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

June 5, 2025

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: MHPV11

Dear Mr. Henson:

On **May 22, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **May 22, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the

OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
IDRCoordinator@health.ok.gov
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

INVESTIGATIVE REPORT

Facility: Prairie House AL
Address: 2450 N. Stone Ridge Dr.
City, State, Zip: Broken Arrow, OK, 74012
Provider #: AL7241
Complaint #: OK00082439
Investigation Date(s): 05/21/25 and 05/22/25

ALLEGATION(S)
enter text The center failed to ensure residents were not physically, verbally or psychosocially abused.
enter text The center failed to ensure adequate supervision to prevent elopement.
The center failed to ensure incidents were reported to the Oklahoma State Department of Health
enter text
enter text

An unannounced on-site investigation was initiated 05/21/2025 at 1:30 P.M.

A sample of ten 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: Upon entrance into the facility and throughout the two day survey staff there was no observance of residents being physically, verbally or psychosocially abused. Also for observance into memory care each staff member has to have their own code for anyone to get in or out. Records reviewed included incident reports, resident records, and in-service training. Residents, employees and family members were interviewed regarding witnessing any form of abuse or elopement.

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: 05/27/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7241	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/22/2025
NAME OF PROVIDER OR SUPPLIER PRAIRIE HOUSE ASSISTED LIVING & MEMOR'		STREET ADDRESS, CITY, STATE, ZIP CODE 2450 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012		
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C 000	INITIAL COMMENTS A relicensure and complaint survey (#OK00082439) was conducted from 05/21/25 through 05/22/25. Deficiencies were cited as a result of the survey. Facility Census: 107 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA- certified nurse aide CPR- cardiopulmonary resuscitation	C 000		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff had CPR training for 2 (CNA #1, and the life enrichment coach) of 5 employees whose record was reviewed. The administrator identified 107 residents resided in the facility. Findings:	C 954		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 954	Continued From page 1 A facility policy titled "Emergency Care," dated 07/01/12, read in part, "Staff will be trained in emergency preparedness, including CPR and first-aid for early management of medical and non-medical emergencies." On 05/22/25 at 3:55 p.m. the administrator was asked for the following employees files to be reviewed for CPR and first aid training. 1. The employee file for CNA #1 showed they were hired on 05/14/19. The file showed CNA #1 had a CPR paper in their file but had no date of completion. 2. The employee file for the life enrichment coach showed they were hired on 09/06/22. The employee file showed the life enrichment coach had a CPR training paper in their file, but with no date of completion. On 05/22/25 at 4:30 p.m., the administrator was asked about the CPR training papers having no date of completion. The administrator stated, "They thought the employees had in service training for first aid and CPR." The administrator could not provide an in-service meeting attended by any of the sample employees. to indicate they had received the CPR training.	C 954			
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by	C1972			

Oklahoma State Department of Health

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Oklahoma State Department of Health

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C1972	Continued From page 3 4. The employee file for CNA #2 showed they was hired on 03/09/23. There was no documentation of abuse training being provided. 5. The employee file for the life enrichment coach showed they were hired on 09/26/22. There was no documentation of abuse training being provided. On 05/22/25 at 4:30 p.m., the administrator was asked about the following employees not having abuse training within 90 days of hire. The administrator stated, "They can't find the records of all the training since the company has changed owners."	C1972			

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

June 17, 2025

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 MHPV11

Dear Mr. Henson:

On **May 22, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **July 15, 2025**.

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

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

Oklahoma State Department of Health

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Oklahoma State Department of Health

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Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/13/2025

Facility Name: Prairie House Assisted Living and Memory Care

License Number: AL7241

Survey Event ID: MHPV11

Date Survey Completed: 5/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954

Based on: Based on record review and interview, the facility failed to ensure direct care staff had CPR training for 2 (CNA #1, and the life enrichment coach) of 5 employees whose record was 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 statutory 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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained?
Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A audit of all current associates CPR training records will be completed to identify others lacking training. Those who are identified lacking completed training will be trained in CPR and documentation of this training will be retined.

All residents have the potential to be affected.

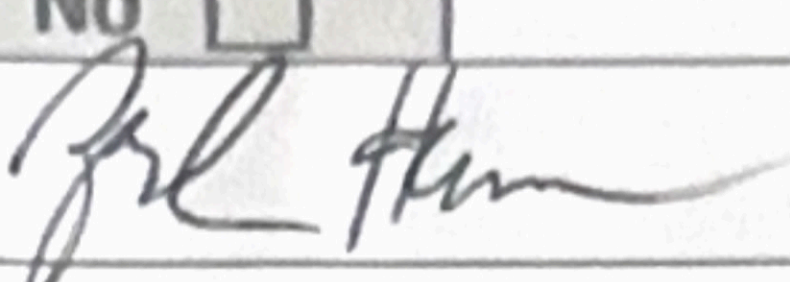
All associates responsible for overseeing completion of training will be inserviced on both state regulation and Legend policy. Furthermore the Residence Director and/or designee will review all new hire's training records monthly to ensure completion of CPR training.

a. The Residence Director and/or designee will complete a audit of all new associates training records monthly to ensure compliance with cited regulation and Legend Senior Living Policy.

b. A audit tool attesting to compliance will be incorporated into and reviewed during monthly quality assurance meetings. 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.

7/15/2025

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature		Zachary Henson 	Date 6/13/2025
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.			



Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/13/2025

Facility Name: Prairie House Assisted Living and Memory Care

License Number: AL7241

Survey Event ID: MHPV11

Date Survey Completed: 5/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1972

Based on: record review and interview, the facility failed to ensure staff were educated on abuse training within 90 days of hire for 5 (chef #1, CMA #1, CNA #1, CNA #2, and the life enrichment coach) of 5 employees whose records were reviewed for abuse training.

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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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

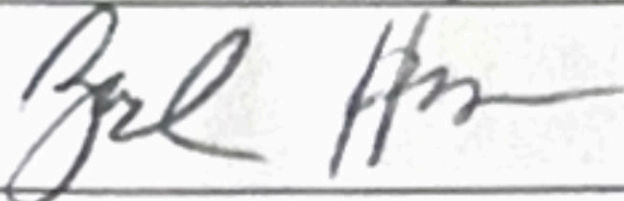
A audit of all current associates abuse training records will be completed to identify others lacking training. Those who are identified lacking completed training will be trained in Resident Abuse, Neglect, and Exploitation and documentation of this training will be retined in their associate file.

All residents have the potential to be affected.

Residence Director and/or designee will review all new hire's training records to ensure completion of Resident Abuse, Neglect, and Exploitation, training within first 90 days of employment.

Enter methods to ensure corrections are sustained:

- All associates responsible to overseeing completion of Resident Abuse, Neglect, and Explotation training will be inserviced on both state regulation and Legend policy regarding such training. The Residence Director and/or designee will complete a audit of all new associates training records monthly to ensure compliance with cited regulation and Legend Senior Living Policy.
- A 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.
- A review of the audit will be kept with the QualityAssurance Minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/15/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Zachary Henson  OAC 310:663-25-4(F)		Date 6/13/2025	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	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.			

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

July 23, 2025

License Number: AL7241
Survey Event ID: MHPV12

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

Dear Mr. Henson:

On **July 18, 2025**, 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 **May 22, 2025**, have now been corrected and your facility is in compliance with licensure standards effective **July 15, 2025**.

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: AL7241	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/18/2025
NAME OF PROVIDER OR SUPPLIER PRAIRIE HOUSE ASSISTED LIVING & MEMOR'		STREET ADDRESS, CITY, STATE, ZIP CODE 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 07/18/25. The facility was in substantial compliance.	{C 000}		

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