OKLAHOMA
State Department
of Health

**Delivery via email to:** shawnee-ed@primroseretirement.com

May 5, 2023

License Number: AL6303

Mr. J.R. Gutierrez, Administrator
Primrose Retirement Community of Shawnee
1905 North Bryan
Shawnee, OK 74804

**RE: Survey Event ID: 745911**

Dear Mr. Gutierrez:

On **May 4, 2023**, 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 May 4, 2023.

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) 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 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
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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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 |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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<br><br>A relicensure survey was conducted from 05/03/23 through 05/04/23.<br><br>Listed below are abbreviations that will be used throughout this document:<br><br>DON - director of nursing<br>GERD - gastroesophageal reflux disease<br>HTN - hypertension<br>Res - resident | C 000 | | |
| C 391 SS=E | 310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE<br><br>(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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the kitchen had the appropriate temperature and sanitizer test strips, kept clean, and maintained in good repair.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 05/03/23, documented 30 residents resided in the facility.<br><br>Findings:<br><br>On 05/03/23 at 9:55 a.m., a tour of the kitchen was conducted. The following observations were made:<br><br>a. ceiling lights were burned out and/or not working, | C 391 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 391 | Continued From page 1<br>b. the ceiling light cover near the mop closet was cracked,<br><br>c. a base board near the mop closet was missing,<br><br>d. there was an accumulation of black residue, food, and grease on the floor and on the wall in the cook area,<br><br>e. there was an accumulation of black residue, food, and grease on the fryer, stove, and oven in the cook area,<br><br>f. there was an accumulation of black residue on the wall in the dish wash area,<br><br>g. there were no high temperature dishwasher test strips,<br><br>h. there were no test strips to measure the sanitizer strength of the bleach water used to sanitize food and non food contact surfaces,<br><br>i. there was an accumulation of black residue inside of the ice machine, and<br><br>j. the lid on the ice machine was broken. When the lid was pushed open it falls off of the machine.<br><br>On 05/03/23 at 10:20 a.m., the dining director was asked what were the protocols for cleaning, checking the dish washer temperature, measuring sanitizer strength, and maintenance of the kitchen. They stated kitchen staff cleaned daily and deep cleaned once a month. They stated maintenance concerns were reported to the executive director or the maintenance director. They stated they were instructed to check the temperature of the dish washer by | C 391 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 391 | Continued From page 2<br>reading the gauges, and they had ordered test strips to measure the sanitizer solution. They were shown and made aware of the above findings. | C 391 | | |
| C 397 SS=E | 310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE<br><br>(4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure whole eggs with their shell intact were pasteurized for eggs served not thoroughly cooked.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 05/03/23, documented 30 residents resided in the facility.<br><br>Findings:<br><br>On 05/03/23 at 9:55 a.m., a tour of the kitchen was conducted. There were boxes and sleeves of non pasteurized whole eggs with their shells intact observed in reach in coolers.<br><br>On 05/03/23 at 10:15 a.m., the dining director | C 397 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 397 | Continued From page 3<br>was asked what the whole eggs with their shells intact in the reach in coolers were used for. They stated they were used for made to order eggs such as over easy and over medium eggs for the residents. They stated the eggs should be pasteurized. They were shown where there was no documentation the eggs were pasteurized on the shell of the eggs or on the boxes of the eggs.<br><br>On 05/03/23 at 10:20 a.m., the dining director stated they had ordered the wrong eggs. | C 397 | | |
| C 522 SS=D | 310:663-5-2(b) ASSESSMENT TIMEFRAMES<br><br>(b) The assisted living center shall complete the comprehensive assessment in accordance with the following:<br>(1) within fourteen (14) days after admission of the resident;<br>(2) once every twelve (12) months thereafter; and<br>(3) promptly after a significant change in the resident's condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure comprehensive assessments were completed 14 days after admission for one (#7) of eight sampled residents reviewed for comprehensive assessments.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 05/03/23, documented 30 residents resided in the facility.<br><br>Findings: | C 522 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 522 | Continued From page 4<br><br>1. A resident assessment, dated 10/15/21, documented a preadmission assessment was completed for Res #7.<br><br>Res #7 was admitted to the facility on 11/02/21 with diagnoses which included HTN, restrictive lung disease, hypothyroidism, emphysema, anxiety, osteoporosis, GERD, and vitamin D deficiency.<br><br>A resident assessment, dated 12/01/21, documented a 14 day assessment was completed.<br><br>There was no documentation a comprehensive assessment was completed 14 days after admission.<br><br>On 05/04/23 at 9:55 a.m., the DON was asked when a 14 day comprehensive resident assessment should be completed. They stated 14 days after the resident moved in. They were shown the resident's 14 assessment. They stated the assessment was not completed within 14 days after they moved in. | C 522 | | |
| C1301 SS=D | 310:663-13-1(a) RESIDENT SERVICE CONTRACT<br><br>(a) Each assisted living center shall furnish to each resident a complete and understandable copy of the resident service contract. | C1301 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 |
|---|---|---|---|---|
| C1301 | Continued From page 5<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the center failed to ensure a resident service contract was available for one (#3) of eight sampled residents.<br><br>The "Assisted Living Resident Condition and Care Overview" form, dated 05/03/23, documented 30 residents resided in the center.<br><br>Findings:<br><br>On 05/04/23 at 11:06 p.m., the executive director was asked if they had located the resident service contract for resident #3. The executive director stated they could not locate it. A completed service contract for resident #3 was not located and/or provided by the center. | C1301 | | |
| C5020 SS=D | 63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up<br><br>3. The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation and shall include the assisted living center and any of the following:<br>a. the personal or attending physician of the resident,<br>b. a home care agency,<br>c. a hospice, or<br>d. other designated persons;<br>The plan of accomodation shall be reviewed at least quarterly by a licensed health care professional. | C5020 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 |
|---|---|---|---|---|
| C5020 | Continued From page 6 | C5020 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to review a plan of accommodation quarterly for one (#4) of one residents reviewed for plan of accommodation.

The "Assisted Living Resident Condition and Care Overview" form, dated 05/03/23, documented 30 residents resided in the facility.

Findings:

Res #4 admitted with diagnoses which included dementia, hypertension, macular degeneration, and glaucoma.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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 |
|---|---|---|---|---|
| C5020 | Continued From page 7<br>A plan of accommodation, signed by the responsible party on 09/26/22, documented Res #4 required a mechanical lift for transfers.<br><br>On record review there was no documentation of review of the plan of accommodation for December 2022 or March 2023.<br><br>On 05/04/23 at 10:50 a.m., the DON stated there was no review of the plan of accommodation. They stated they were not aware that a review needed to be completed. | C5020 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to**: emetrio.Gutierrez@primroseretirement.com

June 15, 2023

License Number: AL6303

Mr. Demetrio Gutierrez, Administrator
Primrose Retirement Community Of Shawnee
1905 North Bryan
Shawnee, OK 74804

**RE: Survey Event 745911**

Dear Mr. Gutierrez:

On **May 4, 2023**, 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 have been corrected and you were in substantial compliance by **May 25, 2023**.

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,**

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 5/8/2023**<br>**Facility Name:** Primrose Retirement Community of Shawnee<br>**License Number:** AL6303<br>**Survey Event ID:** 745911<br>**Date Survey Completed: 5/4/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C391 | Based on: Facility failed to ensure the kitchen had the appropriate temperature and sanitizer test strips, kept clean, and maintained in good repair. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Submission of this POC is not an admission; but rather our willingness to comply.

| **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? | a. ceiling lights were replaced and in working order<br>b. ceiling light near mop closet has been replaced<br>c. base board near mop closet has been replaced<br>d. black residue, food, and grease has been removed/cleaned from floor and on the wall in the cook area<br>e. black residue, food, and grease has been removed/cleaned from the fryer, stove, and oven in the cook area<br>f. black residue on the wall in the dish wash area has been removed/cleaned<br>g. high temperature dishwasher test strips were ordered and were received on 12May23.<br>h. test strips to measure the sanitizer strength of the bleach water used to sanitize food and non food contact surfaces are on hand and being utilized as of 12May23.<br>i. black residue inside of ice machine has been removed/cleaned<br>j. the lid on the ice machine has been ordered |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | A detailed inspection was conducted of the kitchen and no other areas were identified as this had the potential to affect 30 residents. |
| 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? | The Director of Dining (DOD) will conduct a detailed monthly inspection of Kitchen and report finding to QAPI Committee at their Monthly and Quarterly meetings. The Prevention and Maintenance Director (PMT) will inspect the kitchen at least monthly and report findings to the QAPI Committee at their Monthly and Quarterly meetings.Further, the Executive Director (ED) has reached out to US Foods on 11May23 with a request for assistance in review/education of kitchen sanitation. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | DOD and PMT will report status on all items listed in #1 to the QAPI Committee.<br><br>QAPI committee will review reports/monthly cleaning form to ensure all items have been reviewed/addressed as needed.<br><br>DOD and PMT will report at Monthly QAPI Committee x3 then at Quarterly Meeting x3.<br><br>QAPI Committee will review reports and provide comments/ recommendations / and/or request other actions as appropriate. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date 5/18/2023** |

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

| | | | |
|---|---|---|---|
| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 5/8/2023**<br>**Facility Name:** Primrose Retirement Community of Shawnee<br>**License Number:** AL6303<br>**Survey Event ID:** 745911<br>**Date Survey Completed: 5/4/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C397 | Based on: Facility failed to ensure whole eggs with their shell intact were pasteurized for eggs served not thoroughly cooked. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Submission of this POC is not an admission; but rather our willingness to comply.

| **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? | There are no Non-pasturized eggs in the kitchen cooler. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | A detailed inspection was conducted and no other non-pasturized eggs were found as this had the potential to affect 30 residents. |
| 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? | The Director of Dining (DOD) will instruct food vendor not to ever substitute pasturized eggs with non-pasturized eggs. Further, DOD or delegate will inspect and inventory all items upon arrival and will not accept any items not on the order list (including but not limited to non-pasturized eggs). |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | DOD will report all orders that include eggs monthly to QAPI Committee.<br><br>QAPI committee will review orders to ensure the correct eggs were ordered and invoice verifies that pasturized eggs were received.<br><br>DOD will report at Monthly QAPI Committee x3 then at Quarterly Meeting x3.<br><br>QAPI Committee will review reports and provide comments/ recommendations / and/or request other actions as appropriate. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date 5/16/2023** |
|---|---|

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.<br>Facility in Compliance by: Click here to enter a date. | | | |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 5/8/2023**<br>**Facility Name:** Primrose Retirement Community of Shawnee<br>**License Number:** AL6303<br>**Survey Event ID:** 745911<br>**Date Survey Completed: 5/4/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C522 | Based on: Facility failed to ensure comprehensive assessments were completed 14 days after admission for one (#7) of eight sampled residents reviewed for comp assessments |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Submission of this POC is not an admission; but rather our willingness to comply.

| **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? | Resident #7 has all other assessment current. |
| 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 current residents were audited to ensure comprehensive assessmsnets were completed as required. All assessments are current. This had the potential to affect 30 residents. |
| 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? | The Director of Nursing (DON) will review/audit x2 per month, all new admissions to ensure comprehensive 14 day assessments are completed as required. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | DON will report status on all new admit's comprehensive 14 day assessment at the monthly QAPI Committee.<br><br>QAPI committee will review DON's report to ensure all new admits have a 14 day assessment completed as required.<br><br>DON will report at Monthly QAPI Committee x3 then at Quarterly Meeting x3.<br><br>QAPI Committee will review reports and provide comments/ recommendations / and/or request other actions as appropriate. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** Administrator signature required<br>OAC 310:663-25-4(F) | **Date 5/18/2023** |
|---|---|

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.<br>Facility in Compliance by: Click here to enter a date. |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 5/8/2023**<br>**Facility Name:** Primrose Retirement Community of Shawnee<br>**License Number:** AL6303<br>**Survey Event ID:** 745911<br>**Date Survey Completed: 5/4/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C1301 | Based on: Facility failed to ensure one resident service contract was available for one (#3) of eight sampled residents. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Submission of this POC is not an admission; but rather our willingness to comply.

| **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? | Resident #3 has executed a new service agreement. |
| 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 current residents were audited to ensure service agreements were signed. No other residents were found to of not been completed as this had the potential to affect 30 residents. |
| 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? | The Executive Director (ED) will review the Move-In Checklist with Sales Director (SD) to ensure all move-in paperwork (agreement) is completed on Move-In day. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | ED will report status on all new Move-Ins at the monthly QAPI Committee.<br><br>QAPI committee will review ED's report to ensure all new Move-Ins have service agreement properly executed.<br><br>ED will report at Monthly QAPI Committee x3 then at Quarterly Meeting x3.<br><br>QAPI Committee will review reports and provide comments/ recommendations / and/or request other actions as appropriate. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date 5/18/2023** |
|---|---|

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |
|---|---|---|---|

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

| | |
|---|---|
| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 5/8/2023**<br>**Facility Name:** Primrose Retirement Community of Shawnee<br>**License Number:** AL6303<br>**Survey Event ID:** 745911<br>**Date Survey Completed: 5/4/2023** |

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C5020 | Based on: Facility failed to review a plan of accommodation quarterly for one (#4) residents. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Submission of this POC is not an admission; but rather our willingness to comply.

| **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? | Resident #4 has had their plan of accommodation reviewed on 5/8/23. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | No other residents were found to of had a Plan of Accommodation; as this had the potential to affect 30 residents. |
| 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? | The DON will report the number of residents needing a Plan of accommodation monthly to QAPI Committee and the number needing review and if they have been reviewed. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | DON will report status on all residents with a Plan of Accommodation at the monthly QAPI Committee.<br><br>QAPI committee will review DON's report to ensure all Plan of Accommodations have been reviewed as needed.<br><br>DON will report at Monthly QAPI Committee x3 then at Quarterly Meeting x3.<br><br>QAPI Committee will review reports and provide comments/ recommendations / and/or request other actions as appropriate. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date 5/18/2023** |

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

| | | | |
|---|---|---|---|
| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

**Delivery via email to:** demetrio.Gutierrez@primroseretirement.com

June 30, 2023

License Number: AL6303

Mr. Demetrio Gutierrez, Administrator/Executive Director
Primrose Retirement Community Of Shawnee
1905 North Bryan
Shawnee, OK 74804

**RE: Survey Event 745912**

Dear Mr. Gutierrez:

On **June 28, 2023,** an offsite-paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 4, 2023,** have now been corrected effective **May 25, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 |
|---|---|---|---|
| | AL6303 | A. BUILDING: _____ B. WING _____ | R 06/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE RETIREMEMT COMMUNITY OF SHAWNEE | 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<br><br>An offsite/paper revisit was conducted on 06/28/23. 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