OKLAHOMA
State Department
of Health

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

October 16, 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: BGT211

Dear Mr. Henson:

On **October 10, 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 & Memory Care**
Address: **2450 N Stone Ridge Drive**
City, State, Zip: **Broken Arrow, OK, 74012**
Provider #: **AL7241**
Complaint #: **OK00066504**
Investigation Date: **10/10/24**

ALLEGATION
The center failed to ensure residents were not sexually abused.

An unannounced on-site investigation was initiated 10/10/2024 at 8:21 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey residents were observed for signs of abuse. Staff, residents, and families were interviewed regarding abuse. Policies were reviewed as well as resident clinical records and incident reports with investigations.

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: 10/10/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Prairie House Assisted Living & Memory Care**
Address: **2450 N Stone Ridge Drive**
City, State, Zip: **Broken Arrow, OK, 74012**
Provider #: **AL7241**
Complaint #: **OK00068320**
Investigation Date: **10/10/24**

ALLEGATIONS

The facility failed to ensure medications were ordered and available for administration.
The facility failed to provide services according to the contract.

An unannounced on-site investigation was initiated 10/10/2024 at 8:21 a.m.

A sample of three 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 observations of laundry and staff administering medications were conducted. Residents, staff, and families were interviewed regarding medications and laundry services. Documentation of services provided were reviewed as well as resident records, policies, and contracts.

The attached Statement of Deficiencies, Form 2567 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: 10/10/2024

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 _____	C 10/10/2024

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 (#OK00066504 and #OK00068320) were conducted on 10/10/24. Facility Census: 114 The following abbreviations will be used throughout the document. ODH - Oklahoma Department of Health	C 000		
C1952 SS=D	310:663-19-3(b) MAINTENANCE OF RECORDS (b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident confidentiality. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure records were retained and not lost for review by the state agency for one (#1) of four residents sampled for review of records. The administrator identified 114 residents who resided at the facility. Findings: The "Resident Abuse, Neglect and Exploitation" policy, revised 04/30/24, read in part, "Report findings shall be kept in a separate file in the Residence Director's or designee's office...A copy of the report with the investigation findings shall be retained by the community per state guidelines and available for governing state agency's	C1952		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1952	Continued From page 1 review..." Resident #1 had diagnoses which included history of stroke. An ODH Form 283, dated 08/15/24, documented the resident alleged a male staff had sexually assaulted them and did not want to be around the staff. Review of the incident revealed the investigation was incomplete. The administrator was asked to provide the evidence of completion of the investigation. On 10/10/24 at 2:36 p.m., the administrator stated the investigation findings were lost.	C1952		

OKLAHOMA
State Department
of Health

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

October 29, 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: BGT211

Dear Mr. Henson:

On **October 10, 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 **October 29, 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

OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/24/2023

Facility Name: Prairie House Assisted Living and Memory Care

License Number: AL7241

Survey Event ID: BGT211

Date Survey Completed: 10/10/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1952	Based on: record review and interview. The center failed to ensure records were retained and not lost for review by the state agency for (#1) of four residents sampled for review of records.

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 statuary 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 mitigation 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?	All incident reports related to RESIDEDNT ABUSE, NEGLECT AND EXPLOITATION will be reviewed to ensure compliance with 310:663-19-3() and LSL POLICY #04-05-0131P
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 nursing and the Resident Director responsible for completing an investigation of any alleged report of abuse, neglect, and explotation will be completed in compliance with 310:663-19-3() and LSL Policy #0-05-0131P
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. Residence Director and/or designee will complete a audit of incident reports related to any allegation of abuse to ensure that the investigation is complete, recorded, and maintained in the residence. b. The audit tool attesting to compliance will be incorporated into 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 Assuance Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/29/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required.	**Date** Enter date of signature. 10/28/24

10012013

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

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 10/10/2024

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PRAIRIE HOUSE ASSISTED LIVING & MEMOR'	2450 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012

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C1952	Continued From page 1 review..." Resident #1 had diagnoses which included history of stroke. An ODH Form 283, dated 08/15/24, documented the resident alleged a male staff had sexually assaulted them and did not want to be around the staff. Review of the incident revealed the investigation was incomplete. The administrator was asked to provide the evidence of completion of the investigation. On 10/10/24 at 2:36 p.m., the administrator stated the investigation findings were lost.	C1952		

OKLAHOMA
State Department of Health

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

November 7, 2024

License Number: AL7241
Survey Event ID: BGT212

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

Dear Mr. Henson:

On **November 4, 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 **October 10, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **October 29, 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

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 _____	R 11/04/2024

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 An offsite/paper revisit was conducted on 11/04/24. 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