Oklahoma State Department of Health
Creating a State of Health

October 10, 2019

License Number: AL6009

Ms. Tonya Wolfe, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

RE: Survey Event ID: VUBF11

Dear Ms. Wolfe:

On **September 25, 2019**, 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 September 25, 2019.

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 (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 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 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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL6009	A BUILDING _____ B WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF STI	832 S RANGE ROAD STILLWATER, OK 74074

(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 re-licensure survey was conducted 09/24/19 and 09/15/19. Resident census was 41. The following deficient practice was cited.	C 000		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6009	A. BUILDING _____ B. WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF STI	832 S RANGE ROAD STILLWATER, OK 74074

(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
C5010	Continued From page 1	C5010		

This Rule is not met as evidenced by:
Based on interview, and record review, it was determined the center failed to ensure third party staff providing sitter services were from a licensed agency, had current credentials, or had a current background check while providing services for 1 (#6) of 1 sampled resident that utilized the services of a private sitter. This failed practice had the potential for more than minimal harm at a pattern. Findings:

On 09/24/19 at 11:05 a.m., a report on the residents was received from the RN (registered nurse). She stated resident #6 had private sitters who were not hired through a licensed agency. A person who did private sitting had hired other people to work for her providing companion/sitting services and the family of resident #6 had hired her to provide private sitters for resident #6.

On 09/25/19 at 9:30 p.m., resident #6 was observed lying in her bed and her eyes were closed. The sitter was present and she stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6009	A. BUILDING _____ B. WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF STI	832 S RANGE ROAD STILLWATER, OK 74074

(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
C5010	Continued From page 2 she and another sitter alternated days sitting with resident #6. The sitter stated the resident was on hospice services and was on end-of-life-comfort care measures. She stated she only provided companion services, but then said she fed the resident chocolate pudding and scrambled eggs and gave her a nutritional supplement. The sitter stated she and another sitter had been hired to stay with the resident on alternate days. She pointed to a calendar taped to a cabinet door. The calendar was for September, 2019 and both sitter's names were written on alternate days. Above the calendar was a business card with the name of the business, the name of the owner and a phone number. At 10:00 a.m., the administrator stated she called the owner of the business and requested fingerprint background checks on the two sitters that stayed with resident #6. She stated the owner said she looked her workers up on line, but did not print anything out, so she did not have national fingerprint based background checks on any of her workers. At 1:15 p.m., the RN stated the sitter with resident #6 was not a certified long term care aide or a certified feeding assistant. The RN also stated she did not know the sitters were feeding resident #6. She stated as far as she knew the resident was still only taking sips of water and was unable to take food.	C5010		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6009	PRIMROSE RETIREMENT COMMUNITY OF STILLWATER

Type of Survey (select all that apply)

2				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	09/24/2019	09/25/2019	0.25	0.00	15.00	0.00	3.50	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

OCT 10 2019

Oklahoma State Department of Health
Creating a State of Health

October 24, 2019

License Number: AL6009

Ms. Tonya Wolfe, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

RE: Survey Event VUBF11

Dear Ms. Wolfe:

On September 25, 2019, 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 **October 21, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/jt

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/16/2019** **Facility Name:** Primrose Retirement Community of Stillwater **License Number:** AL6009 **Survey Event ID:** September 25, 2019 **Date Survey Completed: 9/26/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010	Based on: The rule is not met as evidenced by: based on interview and record review, it was determined that center failed to ensure that third party providers were from a licensed agency, had current credentials or had background checks on those providing sitter services.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Agreement is made to comply with all rules set forth by Department of Health

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?	Effective 10/21/2019, all private duty sitters are required to be employed thru a LLC Home Health agency. Staff will ensure that private sitters are not involved in any of the care needs of residents, this will be documented in the coordination of care form. (this includes eating)
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All management nursing staff have been educated to this expectation. Notice is now posted outlining the requirement for private sitter services (posted boldly by the main nursing station). Staff will refer residents and /or family members to the occupancy agreement, outlining third party requirements.
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?	All family /residents using private duty sitters have been informed of expectation and guidelines set forth by the state and complied with by Primrose. Proper guidelines are outlined in the Resident Occupancy Agreement (p.35) Administrator will make sure that this guideline is pointed out at time of resident signature of occupancy agreement.
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.	Staff will ensure that all residents are in compliance with state requirements. Ongoing communication with residents and staff, review at monthly QA meetings Will be discussed at the QA meeting scheduled for 10/24. Third party provider forms will be used for sign in/ sign out of all sitters. Monthly audits will ensure that all third party provider paper work is on file and current.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/21/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date** Enter a date of signature. 10-21-2019
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.			

Appendix B STATEMENT REGARDING INDEPENDENT CONTRACTORS/THIRD-PARTY PROVIDERS

In the event a Resident or Resident's Responsible Party contracts with an Independent Contractor or Third-Party Provider for Resident's care, Resident or Resident's Responsible Party hereby acknowledges, agrees, releases, indemnifies, and holds harmless Primrose Retirement Communities, L.L.C. from any and all claims for injuries or damages sustained by Resident, Independent Contractor or other Third Party in connection with any Third-Party Contract, whether occurring within the facility or off- site arising out of the negligent or intentional acts or omissions of any Third-Party Provider providing services for Resident.

Resident or Resident's Responsible Party further agrees to notify such Independent Contractor or Third-Party Provider that Primrose Retirement Communities, L.L.C. is not insuring such Independent Contractor or Third-Party Provider.

Resident has a right to choose a Third-Party Provider of their choice within the state requirements and regulations. Resident must notify the Executive Director and/or Director of Nursing prior to the commencement of any services by a Third-Party Provider at Primrose. Resident understands and acknowledges that the Third-Party Provider must execute a Third-Party Provider Agreement and clear a criminal background check prior to the Third-Party Provider being allowed to provide services to Resident.

Resident Signature	Date
Resident Signature	Date
Resident's Responsible Party Signature	Date
Primrose Staff Signature	Date

PRIMROSE

RETIREMENT COMMUNITIES

PRIMROSE RETIREMENT COMMUNITIES, L.L.C.

RESIDENT THIRD PARTY PROVIDER AGREEMENT

This Agreement is entered into this _____ day of_____, 20___, by and between _____("Resident") and Primrose Retirement Communities, L.L.C. (hereinafter referred to as "Primrose").

Resident has elected to utilize the services of a Third-Party Provider to provide the following services to Resident.

Name of Third- Party Provider:

_____

_____

Services:

What: _____

When: _____

Where: _____

How: _____

Resident understands and acknowledges the Third-Party Provider is not an employee or agent of Primrose and has been retained to provide services solely to Resident.

Resident understands and acknowledges that the Third-Party Provider must execute a Third Party Provider Agreement and clear a criminal background check prior to the Third-Party Provider being allowed to provide services to Resident.

Resident understands and acknowledges that the Third-Party Provider must comply with all applicable policies of Primrose and the terms of the Third Party Provider Agreement in order to continue to serve in the capacity of a Third-Party Provider.

Resident understands and acknowledges that Primrose has the right to terminate the Third Party Provider Agreement and exclude a Third-Party Provider from providing services within Primrose for violation of Primrose policies, breach of the Third Party Provider Agreement or other disruption of Primrose's operations.

PRIMROSE
RETIREMENT COMMUNITIES

RESIDENT HEREBY WAIVES ANY CLAIM AGAINST PRIMROSE ARISING SOLELY OUT OF THE NEGLIGENT OR INTENTIONAL ACTS OR OMISSIONS OF ANY THIRD-PARTY PROVIDER PROVIDING SERVICES TO RESIDENT ("THIRD PARTY PROVIDER CLAIMS"). RESIDENT AGREES TO DEFEND AND INDEMNIFY PRIMROSE FROM AND AGAINST ANY AND ALL SUCH THIRD-PARTY PROVIDER CLAIMS.

I have read, understand and accept the terms of this Agreement.

_____ _____
Resident Signature Date

_____ _____
Responsible Party Signature Date

_____ _____
Primrose Staff Signature Date

PRIMROSE
RETIREMENT COMMUNITIES

ASSISTED LIVING RESIDENT THIRD-PARTY PROVIDER AGREEMENT

This Agreement is entered into this _____ day of _____, 20_____, by and between _____("Third-Party Provider") and Stillwater Retirement, L.L.C. d/b/a Primrose Retirement Community of Stillwater ("Primrose").

1. Third-Party Providers may request a copy of the Primrose Employee Handbook and specific policies as required by this Agreement and the Executive Director.
2. Third-Party Provider will provide a criminal conviction/history check and registry review as required by State guidelines or the appropriate State agency certifies that they have been completed.
3. Third-Party Provider will provide TB screening, or the appropriate State agency certifies that they have been completed.
4. Third-Party Provider is responsible for providing all services for which it was hired. The Director of Nursing/Designee, who integrates the services you provide into resident's Service Plan, will coordinate all Third-Party Provider services.
5. Third-Party Provider will report to the Director of Nursing/Designee on the same day any changes of condition noted in resident's medical condition, any unusual occurrences, and/or the results of any services provided, medical appointments, or other observations made or information received. Third-Party Provider may not leave Primrose without making the report of medical condition, and if necessary, will contact the Director of Nursing/Designee by telephone if the Director of Nursing/Designee is out of the building.
6. Third-Party Provider will immediately record all appropriate information about the services provided and/or changes in resident's condition. The Director of Nursing/Designee will provide instructions on documentation to provide following Primrose policies.
7. Third-Party Provider will review with the Director of Nursing/Designee any follow-up instructions that it wishes Primrose staff to implement and incorporate into resident's Service Plan. Third-Party Provider will familiarize itself with all of its client's service needs and preferences and report any potential conflicts with the service plan, medications and/or treatment records.
8. The Director of Nursing/Designee is responsible for monitoring all nursing service provided. Third-Party Provider will notify Director of Nursing/Designee if/when delegation of any nursing task is proposed. If Third-Party Provider delegates a nursing procedure, the process must be documented according to Primrose's procedures for delegation and be within the State Board of Nursing rules and regulations regarding nurse delegation.
9. Third-Party Provider will follow applicable policies of Primrose. This includes but is not limited to, smoking only in designated areas, remaining violence free, non-solicitation and parking only in designated areas.
10. Third-Party Provider may eat one meal while at Primrose, and must make arrangements with the Executive Director (guest meals have a nominal charge of $_____).

11. While in the building, Third-Party Provider must abide by Primrose employee rules regarding attire. Third-Party Provider must also wear a name badge for identification purposes to include the name of the caregiver and the agency.
12. Third-Party Provider will support and adhere to Primrose's principles of choice, privacy, dignity, independence, and individuality while providing care to Resident.
13. If Third-Party Provider accompanies resident out of the building, Third-Party Provider must follow the procedures of Primrose for signing resident and him/herself in and out of the building.
14. Third-Party Providers are not allowed in Primrose kitchen.
15. Third-Party Provider's children are not allowed in Primrose unless prior approval is obtained from the Executive Director or they are visiting resident at resident's request.
16. Third-Party Provider must not solicit any Primrose residents on behalf of any other assisted living facility.
17. Third-Party Provider must not solicit any employees of Primrose nor may Third-Party Provider sell anything in the building, i.e., raffle tickets, Girl Scout cookies, etc.
18. Third-Party Provider shall indemnify and hold Primrose harmless, its members, principal officers, directors, representatives, employees, legal counsel, predecessors, successors and assigns from and against any and all debts, obligations, losses, claims, liabilities, damages, deficiencies, actions, suits, proceedings, demands, assessments, orders, judgments, writs, decrees, costs and other expenses, including, without limitation, reasonable attorney's fees and accountant's fees, incurred by any of them in defending or compromising actions brought against them arising out of or related to acts or omissions of Third-Party Provider, or in the provision of services or performance of duties by Third-Party Provider pursuant to this agreement, including any delivery of services to Primrose's residents.
19. Nothing in this Agreement contemplates or requires the referral of any client or patient to Third-Party Provider or to Primrose. This Agreement is not intended to influence the judgment of either Third-Party Provider or Primrose in choosing residents or patients. Neither Third-Party Provider nor Primrose shall receive any satisfaction or remuneration for referrals. The parties hereto support a patient/resident's right to choose the medical or residence of his or her choice. The parties specifically intend to abide by all Federal and State anti-fraud and abuse laws.
20. Third-Party Provider will maintain liability insurance with minimum coverage of one million dollars ($1,000,000.00).
21. Third-Party Provider will maintain Workers' Compensation insurance meeting the minimal State requirements.
22. Third-Party Provider will obtain all necessary professional/occupation licensure issued by the state to provide service to its clients. Third-Party Provider will immediately notify Primrose if it should lose its license or become subject to of an investigation by the state licensing authority.
23. Both parties recognize the importance of the HIPAA regulations in maintaining security, privacy, and confidentiality of patient information. Therefore, to the extent that each party's functions are governed by the HIPAA transaction, security and/or privacy regulations, each party shall have appropriate organizational and technical provisions of the HIPAA regulations as they are enacted.

PRIMROSE
RETIREMENT COMMUNITIES

24. This Agreement shall not render Third-Party Provider an employee, partner, agent of, or joint venture with Primrose for any purpose. Third-Party Provider is and will remain an independent third party contractor in Third-Party Providers relationship to Primrose. Primrose shall not be responsible for withholding taxes with respect to Third-Party Provider's compensation hereunder. Third-Party Provider shall have no claim against Primrose hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health, or disability benefits, unemployment insurance benefits, or employee benefits of any kind.

Notice necessary under any provision of this agreement by Third-Party Provider should be given to Primrose's Executive Director.

The person signing below on behalf of Third-Party Provider represents and warrants that they have the authority to enter into this agreement on behalf of Third-Party Provider.

I have read and understand the above guidelines for Third-Party Providers.

Signature of Third-Party Provider Representative	Date
Agency Represented (if applicable)	Date
Primrose Staff Signature	Date