OKLAHOMA
State Department
of Health

Delivery via email to: mjames@beehivebrokenarrow.com

October 17, 2022

License Number: AL7269

Ms. Magen James, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

Survey Event ID: I9RB11

Dear Ms. James:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **October 6, 2022**. 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.

Sincerely,

Lisa Calvin

Lisa Calvin
Long Term Care Enforcement Analyst
Oklahoma State Department of Health

OKLAHOMA
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of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Beehive Homes of Broken Arrow**
Address: **3200 W Washington St.**
City, State, Zip: **Broken Arrow, OK**
Provider #: **AL7269**
Complaint #: **OK00059560**
Investigation Date:: **10/06//22**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed residents were not neglected and failed to ensure coordination of care with other providers.	**US**
2. The center failed to provide contracted services and failed to ensure the center could provide the appropriate level of care for resident acuity.	**US**

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

An unannounced on-site investigation was initiated on Click to enter a date at 11:00 a.m.

A sample of three 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.

The facility was clean, orderly, and without odor. Residents were clean and groomed. Staff was observed assisting resident with their needs. No resident was observed to be in distress. Staff was observed assisting and/or encouraging residents with two meals.

Staff stated which residents required assistance with meals, which residents needed reminding and/or encouragement to eat and which residents were independent with meals. Staff also stated which residents required supplements and the type of supplement the resident preferred.

Record review of the sampled resident facility records documented assessments were completed, and families were notified of changes in condition.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

The facility was clean and without odors. The residents were clean, and groomed. Residents were gathered in the common areas. Residents were observed in the dining area. Staff was observed assisting residents with activities of daily living. Resident needs and requests were observed to be addressed in a timely manner.

Staff stated residents were seen by physicians on a regular basis. Staff stated communication between other providers was essential and completed.

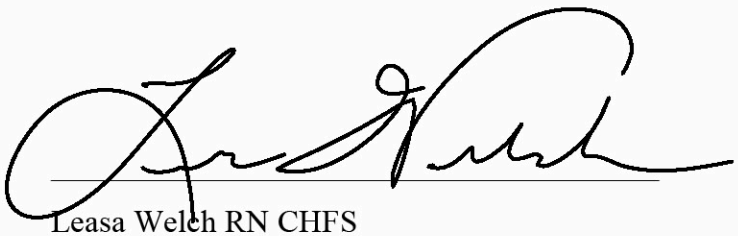
Record review of the sampled residents' medical records documented contracted care was provided by both the center and other providers. Reports and other forms of communication was also well documented in resident records

Determination Summary and Follow-Up Action:.

Deficient practice was unsubstantiated for allegation 1 and 2. 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.



Leasa Welch RN CHFS

Date report completed: 10/10/2022

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
	AL7269	A. BUILDING: _____ B. WING _____	C 10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BROKEN ARROW	3200 W WASHINGTON ST 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 (#OK00059560) was conducted on 10/06/22. No deficiencies were cited.	C 000		

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