OKLAHOMA
State Department
of Health

Delivery via email to: lwheat@beehivebrokenarrow.com

March 6, 2024

License Number: AL7269

Mr. Shane Lee, Administrator/Director
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event ID: V33X11

Dear Mr. Lee:

On **February 28, 2024**, 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.

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 **February 28, 2024**.

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.

OKLAHOMA
State Department of Health

Delivery via email to: lwheat@beehivebrokenarrow.com

March 29, 2024

License Number: AL7269

Mr. Shane Lee, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event V33X11

Dear Mr. Lee:

On **February 28, 2024**, a Licensure inspection with a complaint investigation 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 **March 8, 2024**.

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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 03/11/2024
Facility Name: Beehive Homes of Broken Arrow
License Number: AL7269
Survey Event ID: V33X11
Date Survey Completed: 02/28/2024

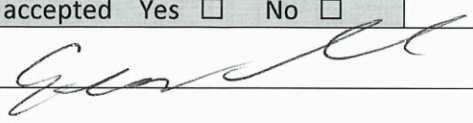
SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711 SS=D	Based on: Each Assisted living Center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	An Annual Fire Inspection shall be completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents of Beehive Homes-Broken Arrow have the potential to be affected by not having an Annual Fire Inspection.
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?	The Broken Arrow Fire Marshall shall be called on annually to complete the Annual Fire Inspection. The Fire Marshall call shall be placed on a Calendar of Routine Duties to be called each February. The call shall be repeated each week until the Fire Inspection is completed. The Safety Committee Chairman shall review the Fire Inspection Report Quarterly for discussion at the Quarterly QA Committee Meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Annual Fire Inspection shall be placed as a routine item for discussion on the agenda of the Quarterly QA Meeting. The Annual Fire Inspection Report discussion shall be entered into the Minutes of the Quarterly Quality Assurance Meeting. The Quality Assurance Committee shall evaluate how affective the Plan is and take further action as indicated.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	03/08/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature 
OAC 310:663-25-4(F)

Date 03/11/2024

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		**Submitted by**	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date:		Surveyor:	
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 03/11/2024 **Facility Name:** Beehive Homes of Broken Arrow **License Number:** AL7269 **Survey Event ID:** V33X11 **Date Survey Completed:** 02/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954 SS=D	Based on: Based on record review and interview, the facility failed to ensure direct care staff received CPR and first aid training for one (CNA #3)

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All Beehive-Homes of Broken Arrow Direct Care staff shall provide evidence of First Aid and Cardiopulmonary Resuscitation to facility Administrator or designee upon employment and renewals as due.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents of Beehive- Homes of Broken Arrow have the potential to be affected by the lack of trained staff in First Aid and Cardiopulmonary Resuscitation.
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?	Employee #3 Self-Terminated. No Direct Care staff shall be allowed to work without current proof of First Aid and Cardiopulmonary Resuscitation. Evidence of First Aid and CPR training shall be kept in employee records. A Master List of all Direct Care Staff renewal dates shall be kept by the DON and reviewed monthly. The DON shall report on First Aid and CPR certification compliance at the Quarterly QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The review of the First Aid and CPR certification compliance shall appear on the agenda of the Quarterly QA meeting. The Quality Assurance Committee shall evaluate the report of compliance and take further action as indicated.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		02/29/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)			**Date** 03/11/2024
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		**Submitted by**	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date:		Surveyor:	
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 03/11/2024 **Facility Name:** Beehive Homes of Broken Arrow **License Number:** AL7269 **Survey Event ID:** V33X11 **Date Survey Completed:** 02/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110 SS=E	Based on: Based on record review and interview, the center failed to have a quality assurance committee to monitor trends, incidents, customer satisfaction measure, and document quality assurance efforts and outcomes.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Beehive- Homes of Broken Arrow has established and shall maintain a Quality Assurance Committee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents of Beehive Homes-Broken Arrow have the potential to be affected with no Quality Assurance program.
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?	The Quality Assurance Committee shall meet a minimum of quarterly. Minutes shall be kept of the Quality Assurance Committee recording the trends and incidents, customer satisfaction and the QA Committees efforts and outcomes. The Administrator or Designee shall chair the Quality Assurance Committee. Forms shall be developed to monitor trends, incidents, customer satisfaction and action plans for improvement.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Minutes shall be kept at each Quarterly QA meeting indicating trends and actions taken. The Quality Assurance Committee shall evaluate all issues brought forth and plan appropriate action.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	02/28/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		**Date**	3-11-24
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		**Submitted by**	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date:		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.			

BEE HIVE HOMES
RESIDENT RIGHTS

It shall be the policy of Bee Hive Homes to guarantee the following rights to our residents:

A. the right to be treated with respect, consideration, fairness, and full recognition of personal dignity and individuality;

B. the right to be transferred, discharged, or evicted by Bee Hive Homes only in accordance with the terms of the signed admission agreement;

C. the right to be free of mental and physical abuse, and chemical and physical restraints;

D. the right to refuse to perform work for Bee Hive Homes;

E. the right to perform work for Bee Hive Homes if the facility consents and if:
   1. the facility has documented the resident's need or desire for work in the service plan,
   2. the resident agrees to the work arrangement described in the service plan,
   3. the service plan specifies the nature of the work performed and whether the services are voluntary or paid, and
   4. compensation for paid services is at or above the prevailing rate for similar work in the surrounding community;

F. the right to privacy during visits with family, friends, clergy, social workers, ombudsmen, resident groups, and advocacy representatives;

G. the right to share a unit with a spouse if both spouses consent, and if both spouses are facility residents;

H. the right to privacy when receiving personal care or services;

I. the right to keep personal possessions and clothing as space permits;

J. the right to participate in religious and social activities of the resident's choice;

K. the right to interact with members of the community both inside and outside the facility;

L. the right to send and receive mail unopened;

M. the right to have access to telephones to make and receive private calls;

N. the right to arrange for medical and personal care;

O. the right to have a family member or responsible person informed by Bee Hive Homes of significant changes in the resident's cognitive, medical, physical, or social condition or needs;

P. the right to leave Bee Hive Homes at any time and not be locked into any room, building, or on the facility premises during the day or night. This right does not prohibit the establishment of house rules such as locking doors at night for the protection of residents;

Q. the right to be informed of complaint or grievance procedures and to voice grievances and recommend changes in policies and services to Bee Hive Homes' staff or outside representatives without restraint, discrimination, or reprisal;

R. the right to be encouraged and assisted throughout the period of a stay to exercise these rights as a resident and as a citizen;

S. the right to manage and control personal funds, or to be given an accounting of personal funds entrusted to Bee Hive Homes, as provided in R432-270-20 concerning management of resident funds;

T. the right, upon oral or written request, to access within 24 hours all records pertaining to the resident, including clinical records;

U. the right, two working days after the day of the resident's oral or written request, to purchase at a cost not to exceed the community standard photocopies of the resident's records or any portion thereof;

V. the right to personal privacy and confidentiality of personal and clinical records;

W. the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

X. the right to be fully informed in a language and in a manner the resident understands of the resident's health status and health rights, including the following:
   1. medical condition;
   2. the right to refuse treatment;
   3. the right to formulate an advance directive in accordance with UCA Section 75-2-1101; and
   4. the right to refuse to participate in experimental research.

All resident rights are confidential. Residents/guardians may see their own files at any reasonable time. Residents are provided any other right established by law.

I have received a copy of the Resident Rights policy to keep for myself. I, by my signature below, state that I have read and understand the Resident Rights policy.

Employee Signature _____ Date _____

OKLAHOMA
State Department
of Health

Delivery via email to: lwheat@beehivebrokenarrow.com

May 2, 2024

License Number: AL7269

Mr. Shane Lee, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event V33X12

Dear Mr. Lee:

On **May 1, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your re-licensure survey with complaints on **February 28, 2024,** have now been corrected effective **March 8, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7269	A. BUILDING: _____ B. WING _____	R-C 05/01/2024

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 On 05/01/24, an offsite/revisit was conducted. The deficiencies were cleared from 02/28/24.	{C 000}		

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

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
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,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Beehive Homes of Broken Arrow**
Address: **3200 West Washington Street South**
City, State, Zip: **Broken Arrow, OK, 74012, Tulsa**
Provider #: **AL7269**
Complaint #: **OK00060303**
Investigation Dates: **02/26/24 through 02/28/24**

ALLEGATIONS

The center failed to ensure medications were administered in a timely manner.
The center failed to ensure an active administrator was onsite.

An unannounced on-site investigation was initiated 02/26/2024 at 8:45 a.m.

A sample of eight 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 various times throughout the survey. Resident hallways were observed for staff assistance and odors. Medication administration was observed.

Grievance reports, incident reports, policies and procedures were reviewed. Resident records including assessments, care plans and medication administration records were also reviewed.

Residents, staff, family members, and the ombudsman were interviewed regarding medication and administration.

The attached Statement of Deficiencies, Form 2567 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: 02/28/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Beehive Homes of Broken Arrow**
Address: **3200 West Washington Street South**
City, State, Zip: **Broken Arrow, OK, 74012, Tulsa**
Provider #: **AL7269**
Complaint #: **OK00061668**
Investigation Dates: **02/26/24 through 02/28/24**

ALLEGATIONS

The facility failed to ensure residents were not abused.
The facility failed to ensure residents received physician ordered meals and snacks according to schedule.

An unannounced on-site investigation was initiated 02/26/2024 at 8:45 a.m.

A sample of eight 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 various times throughout the survey. Resident hallways were observed for staff and resident interactions. Meal service and snacks were observed.

Grievance reports, incident reports, policies and procedures were reviewed. Resident records including physician orders, assessments and plans of care were reviewed.

Residents, staff, family members, and the ombudsman were interviewed regarding abuse, snacks, and diets.

The attached Statement of Deficiencies, Form 2567 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: 02/28/2024

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 02/28/2024

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 relicensure survey was conducted from 02/26/24 through 02/28/24. Complaint investigations (#OK00060303 and OK00061668) were conducted in conjunction with the survey. Facility Census: 20 Listed below are abbreviations that will be used throughout this document. CPR - cardiopulmonary resuscitation DON - director of nurses	C 000		
C 711 SS=D	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure fire safety inspections were completed annually. The DON reported the census was 20.	C 711		

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 02/28/2024

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 711	Continued From page 1 Findings: A document titled "Broken Arrow Fire Inspection Report", dated 09/29/22, documented the center had been inspected on 09/29/22. On 02/26/24 at 1:45 p.m. the DON stated a fire inspection report had not been completed since 09/29/22.	C 711		
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 received CPR and first aid training for one (CNA #3) of four staff reviewed for CPR and first aid training. The DON reported the census was 20. Findings: An undated "Policies and Procedures Manual", read in part, "...Direct care staff shall provide evidence of first aid and cardiopulmonary resuscitation certification to the administrator or	C 954		

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 02/28/2024

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 954	Continued From page 2 designee upon employment and proof of renewal when certification renewals are due. Records of first aid and cardiopulmonary resuscitation certification shall be maintained in the employee's record..." A review of CNA #3's personnel file did not document CPR or first aid training. On 02/28/24 at 9:00 a.m., the DON was asked to provide documentation of CPR and first aid training for CNA #3. On 02/28/24 at 9:15 a.m., the DON stated CNA #3 did not have documentation of current CPR and first aid training.	C 954		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

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 02/28/2024

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
C1110	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the center failed to have a quality assurance committee to monitor trends, incidents, customer satisfaction measures, and document quality assurance efforts and outcomes. The DON reported the census was 20. Findings: An undated "Policies and Procedures Manual", read in part, " ...The administrator will be responsible for ...establishing the quality assurance committee ...The quality assurance committee will meet quarterly. Minutes of the meetings will be kept and filed in quality assurance binder ..." On 02/28/24 at 9:30 a.m., Corporate Nurse Consultant #1 was asked for documentation of quality assurance meetings. On 02/28/24 at 10:00 a.m., Corporate Nurse Consultant #1 stated the facility had no documentation related to the quality assurance committee.	C1110		

OKLAHOMA
State Department of Health

Delivery via email to: lwheat@beehivebrokenarrow.com

March 29, 2024

License Number: AL7269

Mr. Shane Lee, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event V33X11

Dear Mr. Lee:

On **February 28, 2024**, a Licensure inspection with a complaint investigation 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 **March 8, 2024**.

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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 03/11/2024
Facility Name: Beehive Homes of Broken Arrow
License Number: AL7269
Survey Event ID: V33X11
Date Survey Completed: 02/28/2024

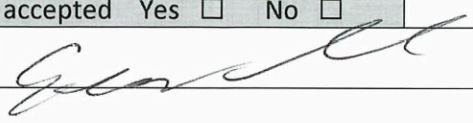
SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711 SS=D	Based on: Each Assisted living Center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	An Annual Fire Inspection shall be completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents of Beehive Homes-Broken Arrow have the potential to be affected by not having an Annual Fire Inspection.
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?	The Broken Arrow Fire Marshall shall be called on annually to complete the Annual Fire Inspection. The Fire Marshall call shall be placed on a Calendar of Routine Duties to be called each February. The call shall be repeated each week until the Fire Inspection is completed. The Safety Committee Chairman shall review the Fire Inspection Report Quarterly for discussion at the Quarterly QA Committee Meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Annual Fire Inspection shall be placed as a routine item for discussion on the agenda of the Quarterly QA Meeting. The Annual Fire Inspection Report discussion shall be entered into the Minutes of the Quarterly Quality Assurance Meeting. The Quality Assurance Committee shall evaluate how affective the Plan is and take further action as indicated.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	03/08/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature 
OAC 310:663-25-4(F)

Date 03/11/2024

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		**Submitted by**	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date:		Surveyor:	
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 03/11/2024 **Facility Name:** Beehive Homes of Broken Arrow **License Number:** AL7269 **Survey Event ID:** V33X11 **Date Survey Completed:** 02/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954 SS=D	Based on: Based on record review and interview, the facility failed to ensure direct care staff received CPR and first aid training for one (CNA #3)

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All Beehive-Homes of Broken Arrow Direct Care staff shall provide evidence of First Aid and Cardiopulmonary Resuscitation to facility Administrator or designee upon employment and renewals as due.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents of Beehive- Homes of Broken Arrow have the potential to be affected by the lack of trained staff in First Aid and Cardiopulmonary Resuscitation.
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?	Employee #3 Self-Terminated. No Direct Care staff shall be allowed to work without current proof of First Aid and Cardiopulmonary Resuscitation. Evidence of First Aid and CPR training shall be kept in employee records. A Master List of all Direct Care Staff renewal dates shall be kept by the DON and reviewed monthly. The DON shall report on First Aid and CPR certification compliance at the Quarterly QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The review of the First Aid and CPR certification compliance shall appear on the agenda of the Quarterly QA meeting. The Quality Assurance Committee shall evaluate the report of compliance and take further action as indicated.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		02/29/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)			**Date** 03/11/2024
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		**Submitted by**	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date:		Surveyor:	
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 03/11/2024 **Facility Name:** Beehive Homes of Broken Arrow **License Number:** AL7269 **Survey Event ID:** V33X11 **Date Survey Completed:** 02/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110 SS=E	Based on: Based on record review and interview, the center failed to have a quality assurance committee to monitor trends, incidents, customer satisfaction measure, and document quality assurance efforts and outcomes.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Beehive- Homes of Broken Arrow has established and shall maintain a Quality Assurance Committee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents of Beehive Homes-Broken Arrow have the potential to be affected with no Quality Assurance program.
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?	The Quality Assurance Committee shall meet a minimum of quarterly. Minutes shall be kept of the Quality Assurance Committee recording the trends and incidents, customer satisfaction and the QA Committees efforts and outcomes. The Administrator or Designee shall chair the Quality Assurance Committee. Forms shall be developed to monitor trends, incidents, customer satisfaction and action plans for improvement.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Minutes shall be kept at each Quarterly QA meeting indicating trends and actions taken. The Quality Assurance Committee shall evaluate all issues brought forth and plan appropriate action.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	02/28/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		**Date**	3-11-24
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		**Submitted by**	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date:		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.			

BEE HIVE HOMES
RESIDENT RIGHTS

It shall be the policy of Bee Hive Homes to guarantee the following rights to our residents:

A. the right to be treated with respect, consideration, fairness, and full recognition of personal dignity and individuality;

B. the right to be transferred, discharged, or evicted by Bee Hive Homes only in accordance with the terms of the signed admission agreement;

C. the right to be free of mental and physical abuse, and chemical and physical restraints;

D. the right to refuse to perform work for Bee Hive Homes;

E. the right to perform work for Bee Hive Homes if the facility consents and if:
   1. the facility has documented the resident's need or desire for work in the service plan,
   2. the resident agrees to the work arrangement described in the service plan,
   3. the service plan specifies the nature of the work performed and whether the services are voluntary or paid, and
   4. compensation for paid services is at or above the prevailing rate for similar work in the surrounding community;

F. the right to privacy during visits with family, friends, clergy, social workers, ombudsmen, resident groups, and advocacy representatives;

G. the right to share a unit with a spouse if both spouses consent, and if both spouses are facility residents;

H. the right to privacy when receiving personal care or services;

I. the right to keep personal possessions and clothing as space permits;

J. the right to participate in religious and social activities of the resident's choice;

K. the right to interact with members of the community both inside and outside the facility;

L. the right to send and receive mail unopened;

M. the right to have access to telephones to make and receive private calls;

N. the right to arrange for medical and personal care;

O. the right to have a family member or responsible person informed by Bee Hive Homes of significant changes in the resident's cognitive, medical, physical, or social condition or needs;

P. the right to leave Bee Hive Homes at any time and not be locked into any room, building, or on the facility premises during the day or night. This right does not prohibit the establishment of house rules such as locking doors at night for the protection of residents;

Q. the right to be informed of complaint or grievance procedures and to voice grievances and recommend changes in policies and services to Bee Hive Homes' staff or outside representatives without restraint, discrimination, or reprisal;

R. the right to be encouraged and assisted throughout the period of a stay to exercise these rights as a resident and as a citizen;

S. the right to manage and control personal funds, or to be given an accounting of personal funds entrusted to Bee Hive Homes, as provided in R432-270-20 concerning management of resident funds;

T. the right, upon oral or written request, to access within 24 hours all records pertaining to the resident, including clinical records;

U. the right, two working days after the day of the resident's oral or written request, to purchase at a cost not to exceed the community standard photocopies of the resident's records or any portion thereof;

V. the right to personal privacy and confidentiality of personal and clinical records;

W. the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

X. the right to be fully informed in a language and in a manner the resident understands of the resident's health status and health rights, including the following:
   1. medical condition;
   2. the right to refuse treatment;
   3. the right to formulate an advance directive in accordance with UCA Section 75-2-1101; and
   4. the right to refuse to participate in experimental research.

All resident rights are confidential. Residents/guardians may see their own files at any reasonable time. Residents are provided any other right established by law.

I have received a copy of the Resident Rights policy to keep for myself. I, by my signature below, state that I have read and understand the Resident Rights policy.

Employee Signature _____ Date _____

OKLAHOMA
State Department
of Health

Delivery via email to: lwheat@beehivebrokenarrow.com

May 2, 2024

License Number: AL7269

Mr. Shane Lee, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event V33X12

Dear Mr. Lee:

On **May 1, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your re-licensure survey with complaints on **February 28, 2024,** have now been corrected effective **March 8, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7269	A. BUILDING: _____ B. WING _____	R-C 05/01/2024

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 On 05/01/24, an offsite/revisit was conducted. The deficiencies were cleared from 02/28/24.	{C 000}		

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