OKLAHOMA
State Department
of Health

Delivery via email to: lgordon.prairiepointe@yahoo.com

August 12, 2021

License Number: AL4102

Ms. Lisa Gordon, Administrator
Prairie Pointe at Stroud
701 West Olive Street
Stroud, OK 74079

Survey Event ID: 7YPS11

Dear Ms. Gordon:

On **August 4, 2021, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.**

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the 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. 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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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 will be completed for each violation; and

(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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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

OKLAHOMA
State Department
of Health

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.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.08.12 16:22:38 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Prairie Point Assisted Living**
Address: **701 West Olive Street**
City, State, Zip: **Stroud, Oklahoma 74079**
Provider #: **AL4102**
Complaint #: **OK00057439**
Investigation Date(s): **08/03/2021 to 08/04/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents received adequate and appropriate medical care.	S

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

An unannounced on-site investigation was initiated on 08/03/2021 at 10:35 a.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, C-1505 and N-1105 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Kristopher Mary Cooper

Mary Cooper RN/CHFS

Date report completed: 08/05/2021

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
	AL4102	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE POINTE AT STROUD	701 WEST OLIVE STREET STROUD, OK 74079

(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
N 000	Initial Comments An abbreviated survey was completed on 08/03/2021 and 08/04/2021 to investigate complaint #OK00057439. Total Residents: 21. The following abbreviations may have been utilized in the writing of this report. CNA (Certified Nursing Assistant) ADON (Assistant Director of Nursing) PPAL (Prairie Pointe Assisted Living)	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was	N1105		

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N1105	Continued From page 1 determined the facility failed to complete a yearly performance review for one (#1) of 10 CNA's reviewed for completed yearly performance reviews. This had the potential to affect all 21 residents who resided in the facility. Findings: On 08/03/21 at 1:35 p.m., "[Named Facility] Skills Review and Demonstration," training records were reviewed. CNA #1 had no documentation of having an initial or yearly skills review completed since her date of hire on 08/28/19. At 2:10 p.m., the ADON was asked if she could provide documentation of yearly performance reviews for CNA #1. At 2:19 p.m., the ADON acknowledged she didn't have any performance reviews for CNA #1	N1105		

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS An abbreviated survey was completed on 08/03/2021 and 08/04/2021 to investigate complaint #OK00057439. Total Residents: 21 The following abbreviations may have been utilized in the writing of this report. CNA (Certified Nursing Assistant) ADON (Assistant Director of Nursing) PPAL (Prairie Pointe Assisted Living)	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to complete a significant change assessment for one (#3) of three sampled residents reviewed for assessments. This had the isolated potential to affect all 21 residents who resided in the facility.	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL4102	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE POINTE AT STROUD	701 WEST OLIVE STREET STROUD, OK 74079

(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 522	Continued From page 1 Findings: Resident #3 was admitted to the facility with diagnoses which included hypertension, atrial fibrillation and gastroesophageal reflux disease. The resident was identified to be level three on the resident roster. "[Named Facility] Resident Services Agreement," defines level three as: "...Level 3 Services: All level 2 services plus ...Personalized assistance including; bathing, dressing and undressing, assistance with transfers and/or ambulation requiring one-person assist and other tasks of daily living..." An Oklahoma State Department of Health final incident report form attachment from incident on 06/23/21 documented, "...CNA #1 turned to hang a towel on the hook by shower so it would be handy to reach when she heard resident hit the floor..." Resident sustained a head injury and was sent to the emergency room and admitted to the hospital. "...Discharge Summary [Named acute care hospital]" dated 06/23/21 to 07/01/21 documented, "...Discharge diagnoses: Orbital fracture, closed, initial encounter, Closed head injury with concussion, Acute pyelonephritis due to bacteremia, Elevated Troponin, Non Q wave myocardial infarction, Ischemic cardiomyopathy" The resident nursing progress note, dated 07/01/21, documented, "...Resident returning from recent hospital stay today returning to [Named facility] on hospice services. Hospice will assist in care...DME equipment delivered, hospital bed, bedside commode, overbed table..." On 08/03/21 at 3:00 p.m., the resident's "Service Plan Document" was reviewed. Service plan dated, 07/29/20 to 07/29/21 documented,	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL4102	A. BUILDING: _____ B. WING _____	08/04/2021

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C 522	Continued From page 2 "...General Health, Stable...Dressing/Grooming, Independent...Bathing, Independent...Mobility/Fall Prevention, Independent with Device..." At 3:10 p.m., the ADON was asked if a significant change assessment was completed when resident was admitted to hospice services. She acknowledged there was not a significant change assessment completed for the resident and the care plan had not been updated.	C 522		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 3	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined the center failed to develop and implement a policy and procedure for three (#1, 2 and #3) of three sampled residents who were identified as a high fall risk.

This had the potential to affect all 21 residents who resided in the facility.

Findings:

1. Resident #1 was admitted to the center with diagnoses which included, hypertension, cerebrovascular accident (stroke) and gout.

The resident was identified to be level 3 on resident roster. "Prairie Pointe Assisted Living Resident Services Agreement defines level three as: "...Level 3 Services: All level 2 services plus...Personalized assistance including; bathing, dressing and undressing, assistance with transfers and/or ambulation requiring one-person assist and other tasks of daily living..."

A "Fall Risk Assessment," dated 05/04/21, documented "...Total: 15...Total score of 10 or above represents a HIGH RISK..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL4102	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE POINTE AT STROUD	701 WEST OLIVE STREET STROUD, OK 74079

(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
C1505	Continued From page 4 On 08/03/21 at 11:00 a.m., Oklahoma State Department of Health Incident reports were reviewed for the resident. Reports documented resident had three unwitnessed falls on 09/11/20, 09/12/20 and 06/11/21. 2. Resident #2 was identified to be level three on resident roster. "[Named Facility] Resident Services Agreement defines level three as: "...Level 3 Services: All level 2 services plus ...Personalized assistance including; bathing, dressing and undressing, assistance with transfers and/or ambulation requiring one-person assist and other tasks of daily living..." A "Fall Risk Assessment, "dated 07/13/21, documented "...Total: 15...Total score of 10 or above represents a HIGH RISK..." On 08/03/21 at 11:00 a.m., Oklahoma State Department of Health Incident reports were reviewed for the resident. Reports documented resident had two unwitnessed falls on 11/13/20 and 05/24/21. 3. Resident #3 was admitted to the center with diagnoses which included: Hypertension, Atrial Fibrillation and Gastroesophageal reflux disease. The resident was identified to be level 3 on resident roster. "[Named Facility] Resident Services Agreement defines level three as: "...Level 3 Services: All level 2 services plus ...Personalized assistance including; bathing, dressing and undressing, assistance with transfers and/or ambulation requiring one-person assist and other tasks of daily living..." A "Fall Risk Assessment," dated 04/30/21,	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL4102	A. BUILDING: _____ B. WING _____	08/04/2021

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C1505	Continued From page 5 documented,"...Total: 13...Total score of 10 or above represents a HIGH RISK..." On 07/13/21 "Fall Risk Assessment" documented, "...Total: 20...Total score of 10 or above represents a HIGH RISK..." On 08/03/21 at 11:00 a.m., Oklahoma State Department of Health Incident reports were reviewed for the resident. Report documented one witnessed fall. At 3:40 p.m., the ADON was asked if the facility had a policy and procedure in place to address residents at high risk for falls. She stated, "No." On 08/04/21, at 11:10 a.m., "Fall Risk Assessment" document used by the facility was reviewed with the ADON. "...INSTRUCTIONS: If the total score is 10 or greater, the resident should be considered HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan..." The ADON was asked if she had a fall prevention protocol in place, she replied, no. She acknowledged she was unaware she needed one in place.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: lgordon.prairiepointe@yahoo.com

August 18, 2021

License Number: AL4102

Ms. Lisa Gordon, Administrator
Prairie Pointe at Stroud
701 West Olive Street
Stroud, OK 74079

Survey Event ID: 7YPS11

Dear Ms. Gordon:

On **August 4, 2021**, agents from our office completed a complaint investigation 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:

- **Tags C0522 & N1105** - The Plan of Correction does not allow time to monitor for correction.
- **Tag C1501** - This tag is not addressed in the POC.

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

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
Date: 2021.08.18 08:53:47 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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: 8/13/2021** **Facility Name:** Prarie Pointe Assitsted Living **License Number:** AL4102 **Survey Event ID:** 7YPS11 **Date Survey Completed: 8/4/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Failed to complete significant change assessment

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 Assessment Form – Significant Change has been performed on resident in question.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	We will make sure if resident has significant change an assessment will be performed in a timely manner.
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?	Implement significant log book to be recorded by DON weekly to assure all significant changes are addressed.
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.	A. Significant change log will be added as regular item discussed at bi-weekly in-service. B. Evaluated weekly by DON. C. Significant change log will be included in quarterly QA as line item for significant change. See Attached Significant Change Log and Revised QA form
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/13/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa Gordon Admin** OAC 310:663-25-4(F)	**Date 8/13/2021**

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: 8/13/2021** **Facility Name:** Prairie Pointe Assistd Living **License Number:** AL4102 **Survey Event ID:** 7YPS11 **Date Survey Completed: 8/4/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: N1105	Based on: Facilty failed to complete a yearly performance review for (#1) of 10 CNA's

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: After further review of the employee yearly performance review, it was determined the review in file was current. It was dated 8/14/2020. The employee's hire date was written below the review date. This may account for the confusion.This is no excuse but Adm/DON had been out 3 weeks prior with husband's COVID illness, in ICU, on a ventilator. This survey came at a very difficult time and we feel this led to the confusion issue. The paperwork was actually there as it was for all of the other CNA's.This employee had an intial skills review on 8/28/19 which was her hire date, again on 8/14/2020 annal review and we have just completed her annual on 8/9/2021.

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 skills and annual reviews will continue to be performed in a timely manner
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Tickler system monitored by > 1 person
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?	Monitored by >1 person
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.	All skills and annual reviews will continue to be performed and documented. B. A Tickler System will ensure all documentation is in file. C. We will add an expiration date to our forms so no question as to date of next review. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/9/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Lisa Gordon Admin OAC 310:663-25-4(F)	**Date 8/13/2021**

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.

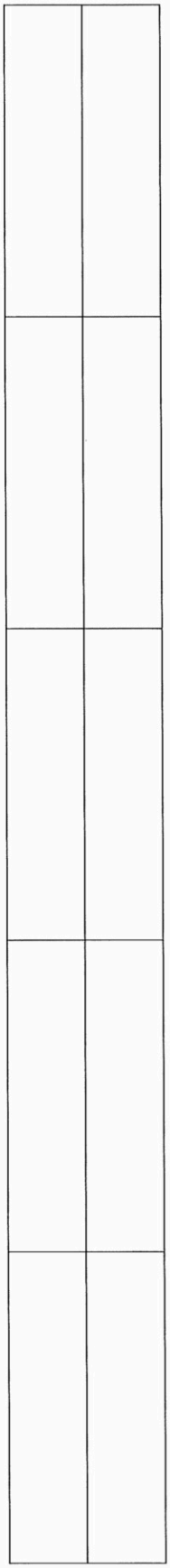
Items Below Are For OSDH Use Only

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.

Significant Change Log

Date	Resident	Change/Health	Staff Reporting	DON Acknowledge Date



Quality Assurance Committee Quarterly Meeting

DATE: _____

CENSUS: _____

ADMISSION: _____

DISCHARGE: _____

HOSPITAL STAY greater than 24 HOURS: _____

FALLS: _____

STATE REPORTABLES: _____

INFECTIONS: _____

DEATHS: _____

ELOPEMENT: _____

SIGNIFICANT CHANGE_____

HIGH FALL RISK RESIDENTS_____

INCIDENTS/ACCIDENTS/STATE REPORTABLES

FRACTURE: _____

HEAD INJURIES: _____

REPORTABLE DISEASE: _____

INCIDENT REQUIRING TREATMENT: _____

OTHER INCIDENT: _____

RESIDENTS QUARTERLY SATISFACTION SURVEYS REVIEWED/ QUALITY EFFORTS and OUTCOMES

ABUSE ALLEGATIONS or INCIDENT of ABUSE

ALLEGATION or INCIDENT of NEGLECT

MISAPPROPRIATION ALLEGATIONS/INCIDENT

STORM, FIRE, UTILITY FAILURE

INCIDENT INVOLVING ANOTHER PROVIDER

_____

_____

_____

SIGNATURES of STAFF ATTENDING THIS MEETING

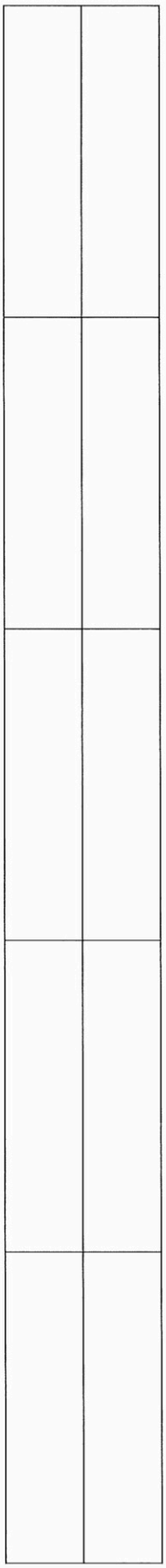
_____ _____

_____ _____

_____ _____

High Fall Risk Residents

Date	Resident	Change/Health	Staff Reporting	DON Acknowledge Date



OKLAHOMA
State Department
of Health

Delivery via email to: hodgensclara@yahoo.com

September 28, 2021

License Number: AL4102

Lisa Gordon, Administrator
Prairie Pointe At Stroud
701 West Olive Street
Stroud, OK 74079

Survey Event ID: 7YPS11

Dear Ms. Gordon:

On **August 4, 2021,** a complaint investigation was conducted at your Assisted Living Center. 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 **October 8, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.09.28 13:40:52 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/27/2021

Facility Name: Prairie Pointe Assistd Living

License Number: AL4102

Survey Event ID: 7YPS11

Date Survey Completed: 8/4/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105	Based on: Facilty failed to complete a yearly performance review for (#1) of 10 CNA's

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: After further review of the employee yearly performance review, it was determined the review in file was current. It was dated 8/14/2020. The employee's hire date was written below the review date. This may account for the confusion.This is no excuse but Adm/DON had been out 3 weeks prior with husband's COVID illness, in ICU, on a ventilator. This survey came at a very difficult time and we feel this led to the confusion issue. The paperwork was actually there as it was for all of the other CNA's.This employee had an intial skills review on 8/28/19 which was her hire date, again on 8/14/2020 annal review and we have just completed her annual on 8/9/2021.

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 skills and annual reviews will continue to be performed in a timely manner
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Tickler system monitored by > 1 person
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?	Monitored by >1 person
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.	All skills and annual reviews will continue to be performed and documented. B. A Tickler System will ensure all documentation is in file. C. We will add an expiration date to our forms so no question as to date of next review. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/8/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Beatrice Simpson LPN, DON** **Date 9/27/2021**

OAC 310:663-25-4(F)

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	9/27/2021	**Submitted by**	Beatrice Simpson LPN, DON

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
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/27/2021

Facility Name: Prarie Pointe Assitsted Living

License Number: AL4102

Survey Event ID: 7YPS11

Date Survey Completed: 8/4/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522	Based on: Failed to complete significant change assessment

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 Assessment Form – Significant Change has been performed on resident in question.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	We will make sure if resident has significant change an assessment will be performed in a timely manner.
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?	Implement significant log book to be recorded by DON weekly to assure all significant changes are addressed.
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.	A. Significant change log will be added as regular item discussed at bi-weekly in-service. B. Evaluated weekly by DON. C. Significant change log will be included in quarterly QA as line item for significant change. See Attached Significant Change Log and Revised QA form
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/8/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Beatrice Simpson LPN,DON** **Date 9/27/2021**

OAC 310:663-25-4(F)

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	9/27/2021	**Submitted by**	Beatrice Simpson LPN, DON

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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
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/27/2021

Facility Name: Prairie Pointe Assisted living

License Number: AL4102

Survey Event ID: 7YPS11

Date Survey Completed: 8/4/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: Enter ID Prefix Tag from Column X4 on STATE FORM.	Based on: Failed to develop and implement a policy and procedure for high fall risk resident (note) Fall policy and procedure existed for each and every incident –just not specifically high fall risk.

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?	Implemented new and more indepeth policy and procedure for High Fall risk residents. See attached
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care plan will identify high fall risk residents and staff will monitor accordingly. High fall fisk log book will be implemented and maintained. Yellow star will be placed by each residents door alerting staff of a high fall risk resident.
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?	Provide staff training on fall reduction as well as resident and their family memebrs on fall reduction strategies.
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.	A. Daily monitoring of High risk residents. B. Added as regular item discussed at bi-weekly in-service and included in quarterly QA as line item for High risk Falls C. High Risk Falls See attached revised QA Form
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/8/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Beatrice Simpson LPN,DON** **Date 9/27/2021**

OAC 310:663-25-4(F)

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	9/27/2021	**Submitted by**	Beatrice Simpson LPN,DON

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Facility in Compliance by: Click here to enter a date.

Quality Assurance Committee Quarterly Meeting

DATE: _____

CENSUS: _____

ADMISSION: _____

DISCHARGE: _____

HOSPITAL STAY greater than 24 HOURS: _____

FALLS: _____

STATE REPORTABLES: _____

INFECTIONS: _____

DEATHS: _____

ELOPEMENT: _____

SIGNIFICANT CHANGE_____

HIGH FALL RISK RESIDENTS_____

INCIDENTS/ACCIDENTS/STATE REPORTABLES

FRACTURE: _____

HEAD INJURIES: _____

REPORTABLE DISEASE: _____

INCIDENT REQUIRING TREATMENT: _____

OTHER INCIDENT: _____

RESIDENTS QUARTERLY SATISFACTION SURVEYS REVIEWED/ QUALITY EFFORTS and OUTCOMES

_____
_____
_____

ABUSE ALLEGATIONS or INCIDENT of
ABUSE_____
_____
_____

ALLEGATION or INCIDENT of NEGLECT

_____
_____
_____

MISAPPROPRIATION ALLEGATIONS/INCIDENT

_____
_____
_____

STORM, FIRE, UTILITY FAILURE

_____
_____
_____

INCIDENT INVOLVING ANOTHER PROVIDER

_____

_____

_____

SIGNATURES of STAFF ATTENDING THIS MEETING

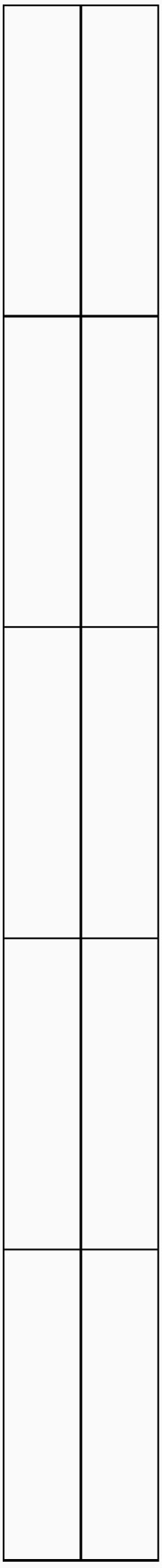
_____ _____

_____ _____

_____ _____

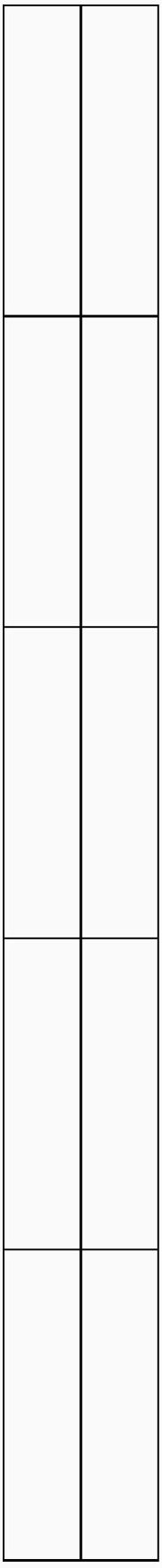
High Fall Risk Residents

Date	Resident	Change/Health	Staff Reporting	DON Acknowledge Date



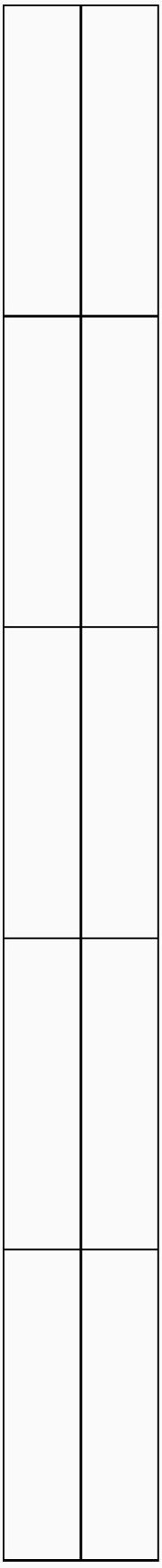
Significant Change Log

Date	Resident	Change/Health	Staff Reporting	DON Acknowledge Date



Significant Change Log

Date	Resident	Change/Health	Staff Reporting	DON Acknowledge Date



OKLAHOMA
State Department
of Health

Delivery via email to: hodgensclara@yahoo.com

May 16, 2022

License Number: AL4102

Ms. Jackie Alexander, Administrator
Prairie Pointe At Stroud
701 West Olive Street
Stroud, OK 74079

Survey Event ID: 7YPS12

Dear Ms. Alexander:

On **May 3, 2022,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 4, 2021,** have now been corrected effective **October 8, 2021.**

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.05.16 10:29:40 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure