
Delivery via email to: livingrose@ymail.com

November 3, 2025

License Number: AL7260

Ms. Tammy Spinazzola, Administrator
Living Rose Christian Assisted Living Home
1108 North Fern Avenue
Broken Arrow, OK 74012

RE: Survey Event ID: 1QKQ11

Dear Ms. Spinazzola:

On **October 15, 2025**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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 (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 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
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 OSDH.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,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Living Rose Christian AL
Address: 1108 N Fern Ave
City, State, Zip: Broken Arrow, Ok
Provider #: AL7260
Complaint #: OK00085426
Investigation Dates: 10/01/25, 10/02/25, 10/06/25-10/10/25 and 10/15/25

ALLEGATIONS
The center failed to ensure adequate nutrition and hydration was provided according to the physicians' orders.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 10/01/2025 at 10:35 a.m.

A sample of six 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:

A tour of the facility was conducted upon entrance and at other times during the survey. Residents were observed in daily activities, receiving medications, during meals, and during dependent care

Staff were observed assisting residents with activities of daily living, passing medications, and preparing meals.

Resident records including assessment, care plans, physician orders, nursing notes, treatment records, and medication administration were reviewed.

Residents were interviewed regarding medication administration, staff assistance, and if their needs were met. Staff were interviewed regarding activities of daily living, meals preparation, qualifications, and documentation.

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: 10/24/2025

INVESTIGATIVE REPORT

Facility: Living Rose Christian AL
Address: 1108 N Fern Ave
City, State, Zip: Broken Arrow, Ok
Provider #: AL7260
Complaint #: OK00086794
Investigation Dates: 10/01/25, 10/02/25, 10/06/25-10/10/25 and 10/15/25

ALLEGATIONS
The center failed to assess, monitor and intervene in a timely manner.

An unannounced on-site investigation was initiated 10/01/2025 at 10:35 a.m.

A sample of six 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:

A tour of the facility was conducted upon entrance and at other times during the survey. Residents were observed in daily activities, receiving medications, during meals, and during dependent care

Staff were observed assisting residents with activities of daily living, passing medications, and preparing meals.

Resident records including assessment, care plans, physician orders, nursing notes, treatment records, and medication administration were reviewed.

Residents were interviewed regarding medication administration, staff assistance, and if their needs were met. Staff were interviewed regarding activities of daily living, meals preparation, qualifications, and documentation.

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Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/24/2025

INVESTIGATIVE REPORT

Facility: Living Rose Christian AL
Address: 1108 N Fern Ave
City, State, Zip: Broken Arrow, Ok
Provider #: AL7260
Complaint #: OK00086856
Investigation Dates: 10/01/25, 10/02/25, 10/06/25-10/10/25 and 10/15/25

ALLEGATIONS
The center failed to ensure residents were protected from abuse.
The center failed to ensure an administrator was designated to be responsible for the operations of the assisted living.
The center failed to have registered nurse supervision of skilled nursing functions.
The center failed to have a licensed dietitian or qualified nutritionist to develop the assisted living center's diet plan and address the individual needs of residents with special diets.
The center failed to ensure the number of residents admitted did not exceed the number the center was licensed for.

An unannounced on-site investigation was initiated 10/01/2025 at 10:35 a.m.

A sample of six 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:

A tour of the facility was conducted upon entrance and at other times during the survey. Residents were observed in daily activities, receiving medications, during meals, and during dependent care

Staff were observed assisting residents with activities of daily living, passing medications, and preparing meals.

Resident records including assessment, care plans, physician orders, nursing notes, treatment records, and medication administration were reviewed.

Residents were interviewed regarding medication administration, staff assistance, and if their needs were met. Staff were interviewed regarding activities of daily living, meals preparation, qualifications, and documentation.

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: 10/24/2025

INVESTIGATIVE REPORT

Facility: Living Rose Christian AL
Address: 1108 N Fern Ave
City, State, Zip: Broken Arrow, Ok
Provider #: AL7260
Complaint #: OK00086942
Investigation Dates: 10/01/25, 10/02/25, 10/06/25-10/10/25 and 10/15/25

ALLEGATIONS
The center failed to ensure every two hour rounds were completed according to the plan of care/standard of care/policy and procedure.
The center failed to ensure food was served in adequate portions and with variety.
The center failed to ensure the number of residents did not exceed the number of residents they were licensed for.
The center failed to ensure an administrator was available and responsible for management of the center.

An unannounced on-site investigation was initiated 10/01/2025 at 10:35 a.m.

A sample of six 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:

A tour of the facility was conducted upon entrance and at other times during the survey. Residents were observed in daily activities, receiving medications, during meals, and during dependent care

Staff were observed assisting residents with activities of daily living, passing medications, and preparing meals.

Resident records including assessment, care plans, physician orders, nursing notes, treatment records, and medication administration were reviewed.

Residents were interviewed regarding medication administration, staff assistance, and if their needs were met. Staff were interviewed regarding activities of daily living, meals preparation, qualifications, and documentation.

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: 10/24/2025

INVESTIGATIVE REPORT

Facility:
Address:
City, State, Zip:
Provider #:
Complaint #:
Investigation Date(s):

ALLEGATIONS
The center failed to ensure the menu and special diets were developed by the licensed dietician.
The center failed to ensure the number of residents did not exceed the number of residents they were licensed for.
The center failed to ensure residents were protected from abuse.
The center failed to provide contracted services.

An unannounced on-site investigation was initiated 10/01/2025 at 10:35 a.m.

A sample of six 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:

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Residents were interviewed regarding medication administration, staff assistance, and if their needs were met. Staff were interviewed regarding activities of daily living, meals preparation, qualifications, and documentation.



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: [Click to Enter a Date](#)

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/15/2025
NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00085426, OK00086794, OK00086856, OK00086942, and #OK00087302) was conducted on 10/01/25 through 10/02/25, 10/06/25 through 10/10/25 and 10/15/25. Deficiencies were cited as a result of the survey. Facility Census: 6 Listed below are abbreviations that will be used throughout this document: CMA - certified medical assistant CNA - certified nursing aide MAT - medication administration technician MAR - medication administration record mg - milligram IJ - immediate jeopardy IV - intravenous PICC - peripherally inserted central catheter	C 000		
C 301 SS=E	310.663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure 1 (#3) of 6	C 301		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/15/2025
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C 301	Continued From page 1 sampled residents did not exceed the level of care the center and/or licensee was able to provide. CNA #1 identified six residents resided in the center. Findings: On 10/01/25 at 10:35 a.m., an initial tour of the facility was conducted. The following observations were made by the survey team: a. The center consisted of three bedrooms, bedroom 1 had a single bed, bedrooms 2 and 3 contained two twin beds. b. There were six recliners in the living room. Five residents were seated in recliners. c. A list of six residents and emergency numbers was observed posted on the refrigerator. The center's license showed they were licensed for five beds. A review of resident assessments showed the following admission dates: a. Resident #1 was admitted on 03/09/2023 b. Resident #2 was admitted on 10/21/2018 c. Resident #3 was admitted on 04/01/2025 d. Resident #4 was admitted on 02/24/2024 e. Resident #5 was admitted on 07/18/2025 f. Resident #6 was admitted on 07/17/2025 On 10/01/25 at 10:35 a.m., CNA #1 stated the center currently had six residents, one of the residents (Resident #1) was currently in hospital. On 10/06/25 at 2:42 p.m. Staff #1 stated Resident #3 did not have a room and slept on an air mattress. Staff #1 stated they did not know	C 301		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/15/2025
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C 301	Continued From page 2 where the air mattress was set up at night. On 10/07/25 at 5:33 a.m., Staff #4 stated Resident #3 was "an extra" and slept on an air mattress in the living room.	C 301		
C 344 SS=E	310:663-3-4(b)(4) APPROPRIATE PLACEMENT (b) The resident shall not be eligible for placement in the assisted living center under one (1) or more of the following circumstances: (4) The assisted living center is unable to meet the resident's needs for privacy or dignity. Based on observation and interview, the facility failed to ensure resident's right to privacy and dignity were provided for 3 (#2, 3, and #4) of 5 sampled residents reviewed for dignity and privacy. CNA #1 identified six residents resided in the facility. Findings: On 10/01/25 at 10:35 a.m., an initial walk through of the facility was conducted. The facility was observed to consist of three bedrooms, a kitchen, a living room with a dining table, a full bath and a one half bath. One shower was observed in the full bath. Bedroom 1 was observed to have one twin sized bed. Bedroom 2 was observed to have two twin beds. Bedroom 3 was observed to contain two twin beds. A curtain or divider for privacy was not observed between the beds in rooms 2 or 3. Five residents were observed sitting in recliners in the living room.	C 344		

Oklahoma State Department of Health

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C 344	Continued From page 3 On 10/07/25 at 5:50 a.m., Staff #4 was observed demonstrating inflation of an air mattress and placement in the living room between the rows of recliners. An annual resident assessment form, dated 04/01/25, showed diagnoses for Resident #3 which included Alzheimer's disease, dementia, and kidney failure. On 10/01/25 at 10:42 a.m., CNA #1 stated there were five residents currently in house with one resident in the hospital. CNA #1 stated room 1 belonged to Resident #1, who was currently in the hospital. They stated room 2 was shared by Resident #2 and Resident #4. CNA #1 stated Resident #2 and Resident #4 were not of the same sex, related, or a couple, they just shared the room. CNA #1 stated room 3 as belonging to Residents #5 and #6. On 10/06/25 at 10:35 a.m., a family member stated they were unaware Resident #2 shared a room with a member of the opposite sex. They stated, "That doesn't seem right." On 10/06/25 at 2:42 p.m. CNA #1 stated Resident #3 slept on an air mattress. CNA #1 stated they did not know where the air mattress was set up at night. On 10/07/25 at 5:33 a.m., Staff #4 stated Resident #3 was "an extra" and slept on an air mattress in the living room. On 10/07/25 at 5:37 a.m., Resident #3 stated they did not know where they slept. By the end of the survey, the facility had not	C 344		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/15/2025
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C 344	Continued From page 4 provided documentation of diagnoses or physician orders for Resident #2 and #4. or provided a service contract for Resident #3 for review of contracted room accommodations.	C 344		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a. Food items were labeled and dated for the dates of storage in 1 of 1 refrigerator/ freezer combination reviewed for food storage. b. A three compartment sink was utilized to hand wash dishes. CNA #1 identified six residents ate from the kitchen. Findings: On 10/01/25 at 10:35 a.m., an initial tour of the kitchen was conducted and the following observation were made: a. Two gallon cartons contained a white liquid were observed. The gallon cartons did not have an identifying labels, expiration dates or open dates. One carton was open and 2/3 empty, the other carton was full,	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/15/2025
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C 391	Continued From page 5 b. Two bowls of a brown colored puree in the refrigerator were covered in plastic wrap. No dates or identifying information was observed, c. Casserole in the refrigerator was not labeled or dated, d. Two casseroles in the freezer were not labeled or dated, and e. The kitchen contained a non commercial dishwasher and a two compartment sink. On 10/07/25 at 7:28 a.m., Staff #4 was observed washing the breakfast dishes by putting some dish soap on the dishes and washing them by hand and a scrubber. The dishes were rinsed under running water and placed in the dishwasher. On 10/07/25 at 7:28 a.m., Staff #4 stated they washed the dishes in the sink, placed them in the dishwasher to air dry, then put the dishes in the cabinet. By the end of the survey on 10/15/25, a kitchen policy for food storage had not been provided.	C 391		
C 398 SS=F	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department.	C 398		

Oklahoma State Department of Health

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C 398	Continued From page 6 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure dietary staff attended a food service training program as approved by the Oklahoman State Department of Health for 6 (#1, 2, 3, 4, 5, and #6) of 6 sampled dietary staff reviewed for food handler licenses. CNA #1 identified six residents resided in the facility. Findings: On 10/01/25 at 10:35 a.m., an entrance conference was held with CNA #1 and a request was made for staff records and certifications. On 10/01/25 at 11:35 a.m., CNA #1 was observed heating and serving food for the residents. On 10/06/25 at 11:14 a.m., Staff #6 stated they made dinner for the residents during their shift. Staff #6 was asked if they had a food handler's license. They stated, "Not yet, I need to get that." By the end of the survey on 10/15/25, the facility had not provided documentation of staff qualifications for food preparation.	C 398		
C 724 SS=F	310:663-7-2(4-5) PRIVACY AND INDEPENDENCE Each assisted living center shall ensure privacy and independence for its residents, to include the following: (4) no more than four (4) residents sharing toilet facilities; (5) no more than four (4) residents sharing	C 724		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
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C 724	Continued From page 7 bathing facilities provided that the Department may approve more than four (4) residents per bathing facility based on documentation that the design of the bathing facility is appropriate to the special needs of each resident who uses the bathing facility; This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure no more than four residents shared a toilet or bathing facilities for 5 (#1,2, 3, 4, and #5) of 5 sampled residents reviewed for assistance with daily living. CNA #1 identified five residents currently resided in the facility and one resident was currently in the hospital. Findings: On 10/01/25 at 10:35 a.m., an initial tour of the facility was conducted. The facility was observed to consist of seven rooms. The rooms were: a. a kitchen, b. a living room dining room combination, c. a full bath with a sink, a toilet, and a shower, d. a one half bath with a toilet and a sink, and e. three bedrooms. On 10/01/25 at 10:35 a.m., an undated sign posted in the main bathroom listed one designated shower day for each resident. On 10/01/25, at 12:40 p.m., CNA #1 was observed to assist each resident, one at a time, from the living room to the bathroom off the main hallway.	C 724		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
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C 724	Continued From page 8 On 10/15/25 at 12:47 p.m., CNA #1 stated the residents all used the bigger bathroom in the hall, the half bath was for staff use.	C 724		
C 930 SS=E	310:663-9-3(1-3) STAFF QUALIFICATIONS Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials: (1) a license issued by the State Board of Examiners for Nursing Home Administrators; or (2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or (3) a nationally recognized assisted living certificate of training and competency for assisted living administrators that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure an administrator was designated and responsible for the day to day operations of the center for 19 days from 10/01/25 through 10/19/25. CNA #1 identified six residents resided in the center.	C 930		

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C 930	Continued From page 9 Findings: On 10/01/25 at 10:35 a.m., the administrator was not present in the facility. On 10/01/25 at 10:42 a.m., access to the center's documentation of resident clinical records, weights, MARs, physician orders, employee files, and policies was made. On 10/01/25 at 10:35 a.m., CNA #1 stated the administrator was not available and they did not know who was in charge while the administrator was away. CNA #1 stated they did not have access to the requested records. CNA #1 stated staff had access to the resident MARs. CNA #1 stated the administrator had the other requested documentation. On 10/01/25 at 11:30 a.m., CNA #1 stated the administrator was on vacation and did not know when the administrator would return. On 10/02/25 at 10:39 a.m., CMA #2 stated they did not know where the administrator was and was unsure when they would return. On 10/06/25 at 2:15 p.m., CNA #1 stated the administrator would be back in a week. On 10/09/25 at 3:13 p.m., a phone call was made to the administrator. The call was not answered and a message was left stating the need for documentation to complete the survey. On 10/09/25 at 4:26 p.m., a phone call was made to the administrator. The call was not answered. A recording was heard stating the mail box was full.	C 930		

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C 930	Continued From page 10 On 10/10/25 at 8:42 p.m., a phone call was made to the administrator. The call was not answered and a message was left. On 10/15/25 at 10:23 a.m., CNA #3 stated the administrator was in Italy. On 10/15/25 at 10:55 a.m., CNA #1 stated the administrator would return from vacation on 10/19/25. On 10/15/25 at 11:02 a.m., a phone call was made to the administrator. The call was not answered.	C 930		
C 940 SS=L	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: On 10/10/25, an IJ situation was determined to exist related to the facility's failure to provide documentation of a dietary consultant or nutritionist to oversee menu nutrition and resident weight management. No dietary oversight or weight management by the facility had the potential for serious adverse outcomes for the resident. On 10/10/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.	C 940		

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C 940	Continued From page 11 On 10/10/25 at 3:03 p.m., the administrator was not in the building but was called by CNA #1 and placed on speaker. CNA #1 and the administrator were notified of the IJ situation. A plan of removal was not received. The deficiency remained at an IJ level. Based on observation, record review, and interview the facility failed to provide: a. documentation of a dietitian or nutritional consultant, and b. documentation of resident weights and weight management for 6 (#1, 2, 3, 4, 5, and #6) of 6 sampled residents reviewed for dietary and nutritional consults. CNA #1 identified six residents ate in the facility. Findings: On 10/01/25 at 10:35 a.m., during the initial tour of the facility, Resident #3 was observed in a recliner in the living room area. Resident #3 was observed to be underweight, with prominent facial bones and shinbones. There was no menu observed to be posted. On 10/01/25 at 11:41 a.m., CNA #1 was observed to assist Resident #3 to eat lunch which was a bowl of puree that was brown in color. On 10/01/25 at 10:43 a.m., CNA #1 stated the administrator was on vacation. CNA #1 stated they did not know when the administrator would return. CNA #1 was asked who was in charge while the administrator was away. CNA #1 shrugged their shoulders and stated they all were. CNA #1 stated they were unaware if there was a dietitian, of the existence of menus, and did not	C 940		

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C 940	Continued From page 12 know if or where resident weights were documented. CNA #1 stated they did not weigh the residents. CNA #1 reported the administrator usually made the lunch for the residents and put it in the freezer or refrigerator and staff heated it up and served it. CNA #1 stated staff prepared breakfast and dinner for the residents. On 10/02/25 at 11:00 a.m., CNA #2 stated the facility did not have menus, and did not have knowledge of a dietician. They stated the administrator bought and made the food for the residents they served at lunch time. On 10/06/25 at 11:14 a.m., Staff #6 stated they had had never seen a dietician, a physician, or an RN consultant. They stated they did not make the puree for Resident #3. Staff #6 stated the puree was made by another staff member on a different shift. Staff #6 stated they did not know what was in the puree On 10/09/25 at 3:13 p.m., the administrator was called, there was no answer, a message was left requesting a return phone call. On 10/09/25 at 4:26 p.m., a phone call was made to the administrator, there was no answer. A recording was heard stating the mailbox was full. On 10/10/25 at 8:42 a.m., the administrator was called, there was no answer and a message was left that stressed the importance of a return call and the need for information needed to complete the survey. On 10/15/25 at 11:02 a.m., the administrator was called. There was no answer and a message was left again stressing the importance of the facility providing the documentation necessary to	C 940		

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C 940	Continued From page 13 complete the survey. By the end of the survey on 10/15/25, a plan of removal for the IJ, documentation of resident weights, physician orders, a dietician, or facility policies had not been provided by the facility. An exit interview was conducted with CNA #1.	C 940		
C 951 SS=L	310:663-9-5(a) - USE 6000 STAFF QUALIFICATIONS (a) All of the assisted living center's employees shall be subject to the requirements for criminal arrest checks applicable to nurses aides under 63 O.S. Supp. 1997, Section 1-1950.1. 63-1-1950.1(B) 1. Except as otherwise provided by subsection C of this section, before any employer makes an offer to employ or to contract with a nurse aide or other person to provide nursing care, health-related services or supportive assistance to any individual except as provided by paragraph 4 of this subsection, the employer shall provide for a criminal history background check to be made on the nurse aide or other person pursuant to the provisions of this section. If the employer is a facility home or institution which is part of a larger complex of buildings, the requirement of a criminal history background check shall apply only to an offer of employment or contract made to a person who will work primarily in the immediate boundaries of the facility, home or institution. 2. Except as otherwise specified by subsection D of this section, an employer is authorized to obtain any criminal history background records	C 951		

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C 951	Continued From page 14 maintained by the Oklahoma State Bureau of Investigation which the employer is required or authorized to request by the provisions of this section. 3. The employer shall request the Bureau to conduct a criminal history background check on the person and shall provide to the Bureau any relevant information required by the Bureau to conduct the check. The employer shall pay a fee of Fifteen Dollars (\$15.00) to the Bureau for each criminal history background check that is conducted pursuant to such a request. 4. The requirement of a criminal history background check shall not apply to an offer of employment made to: a. a nursing home administrator licensed pursuant to the provisions of Section 330.53 of this title, b. any person who is the holder of a current license or certificate issued pursuant to the laws of this state authorizing such person to practice the healing arts, c. a registered nurse or practical nurse licensed pursuant to the Oklahoma Nursing Practice Act, d. a physical therapist registered pursuant to the Physical Therapy Practice Act, e. a physical therapist assistant licensed pursuant to the Physical Therapy Practice Act, f. a social worker licensed pursuant to the provisions of the Social Worker's Licensing Act, g. a speech pathologist or audiologist licensed pursuant to the Speech-Language Pathology and Audiology Licensing Act, h. a dietitian licensed pursuant to the provisions of the Licensed Dietitian Act, i. an occupational therapist licensed	C 951		

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C 951	Continued From page 15 pursuant to the Occupational Therapy Practice Act, or j. an individual who is to be employed by a nursing service conducted by and for the adherents of any religious denomination, the tenets of which include reliance on spiritual means through prayer alone for healing. 5. At the request of the employer, the Bureau shall conduct a criminal history background check on any person employed by the employer, including the persons specified in paragraph 4 of this subsection at any time during the period of employment of such person. 63-1-1950.1(C) 1. An employer may make an offer of temporary employment to a nurse aide or other person pending the results of the criminal history background check on the person. The employer in such instance shall provide to the Bureau the name and relevant information relating to the person within seventy-two (72) hours after the date the person accepts temporary employment. The employer shall not hire or contract with a person on a permanent basis until the results of the criminal history background check are received. 2. An employer may accept a criminal history background report less than one (1) year old of a person to whom such employer makes an offer of employment or employment contract. The report shall be obtained from the previous employer or contractor of such person and shall only be obtained upon the written consent of such person.	C 951		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING ROSE CHRISTIAN ASSISTED LIVING HOME

1108 NORTH FERN AVENUE
BROKEN ARROW, OK 74012

This LEVEL A is not met as evidenced by:

Oklahoma State Department of Health

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C 951	Continued From page 17 On 10/10/25, an IJ situation was determined to exist related to the facility's failure to ensure staff were qualified to administer intravenous medication via a PICC line. Resident #1, who was currently in the hospital, had required intravenous medication via a PICC line while living at the facility. There were no licensed or registered staff employed at the facility. This task was beyond their scope of practice and had the potential for putting the resident at risk of serious adverse outcomes. On 10/10/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 10/10/25 at 3:03 p.m., the administrator was not in the building but was called by CNA #1 and placed on speaker. CNA #1 and the administrator were notified of the IJ situation. A plan of removal was not provided. The deficiency remained at a level of IJ. Based on record review and interview, the facility failed to ensure staff were performing duties within the scope of their practice for 1 (#1) of 1 sampled resident reviewed for administration of medication through a PICC line. CNA #1 identified six residents resided in the facility, and one resident had a PICC line. Findings: A pharmacy order, dated 06/30/25, documented Resident #1 had a diagnosis of chronic osteomyelitis [a bone infection]. The order showed Ancef [an antibiotic] was to be administered every 12 hours via an IV push. The	C 951		

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C 951	Continued From page 18 IV line was to be flushed with normal saline before and after each dose of medication. The unused lumens (access ports to the PICC line) were to be flushed with normal saline every twelve hours, then flushed with 3-5 milliliters of heparin (an anticoagulant). On 10/01/25, the MARs were requested for Resident #1. The September and October 2025 MARs were reviewed. The MARs did not show documentation of the medication Ancef was administered. A review of employee files or certifications was not available during the survey. A review of the Oklahoma Board of Nursing registry did not show the administrator had a nursing license. On 10/01/25 at 10:35 a.m., CNA #1 stated they did not have access to staff certifications. CNA #1 stated they were a CNA and had their MAT. They stated the other staff were also CNAs and but did not know their other qualifications. On 10/08/25 at 2:37 p.m., family member #2, a relative of Resident #1, stated they had witnessed both staff and the administrator administer the IV medication through the PICC line for Resident #1. Family Member #2 stated they did not recall the name of the staff. On 10/09/25 at 12:47 p.m., CNA #3 stated they had not administered the IV medication for Resident #1. They then stated that was incorrect, they had administered the antibiotic through the PICC line for Resident #1. CNA #3 stated they had a CNA license and a MAT license. CNA #3 stated they knew they did not have the	C 951		

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C 951	Continued From page 19 qualifications to administer the IV medication but had done so at the insistence of the administrator. They stated the administrator had given them instructions on how to administer the medication over the phone. On 10/09/25 at 2:48 p.m., home health nurse #1 stated administration of the IV medication for Resident #1 was not the duty of the home health staff. They stated home health staff changed the dressings on the PICC line and drew labs. They stated the administrator was asked if the staff at the facility required education related to the administration of the IV medication and the administrator was adamant education was not necessary. On 10/09/25 at 3:13 p.m., the administrator was called, there was no answer. A message was left stating the importance of having access to documentation needed to complete the survey. On 10/09/25 at 4:26 p.m., the administrator was called, there was no answer. A recording reported the mailbox was full. On 10/10/25 at 8:42 a.m., the administrator was called, there was no answer. A message was left stating the importance and urgency for access to the information needed to complete the survey. On 10/15/25 at 11:02 a.m., the administrator was called. There was no answer. A message was left again stressing the need for documentation to complete the survey. By the end of the survey, the facility not provided a plan of removal. On 10/15/25 at 12:54 p.m., and exit interview was	C 951		

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C 951	Continued From page 20 conducted with CNA #1.	C 951		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to	C1512		

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NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
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C1512	Continued From page 21 occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 10/10/25, an IJ situation was determined to exist related to the facility's failure to ensure a resident was free from abuse. Resident #4 stated the administrator had banged their head against a wall and had shaken their head back and forth. On 10/10/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 10/10/25 at 3:03 p.m., the administrator was not in the building but was called by Staff #1 and placed on speaker. CNA #1 and the administrator were notified of the IJ situation.	C1512		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
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C1512	Continued From page 22 A plan of removal was not received from the facility. The deficiency remained at the level of an IJ. Based on record review and interview, the facility failed to ensure a resident were free from abuse for 1 (#4) of 5 sampled residents reviewed for abuse. CNA #1 identified six residents resided in the facility. Findings: On 10/01/25 at 10:35 a.m., an entrance conference was held with CNA #1. A request was made for access to facility policies, staff clinical certifications, and resident clinical records. A review of the clinical records provided for Resident #4 did not show diagnoses. On 10/06/25 at 10:20 a.m., previous employee #1 stated they had witnessed abuse by the administrator. They stated the administrator grabbed Resident #4 by their chin and shook their face back and forth. They stated the administrator had told Resident #4 to hold their head up. On 10/06/25 at 2:28 p.m., Resident #4 stated the staff were not always nice. They stated staff had smashed their head against a bathroom wall and grabbed their face and shook it back and forth. Resident #4 stated they were afraid to say who had done this because they were very vulnerable and could not do anything for themselves anymore. Resident #4 was asked if the administrator had done these things. They	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 23 stated, yes. On 10/09/25 at 3:13 p.m., the administrator was called, there was no answer, a message was left requesting a return phone call. On 10/09/25 at 4:26 p.m., a phone call was made to the administrator, there was no answer. A recording was heard stating the mailbox was full. On 10/10/25 at 8:42 a.m., the administrator was called, there was no answer and a message was left that stressed the importance of a return call and the need for information needed to complete the survey. On 10/15/25 at 11:02 a.m., the administrator was called. There was no answer and a message was left again stressing the importance of the facility providing the documentation necessary to complete the survey. By the end of the survey on 10/15/25, no documentation of an abuse policy, staff education on recognizing and reporting of abuse, or documentation of background checks for staff had been provided by the facility. On 10/15/25 at 12:54 p.m., an exit interview was conducted with CNA #1 present.	C1512		
C1933 SS=L	310:663-19-2(b)(3) MEDICATION ADMINISTRATION (b) An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished. (3) Only a licensed nurse, physician,	C1933		

Oklahoma State Department of Health

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C1933	Continued From page 24 pharmacist, certified medication aide or medication aide technician may dispense for administration these medications and only upon a physician's written order for as needed or nonscheduled dosage regimens. The physician's written order shall be maintained in the resident's clinical record. This LEVEL B is not met as evidenced by: On 09/10/25, an IJ situation was determined to exist related to the facility's failure to ensure medications were administered according to physician orders. Medications were administered without checking physician orders, medications were relabeled for a different resident and medications were observed to be different pills in the same bottle of medication. This widespread practice had the potential for serious harm, injury or death to the residents. On 09/10/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 09/10/25 at 3:03 p.m., the administrator was not in the facility and was contacted by CNA #1 and placed on speaker phone. CNA #1 and the administrator were notified of the IJ situation. A plan of removal was not received from the facility. The deficiency remained at a level of immediate jeopardy. Based on observation, record review, and interview, the facility failed to ensure physician orders were followed for medication administration for 5 (#1, 2, 3, 4, and #5) of 6 sampled residents reviewed for physician orders.	C1933		

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C1933	Continued From page 25 CNA #1 identified six residents resided in the facility who received medications. Findings: On 10/09/25 at at 9:31 a.m., CNA #2 was observed during medication pass. CNA #2 opened a bottle labeled aspirin 81 mg for Resident #3. CNA #2 poured multiple pills into the cap of the aspirin bottle. Two different pills were observed in the cap. One pill was observed as a scored pink tablet and the other was a smaller shiny yellow tablet. The bottle label described the medication it contained to be a small yellow enteric coated tablet. On 10/09/25 at 9:37 a.m., CNA #2 retrieved the box and the MAR labeled with Resident #2's name from the medication closet. CNA #2 reviewed the MAR for medications to dispense at this time. CNA #2 picked up a bottle from Resident #2's box, but the bottle was empty. The prescription bottle was tall, green and the label read Eliquis, 2.5 mg. The name on the prescription label was marked out with a black marker and Resident #2's name was hand written in ink on the label. The name under the black marker was still readable and the printed name showed the prescription was filled for Resident #1. This medication was not administered and CNA #2 was unable to locate a bottle of Eliquis for Resident #2. On 10/01/25, records for Resident #1, 2, 3, 4, 5, and #6 were reviewed. These resident records consisted of a physical folder. No physician orders were present in any of the resident records.	C1933		

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C1933	Continued From page 26 On 10/02/25 at 10:42 a.m., CNA #1 stated they did not have access to any of the resident's medical records. CNA #1 stated they had never seen any physician orders, or other medical records. They stated the administrator kept those records. CNA #1 stated they did not know if the facility had an RN. CNA #1 stated they administered the medications according to the MAR. On 10/06/25 at 10:42 a.m., previous employee #1 stated they had administered medications while employed at the facility, but had never seen physician orders, only the MAR. They stated the administrator filled out the MAR each month. On 10/06/25 at 11:14 a.m., Staff #6 stated they did not have access to physician orders and administered medications according to what was written on the MAR. On 10/07/25 at 9:00 a.m., CNA #2 stated they did not have access to physician orders, they passed medications according to the instructions on the MAR. On 10/09/25 at 9:50 a.m., CNA #2 stated they had seen a bottle of the prescribed medication Eliquis for Resident #2 in the past, but could not locate one at this time. CNA #2 stated they assumed both medications in the aspirin bottle were aspirin, and the bottle had been refilled. CNA #2 stated they "don't really know what they (the pills) are." On 10/09/25 at 3:13 p.m., a phone call was made to the administrator. The administrator did not answer and a message was left stating the importance of returning the call in order to obtain access to facility documentation.	C1933		

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C1933	Continued From page 27 On 10/09/25 at 4:26 p.m., again attempted to reach the administrator by phone. There was no answer. A recording was received that stated the mailbox was full and could not receive messages. On 10/15/25 at 11:02 a.m., a phone call was made to the administrator. There was no answer and a message was left stating the urgency of receiving documentation to complete the survey. On 10/15/25 at 12:54 p.m., an exit interview was conducted with CNA #1.	C1933		
C1951 SS=F	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure accurate clinical records were available for 6 (#1, 2, 3, 4, 5, and #6) of 6 sampled residents reviewed for clinical records. CNA #1 identified six residents resided in the facility. Findings: On 10/01/25 at 10:42 a.m., a request was made for access to clinical records for all residents	C1951		