OKLAHOMA
State Department of Health

Delivery via email to: dparke@canoebrookal.com

September 13, 2024

License Number: AL7262

Mr. Darrell Parke, Administrator
Broken Arrow Assisted Living
2621 South Elm Place
Broken Arrow, OK 74012

Survey Event ID: EGUP11

Dear Mr. Parke:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **August 13, 2024**. 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) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
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of Health

INVESTIGATIVE REPORT

Facility: **Broken Arrow Assisted Living**
Address: **2621 South Elm Place**
City, State, Zip: **Broken Arrow, Ok. 74012**
Provider #: **AL7262**
Complaint #: **OK00065967**
Investigation Date(s): **08/13/24**

ALLEGATION(S)
The center failed to protect the resident from abuse by staff.

An unannounced on-site investigation was initiated 08/13/2024 at 11:30 a.m.

A sample of three 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:
On arrival and throughout the survey, resident/staff interactions were observed. Staff were observed to interact with residents in a kind and respectful manner.

Interviews were conducted with staff and residents regarding abuse. Facility staff denied any knowledge of abuse occurring in the facility and were able to identify key components of the facility abuse policy. Residents were interviewed and denied any abuse or knowledge of abuse occurring in the facility.

Clinical records were reviewed. Facility records were reviewed. Employee records were reviewed. Facility policy and procedures were reviewed.

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: 08/13/2024

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 _____	C 08/13/2024

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 A complaint investigation (#OK00065967) was conducted on 08/13/24. No deficiencies were cited. Facility Census: 36	C 000		

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