OKLAHOMA
State Department
of Health

Delivery via email to: jackie.prairiepointe@yahoo.com; jlalexander1955@yahoo.com; jalexander@prairiepointe.net

April 9, 2025

License Number: AL4102

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

RE: Survey Event ID: SETJ11

Dear Ms. Alexander:

On **March 27, 2025**, agents from our office concluded a State Licensure survey 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 **March 27, 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
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

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

Enclosure

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 _____	03/27/2025

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 000	INITIAL COMMENTS A relicensure survey was conducted from 03/26/25 through 03/27/25. Facility Census: 19 Listed below are abbreviations that will be used throughout this document: CNA - certified nursing assistant CMA - certified medication aide DON - director of nursing MAR- medication administration record ml - milliliter	C 000		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to have a licensed dietician or qualified nutritionist to plan diets and address the needs of residents. The administrator identified 19 residents resided in the center. Findings: On 03/26/25 at 12:20 p.m., the lunchtime meal was observed. The residents had an option of two different menu selections, a salad, and a fruit bar. None of the meals were designated as any type	C 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 940	Continued From page 1 of special diet and none of the individual foods included in the meals were recommended as part of any special diet. The menu was not signed by a dietician. On 03/26/25 at 8:55 a.m., during an initial kitchen tour, cook #1 was asked about special diets. Cook #1 stated they only had one menu that they cooked and served from, and they did not have any special diets. A review of quarterly kitchen and resident reviews showed 07/21/21 was the last licensed dietician review. On 03/26/25 at 9:00 a.m., the administrator stated they did not have a dietician and did not have specialize menus for special diets. The administrator stated all residents were served from the kitchen and they were served regular diets from pre-planned weekly menus. The administrator state the residents ordered the meal they wanted from the menu for lunch and dinner and the kitchen served what the residents ordered. The administrator stated breakfast on the weekly menu showed residents choice of bacon and sausage, but not other items listed. The administrator stated they served regular breakfast items per resident request. On 3/26/25 at 1:00 p.m., the administrator stated there had not been a licensed dietician or nutritionist since 07/21/21.	C 940		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The	C1923		

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C1923	Continued From page 2 medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an accurate record of medication administration for 1 (#9) of 3 residents sampled for medication administration. The DON identified 19 residents who received medications. Findings: A undated facility policy titled "Medication Control Policy," read in part, "when a narcotic is given it is marked in the narcotic control book and on the MAR." Resident #9 had diagnoses which included depression, heart failure, and hypertension. An individual narcotic resident count sheet, dated	C1923		

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C1923	Continued From page 3 03/05/25 at 8:30 p.m., showed lorazepam (antianxiety medication) 0.5 ml was removed from the medication count. A MAR, dated 03/05/25, did not show lorazepam 0.5 ml was given to the resident at 8:30 p.m. On 3/27/25 at 4:30 p.m., the DON stated lorazepam was not documented on the MAR at 8:30 p.m., so it did not show that it was given to the resident.	C1923		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 4 (CMA #1, CNA #2, CNA #3, and CNA #5) of 5 employees whose records were reviewed. The administrator identified 19 residents resided in the center. Findings:	C1972		

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C1972	Continued From page 4 1. CMA #1 was hired 04/16/24 and abuse training was completed on 11/01/24. No documentation of training was completed within 90 days of hire. 2. CNA #2 was hired on 06/04/24 and abuse training was completed on 11/01/24. No documentation of training was completed within 90 days of hire. 3. CNA #3 was hired 07/18/24 and abuse training was completed on 11/01/24. No documentation of training was completed within 90 days of hire. 4. CNA #5 was hired 01/27/25. There was no documentation of abuse training. On 03/26/25 at 2:45 p.m., the administrator stated they did not know employees had to have abuse training within 90 days of hire. The administrator stated they had been doing it every six months for all employees.	C1972		
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	C6000		

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C6000	Continued From page 5 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. 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	C6000		

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C6000	Continued From page 6 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. 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 3 (CMA #1, CNA #2, and CNA #5) of 5 sampled personnel files reviewed. The administrator identifed 19 residents resided in the center. Findings: The undated employee handbook, read in part, " employment is based on the return of a clean background." 1. CMA #1 was hired on 04/16/21. There was no documentation registry screening and background checks were completed until 03/26/25. 2. CNA #2 was hired on 06/04/24. There was no	C6000		

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 _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 7 documentation registry screening and background checks were completed until 6/11/24. 3. CNA #5 was hired on 01/27/25. There was no documentation registry screening and background checks were completed until 03/26/25. On 03/26/25 at 3:30 p.m., the administrator was interviewed regarding the registry screening and background checks completion process when employees were hired. The administrator stated they did not have a good hiring process in place to make sure it was consistently done.	C6000		

OKLAHOMA
State Department
of Health

Delivery via email to: jackie.prairiepointe@yahoo.com; jlalexander1955@yahoo.com; jalexander@prairiepointe.net

April 24, 2025

License Number: AL4102

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

RE: Survey Event SETJ11

Dear Ms. Alexander:

On **March 27, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 4, 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,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/16/2025

Facility Name: Prairie Pointe Assisted Living

License Number: AL4102

Survey Event ID: SETJ11

Date Survey Completed: 3/27/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1972 SS=E	Based on: The center failed to ensure staff were educated on abuse within 90 days of hire for 4 (CMA #1, CAN #2, CAN #3, and CAN #5) of 5 employees whose records were interviewed.

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?	No residents were affected.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No residents were affected.
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?	We have made a new policy and procedure for abuse and neglect training. Training will be provided in the employment pack and gone over with Administrator or DON before start date. Prairie Pointe will also go over, educate and sign every month for 6 months then every 6 months in May and November and as needed.
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.	DON and/or Administrator will go over and educate new employees and every month for 6 months at inservice. If an employee misses an inservice DON/ADM. Will go over the inservice in person with employee. DON is adding orientation to QA. Signatures from orientation of employment and signatures from inservices concerning abuse.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/4/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jackie Alexander4-16-25 OAC 310:663-25-4(F)	**Date 4/16/2025**

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

CORRECTED/REVISED NOTICE

Delivery via email to: jackie.prairiepointe@yahoo.com; jlalexander1955@yahoo.com; jalexander@prairiepointe.net

April 29, 2025

License Number: AL4102

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

RE: Survey Event SETJ11

This notice replaces and corrects the notice sent on April 24, 2025

Dear Ms. Alexander:

On **March 27, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 9, 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,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health
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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/16/2025

Facility Name: Prairie Pointe Assisted Living

License Number: AL4102

Survey Event ID: SETJ11

Date Survey Completed: 3/27/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 940 SS=E	Based on: observation, record review, and interview, the center failed to have a licensed dietician or qualified nutritionist to plan diets and address the needs of residents.

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?	No resident affected.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No resident affected.
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?	Dietician will inspect kitchen and review and approve menus. Wrote policy and procedure concerning dietician.
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.	Dietician agreed to yearly visits and PRN if needed. Keep in touch with dietician and if menu needs to be changed will document in a spiral notebook. Will go over dietcians report annually at QA. Will have report at least yearly from dietician from yearly inspection of kitchen and menus.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jackie Alexander** **Date 4/16/2025**

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	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: 4/16/2025** **Facility Name:** Prairie Pointe Assisted Living **License Number:** AL4102 **Survey Event ID:** SETJ11 **Date Survey Completed: 3/27/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923 SS=D	Based on: C1923-310,66 3-19-2 (a) (3) SS=D

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?	No resident was affected Resident and staff member no longer here
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No resident affected
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?	See page 1, question 3
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.	DON to oversee and check MAR for any missing sign out Random MAR checks will be done by DON, see attached Add med errors to QA form to be checked quarterly DON-log of checks
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Initial done 3-31,25. On going random and quarterly checks
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jackie Alexander** OAC 310:663-25-4(F)	**Date 4/16/2025**

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: 4/16/2025

Facility Name: Prairie Pointe Assisted Living

License Number: AL4102

Survey Event ID: SETJ11

Date Survey Completed: 3/27/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1972 SS=E	Based on: The center failed to ensure staff were educated on abuse within 90 days of hire for 4 (CMA #1, CAN #2, CAN #3, and CAN #5) of 5 employees whose records were interviewed.

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?	No residents were affected.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No residents were affected.
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?	We have made a new policy and procedure for abuse and neglect training. Training will be provided in the employment pack and gone over with Administrator or DON before start date. Prairie Pointe will also go over, educate and sign every month for 6 months then every 6 months in May and November and as needed.
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.	DON and/or Administrator will go over and educate new employees and every month for 6 months at inservice. If an employee misses an inservice DON/ADM. Will go over the inservice in person with employee. DON is adding orientation to QA. Signatures from orientation of employment and signatures from inservices concerning abuse.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/4/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jackie Alexander4-16-25 OAC 310:663-25-4(F)	**Date 4/16/2025**

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: 4/16/2025

Facility Name: Prairie Pointe Assisted Living

License Number: AL4102

Survey Event ID: SETJ11

Date Survey Completed: 3/27/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C6000 SS=E	Based on: record review and interview, the center failed to conduct registry screening and background checks for staff upon hire for 3 (CMA #1, CAN #2, and CAN #5 of 5 sampled personnel files reviewed.

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?	No residents are affected.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No residents affected.
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?	Administrator has taken over doing all crimanl history background checks. Administrator will conduct all ok screens and will not allow any employee to start work until registry screening is complete, paid for, and printed for file.
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.	DON will check to make sure administrator has completed the registry screening before employee can start work. Both DON and Administrator will check each new employee file to make sure criminal history is complete before filing. New employees orientation will have check off to be sure criminal history has been complete. Each employee file will have criminal history completed and will be part of each file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jackie Alexander** **Date 4/16/2025**
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	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.

orientation packet

Abuse, Neglect and Exploitation, Policy

Policy overview

Prairie Pointe is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the administrator, assistance administrator, or the Director of Nursing for investigation and appropriated follow-up.

Policy Detail

1. **Definitions:**
    a. **"Abuse"** is defined in Oklahoma as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, impairment or mental anguish.
    Abuse can also be taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute such photographs and recordings on social media.
    b. **"Neglect"** is defined in Oklahoma as the failure to provide goods and services necessary to avoid physical harm, mental anguish or illness.
    c. **"Exploitation"** (Misappropriation of Property) is defined in Oklahoma as the taking, secretion, misapplication, deprivation, transfer or attempted transfer to any person not entitled to receive any property, real or personal, or anything of value belonging to or under the legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of resident property.
2. **Response to Incident:**
    a. Protection of Resident. Upon learning of alleged abuse, neglect or exploitation, the supervisor on duty should attempt to take necessary steps to ensure that residents are protected from subsequent episodes of abuse, neglect or exploitation while a determination on the matter is pending.
    b. Provision of Medical Attention. Any person who is harmed during an incident should be provided medical attention, as appropriate.
3. **Investigation:**
    a. Internal Investigation. Upon receipt of an allegation of abuse, neglect or exploitation, the Administrator or designee, should conduct a confidential internal investigation of the incident.
    b. Manner of Conducting Investigation. The investigation should be conducted confidentially and in a manner that is least disruptive to the on-going delivery of services and daily routine of the community.
        i. The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community.

ii. Witnesses should be interviewed separately so that their statements are not influenced by others recollections. The interviews should occur in a private area.
iii. After an interview is completed, instruct the person questioned not to discuss the events surrounding the incident/occurrence with others. Explain that a personal recollection of an event can become blurred when hearing additional information second hand from others.
iv. A written summary of the investigation shall be prepared and reported to the SHDA, the governing board of Prairie Pointe.

c. Investigation Record. The Executive Director of designee should maintain a written record of the investigation. A summary of interviews should be prepared by the Executive Director or designee, including the date, time, name of person being quest6ioned and an impartial report of the facts. See internal investigation of incidents/occurrences.

d. Employment Response Based upon Investigation Results. Based upon the results of its investigation, Prairie Pointe may take such action as it deems appropriate with respect to the employment or contract status of the accused, up to and including termination of employment or the contract.

4. External Reporting/Notification

a. See attached subchapter 19. Section 310:663-19-1 Oklahoma Statutes.

employee signature orientation pack

ABUSE, NEGLECT, EXPLOITATION

Residents of Prairie Pointe at Stroud have the right to be free from abuse, neglect, and exploitation and are to be treated with respect. Employees who have a reasonable cause to believe that a resident is in a state of abuse; or employees witnessing a violation of these rights which result in abuse, neglect, or exploitation will report these observations to the proper authority immediately. Violation of these will be grounds for immediate termination.

All employees will receive training in recognizing and reporting abuse.

Provide a verbal report to Adult Protective Services and OSDH by use of reporting system in place.

Employee Signature:_____

Date:_____

ABUSE AND NEGLECT

POLICY-

Prairie Pointe Assisted Living will provide staff training within 90 days of employment, in the identification of abuse and neglect of residents and misappropriation of resident property and the facilities policies and procedures concerning the same. Verification of the training shall be written, signed by staff, and retained in personnel files.

PROCEDURE

Training will be provided in employment pack and gone over with Administrator or DON before start date to be employed.

Training and education concerning abuse and neglect will also be gone over, educated, and signed every 6 month, in May and November, and as needed.

DIETICIAN SERVICES

POLICY-

It is the policy of Prairie Pointe Assisted Living to provide a dietician to inspect the kitchen and sign/go over menu's to assure residents needs are being met. They will inspect once a year and PRN.

PROCEDURE-

Kitchen will adhere to cleaning schedule, temperature logs, labeling & dating at all times.

When new menu's are made the dietitian will be contacted to go over and sign.

Prairie Pointe will make sure residents diets are followed according to the Dr. order and that all nutrition needs are met.

Prairie Pointe will serve reg diets. Residents an substitute for another item or size of item at any time.

Prairie Pointe residents can refuse any item they don't want. We do provide some sugar free items if they request.

Menu

Date	Breakfast	Lunch	Dinner
Monday April 7	Resident's Choice Bacon/Sausage	Buffalo Wings Sweet Potato Fries Basket Coconut Delight	Sloppy Joes Cheese Puffs Pears
Tuesday April 8	Resident's Choice Bacon/Sausage	Pork chops Hashbrown Casserole Fried Okra Cherry Dump cake	Club Sandwich Pea Salad Chocolate chip Cookies
Wednesday April 9	Resident's Choice Bacon/Sausage	Philly Cheese Steak Onion Rings Cookie Brownie Cookie	Chicken and Rice Roll Fluff
Thursday April 10	Resident's Choice Bacon/Sausage	Salmon Patties Hominy Green Beans Cinnamon Cresent	Biscuits and Gravy Sausage Fresh Fruit
Friday April 11	Resident's Choice Bacon/Sausage	Country Fried Steak Mashed Potatoes Gravy Frozen Veggies Poke Cake	Pizza Salad Bar Ice cream
Saturday April 12	Resident's Choice Bacon/Sausage	Lasagna Ceasar Salad French Bread Cooks Choice	Grilled Cheese Tomato Soup or Chicken and noodle Oreo Whip
Sunday April 13	Resident's Choice Bacon/Sausage	Fried Chicken Potato Salad Candied Carrots Roll Peach Cobbler	Chili Crackers Assorted Desserts

Salad & Fruit Bar Available Daily

Menu

Date	Breakfast	Lunch	Dinner
Monday March 31	Resident's Choice Bacon/Sausage	Swedish Meatballs Read mashed Potatoes Ceasar Salad Ice Cream Sundae	Egg Rolls Fried Rice Fresh Fruit
Tuesday April 1	Resident's Choice Bacon/Sausage	Fried Fish French Fries Coleslaw Potato Salad Banana Pudding	French Toast Sausage Fluff
Wednesday April 2	Resident's Choice Bacon/Sausage	Chicken Fried Chicken Scalloped Potatoes Broccoli Cake Cookies	Chicken Red Jell-O with Fruit cocktail
Thursday April 3	Resident's Choice Bacon/Sausage	BLT Tater Tots Cake	Ground beef Casserole Bread Pistachio Pudding
Friday April 4	Resident's Choice Bacon/Sausage	Hamburger Steak Mashed Potatoes Brown Gravy Steamed Veggies Bread Pudding	Chef's Salad Assorted Crackers Ice Cream
Saturday April 5	Resident's Choice Bacon/Sausage	BBQ Chicken legs Baked Beans Potato Salad Lemon Bars	Broccoli Cheese Soup Crackers Muffins
Sunday April 6	Resident's Choice Bacon/Sausage	Roast Potatoes Carrots Roll Pie	Tuna Salad Sandwich Macaroni Salad Assorted Desserts

Salad & Fruit Bar Available Daily

Menu

Date	Breakfast	Lunch	Dinner
Monday March 24	Resident's Choice Bacon/Sausage	Beans Fried potatoes Cornbread Apple Cobbler	Chicken and Noodles Roll Cookie
Tuesday March 25	Resident's Choice Bacon/Sausage	Steak Fingers Mashed Potatoes Mix Veggies Coffee Cake	Chili Dogs Chips Orange Jello with Mandarin Oranges
Wednesday March26	Resident's Choice Bacon/Sausage	Fried Shrimp Or chicken strips French Fries Coleslaw 3 cup peanut butter Cookies	Taco salad Cherry dump cake
Thursday March 27	Resident's Choice Bacon/Sausage	Tamale Casserole ' Guacamole Salad Ice Cream Sundae	Cheese Omelet Ham Fresh fruit
Friday March 28	Resident's Choice Bacon/Sausage	Chicken strip basket w/FF gravy or ketchup	Potato soup Cottage cheese Muffins
Saturday March 29	Resident's Choice Bacon/Sausage	Pulled pork Sandwich Potato Salad Cooks choice	Pizza Salad Bar Ice cream
Sunday March 30	Resident's Choice Bacon/Sausage	Turkey Dressing Fried okra Roll Pie	Tuna sandwich Broccoli Salad Assorted Desserts

Salad & Fruit Bar Available Daily

Menu

Date	Breakfast	Lunch	Dinner
Monday April 14	Resident's Choice Bacon/Sausage	Smoked Sausage Cabbage Fried Potatoes Pecan Bars	Fish Sticks Coleslaw Fruit Salad
Tuesday April 15	Resident's Choice Bacon/Sausage	Homemade Burritos Fresh Avocado Salad Chips & Queso Mexican wedding cake	Chicken Salad Sandwich Macaroni Salad Rise Krispies
Wednesday April 16	Resident's Choice Bacon/Sausage	Chicken Spaghetti Garden Salad French Bread Apple Cinnamon Roll Cobbler	Waffles Sausage Banana Nut Muffins
Thursday April 17	Resident's Choice Bacon/Sausage	Burgers Tater Tots All the Fixings Peacher Cobbler	Ground beef Casserole Bread Ice Cream
Friday April 18	Resident's Choice Bacon/Sausage	Swiss Pork Patty with Sauce Roasted Potatoes Broccoli Cooks Choice Dessert	Chef Salad Crackers Assorted Desserts
Saturday April 19	Resident's Choice Bacon/Sausage	Salsibury Steak Mashed Potatoes Butter Beans Poke Cake	Creamy Chicken Noodle Soup Crackers Cookie
Sunday April 20	Resident's Choice Bacon/Sausage	Ham Sweet Potatoes Baked Beans Roll Pie	Pimento Cheese Sandwich Salad Bar Chips Pineapple Upside down cake

Salad & Fruit Bar Available Daily

NS GROUP
Consulting Division
Southwest Region

CONSULTANT DIETITIAN RECOMMENDATIONS FOR PRIMARY CARE PROVIDER

FACILITY: Prairie Pointe Assisted Living	**DATE**: 4/9/2025
ADMINISTRATOR: Jackie Alexander	**DON/QIDP**: Bea Simpson
RD/LD CONSULTANT: Lisa Driver MS, RD/LD	**DIETARY MNGR**: Jene Hooks

DIETARY DEPARTMENT & MEAL SERVICE

Topic / Item	Yes	No	Comments
Kitchen is sanitary (floor, stove, oven, prep area, etc.)		X	Inside the oven and inside microwave
Food covered, labeled & dated in pantry, refrigerator, freezer		X	Few canned items needed dated
Kitchen is free of pests	X		
Products are within use-by date or expiration date	X		
Opened packages are re-sealed and dated properly		X	Scoop in oatmeal container
Dishes are in good condition, stored properly and sanitized	X		
Silverware is stored to encourage contact with handles only		X	Make sure utensils are HANDLES UP
Storeroom in proper order and food stored correctly	X		
Equipment is in proper working order		X	Inside drawers: Need cleaned and found dirty spoon.
Refrigerator is at or below 41°F	X		
Freezer is at proper temperature (food is solid frozen)	X		
Temperatures of foods are not in danger zone (41-135°F)	X		
Dish machine sanitizer is in working order	X		
Menus are posted. Menu is available for special diets.	X		
Three-day food supply is available for emergencies	X		
Other: Vents and hood		X	Vents and hood needs degreased/cleaned

Revised 9-5-2021

COMMENTS: Worked with new DM and gave an Inservice on sanitations and dish machine. Signed new menus.

Dietitian: Lisa Driver MS, RD/LD_____ Date: 4/9/2025

RANDOM MEDICATION CHECKS BY DON.

Date	Resident	Routine	PRN	Follow UP	Staff	Med Error	DON	Comments
2/15/25	#IG-107	✓	/	/	JD	/	BS	~~clear~~

OKLAHOMA
State Department of Health

Delivery via email to: jackie.prairiepointe@yahoo.com; jlalexander1955@yahoo.com; jalexander@prairiepointe.net

May 6, 2025

License Number: AL4102
Survey Event ID: SETJ12

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

Dear Ms. Alexander:

On **May 5, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **March 27, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **April 9, 2025**.

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

Respectfully,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL4102	A. BUILDING: _____ B. WING _____	R 05/05/2025

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 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/05/25. The facility was in substantial compliance.	{C 000}		

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