OKLAHOMA
State Department
of Health

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

July 3, 2025

License Number: AL4102

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

Survey Event ID: 4KU411

Dear Ms. Alexander:

On **June 5, 2025,** 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 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 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 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 a 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Prairie Pointe AL Stroud**
Address: **701 West Olive Street**
City, State, Zip: **Stroud, Okla 74079**
Provider #: **AL4102**
Complaint #: **OK00082628**
Investigation Date(s): **06/04/2025 thru 06/05/25**

ALLEGATION(S)

The facility failed to ensure residents received their medications according to physician orders.
The facility failed to ensure the residents received assistance with grooming and hygiene.
The facility failed to assess, monitor and/or intervene in a timely manner after a fall with injury.
The facility failed to notify the representative when there was a change in condition.
The center failed to ensure incidents required to be reported to the OSDH were reported.
The center failed to ensure resident medication was returned to the family upon discharge or death or a disposition of the medication was provided to the family.

An unannounced on-site investigation was initiated 06/04/2025 at 09:40 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance to the facility and at various times throughout the survey. Staff /resident interactions were observed and interviews conducted. Residents communicated they felt safe and comfortable within the facility. Staff stated they were routinely in-serviced on medications, fall and safety protocols. The sampled residents' clinical records were reviewed. Incident reports, State Reportable incident reports, facility investigations, facility policy/procedures, facility in-services, treatment records, and hospital records were included in the review.
Residents were interviewed regarding the allegations of the complaint.
Resident representatives were interviewed regarding the allegations of the complaint.
Staff were interviewed regarding the allegations of the complaint.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/05/2025

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 _____	C 06/05/2025

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 A complaint investigation (#OK00082628) was conducted from 06/04/25 through 06/05/25. Deficiencies were cited as a result of the survey. Facility Census: 19	C 000		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported	C1912		

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July 14, 2025

License Number: AL4102

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

Survey Event ID: 4KU411

Dear Ms. Alexander:

On **June 5, 2025**, 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:

- **C1912:** It needs to be reported and followed in the Quality Assurance process.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

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In-Service/Training Log

This in-service, conducted on (date/time) ~~May~~ June 13th 2025, 9am to 10 am Informs and educates employees on PAYROLL, Residents right, Abuse, Accident/incident reports,
Conducted by::Beatrice Simpson LPN/DON , Jackie Alexander ADM

Name Title

Name, *printed*	Signature	Department/Title
Bethani Byford	Bethani Byford	
Jamie Duncan	Jamie Duncan	CNA I MAT
Angela Robison	Angela Robison	CMA / CMA
Jo Weeks	Jo Weeks	Cook
Holly Fleshman	Holly Fleshman	CNA / Med
Deana Hess	Deana Hess	CNA / MAT
Crystal McCoy	Crystal McCoy	CNA
Leah Ackerman	Leah Ackerman	HC
Kaden morton	Kaden morton	CNA / MAT
Lynnkisha Parker	Lynnkisha Parker	CNA - MAT
Cody Bair	Cody Bair	CNA
Missy Case	Missy Case	HSK
Lynne Gonzales	Lynne M Gonzales	CNA / MAT

INSERVICE 6/13/2025

1. Residents' rights and responsibilities.
2. Free of abuse, neglect both physically and mentally.
3. Right to be treated kind and politely every situation.
4. Follow the Oklahoma rights and responsibilities.

CNA/CMA

Thank you for all you do.

IF YOU HAVE TIME TO LEAN, YOU HAVE TIME TO CLEAN.

1. C/o a lot of sitting around in the activity room. Talking, phone, computer. This has got to stop. Find something to do. Breaks are one thing sitting is another.
2. C/O personal trash is not being pickedup, especially on the weekend. Trash at puzzle tables not getting carried out.
3. Hallways are scheduled to be cleaned. But if you notice something needs swept, DO IT!
4. Roll silverware 1st shift, 2nd shift, and 3rd shift.

OKLAHOMA RESIDENTS' RIGHTS AND RESPONSIBILITIES

A. All principles enunciated in this section shall be posted in a conspicuous, easily accessible place in each facility and each resident and personally appointed representative, if any, shall be provided a copy of these principles and advised verbally prior to or upon admission. The facility shall ensure that its staff is familiar with and observes the rights and responsibilities enumerated in this section. The facility shall make a available to each resident, upon reasonable requests, a current written statement of such rights.

B. Residents' rights and responsibilities include, but are not limited to the following:

1. Every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and the facility shall encourage and assist in the exercise of these rights.

2. Every resident has the right to have private communications, including telephonic communications and visits and consultations with the physician, attorney, meetings of family and resident groups or any other person or persons of his choice, and may send and promptly receive, unopened, his personal mail;

3. Every resident has the right, without fear of reprisal or discrimination, to present grievances with respect to treatment or care that is or fails to be furnished on behalf of himself or others to the facility's staff or administrator, to governmental officials or outside of the facility to work for improvements in resident care. The family of a resident has the right to meet in the facility with other residents' families. Every resident including those with respect to the behavior of other residents;

4. Every resident has the right to manage his own financial affairs, unless the resident delegate the responsibility, in writing to the facility. The resident shall have at least a quarterly accounting of any personal financial transactions undertaken in his behalf by the facility during any period of time the resident has delegated such responsibilities to the facility;

5. Every resident has 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 his attending physician of his medical condition and advised in advanced 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 of changes in care and treatment. Every resident shall have the right to refuse.

6. Every resident shall have privacy for spousal visits. Every resident may share a room with their spouse, if the spouse is residing in the same family.

7. When a physician indicates it is appropriate, a facility shall immediately notify the resident's next of kin, or representative, of the resident's death or when the resident's death appears to be imminent;

8. Every resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

9. Every resident has the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Department with respect to the facility and any plan of correction in effect with respects to the facility.

C. No licensed facility shall deny appropriate care on the basis of the resident's source of payment as defined in the regulations. Appropriate care shall not include duplication of services by a nursing home, hospice, or any combination of care providers.

D. Each facility shall prepare a written plan and provide appropriate staff training to implement each resident's rights as stated in this section.

E. Any person convicted of violating any provision of this section shall be guilty of a misdemeanor, punishable by a fine of not less than One Hundred Dollars ($100.00) Nor more than Three Hundred Dollars ($300.00) or imprisonment in the county jail for not more than thirty (30) days, or by both such fine and imprisonment.

F. In addition to the penalties provided in this section, an action may be brought against an individual by any resident who is injured by any violation of this section, or who shall suffer injury from any person who threats would cause a violations of this section if carried through, may maintain an action to prevent, retrain or enjoin a violation or threatened violation, if a violation or threatened violations of this section shall be established in any action, the court shall enjoin and restrain or otherwise prohibit the violation or threatened violation and asses in favor of the plaintiff and against the defendant the cost of the suit, and the reasonable attorney fees incurred by the plaintiff. If damages are alleged and proved in the action, the plaintiff shall be entitled to recover from the defendant the actual damages sustained by the plaintiff, if it is an action that the

defendants conduct was willful or in reckless disregard of the rights provided by this section, punitive damages may be assessed.

G. Any employee of a state agency that inspects any nursing facility or special facility shall report any flagrant violations of this act or any other statute to the administrative head of the state agency, who shall immediately take whatever steps are necessary to correct the situation including, when appropriate, reporting the violations to the district attorney of the country in which the violation occurred.

H. Upon death of a resident who has no sources of payment for the funeral services the facility shall immediately notify appropriate county officials who shall be responsible for funeral and burial procedures of the deceased in the same manner as with any indigent resident of the county.

ACKNOWLEDGMENT

I have received a copy of the OKLAHOMA RESIDENT'S RIGHTS AND RESPONSIBILITES.

Date_____ Residents Signature_____

Discussed and reviewed Fall procedure , notifications of falls. Filling out form correctly . as listed in policy and procedure. Question and answer times with staff concerning Abuse, Incident and accident reports.

Also reviewed timely incident reportable procedures.

Jackie Alexander
6-13-25

Simpson Tomlinson 6/13/25

FALL PROCEDURE

- ASK THEM→ DID HE/SHE HIT THEIR HEAD ON ANYTHING LIKE FURNITURE/ FLOOR ETC.
  - IF NO→ WRITE IN INCIDENT REPORT DENIES HITTING HEAD
  - IF YES→ DO NOT MOVE THE RESIDENT AND REPORT TO LPN OR LICENSED NURSE. IF LPN OR LICENSED NURSE ARE NOT AVAILABLE, NOTIFY ADMINISTRATOR AND CALL AMBULANCE
- CHECK HEAD→ FOR GOOSE EGGS, OPEN AREAS, OR BLEEDING
  - GOOSE EGG-APPLY ICE
  - OPEN AREA- APPLY PRESSURE BANDAGE
  - IF OPEN AREA NEEDS SUTURES- CALL AMBULANCE AND APPLY PRESSURE
- ASK IF HURTING ANYWHERE
  - IF HIP OR NECK PAIN→DO NOT MOVE RESIDENT
    - KEEP RESIDENT COMFORTABLE AS POSSIBLE ON FLOOR
    - CALL AMBULANCE AND LET EMT'S MOVE RESIDENT
- ALWAYS GET A FULL SET OF VITAL SIGNS
  - BLOOD PRESSURE, PULSE, RESPIRATIONS, TEMPERATURE, 02
- CHECK FOR ABRASIONS
  - COVER WITH A NONSTICK DRY BAND-AID
- CHECK ARMS
  - IS THERE AN INCREASE OF PAIN TO SHOULDERS OR ELBOWS?
  - CAN THEY GRASP YOUR HANDS? ARE THEIR HAND GRASPS EQUAL?
  - IF ANY OF THE ABOVE, NOTIFY LPN OR LICENSED NURSE AND CALL AMBULANCE FOR FURTHER CARE
- CHECK ALL EXTREMITIES
  - MAKE SURE THEY ARE ABLE TO MOVE ALL EXTREMITIES WITH NO DISCOMFORT
  - IF DISCOMFORT IS REPORTED, NOTIFY LPN OR LICENSED NURSE AND CALL AMBULANCE

- **EVERY FALL OR INCIDENT WILL NEED A NURSE'S NOTE TO BE COMPLETED BY THE MAT OR CMA ON THAT SHIFT**

  - WRITE DOWN HOW THE RESIDENT WAS FOUND AND WHERE
  - WRITE DOWN IF THE RESIDENT COMPLAINS OF ANY PAIN
  - WRITE DOWN IF THE RESIDENT HIT THEIR HEAD
  - WRITE DOWN ALL VITALS SIGNS
  - WRITE DOWN IF AMBULANCE WAS CALLED
  - SIGN AND DATE NURSE NOTE AND GIVE TO LPN OR LICENSED NURSE

Quality Assurance Committee Quarterly Meeting

DATE: 6-30-25

CENSUS: 20

ADMISSION: 4-1-25 #209 (1) 4-16-25 #205 (1)

DISCHARGE: Ø

HOSPITAL STAY greater than 24 HOURS: 1- #101 (4)

FALLS: 4-7- #207 (1) -5-9 #111 (2) -6-12 #103 (3) - 6-19 - #202

STATE REPORTABLES: Ø

INFECTIONS: #206 (1) -

DEATHS: 4-20 #110 (1) PT -

ELOPEMENT: Ø

SIGNIFICANT CHANGE 6-24-25 #207 (1)

HIGH FALL RISK RESIDENTS 102, 104, 108, 201, 204, 206

INCIDENTS/ACCIDENTS/STATE REPORTABLES

FRACTURE: Ø

HEAD INJURIES: Ø

REPORTABLE DISEASE: Ø

INCIDENT REQUIRING TREATMENT: Ø

OTHER INCIDENT: Ø

RESIDENTS QUARTERLY SATISFACTION SURVEYS REVIEWED/ QUALITY EFFORTS and OUTCOMES

See attached

ABUSE ALLEGATIONS or INCIDENT of ABUSE

NA

ALLEGATION or INCIDENT of NEGLECT

NA

MISAPPROPRIATION ALLEGATIONS/INCIDENT

NA

STORM, FIRE, UTILITY FAILURE

NA

RESIDENT SATISFACTION SURVEY

Resident Name: Prairie Pointe AL **Apartment Number:** _____

Community: STROUD

Person completing survey *(relationship)* Simpson Grayson **Date:** 6-30-25

	All of the time	Most of the time	Some of the time	Never	Comments
The Care Partners are courteous and caring in their attitude.	𝍸	III			
1. The A.L. Director is responsive to my needs and concerns as well as my family's concerns.	𝍸 I	II II			
2. The personal care assistance (bathing, dressing, etc.) I receive is satisfactory.	III				
3. I receive the services for which I am paying.	𝍸 I	IIII			
4. I am satisfied with the assistance I receive with my medications.	II	III			
5. The staff respond to my calls for help quickly and courteously.	𝍸 I	III			
6. The staff performs their duties completely and well.	𝍸 I	III			
7. I am satisfied with the quality of life in the community.	𝍸 I	IIII			
9. I am comfortable going to the A.L. Director with my concerns or questions.	𝍸 I	IIII			
10. The administration is responsive to my needs and concerns.	𝍸	IIII			

Other things you would like for us to know: ① Great staff, pleasant + professional ② some of the boys that work in the Kitchen are in serving food Area a bit arragant.

Fire Drill Report

ALWAYS NOTIFY THE FIRE DEPARTMENT BEFORE CONDUCTING A FIRE DRILL.

IF THE FIRE ALARM IS AUTOMATICALLY TRANSMITTED TO A MONITORING COMPANY, MAKE SURE THEY ARE NOTIFIED AS WELL.

COMPLETE BEFORE DRILL

1. Simulated Situation: Fire X Smoke _____ Other _____
2. Location: Kitchen ____, Dining ____ Lobby ____ Office X Apartment ____ Other _____
3. Extent of Smoke: Noxious ____ Entire Room X Corridor ____ Light ____
   Smoldering ____ Heavy ____ Other _____
4. Type of Fire: Bed ____ Wastebasket ____ Kitchen ____ Range ____ Other X - electric - computer
5. Extent of Fire: Large ____ X Small ____ Explosion ____ Electrical ____ Paper ____ Wood ____
   Controllable ____ Other _____

COMPLETE AFTER DRILL

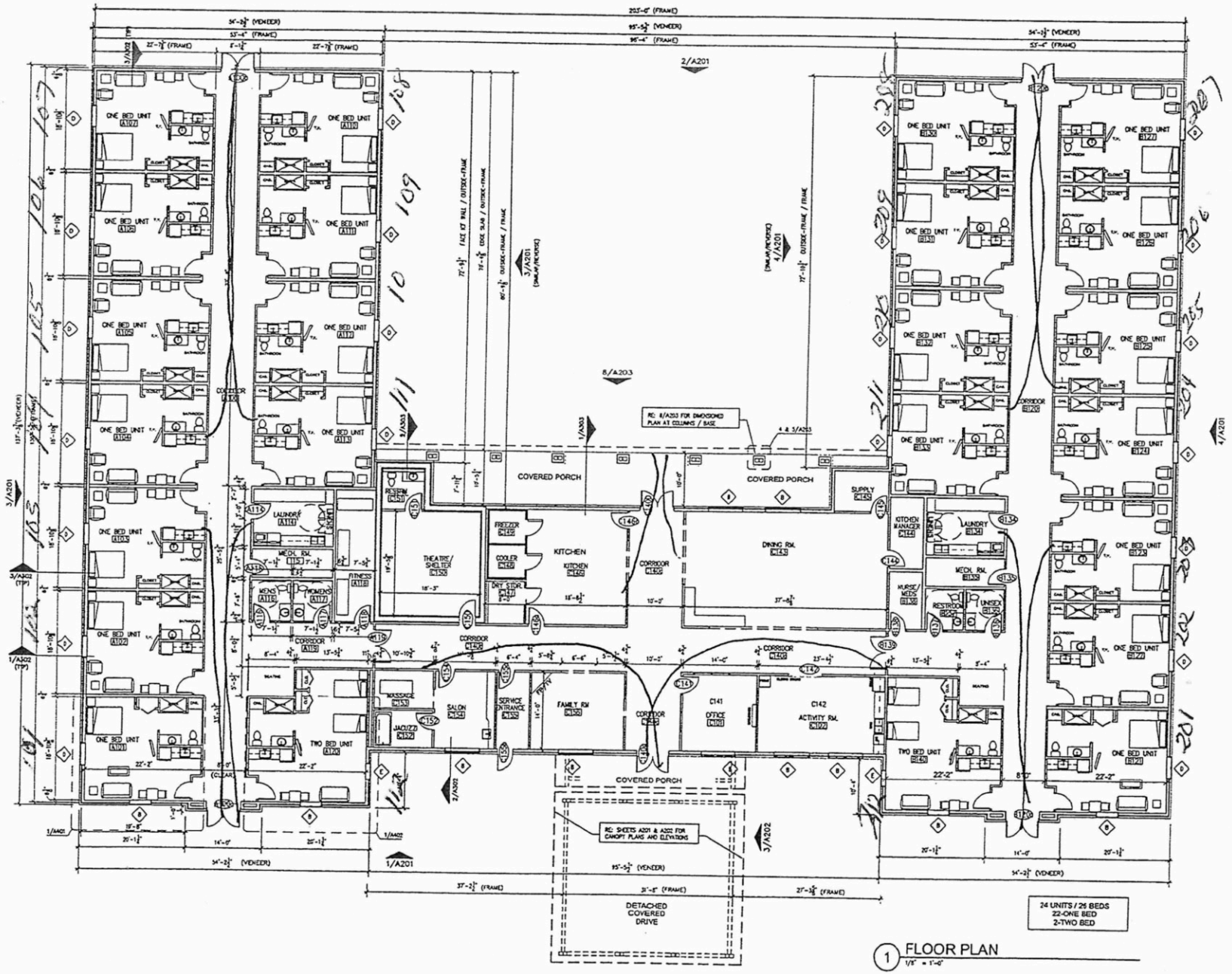
1. Fire Drill: Date 6-16-25 Start Time: 0452 (AM)/PM Total Time of Drill 35min
2. Was fire department on site for the drill? NO
3. Did staff use proper judgment? yes
4. What action was taken? called adm, DON
5. Was fire department called by staff? (simulated) Yes When? auto fire alarm
6. Were residents in halls removed to an area of safety? yes
7. Were all halls, corridors and other means of egress maintained clear and free of obstruction? Yes
8. Were all corridor doors closed? Yes
9. Who responded to the fire, and with what equipment? hmm - extinguisher
10. Were exits monitored by staff? yes
11. Was building evacuated? NO
12. Was fire extinguished by staff or fire department? staff
13. Who sounded "All Clear" and shut off alarm? Jackie
14. Was the emergency plan executed correctly? yes
15. Was all staff aware of their responsibilities? yes
16. Did the personnel in different areas or wings:
    a. Hear the fire alarm? yes
    b. Respond promptly to the fire alarm? yes
    c. Follow accepted procedures calmly, smoothly, and efficiently? yes
    d. Seem to know their fire procedures? yes
    e. Return to their proper stations? yes
    f. Stand by until "All Clear" was given? yes
    g. Hear the "All Clear" announcement? yes

Comments / Recommendations _____

Names of Participants:
Bea Simpson DON Lynn M Douglas CNA Jaelene Alexander Adm

Report Completed By: Bea Simpson Title: LPN DON

Keep copy of completed form in the facility and present to the surveyor at the time of the inspection.



1 FLOOR PLAN
1/8" = 1'-0"

PRAIRIE POINTE AT STROUD
"a community of care"

725 OLIVE STREET
STROUD, OKLAHOMA

pmadesigngroup
design interiors consulting

Edmond, Oklahoma
www.pmadesign.net

BY

STATE OF OKLAHOMA
3782
LICENSED ARCHITECT

CONSULTANTS

KEY PLAN

ISSUED

no.	date	description
1	07/08/15	FLOOR REVISION
2	09/05/15	ADD DIMENSIONS
3	09/24/15	REVISE DIMENSIONS

PROJECT NO. 14008
ISSUED ON:
ISSUED BY:
REVISED ON:

date 02/19/2015
BID / CONSTRUCT DOCUMENTS

FLOOR PLAN (REVISED)
SHEET NO.
A101
SHEET NO.

INCIDENT INVOLVING ANOTHER PROVIDER

NA

SIGNATURES of STAFF ATTENDING THIS MEETING

Simpson LPN/DON — Jamie Duncan

Jackie Alexander Adm — Cody Bauer

Brooke Dewing

5/29/25 new stove. BS

6/11/25 Discussed Abuse, Accident/Incident. Timely manner to report incident reportables - BS

OKLAHOMA
State Department
of Health

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

July 16, 2025

License Number: AL4102

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

Survey Event ID: 4KU411

Dear Ms. Alexander:

On **June 5, 2025,** 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 Amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 13, 2025**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL4102	A. BUILDING: _____ B. WING _____	C 06/05/2025

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 A complaint investigation (#OK00082628) was conducted from 06/04/25 through 06/05/25. Deficiencies were cited as a result of the survey. Facility Census: 19	C 000	IN REFERENCE TO DEFICIENCY C1912 To correct this deficiency we have reviewed procedures for accident/incident reports. We educated in inservice on 6-13-25, about procedures for falls, accident, and incident reports and follow-up on both. Also when to send to the state and to always call PCP, DON, ADM, and family with each one whether they are sent out or not. We will educate once a month for six months and then quarterly or as needed after the first six month. 7/15/2025 Added a updated Quality Assurance attachment for reporting and follow up. Also added, Date of Report and What Action was taken to prevent from reoccurring section	6-13-25
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported	C1912		

How C1912 is Reported and Followed in the QA Process

To ensure compliance and continuous improvement, the corrective action for Deficiency C1912—related to accident/incident report procedures—is both reported and monitored through the Quality Assurance process as follows:

Reported in QA:

The deficiency was identified during a survey/review and documented as C1912.

A Plan of Correction was submitted, detailing the steps taken to address the deficiency.

The corrective action was implemented through an in-service education session on June 13, 2025, covering:

Procedures for reporting falls, accidents, and incidents.

Clarification on when reports must be sent to the state.

Protocols for notifying key individuals: PCP (Primary Care Provider), DON (Director of Nursing), ADM (Administrator), and family—regardless of whether the incident report is sent out or not.

Followed in QA:

The facility committed to ongoing staff education:

Monthly in-services for the first six months.

Followed by quarterly education or more frequently as needed

These educational sessions will be tracked and documented as part of the facility's QA program to ensure:

Staff understanding and compliance.

Continued improvement and reduced recurrence of the deficiency.

The QA team will review incident reports, education logs, and follow-up actions during audits or QA meetings to verify the effectiveness of the correction.

Any trends or repeated issues will trigger immediate re-education or corrective measures, ensuring accountability and quality care.

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: _____

Date reported:_____ What action was taken to correct or prevent from happening again._____.

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

_____ _____

_____ _____

_____ _____

OKLAHOMA
State Department
of Health

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

July 23, 2025

License Number: AL4102
Survey Event ID: 4KU412

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

Dear Ms. Alexander:

On **July 18, 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 **June 5, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **June 13, 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-C 07/18/2025

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 07/18/25. 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