Oklahoma State Department of Health
Creating a State of Health

August 15, 2019

License Number: AL7262

Mr. Tim Stimson, Administrator
Broken Arrow Assisted Living
2621 South Elm Place
Broken Arrow, OK 74012

Survey Event ID: JO8W11

Dear Mr. Stimson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **July 30, 2019**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Sue Davis

Sue Davis
Long Term Care Enforcement Coordinator
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Broken Arrow Assisted Living**
Address: **2621 South Elm Place**
City, State, Zip: **Broken Arrow, OK. 74012**
Provider #: **AL7262**
Complaint #: **OK#53688**
Investigation Date(s): **07/30/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide an abuse free environment.	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on **07/30/2019** at 2:30 p.m.

A sample of 6 residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation. An investigation specific to the center providing an abuse free environment was conducted.

A tour of the center was conducted, residents were observed interacting with staff in the common area of the center. No abuse was observed throughout this investigation and both residents and staff were interviewed related to any abuse at the center. Resident's all denied any type of abuse when interviewed including the resident documented in the complaint. The residents interviewed stated they liked living at the center and loved the staff. No complaints related to staff were received during the interviews.

Multiple staff were interviewed and all denied any kind of abuse at the center. Staff denied anyone including the administrator (ADM) spoke to residents in a loud voice. The ADM was asked if he had ever yelled or became angry with a resident. He said he had not ever yelled or spoke to residents in a loud voice. The ADM said there had been no complaints received related to any kind of abuse (staff or resident).

The ADM was asked if any residents took things from him or other residents. The ADM said resident #2 had dementia and she had taken candy from a bowl in his office. The ADM said when resident #2 wonders through she takes some candy but it was not stealing since it was for everyone to enjoy. The ADM said resident #2 occasionally will take Kleenex and the like from different areas but staff see the items on her walker and return them, it was not an issue and he did not consider this a misappropriation of property. The ADM said he had received no complaints from anyone (resident or staff).

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation 1. No further action is required. A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Justina Leach RN/CHFS

Date report completed: 07/31/2019

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
	AL7262	A. BUILDING. _____ B. WING _____	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROKEN ARROW ASSISTED LIVING	2621 SOUTH ELM PLACE 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 abbreviated survey was conducted on 07/30/19, to investigate complaint #53688. The resident census was 22. No deficient practice was cited.	C 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7262	BROKEN ARROW ASSISTED LIVING

Type of Survey (select all that apply)

3								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID JV 1. 32388	07/30/2019	07/30/2019	0.50	0.00	1.75	0.00	2.50	1.50
2. 18273 CR	07/30/2019	07/30/2019	0.50	0.00	1.75	0.00	2.25	2.00
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12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

AUG 19 2019