
Delivery via email to: admin@beehivebrokenarrow.com

April 23, 2025

License Number: AL7269

Trischa Matos, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event ID: NC2D11

Dear Ms. Matos:

On **April 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.

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 **April 15, 2025**.

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.

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

Enclosure

INVESTIGATIVE REPORT

Facility: Beehive Homes of Broken Arrow
Address: 3200 W. Washington St.
City, State, Zip: Broken Arrow, Ok., 74012
Provider #: AL7269
Complaint #: OK00075894
Investigation Date: 04/09/25 through 04/15/25

ALLEGATION(S)
1. The facility failed to ensure residents were not physically, verbally or psychosocially abused
2. The facility failed to ensure assistance with activities of daily living were provided in a timely manner and according to the plan of care.

An unannounced on-site investigation was initiated 04/09/2025 at 1:10 p.m.

A sample of three participants, including any identified participants, 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: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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: 04/15/2025

INVESTIGATIVE REPORT

Facility: Beehive Homes of Broken Arrow
Address: 3200 W. Washington St.
City, State, Zip: Broken Arrow, Ok., 74012
Provider #: AL7269
Complaint #: OK0008006
Investigation Date: 04/09/25 through 04/15/25

ALLEGATION(S)		
1. The center failed to ensure residents/family members/legal surrogates could exercise the right to voice grievances in behalf of residents without retribution.	N	
2. The center failed to ensure residents were administered medications as prescribed by physicians.	N	
3. The facility failed to ensure residents' privacy is protected.	N	
4. The center failed to assess, monitor, and intervene in a timely manner for residents who experienced falls.	N	
5. The center failed to provide incontinent care, in a timely manner, for dependent residents.	N	
6. The center failed to ensure residents were treated with dignity and respect	N	
7. The center failed to ensure residents received meals that were served in a timely manner.	N	
8. The center failed to ensure staff were trained for assigned task.	N	
9. The center failed to have adequate staffing to meet the needs of residents	Y	
10. The facility failed to protect residents' rights to have property remain in his/her room as per contract.	N	
11. The facility failed to ensure resident billing was accurate and per the contracted agreement.	N	

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Facility: Beehive Homes of Broken Arrow
Address: 3200 W. Washington St.
City, State, Zip: Broken Arrow, Ok., 74012
Provider #: AL7269
Complaint #: OK00080484
Investigation Date: 04/09/25 through 04/15/25

ALLEGATION(S)
1. The facility failed to ensure adequate supervision to prevent a fall with a major injury.

An unannounced on-site investigation was initiated 04/09/2025 at 1:10 p.m.

A sample of three participants, including any identified participants, 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.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/15/2025

INVESTIGATIVE REPORT

Facility: Beehive Homes of Broken Arrow
Address: 3200 W. Washington St.
City, State, Zip: Broken Arrow, Ok., 74012
Provider #: AL7269
Complaint #: OK00080565
Investigation Date: 04/09/25 through 04/15/25

ALLEGATION(S)
1. The facility failed to ensure residents were not physically, verbally or psychosocially abused

An unannounced on-site investigation was initiated 04/09/2025 at 1:10 p.m.

A sample of three participants, including any identified participants, 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.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/15/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/15/2025
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BROKEN ARROW		STREET ADDRESS, CITY, STATE, ZIP CODE 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 on 04/09/25 through 04/10/25 and 04/14/24 through 04/15/25. Complaint investigations (#OK00075894, OK00080006, OK00080484, and #OK00080565) were conducted in conjunction with the survey. Facility Census: 41 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA - certified nursing assistant DON - director of nursing HHA - home health aide	C 000		
C 711 SS=F	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 a completed annual fire	C 711		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 711	Continued From page 1 inspection was conducted for 2025. The executive director identified 41 residents resided in the center. Findings: There was a fire inspection dated 03/11/25 with multiple deficiencies. The deficiencies had a timeline of 29 days for correction. There was no follow up with the fire marshal for evaluation of corrected deficiencies. On 04/10/25 at 2:00 p.m., the executive director was asked if they had followed up on the fire inspection deficiencies. They stated they had left messages for the fire marshal to come back out for re-inspection, but had not heard back from them or scheduled them to return.	C 711		
C 910 SS=F	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 910		

Oklahoma State Department of Health

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C 910	Continued From page 2 This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to provide adequate nursing supervision to ensure needs were met for facility residents. The executive director identified 41 residents resided in the center. Findings: On 04/09/25 from 3:32 p.m. until 4:05 p.m., there were residents observed in the television area near front door with no staff supervision. There were multiple residents with walkers, wheelchairs, and Broda chairs. Residents present were confused and those that were ambulatory with walkers were unsteady and had difficulty getting up and down out of chairs. Facility staff schedules for 03/31/25 thru 04/13/25 showed five staff on the 7 a.m. - 3 p.m. shift, four on the 3 p.m. - 11 p.m. shift, and three on 11 p.m. - 7 a.m. shift for the current census of 41 residents in two separate wings. On 04/09/25 at 4:00 p.m., an agency nursing assistant stated they had been helping another aide in a resident room and there were only two	C 910		

Oklahoma State Department of Health

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C 910	Continued From page 3 staff assigned to each hall this evening, which included the medication aide. A resident condition and overview form, dated 04/09/25, showed 41 residents were not capable of responding to emergency situations without physical assistance from staff of the facility or were not capable of self preservation. On 04/10/25 at 8:30 a.m., the ombudsman stated, "There is a tremendous amount of turnover in staffing and a lot of agency staff is being used which does not allow for consistent care with residents." On 04/10/25 at 9:15 a.m., Resident #2 stated they did not feel like there was ever enough staff so they called their family if they needed anything. On 04/10/24 at 10:00 a.m., HHA #1 and HHA #2 stated the company they worked for sent two staff members together due to the facility not having enough staff to help them give showers and personal care to residents they were assigned to. On 4/10/25 at 10:32 a.m., family member #1 was interviewed. They stated another resident fell in their family members room and it was four hours before they could get anyone to help them. The family member was unable to give the date or time of occurrence, but stated an aide came into their room and stated they could not get them up by themselves, and they did not have any help until the next shift came in. On 04/10/25 at 2:00 p.m., the executive director was asked about staffing related to acuity of residents. They stated they did feel they needed more staff available for residents and were talking with their boss regarding staffing.	C 910		

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C 910	Continued From page 4 On 04/14/25 at 12:30 p.m., family member #2 was interview. They stated they were concerned with amount of staff available. They stated many residents required two person assist and there were often only two staff members assigned to a hall. Family Member #2 stated they were concerned with the amount of staff available to care for the residents that needed a lot of assistance as most had dementia and were chair bound.	C 910		
C 954 SS=E	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 center failed to ensure direct care staff had first aide and cardiopulmonary resuscitation training for 4 (CMA #1, CMA #2, CNA #2, and CNA #4) of 5 sampled personnel files reviewed. The executive director identified 41 residents resided in the center. Findings: The undated staff qualifications policy, read in	C 954		

Oklahoma State Department of Health

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C 954	Continued From page 5 part, "direct care staff shall provide evidence of first aid and cardiopulmonary resuscitation training to the administrator or designee upon employment." 1. A facility staff list, dated 04/09/25, showed CMA #1 was hired 10/08/24. There was no documentation of first aid and cardiopulmonary resuscitation training upon hire. 2. A facility staff list, dated 04/09/25, showed CMA #2 was hired on 03/04/25. There was no documentation of first aid and cardiopulmonary resuscitation training upon hire. 3. A facility staff list, dated 04/09/25, showed CNA #2 was hired on 03/15/25. There was no documentation of first aid and cardiopulmonary resuscitation training upon hire. 4. A facility staff list, dated 04/09/25, showed CNA #4 was hired on 02/03/25. There was no documentation of first aid and cardiopulmonary resuscitation training upon hire. On 04/15/25 at 2:35 p.m., the executive director was interviewed regarding the requirements for first aid and cardiopulmonary resuscitation training. The executive director stated they did not know first aid and cardiopulmonary resuscitation training were required. They were asked if they were following first aid and cardiopulmonary resuscitation training per their policy. The executive director stated they were not. They stated they did not realize the policy showed they were to have first aid and cardiopulmonary resuscitation training upon hire.	C 954		

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C1110	Continued From page 6	C1110		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to establish a quality assurance committee that met at least quarterly. The executive director identified 41 residents resided at the facility. Findings: There was no documentation the quality assurance committee met quarterly from 08/22/24 through 03/15/25. On 04/15/25 at 3:00 p.m., the executive director was asked if there was documentation that showed the quality assurance committee met	C1110		

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C1110	Continued From page 7 from 08/22/24 thru 03/15/25. They stated there was no documentation for that time period.	C1110		
C1931 SS=E	310:663-19-2(b)(1) 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. (1) The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident. This Rule is not met as evidenced by: Based on observation, record review, and interview the center failed to ensure medications were stored per pharmacy labeling and medication recommendations for one of two medication carts observed. The executive director identified 41 residents resided in assisted living. Findings: On 04/10/25 at 12:30 p.m., a narcotic drawer in medication cart #1 was checked with the DON and agency CMA. Three bags containing lorazepam (an antianxiety medication) were observed in the drawer held at room temperature. There was a blue "Refrigerate" sticker present on the bags containing the medication. A pharmacy recommendation report, dated 02/06/25, showed lorazepam was to be stored under refrigeration per pharmacy labeling and	C1931		

Oklahoma State Department of Health

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C1931	Continued From page 8 drug monograph. On 04/10/25 at 12:35 p.m., the DON was asked where medication with "Refrigerate" stickers should be stored. The DON stated, "They should be stored in medication refrigerator in medication room."	C1931		
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section.	C6000		

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NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BROKEN ARROW		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C6000	Continued From page 9 a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services.	C6000		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/15/2025
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BROKEN ARROW		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C6000	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct registry screening and background checks for staff upon hire for 4 (CMA #2, CMA #4, CNA #2, and CNA #3) of 5 sampled personnel files reviewed. The executive director identified 41 residents resided in the center. Findings: An undated staff qualifications policy, read in part, "prior to employment, the administrator or designee shall conduct criminal arrest background checks." 1. A facility staff list, dated 04/09/25, showed CMA #2 was hired on 03/04/25. There was no documentation registry screening and background checks were completed until 03/31/25 (27 days after hire). 2. A facility staff list, dated 04/09/25, showed CNA #2 was hired on 03/15/25. There was no documentation registry screening and background checks were completed until 03/31/25 (16 days after hire). 3. A facility staff list, dated 04/09/25, showed CNA #3 was hired on 03/21/25. There was no documentation registry screening and background checks were completed until 03/31/25 (10 days after hire). 4. A facility staff list, dated 04/09/25, showed CNA	C6000		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/15/2025
NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF BROKEN ARROW		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C6000	Continued From page 11 #4 was hired on 02/03/25. There was no documentation registry screening and background checks were completed until 02/05/25 (two days after hire). On 04/15/25 at 2:30 p.m., the executive director was interviewed regarding the registry screening and background checks completion process when employees were hired. The executive director stated they had a 60 day provisional window to receive the background checks. They were asked if they were conducting registry screening and background checks per their policy. They stated they were not. The executive director stated they did not realize the policy stated they were to be done before hire.	C6000		

Delivery via email to: Lyndy Wheat <lwheat@beehivebrokenarrow.com>

May 29, 2025

License Number: AL7269

Lyndy Wheat, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event NC2D11

Dear Ms. Wheat:

On **April 15, 2025**, agents from our office completed an Assisted Living Center survey with complaint investigations at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **ALL TAGS:** The plan of correction exceeds 60 days from the survey exit.

Please provide an Amended plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,



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: 4/30/2025

Facility Name: Beehive Homes of Broken Arrow

License Number: AI 7269

Survey Event ID: NC2D11

Date Survey Completed: 4/15/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711

Based on: Each assisted living 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: Please see attached documentation of clearance from the Broken arrow Fire Department.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The annual fire inspection Shall be completed yearly in a timely manner.

All residents of Beehive homes of Broken Arrow have the potential to be affected by not having an annual fire inspection.

The Broken Arrow Fire Marshall shall be called on annually in January to complete the Annual Fire Inspection March.

Contracting with a different fire protection company that can/will perform timely effective inspections and maintenance of fire protection system. To maintain compliance with fire safety regulations to ensure resident safety.

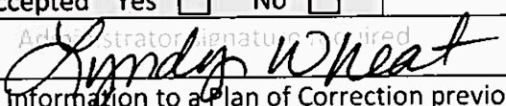
The Safety Chairman representative will review the fire marshal's report at quarterly QA meeting.

The annual fire inspection and fire protection reports shall be placed as a routine item for discussion on the agenda of the quarterly QA meeting.

The annual Fire Inspection and fire protection Report discussion shall be entered into the minutes of the Quarterly QA Meeting

The Quality Assurance Committee shall evaluate how effective the plan is and take further action as needed.

Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		4/11/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) 		Date 	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: 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.			

Inspection No:	202504236583
Inspection Date:	04/23/2025
Inspection Time:	0.03
Inspected By:	HEAPS, TIMOTHY

BROKEN ARROW FIRE FIRE INSPECTION REPORT



Inspection and Compliance Orders				
Facility:	Beehive Homes	Address:	3200 West Washington Street	
Phone:				
Fax:		City:	Broken Arrow	
Email:		State:	Oklahoma	Postal Code: 74011
Primary Contact				
Contact:		Work:		
Email:		Cell:		

Inspection Type:	Re-Inspection
------------------	---------------

Violation Code	Days to Correct*	Violation	Notes	Location
	30			

Inspection Notes:

Inspector : Tim Heaps	
--------------------------	--

* Number of days to correct from date inspected.

A variance procedure is available. Please contact the inspector named for further assistance with this or any other matter.

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 4/30/2025	
	Facility Name: Beehive Homes Of Broken	
	License Number: AI7269	
	Survey Event ID: NC2D11	
Date Survey Completed: 4/15/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C910 SS=F	Based on: Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of Oklahoma Nurson Practice Act , 59 O.S. Supp 1997 section 567.1 et seq.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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?		Resident #2 states he felt there was not adequate staffing in place. Corrective action will be accomplished by monitoring resident service plans to maintain adequate staffing model to meet all resident needs, while adjusting staff number according to resident care needs.
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 have the potential to be affected by not having adequate staff available to meet each resident's individual needs.
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?		A) staff ratios for each shift have been increased. B) staff shall be trained on the importance of timely call offs to allow appropriate replacements. C) staff shall be trained on the date future schedules are developed in order for them to request time off as needed to prevent late call offs. D) make scheduling flexible for staff to prevent future call offs. E) admission assessment staff shall receive training on identifying appropriate residents to be admitted. F) initiate interviews with all terminated staff to be evaluated by the quality assurance committee.
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 director of nursing service shall bring any identified issues with difficulty in meeting staffing requirements to the quality assurance committee for evaluation planning and implementation. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		6/14/2025
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 4/30/2025	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: 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.			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/30/2025

Facility Name: Beehive Homes Of Broken Arrow

License Number: AL7269

Survey Event ID: NC2D11

Date Survey Completed: 4/15/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954 SS=E

Based on: assisted living center's direct care staff shall be trained in first aid and cardio pulmonary resuscitation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

6/14/2025

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Administrator signature required

OAC 310:663-25-4(F)

Sydney Wheat

Date Enter a date of signature.

4/30/25

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 Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [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.](#)

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 4/25/2025		
	Facility Name: Beehive Homes of Broken Arrow		
	License Number: AL 7269		
	Survey Event ID: NC2D11		
			Date Survey Completed: 4/15/2025
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1110 SS=E		Based on: each assisted living center shall establish and maintain an internal quality assurance meeting that meets at least quarterly. The committee shall one monitor trends and incidents to monitor customer satisfaction measures and 3 document quality assurance efforts and outcomes.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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?		A quality assurance program has been developed.	
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 have the potential to be affected by not having a functioning 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?		A) the quality assurance program shall make quarterly during the first week of March June September and December. B) Trends incidents and customer satisfaction shall be monitored for problems. C) quality assurance committee evaluations and actions shall be documented and maintained in a notebook.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		The RN consultant shall document quarterly in the RN consultant report the progress the Quality Assurance Committee is making with identified problems assuring the committee is functioning.	
a. How the correction will be evaluated for effectiveness;		Enter methods to evaluate for effectiveness:	
b. How the correction will be incorporated into the center's quality assurance system; and		Enter methods to incorporate into QA system:	
c. How monitoring records will be kept to evidence the correction.		Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/14/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) <i>Andy Wheat</i>		Date Enter a date of signature. 4/30/2025	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [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.](#)



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/30/2025

Facility Name: Beehive Homes Of Broken Arrow

License Number: AL 7269

Survey Event ID: NC2D11

Date Survey Completed: 4/15/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1931 SS=E

Based on: an assisted living center may maintain non prescription drugs for dispensing from a common or bulk supply if all the following are accomplished 1 the assisted living center shall have had and followed a written policy and procedure to assure safety and dispensing and documenting medications given to each resident. This rule is not met as evidenced by based on observation record review and interview the center failed to ensure medications were stored per pharmacy labeling and medication recommendations for one of two medication carts observed

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Beehive Homes as placed identified medication in a locked refrigerator in a locked medication room. No specific resident was cited.

All residents have the potential to affected by inappropriate storage of medications.

a) A lock has been placed on the medication refrigerator to safely manage Scheduled II medications requiring refrigeration. b) Certified medication staff shall be trained on correct medication storage, reading and following directions on pharmacy labels. C) Licensed staff shall be trained on management of Pharmacy consultant reports. .

All identified errors in medication storage shall be take to the Quality Assurance Committee for evaluation and further action.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

6/14/2025

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required

Syndee Wheat

Date Enter date of signature.

4/30/2025

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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: 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.			



Medication Storage Best Practice Guidelines

- Medication carts and storage rooms **must be locked at all times.**
- Refrigerator: A refrigerator temperature log must be posted on outside of refrigerator and logged daily; temperature must be 36 to 46 degrees Fahrenheit.
- Med room: Med room temperature should be monitored and logged daily; temperature must be 60 to 80 degrees Fahrenheit.
- Date opened: All flushes, multi-dose vials, irrigation solution and IV fluids must be marked with date opened or first used.
- Insulin: All vials or pens should be refrigerated until opened for use. Stability of in use opened Insulin products or Insulin products stored at room temperature vary greatly by manufacturer, size, and type. Please refer to manufacturer guidelines and or dispensing label instructions for expiration timeframes
- Inhalers: Store in plastic bag or box.
- Scoops for multi-dose nutritional products; store in plastic bag and rubber band to canister
- Controlled Substances: Must be double locked, even if refrigerated.
- Pharmacy Labels: All prescription medications must have a pharmacy label attached. If the item is very small, the label may be affixed to a plastic bag or vial.
- Medication carts should be checked on a monthly basis, or more often, to be sure all medications are in date and have required dating.
- Medications should be stored separated by route of administration.
- Do not store treatment items, supplies, ointments etc. in medication cart.
- In any case where the expiration date on a manufacturer original packaging conflicts with a standard pharmacy label or other addition label, the manufacturer stated expiration date will take precedence.

Medication Storage Information



Inhalers

Product	Storage	Expiration Date
Advair Discus/Wixela Inhub AirDuo, Digihaler, AirDuo RespiClick (Fluticasone/Salmeterol) Advair HFA (Fluticasone/Salmeterol)	Room Temp.	30 days after foil pouch is opened, or when counter reads "0" Discard when counter reads "0"
Albuterol Inhalation	Room Temp. (Opened) MUST REMAIN IN FOIL TO PROTECT FROM LIGHT	Manf. Exp. On Package
Anoro Ellipta (Umeclidinium/Vilanterol)	Room Temp. In original, unopened foil container	6 weeks after opening foil tray
Asmanex Asmanex HFA (Mometasone)	Room Temp.	45 days 12 mos. or when counter reads "0"
Brovana (Aformoterol)	Room Temp. Protect from light.	Use within 42 days of opening foil pouch.
Breo Ellipta (Fluticasone/Vilanterol)	Room Temp.	6 weeks after opening foil tray
Combivent Respimat Inhaler (Albuterol/Ipratropium)	Room Temp. (Unopened) Room Temp. (Opened)	90 days from date opened and in use
DuoNeb Inhalation (Albuterol/Ipratropium)	Room Temp. (Unopened) Room Temp. (Opened) MUST REMAIN IN FOIL TO PROTECT FROM LIGHT	7 days once removed from foil pouch
Dulera (Mometasone/Formoterol)	Room Temp.	12 mos. or when counter reads "0"
Flovent Flovent Diskus (Fluticasone)	Room Temp. Room Temp.	8 weeks 6 weeks once removed from foil pouch
Perforomist neb. Vials (Formoterol)	Room Temp.	3 mos.
Pulmicort Respules; Pulmicort Flexhaler (Budesonide)	Room Temp. Room Temp.	2 weeks after opening pouch 12 mos. or when counter reads "0"
Serevent Diskus (Salmeterol)	Room Temp.	6 weeks after opening pouch
Spiriva Respimat; Spiriva Handihaler (Tiotropium)	Room Temp. Room Temp.	3 mos. 12 mos.
Stiolto Respimat (Tiotropium/Olodaterol)	Room Temp.	3 mos. after cartridge inserted into inhaler
Striverdi Respimat (Olodaterol)	Room Temp.	3 mos. after cartridge inserted into inhaler
Symbicort (Budesonide/Formoterol)	Room Temp.	3 mos. after opening pouch
Tudorza (Aclidinium)	Room Temp.	45 days after opening pouch
Trellegy Trellegy Ellipta	Room Temp. Room Temp.	6 weeks after opening foil tray 6 weeks after opening foil tray
Xopenex Solution; Xopenex HFA (Levalbuterol)	Room Temp. Protect from light. Room Temp.	14 days after opening pouch 12 mos.
ProAir, Proventil, Ventolin HFA (Albuterol)	Room Temp.	12 mos.

Ophthalmic/Nasal Products

Product	Storage	Expiration Date
Xalatan, Xelpros (Latanoprost) Roklatan (Netarsudil/Latanoprost)	Refrigerate until opened; May store at room temp after opened	Discard 42 days after opening
Azasite (Azithromycin)	Refrigerate until opened; Store refrigerated or at room temp after opened	Discard 14 days after opening
Miacalcin Spray (Calcitonin)	Refrigerate until opened; Store upright	Discard 35 days once opened
Cosopt PF (dorzolamide/timolol)	Do not freeze	May store in opened foil pouch for 15 days

Medication Storage Information



Vaccines/Skin Tests

Product	Storage	Expiration Date
<i>Aplisol, Tubersol (Tuberculin PPD)</i>	Refrigerator	Discard 30 days after opened; protect from light
<i>Influenza virus vaccine</i>	Refrigerator	Discard if frozen; Discard after stated expiration date; protect from light
<i>Pneumococcal conjugate vaccines (various)</i>	Refrigerator	Discard if frozen
<i>Shingrix (Zoster vaccine recombinant)</i>	Refrigerator	Store in the refrigerator and discard within 6 hours of reconstitution Do not freeze; protect from light
<i>Arexvy (RSV recombinant vaccine)</i>	Refrigerator	Do not freeze; protect from light

Insulin Products

(*do not use any insulin products that have been frozen)

Product	Storage/Expiration Date
<i>Apidra, Apidra Solostar</i>	Refrigerate prior to use; Discard 28 days after opening or removing from refrigerator
<i>Humalog, Humalog Pen, Insulin Lispro</i>	Refrigerate prior to use; Discard 28 days after opening or removing from refrigerator
<i>Humalog Mix Pen 75/25, 50/50; Humulin 70/30 pen</i>	Discard 10 days after opening or removing from refrigerator
<i>Humulin R, Humulin N, Humulin 70/30 vials</i>	Discard 31 days after opening or removing from refrigerator
<i>Lantus, Semglee, Basaglar (Insulin Glargine)</i>	Discard 28 days after opening or removing from refrigerator
<i>Novolog, Novolog Flexpen, Insulin Aspart</i>	Discard 28 days after opening or removing from refrigerator
<i>Byetta (Exenatide), Byduron BCise (Exenatide)</i>	Discard 30 days after opening or removing from refrigerator Discard 4 weeks after removing from refrigerator
<i>Novolin, Novolin R, Novolin 70/30</i>	Discard 42 days after opening or removing from refrigerator
<i>Levemir (Insulin Detemir)</i>	Discard 42 days after opening or removing from refrigerator
<i>Toujeo SoloStar (Insulin Glargine)</i>	Discard 56 days after opening or removing from refrigerator
<i>Trulicity</i>	Discard 14 days after removing from refrigerator
<i>Mounjaro, Zepbound (Tirzepatide)</i>	Discard 21 days after removing from refrigerator
<i>Ozempic, Wegovy (Semaglutide)</i>	Discard 56 days after opening or removing from refrigerator; Discard 28 days after removing from refrigerator; for single use only
<i>Xultophy (Insulin degludec and liraglutide)</i>	Discard 21 days after opening or removing from refrigerator
<i>Soliqua (Insulin glargine and lixisenatide)</i>	Discard 28 days after opening or removing from refrigerator
<i>Victoza, Saxenda</i>	Discard 30 days after opening or removing from refrigerator

Miscellaneous Medications

Product	Storage	Expiration Date
<i>Aranesp (Darbepoetin)</i>	Refrigerator	Single use vial only
<i>Procrit/Epogen (Epoetin alfa)</i>	Refrigerator	Multidose-Discard 21 days after initial entry
<i>Neupogen (Filgrastim)</i>	Refrigerator	Single use vial only
<i>Forteo (Teriparatide)</i>	Refrigerator (at all times)	Discard 28 days after initial use
<i>Nitrostat (Nitroglycerin)</i>	Room temperature/protect from light	Per manufacturer dating on container

Defer to the manufacturer stated expiration date on original product labeling if it is less than the time listed in this reference.

References: Facts and Comparisons by Clinical Drug Information, LLC accessed July 2024

Medication Refrigerator Temperature Log

(Range 36°F - 46°F)

Month: _____ Year: _____

Date	Time	Temperature	Notes (for temperature adjustments and rechecks)	Initials
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
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31				

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 4/30/2025	
	Facility Name: Beehive Homes of Broken Arrow	
	License Number: AL 7269	
	Survey Event ID: NC2D11	
		Date Survey Completed: 4/15/2025
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C6000 SS=EE	Based on: 63 OS 1-1947 (F) criminal history background check	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 residents of behave homes of Broken Arrow has the potential to be affected by not having criminal background checks and registry screening completed prior to employment we have homes of Broken Arrow shall complete a criminal background check on each employee in compliance with regulations and updated policy.
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 behave homes of Broken Arrow have the potential to be affected by criminal background checks not being completed on employees.
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?		A) criminal background check shall be completed on all employees in compliance with state regulations and current updated policy. B) A master list of all employees shall be kept listing date a criminal background in registry screening was requested and when the results were returned C) the executive director and director of nursing shall randomly check all master lists verifying criminal background checks are current on all employees.
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.		Any identified lapses in protocol shall be taken to the quality assurance committee for further evaluation and action. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		Click here to enter a date when corrective action will be completed.
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator signature required 		Date Enter a date of signature. 4/30/2025

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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: 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.			

Delivery via email to: Lwheat@beehivebrokenarrow.com

June 27, 2025

License Number: AL7269

Lyndy Wheat, Administrator
Beehive Homes Of Broken Arrow
3200 W Washington St
Broken Arrow, OK 74012

RE: Survey Event NC2D11

Dear Ms. Wheat:

On **April 15, 2025**, a Licensure inspection with 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 amended 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 **June 11, 2025**.

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, 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: 4/30/2025

Facility Name: Beehive Homes of Broken Arrow

License Number: AI 7269

Survey Event ID: NC2D11

Date Survey Completed: 4/15/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711

Based on: Each assisted living 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: Please see attached documentation of clearance from the Broken arrow Fire Department.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The annual fire inspection Shall be completed yearly in a timely manner.

All residents of Beehive homes of Broken Arrow have the potential to be affected by not having an annual fire inspection.

The Broken Arrow Fire Marshall shall be called on annually in January to complete the Annual Fire Inspection March.

Contracting with a different fire protection company that can/will perform timely effective inspections and maintenance of fire protection system. To maintain compliance with fire safety regulations to ensure resident safety.

The Safety Chairman representative will review the fire marshal's report at quarterly QA meeting.

The annual fire inspection and fire protection reports shall be placed as a routine item for discussion on the agenda of the quarterly QA meeting.

The annual Fire Inspection and fire protection Report discussion shall be entered into the minutes of the Quarterly QA Meeting

The Quality Assurance Committee shall evaluate how affective the plan is and take further action as needed.

Enter methods to keep monitoring records: