

**Delivery via email to:** [LivingRose@ymail.com](mailto:LivingRose@ymail.com)

April 17, 2023

License Number: AL7260

Ms. Tammy Spinazzola, Administrator  
Living Rose Christian Assisted Living Home  
1108 North Fern Avenue  
Broken Arrow, OK 74012

**RE: Survey Event ID: YT5J11**

Dear Ms. Spinazzola:

Enclosed is a report of the inspection in conjunction with a complaint investigation conducted at your Assisted Living Center on **April 14, 2023**. No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

*Katie Stagner*

Katie Stagner  
Long Term Care Enforcement Analyst  
Oklahoma State Department of Health

Enclosure

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**INVESTIGATIVE REPORT  
LICENSURE**

**Facility:** Living Rose Christian Assisted Living Home  
**Address:** 1108 N. Fern Ave  
**City, State, Zip:** Broken Arrow, OK, 74012  
**Provider #:** AL7260  
**Complaint #:** OK00055746  
**Investigation Dates:** 04/13/23 and 04/14/23

| ALLEGATION | S = SUBSTANTIATED<br><br>US = UNSUBSTANTIATED |
|------------|---|
|------------|---|

|   |    |
|---|----|
| 1. The center failed to provide safe medical care and services, and failed to notify family regarding significant changes in condition. | US |
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☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 04/13/2023 at 7:45 a.m.

A sample of four residents including any identified resident was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

**A Description of Significant Findings Related to Each Allegation is Provided Below:**

**Allegation #1:** Deficient practice was unsubstantiated related to this allegation.

During the survey, sampled residents were observed to be eating breakfast at the dining table and reclined in their chair watching television. Sampled residents were observed to be clean and well kempt. Staff was observed to administer medications as prescribed by the physician. When sampled residents were observed to get up from the dining table they were assisted by staff. Staff stayed with the resident until seated in their chair to watch television. One sampled resident was observed to receive home health services with therapy. Another sampled resident was observed to receive hospice care. The sampled resident on hospice care was observed to be repositioned, cleaned, and fed in their bed. Staff were observed to be caring and to speak in respectful tones.

Sampled residents stated they received the care they required. Sampled residents stated they enjoyed living at Living Rose and enjoyed the staff.

Staff stated they enjoyed their position at Living Rose Assisted Living and felt it was a very home-like environment. Staff stated they always provided stand-by assist while residents transferred or walked throughout the home for safety purposes. Staff stated they had not had any falls with injury. Staff stated they were not aware of any fractures that resulted from a fall. The administrator/owner was asked about a resident who had a fractured leg and passed away in 2020. The administrator/owner stated they did recall the incident and the closed record was provided.

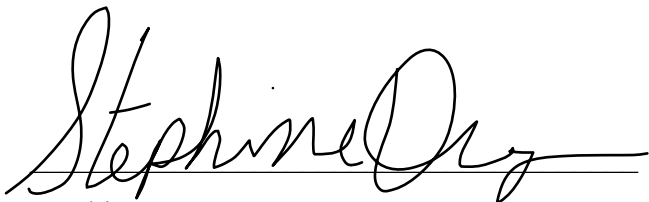
Review of clinical records for the sampled residents revealed no falls since they had admitted. Review of state reported incidents revealed no falls with injury in the past year. Review of the closed record revealed the sampled resident had not fallen and fractured their leg. The record documented the resident had simply stood from the dining table with staff assistance to transfer to their wheelchair and their leg snapped. The record documented the resident's bone had protruded through the skin and the resident was laid down on the floor until 911 was called and the EMS arrived. The record documented the administrator notified the family of the incident. The record documented the resident had returned from the hospital on hospice and bed-bound with an order for non-weight bearing. The record documented the resident's representative was present the day the resident went non-responsive and hospice was notified. The record documented the resident passed away several days later with the resident representative present and hospice was notified.

#### **Determination Summary and Follow-Up Action:**

Deficient practice was unsubstantiated for allegation one. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read 'Stephine Organ', with a horizontal line underneath.

Stephine Organ, RN, CHFS III

Date report completed: 04/14/2023

Oklahoma State Department of Health

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|---|---|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL7260</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/14/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LIVING ROSE CHRISTIAN ASSISTED LIVING HOME</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1108 NORTH FERN AVENUE<br/>BROKEN ARROW, OK 74012</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 000   | <p>INITIAL COMMENTS</p> <p>A relicensure survey was conducted from 04/13/23 through 04/14/23. A complaint investigation (#OK00055746) was conducted in conjunction with the survey. No deficiencies were cited.</p> | C 000   |  |  |

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE