OKLAHOMA
State Department of Health

Delivery via email to: stillwater-ed@primroseretirement.com

October 31, 2025

License Number: AL6009

Ms. Alissa Ryan, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

RE: Survey Event ID: REY111

Dear Ms. Ryan:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **October 16, 2025.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

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

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: **Primrose Retirement Community of Stillwater**
Address: **823 S Range Road**
City, State, Zip: **Stillwater, Oklahoma 74074**
Provider #: **AL6009**
Complaint #: **OK00084788**
Investigation Date: **10/14/25 through 10/16/25**

ALLEGATION(S)
1. The center failed to assess, monitor and intervene in a timely manner for a change in condition.
2. The center failed to implement effective interventions to prevent falls.
3. The center failed to ensure records were not falsified.
4. The center failed to ensure the staff were qualified.
5. The center failed to ensure food was prepared and served under sanitary conditions.

An unannounced on-site investigation was initiated 10/14/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

The attached State form, Statement of Deficiencies, 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: 10/14/2025

OKLAHOMA
State Department
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INVESTIGATIVE REPORT

Facility: **Primrose Retirement Community of Stillwater**
Address: **823 S Range Road**
City, State, Zip: **Stillwater, Oklahoma 74074**
Provider #: **AL6009**
Complaint #: **OK00085342**
Investigation Date: **10/14/25 through 10/16/25**

ALLEGATION(S)
1. The center failed to ensure residents were not abused

An unannounced on-site investigation was initiated 10/14/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

The attached State form, Statement of Deficiencies, 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: 10/14/2025

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 _____	C 10/16/2025

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 relicensure survey with complaints (#OK00084788, and #OK00085342) was conducted from 10/14/25 through 10/16/25. Deficiencies were cited as a result of the survey. Facility Census: 42 Listed below are abbreviations that will be used throughout this document: CNA - certified nursing assistant DM - dietary manager DON - director of nurses ED - executive director	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. open food items were labeled with the open/use by date, and b. temperature and dishwasher sanitization documentation was completed for 3 of 3 dietary observations. The ED identified 42 residents received nutrition from the kitchen.	C 391		

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 391	Continued From page 1 Findings: On 10/14/25 at 9:00 a.m., the following food items were observed in the stainless-steel refrigerator located against the middle of the main kitchen against the wall: a. an opened 48-ounce Hershey strawberry syrup, in the original container, did not show an open/use by dates, b. an opened one gallon container of white milk did not show an open/used by date, and c. an opened five-pound bag mozzarella cheese did not show an open/used by date. On 10/14/25 at 9:10 a.m., a review of the dishwasher sanitization log book did not show documentation for 02//01/25 to 10/14/25. On 10/14/25 at 9:24 a.m., the refrigerator log in the main kitchen did not show documentation the temperature for 10/01/25 and 10/02/25 was obtained. On 10/14/25 at 1:50 p.m., the following food items were observed in a stainless steel refrigerator on a second-floor pub area. a. an opened 16-ounce Mexican style cheese in the original bag, did not show an open/use by date, b. a 12 fluid ounce frozen lemonade concentrate, with an expiration date of 10/18/24, and c. an opened 48-ounce triple berry blend fruit in the original bag, did not show an open/use by date. On 10/14/25 at 2:15 p.m., a refrigerator/freezer log sheet in a second-floor pub refrigerator, no identifed month, showed no documentation for days 13 and 14.	C 391		

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C 391	Continued From page 2 A policy titled "Community Food Labeling and Dating," revised 11/06/24, read in part, "a. establish a date marking system and train employees accordingly. The best practice for a date marking system would be to include a label with the product name, the date it was prepared or opened"..."check temperature log to ensure proper procedures are being followed and sign off on these logs every day." On 10/14/25 at 9:15 a.m., the certified dietary manager was shown the main kitchen refrigerator log. They stated, "If no dishwasher paperwork is this binder, it will not be located anywhere else. I can say it has not been consistent and not done." On 10/14/25 at 9:18 a.m., the certified dietary manager stated, "The dietician comes to the facility and gives us a grade on the kitchen." On 10/14/25 at 9:22 a.m., the certified dietary manager stated, "All the chefs in the kitchen are responsible for the documentation of the refrigerator and freezer in the main kitchen." On 10/14/25 at 2:17 p.m., the activity director opened the pup area refrigerator and stated, "the cheese is dry and not fresh, I do not know when it was opened." On 10/14/25 at 2:18 p.m., the activity director opened the pup area refrigerator and stated, "The fruit has crystals and is freezer burnt, I do not know when the bag was opened there is no date." On 10/14/25 at 2:22 p.m., the activity director was shown the refrigerator/freezer log sheet on the pup area refrigerator. The activity director stated, "That is an old refrigerator log sheet. Those	C 391		

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C 391	Continued From page 3 initials are from an old activity's director initials and they left in July. I did not know there was even a log for temperatures." On 10/15/25 at 9:21 a.m., cook #1 was shown the items in the first floor main refrigerator. They stated, "All the open food needs dates." On 10/15/25 at 12:40 p.m., the ED was shown the open items in the first floor main refrigerator. They stated, "Open food items need a date when opened." On 10/15/25 at 12:42 p.m., the ED was shown the dishwasher logbook. They stated, "This is very out of date, and the staff have not been doing the logs." On 10/15/25 at 12:43 p.m., the ED was shown the first floor main refrigerator temperature log. They stated,"Those need updated as well."	C 391		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced	C 522		

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C 522	Continued From page 4 by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed within 14 days of admission for 1 (#7) of 8 sampled residents reviewed for completion of comprehensive assessments. The DON identified 42 residents resided in the center. Findings: On 10/16/25 at 11:15 a.m., a review of Resident #7's electronic medical record showed the resident was admitted to the facility on 09/19/25. An OSDH resident assessment form, marked as preadmission and annual, was provided by the facility showing an admission date of 09/19/25 and assessment date of 10/14/25. The comprehensive assessment was completed 25 days after admission. On 10/16/25 at 12:10 p.m., the DON was asked about the process for admission of residents and assessments. The DON stated they do a pre move in assessment and use it as a screening to ensure the potential resident qualifies for the care they were able to provide. They stated after they move in, they do a comprehensive admission assessment within 14 days, then a thirty-day assessment, and then every six months unless there was a change of status. The DON was asked about the comprehensive assessment that should occur in first 14 days for Resident #7. The DON stated they were unable to locate any other assessments and it should have been completed.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT	C 542		

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C 542	Continued From page 5 (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure that assessments were coordinated and signed by a registered nurse or the resident's personal physician for 1 (#2) of 8 sampled residents reviewed for completion of comprehensive assessments. The DON identified 42 residents resided in the facility. Findings: On 10/16/25 at 10:50 a.m., a review of Resident #2's computer medical record showed a preadmission assessment completed on 05/16/25, and a move in assessment completed 06/10/25. The assessment did not show a registered nurse or personal physician coordination of care signature. On 10/16/25 at 12:10 p.m., the DON was asked about the process for admission of residents and assessments. The DON stated they do a pre move in assessment and use it as a screening to ensure the potential resident qualifies for the care they were able to provide. They stated after they move in, they do a comprehensive admission assessment within 14 days, then a thirty-day assessment, and then every six months unless	C 542		

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 542	Continued From page 6 there was a change of status. The DON was asked about the coordination of care review with registered nurse or personal physician. The DON stated they do the assessment on the OSDH form to capture signatures but were unable to locate these forms for this resident.	C 542		
C1972 SS=D	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 1 (CNA #2) of 5 sampled employees whose records were reviewed for training. The DON identified 42 residents resided in the center. Findings: On 10/15/25, a review of CNA #2's employee record showed they were hired at the facility on 06/12/25. Their employee record showed they received abuse training on 10/07/25 which was outside 90 days of hire, which would have been	C1972		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1972	Continued From page 7 by 09/10/25. On 10/15/25 at 11:45 a.m., the ED was asked for documentation of CNA #2's abuse training within 90 days of hire. The ED stated, "CNA #2 was out compliance."	C1972		

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Delivery via email to: alissa.ryan@primroseretirement.com

November 12, 2025

License Number: AL6009

Ms. Alissa Ryan, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

RE: Survey Event REY111

Dear Ms. Ryan:

On **October 16, 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 **November 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,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/10/2025

Facility Name: Primrose Retirement Community of Stillwater

License Number: AL6009

Survey Event ID: REY111

Date Survey Completed: 10/16/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: 310-663-3-8(a) (a) Food shall be stored, prepared and served inaccordance with Chapter 257 of this Title (relating to food serviceestablishments) with the following additional requirements. This standard is not met in evidence by a. open food items were labeled with an open/use by date, and b. the temperature and dishwasher sanitation documentation was completed for 3 of 3 dietary observations.

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?	ED and Dining Service Director will review company policy and state regulation for dishwasher temperatures and food labeling. Food identified without a date opened/use by date was discarded.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Dining Service Director will continue to monitor the dishwasher log and food labeling to ensure compliance and safety. Food identified without a date opened/use by date was discarded.
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?	Dining Service Director will follow onboarding and training guidelines to ensure all staff are trained appropriately in how to label food and document dishwasher temperature and sanitation log.
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.	Dining service director will continue to monitor the dishwasher temperature and sanitation log and food labeling. Audit refrigerator for labels and dish temperature logs 2x/week x 4 weeks, 1x/week x 2 weeks, 1x month x 2 months. Audits will be provided to QA for review and monitoring to ensure sustained compliance. Monthly dishwasher temperature and sanitation logs will be kept in the kitchen logs binder. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/13/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Alissa Ryan	**Date 11/10/2025**

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	11/10/2025	**Submitted by**	Alissa Ryan
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

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

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/10/2025

Facility Name: Primrose Retirement Community of Stillwater

License Number: AL6009

Survey Event ID: REY111

Date Survey Completed: 10/16/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522	Based on: 310:663-5-2(b) The assisted living center shall complete the comprehensiveassessment in accordance with the following:(1) within 14 days after admission of the resident; (2) once every 12 months thereafter and (3) promptly after a significant change in the resident's condition.

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?	ED and DON will review company policy and Title 310 regarding resident assessments. Resident #7 assessment was reviewed without change.
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 resident assessments who moved in within the last 14 days have a completed assessment.
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?	14-day resident assessment due dates will be added to DON and ED shared calendar. ED will ensure DON has completed 14-day assessment and all signatures have been obtained.
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 complete and sign assessments by due date. All signatures will be obtained from all required parties. All new assessments will be reviewed to ensure completion and required signatures obtained at QA meeting monthly. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Alissa Ryan OAC 310:663-25-4(F)	**Date 11/10/2025**

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	11/10/2025	**Submitted by**	Alissa Ryan

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License Number: AL6009

Survey Event ID: REY111

Date Survey Completed: 10/16/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542	Based on: 310:663-5-4(b) All assessments must be coordinated and signed by registered nurse or the residents personal physician.

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?	DON identified the assessment that was missing the RN/physician signature. RN reviewed the assessment and signed.
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 assessments reviewed to ensure RN or physician signature is obtained.
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?	RN/physician will sign assessments as needed. DON and ED will verify that all assessments have been reviewed and signed.
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.	ED and DON will verify that all assessment have been reviewed and signed by RN or physician. Assessments cannot be finalized in system unless all signatures have been obtained. ED and DON will review assessment compliance monthly in QA meeting to ensure they are completed successfully for the next 3 months. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Alissa Ryan** OAC 310:663-25-4(F)	**Date 11/10/2025**

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	11/10/2025	**Submitted by**	Alissa Ryan

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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: 11/10/2025** **Facility Name:** Primrose Retirement Community of Stillwater **License Number:** AL6009 **Survey Event ID:** REY111 **Date Survey Completed: 10/16/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1972	Based on: 310:663-19-4 (c) The assisted living center shall provide staff within 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 in evidence by: Based on record review and interview, the center failed to ensure staff were educated on absue within 90 days of hire for 1 (CAN#2) of 5 sampled employees whose records were reviewed for training.

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?	Identified employee completed training.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Verified all employee training in identification of abuse and neglect of residents and misappropriation of resident property is up to date and completed.
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?	Employees will be assigned require training and will completed them within 90 days of hire. DON will verify they are completed within the timeframe.
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.	Employees will complete the required trainings before 90 days of hire. Successful completion will be monitored for all new hires and discussed in monthly QA meeting for the next 3 months. Records of all employee training will be kept. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Alissa Ryan** OAC 310:663-25-4(F)	**Date 11/10/2025**

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	11/10/2025	**Submitted by**	Alissa Ryan
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

Delivery via email to: stillwater-ed@primroseretirement.com

November 20, 2025

License Number: AL6009
Survey Event ID: REY112

Ms. Alissa Ryan, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

Dear Ms. Ryan:

On **November 17, 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 **October 16, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **November 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
	AL6009	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

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 An offsite/paper revisit was conducted on 11/17/25. 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