01/12, read in parts, " ...An Incident Occurrence Report will be initiated at the time of a resident's witnessed or unwitnessed fall, report of falls and post-fall interventions and tracking will be implemented ...Staff completing the Incident Occurrence Report after a resident fall (witnessed and/or un-witnessed) will complete a post-fall evaluation and submit the completed form to the Healthcare Coordinator for review ..."	C1505		

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C1505	Continued From page 6 A "Weights and Vital Signs Assessment" policy, dated 07/01/12, read in part, " ...The Healthcare Coordinator will communicate any significant changes in weight or vital signs to the resident's physician or other healthcare provided and make appropriate intervention as indicated or as ordered by the health care provided ..." 1. Res #1 had diagnoses which included Alzheimer's Disease and epilepsy. An admission assessment, dated 03/07/24, documented the resident was confused at times and ambulated without staff assistance with the use of a walker. A nurse note, dated 05/09/24, documented Res #1 had an unwitnessed fall beside the bed without injury. The note documented the DON was notified and the physician and resident representative would be notified. The incident occurrence tracking log had no documentation of the fall. On 07/02/24 at 11:56 a.m., the health care director stated an incident report should be completed after all falls. They stated an incident report could not be located regarding the fall on 05/09/24. The healthcare director stated there was no way to know if the physician or the resident's representative was notified of the fall. On 07/02/24 at 1:50 p.m., Res #1's representative stated they were never made aware of the fall on 05/09/24. 2. Res #2 had diagnoses which included dementia and hypertension.	C1505		

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C1505	Continued From page 7 A negotiated service agreement, dated 03/05/24, documented three meals per day with snacks and no special dietary requirements. The agreement documented no special nutrition needs and for staff to notify the healthcare director of any changes and the healthcare director to update the negotiated service agreement as necessary. Res #2's medical record documented the following weights: November 2023 = 148 lbs. January 2024 = 143 lbs. February 2024 = 138 lbs. March 2024 = 140.6 lbs. April 2024 = 130 lbs. May 2024 = 126 lbs. The documentation indicated a 14.86% weight loss in six months. There was no documentation that the weight loss had been reported to the physician. There was no documentation that interventions had been implemented to address weight loss. A nurse note, dated 04/24/24, documented Res #2 was on post fall charting with an abrasion noted to leg area. A nurse noted, dated 05/28/24, documented Res #2 had an unwitnessed fall in their room with minor injury. The note documented the DON and representative were notified and the physician would be notified. The incident occurrence tracking log had no documentation of the falls.	C1505		

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C1505	Continued From page 8 On 07/01/24 at 1:08 p.m., Res #2's representative stated they were never made aware of the fall on 04/24/24 or of the resident's weight loss. They stated no interventions had been put in place to address the weight loss for Res #2. On 07/02/24 at 1:45 p.m., the healthcare director stated Res #2's weight loss should have been reported to the physician in a timely manner and orders/interventions put in place to address the weight loss. On 07/02/24 at 2:00 p.m., the healthcare director stated an incident report could not be located regarding the falls on 04/24/24 or 05/28/24. The healthcare director stated there was no way to know if the physician or the resident's representative was notified of the falls.	C1505		
C1532 SS=E	310:663-15-3(b) POSTED COMPLAINT PROCEDURES (b) Every assisted living center shall conspicuously post for display in an area accessible to residents, employees and visitors, the continuum of care facility's or assisted living center's complaint procedure specified in paragraph (a) and a description, provided by the Department, of complaint procedures established under this rule and the name, address and telephone number of a person authorized by the Department to receive complaints. A copy of the complaint procedure shall also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. This REQUIREMENT is not met as evidenced	C1532		

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C1532	Continued From page 9 by: Based on observation and interview, the center failed to ensure the complaint procedure was posted in an area accessible to residents. Findings: On 07/01/24 at 1:00 p.m., a tour of the center was conducted. The center's complaint procedure was not observed posted anywhere in the center. On 07/03/24 at 9:40 a.m., the administrator and the healthcare director were asked where in the center the complaint procedure was posted. The administrator and the healthcare director conducted an inspection of the center at this time. On 07/03/24 at 10:00 a.m., the healthcare director stated the complaint procedures were not found posted anywhere. They stated the center's interior had recently been painted and the procedures must not have been replaced.	C1532		

OKLAHOMA
State Department
of Health

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

August 14, 2024

License Number: AL7241

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

Survey Event ID: 8ERS11

Dear Mr. Henson:

On **July 3, 2024,** 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 10, 2024**.

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,

Clorissa Nubine

Clorissa Nubine, 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
	AL7241	A. BUILDING: _____ B. WING _____	07/03/2024

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 Complaint investigations (#OK00065562 and #OK00065232) were conducted on 07/01/24 through 07/03/24. Facility Census: 116 Listed below are the abbreviations that will be used througout this document. DON - director of nursing lbs - pounds Res - resident	C 000		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative and the person completing the form for two (#1 and #2) of four sampled residents reviewed for comprehensive assessments. The administrator identified 116 residents resided at the center.	C 543	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C543)	

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 _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 543	Continued From page 1 Findings: Res #1's comprehensive assessment, dated 03/07/24, was not signed by the resident and/or their representative. Res #2's comprehensive assessment, dated 05/13/24, was not signed by the resident and/or their representative. On 07/02/24 at 11:30 a.m., the healthcare director stated the assessments should have been signed by the resident and/or their representative. They stated not knowing if the residents and/or their representatives had been personally interviewed during the assessment process due to the lack of signatures.	C 543		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a negotiated service agreement/care plan in consultation with the resident and/or their representative for two (#1 and #2) of four sampled residents whose records were reviewed.	C 552	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C552)	

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 _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 552	Continued From page 2 The administrator identified 116 residents who resided in the facility. Findings: A "Negotiated Service Agreement" policy, dated 07/01/12, read in parts, " ...The Resident Director and Healthcare Coordinator shall develop a negotiated service agreement in collaboration with the resident, their legal or assigned representative, physician and other appropriate healthcare providers ...Each individual involved in the development of the Negotiated Service Agreement shall sign the agreement ..." 1. Res #1 had diagnoses which included Alzheimer's Disease and epilepsy. A negotiated service plan, dated 04/08/24, had no signature from the resident and/or their representative to reflect consultation in the development. 2. Res #2 had diagnoses which included dementia and hypertension. A negotiated service plan, dated 03/05/24, had no signature from the resident and/or their representative to reflect consultation in the development. A negotiated service plan, dated 05/19/24, had no signature from the resident and/or their representative to reflect consultation in the development. On 07/02/24 at 11:40 a.m., the healthcare director stated the negotiated service agreements were the residents' care plans. They stated the agreements should have been signed by the	C 552		

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 _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 552	Continued From page 3 resident and/or their representative to reflect consultation in the development process.	C 552		
C1325 SS=D	310:663-13-2(5) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (5) dispute resolution and grievance procedures; This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the resident service contract clearly stated grievance procedures for two (#1 and #3) of four sampled residents whose service contracts were reviewed. The administrator identified 116 residents who resided in the facility. Findings: On 07/03/24 at 9:00 a.m., resident service contracts were reviewed. Res #2's contract, dated 03/31/22, did not contain a clear statement of grievance procedures. Res #3's contract, dated 10/31/22, did not contain a clear statement of grievance procedures. On 07/03/24 at 9:50 a.m., the healthcare director stated the service contracts did not contain grievance procedures. They stated the facility's service contracts had been updated about a year	C1325	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C1325)	

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 _____	07/03/2024

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C1325	Continued From page 4 ago to document the grievance procedures, but the old contracts did not contain this statement.	C1325		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C1505)	

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 _____	07/03/2024

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C1505	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete an internal incident report related to falls for two (#1 and #2) of four residents sampled for falls and address weight loss for one (#2) of four residents whose records were reviewed. The administrator identified 116 residents who resided in the facility. An incident occurrence tracking log documented 49 falls in the last three months. Findings: An "Incidence Occurrence Reporting" policy, dated 07/01/12, read in parts, " ...An Incidence Occurrence Report must be completed in the event that a resident experiences an incidence or occurrence such as witnessed or alleged falls ...The nurse, physician, and resident's legal representative should be notified of events requiring an incidence occurrence report ...All incidents must be recorded on the Incidence Occurrence Tracking Log ..." A "Falls Management" policy, dated 07/01/12, read in parts, " ...An Incident Occurrence Report will be initiated at the time of a resident's witnessed or unwitnessed fall, report of falls and post-fall interventions and tracking will be implemented ...Staff completing the Incident Occurrence Report after a resident fall (witnessed and/or un-witnessed) will complete a post-fall evaluation and submit the completed form to the Healthcare Coordinator for review ..."	C1505		

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 _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 6 A "Weights and Vital Signs Assessment" policy, dated 07/01/12, read in part, " ...The Healthcare Coordinator will communicate any significant changes in weight or vital signs to the resident's physician or other healthcare provided and make appropriate intervention as indicated or as ordered by the health care provided ..." 1. Res #1 had diagnoses which included Alzheimer's Disease and epilepsy. An admission assessment, dated 03/07/24, documented the resident was confused at times and ambulated without staff assistance with the use of a walker. A nurse note, dated 05/09/24, documented Res #1 had an unwitnessed fall beside the bed without injury. The note documented the DON was notified and the physician and resident representative would be notified. The incident occurrence tracking log had no documentation of the fall. On 07/02/24 at 11:56 a.m., the health care director stated an incident report should be completed after all falls. They stated an incident report could not be located regarding the fall on 05/09/24. The healthcare director stated there was no way to know if the physician or the resident's representative was notified of the fall. On 07/02/24 at 1:50 p.m., Res #1's representative stated they were never made aware of the fall on 05/09/24. 2. Res #2 had diagnoses which included dementia and hypertension.	C1505		

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 _____	07/03/2024

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C1505	Continued From page 7 A negotiated service agreement, dated 03/05/24, documented three meals per day with snacks and no special dietary requirements. The agreement documented no special nutrition needs and for staff to notify the healthcare director of any changes and the healthcare director to update the negotiated service agreement as necessary. Res #2's medical record documented the following weights: November 2023 = 148 lbs. January 2024 = 143 lbs. February 2024 = 138 lbs. March 2024 = 140.6 lbs. April 2024 = 130 lbs. May 2024 = 126 lbs. The documentation indicated a 14.86% weight loss in six months. There was no documentation that the weight loss had been reported to the physician. There was no documentation that interventions had been implemented to address weight loss. A nurse note, dated 04/24/24, documented Res #2 was on post fall charting with an abrasion noted to leg area. A nurse noted, dated 05/28/24, documented Res #2 had an unwitnessed fall in their room with minor injury. The note documented the DON and representative were notified and the physician would be notified. The incident occurrence tracking log had no documentation of the falls.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 8 On 07/01/24 at 1:08 p.m., Res #2's representative stated they were never made aware of the fall on 04/24/24 or of the resident's weight loss. They stated no interventions had been put in place to address the weight loss for Res #2. On 07/02/24 at 1:45 p.m., the healthcare director stated Res #2's weight loss should have been reported to the physician in a timely manner and orders/interventions put in place to address the weight loss. On 07/02/24 at 2:00 p.m., the healthcare director stated an incident report could not be located regarding the falls on 04/24/24 or 05/28/24. The healthcare director stated there was no way to know if the physician or the resident's representative was notified of the falls.	C1505		
C1532 SS=E	310:663-15-3(b) POSTED COMPLAINT PROCEDURES (b) Every assisted living center shall conspicuously post for display in an area accessible to residents, employees and visitors, the continuum of care facility's or assisted living center's complaint procedure specified in paragraph (a) and a description, provided by the Department, of complaint procedures established under this rule and the name, address and telephone number of a person authorized by the Department to receive complaints. A copy of the complaint procedure shall also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. This REQUIREMENT is not met as evidenced	C1532	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C1532)	

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 _____	07/03/2024

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C1532	Continued From page 9 by: Based on observation and interview, the center failed to ensure the complaint procedure was posted in an area accessible to residents. Findings: On 07/01/24 at 1:00 p.m., a tour of the center was conducted. The center's complaint procedure was not observed posted anywhere in the center. On 07/03/24 at 9:40 a.m., the administrator and the healthcare director were asked where in the center the complaint procedure was posted. The administrator and the healthcare director conducted an inspection of the center at this time. On 07/03/24 at 10:00 a.m., the healthcare director stated the complaint procedures were not found posted anywhere. They stated the center's interior had recently been painted and the procedures must not have been replaced.	C1532		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/30/2024** **Facility Name:** Prairie House Assisted Living and Memory Care **License Number:** AL7241 **Survey Event ID:** 8ERS11 **Date Survey Completed: 7/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543	Based on: record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative and the person completing the form for two (#1 and #2) of four sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	At time of survey residents #'s 1 and 2 had been discharged from the community.
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 have the potential to be affected.
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?	An in-service of all nursing team members responsible for completion of the comprehensive assessment in accordance with 310:663-5-4(c) CONDUCT OF ASSESSMENT will be completed.
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.	Enter methods to ensure corrections are sustained: a. The Residence Director and/or designee will complete a random audit of the completed comprehensive assessments to ensure that a personal interview between the resident or resident's personal representative and the person completing the form has been completed. The signatures of applicable parties to serve as attestation. b. The audit tool attesting to compliance will be incorporated into the monthly quality assurance. Upon review, any need for additional action will be put into place. c. A review of the audit will be kept with the Quality Assurance Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/10/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Jack Stenger		**Date** Enter a date of signature. 8/6/24	
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.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/30/2024** **Facility Name:** Prairie House Assisted Living and Memory Care **License Number:** AL7241 **Survey Event ID:** 8ERS11 **Date Survey Completed: 7/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 552	Based on: record review and interview, the facility failed to develop a negotiated service agreement/care plan in consultation with the resident and/or their representative for two (#1 and #2) of four sampled residents whose records were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	At time of survey residents #'s 1 and 2 had been discharged from the community.
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 have the potential to be affected.
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?	An in-service of all nursing team members responsible for development of a negotiated service agreement/care plan in accordance with 310:663-5-5(2) USE OF ASSESSMENT and Legend Senior Living Policy #10-01-0150P (Negotiated Service Agreement) will be completed.
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.	Enter methods to ensure corrections are sustained: a. The Residence Director and/or designee will complete a random audit of the completed negotiated service agreement/ care plan(s) to ensure that a consultation between the resident or resident's personal representative and the team member responsible for completing the NSA/care plan has been completed. The signatures of applicable parties to serve as attestation. b. The audit tool attesting to compliance will be incorporated into the monthly quality assurance. Upon review, any need for additional action will be put into place. c. A review of the audit will be kept with the Quality Assurance Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/10/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator's signature is required.	**Date** Enter a date of signature.	8/16/24
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.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/30/2024** **Facility Name:** Prairie House Assisted Living and Memory Care **License Number:** AL7241 **Survey Event ID:** 8ERS11 **Date Survey Completed: 7/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1325	Based on: record review and interview, the center failed to ensure the resident service contract clearly stated grievance procedures for two (#1 and #3) of four sampled residents whose service contracts were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	At time of survey resident #1 had been discharged. Completion of a new contract with Resident #3 will be completed which includes the clearly stated grievance procedures.
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 with a signed contract under the previous owner (Wind River) have the potential to be affected.
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?	Residence Director and/or designee will draft new contracts with (Legend Senior Living) and obtain signatures for those residents that are under the old contract (Wind River) in accordance with 310:663-13-2(5) CONTENTS OF CONTRACT
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.	Enter methods to ensure corrections are sustained: a. The Residence Director and/or designee will complete a audit of those residents that require a new contract to ensure that all resident's have a contract with the clearly stated grievance procedures. b. The audit tool attesting to compliance will be incorporated into the monthly quality assurance. Upon review, any need for additional action will be put into place. c. A review of the audit will be kept with the Quality Assurance Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/10/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature. 8/16/24	
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.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/30/2024** **Facility Name:** Prairie House Assisted Living and Memory Care **License Number:** AL7241 **Survey Event ID:** 8ERS11 **Date Survey Completed: 7/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505	Based on: record review and interview, the center failed to complete an internal incident report related to falls for two (#1 and #2) of four residents sampled for falls and address weight loss for one (#2) of four residents whose records were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	At time of survey resident #1 and #2 had been discharged.
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 have the potential to be affected.
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?	An in-service of clinical team members responsible for completing an internal incident report will be completed in accordance with 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care and Legend Senior Living Policies #10-01-0240P (Incident Occurrence Reporting), #10-01-0120P (Falls Management). An in-service of clinical team members responsible for recording and reporting weights in accordance with 10:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care and Legend Senior Living Policy #10-01-1040P (Weights and Vital Signs Assessment) will be completed.
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.	Enter methods to ensure corrections are sustained: a. The Residence Director and/or designee will complete a audit of those residents reported to have fallen and those residents reported with weight loss to ensure the completion of an internal incident report and that those residents with reported weight loss have been addressed in compliance with cited regulation and Legend Senior Living Policy. b. The audit tool attesting to compliance will be incorporated into the monthly quality assurance. Upon review, any need for additional action will be put into place. c. A review of the audit will be kept with the Quality Assurance Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/10/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date** Enter a date of signature.	8/6/24
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.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/30/2024** **Facility Name:** Prairie House Assisted Living and Memory Care **License Number:** AL7241 **Survey Event ID:** 8ERS11 **Date Survey Completed: 7/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1532	Based on: observation and interview, the center failed to ensure the complaint procedure was posted in an area accessible to residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Complaint procedure to be posted in an area accessible to residents.
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 have the potential to be affected.
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?	Residence Director and/or designee will ensure the Complaint Procedure is posted in an area accessible to residents in accordance with 310:663-15-3(b) POSTED COMPLAINT PROCEDURES
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.	Enter methods to ensure corrections are sustained: a. The Residence Director and/or designee will randomly audit the location of the Complaint Procedure to make certain the procedure for filing a complaint is in an area accessible to residents and attest with dates using an audit tool. b. The audit tool attesting to compliance will be incorporated into the monthly quality assurance. Upon review, any need for additional action will be put into place. c. A review of the audit will be kept with the Quality Assurance Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/10/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.		**Date** Enter a date of signature. 8/6/24	
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.			

OKLAHOMA
State Department
of Health

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

September 11, 2024

License Number: AL7241
Survey Event ID: 8ERS12

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

Dear Mr. Henson:

On **September 10, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **July 3, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **September 10, 2024**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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
	AL7241	A. BUILDING: _____ B. WING _____	07/03/2024

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 Complaint investigations (#OK00065562 and #OK00065232) were conducted on 07/01/24 through 07/03/24. Facility Census: 116 Listed below are the abbreviations that will be used througout this document. DON - director of nursing lbs - pounds Res - resident	C 000		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative and the person completing the form for two (#1 and #2) of four sampled residents reviewed for comprehensive assessments. The administrator identified 116 residents resided at the center.	C 543	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C543)	

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 _____	07/03/2024

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 543	Continued From page 1 Findings: Res #1's comprehensive assessment, dated 03/07/24, was not signed by the resident and/or their representative. Res #2's comprehensive assessment, dated 05/13/24, was not signed by the resident and/or their representative. On 07/02/24 at 11:30 a.m., the healthcare director stated the assessments should have been signed by the resident and/or their representative. They stated not knowing if the residents and/or their representatives had been personally interviewed during the assessment process due to the lack of signatures.	C 543		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a negotiated service agreement/care plan in consultation with the resident and/or their representative for two (#1 and #2) of four sampled residents whose records were reviewed.	C 552	"Refer to POC Template, Survey Event ID #8ERS11, ID Prefix Tag (C552)	