



Oklahoma State Department of Health
Creating a State of Health

August 7, 2019

License Number: AL6303

Ms. Catina Elliott, Administrator
Primrose Retirement Community Of Shawnee
1905 North Bryan
Shawnee, OK 74804

RE: Survey Event ID: JTFP11

Dear Ms. Elliott:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **July 11, 2019**. 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) 820-9922.

Sincerely,

Patty Scott
Long Term Care
Oklahoma State Department of Health

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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/11/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PRIMROSE RETIREMENT COMMUNITY OF SH

**1905 NORTH BRYAN
SHAWNEE, OK 74804**

(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 07/10/19 and 07/11/19. Resident census was 38. No deficient practice was cited.	C 000		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number AL6303	Provider/Supplier Name PRIMROSE RETIREMENT COMMUNITY OF SHAWNEE
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Type of Survey (select all that apply)

☒ 2 ☐ ☐ ☐ ☐

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | 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. <i>fm</i> 34460	07/10/2019	07/11/2019	0.75	0.00	16.00	0.00	4.50	0.50
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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
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Total SA Clerical/Data Entry Hours....	0.00	Total RO Clerical/Data Entry Hours.....	0.00
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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

AUG 08 2019 *fm*