OKLAHOMA
State Department
of Health

Delivery via email to: steven.sallee@primroseretirement.com

June 4, 2024

License Number: AL6303

Mr. Steven Sallee, Administrator
Primrose Retirememt Community Of Shawnee
1905 North Bryan
Shawnee, OK 74804

RE: Survey Event ID: 6U3X11

Dear Mr. Sallee:

On **May 30, 2024**, agents from our office concluded a State Licensure survey with complaint investigation 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 30, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Clorissa Nubine

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Primrose Retirement Community of Shawnee**
Address: **1905 North Byran**
City, State, Zip: **Shawnee, OK 74804**
Provider #: **AL6303**
Complaint #: **OK00062027**
Investigation Dates: **05/24/24 and 05/28/24 through 05/30/24**

ALLEGATIONS
1.The center failed to ensure residents were not physically, verbally, or psychosocially abused.
2.The center failed to assess, monitor, and intervene in a timely manner for a resident with a change in condition and failed to ensure staff tested residents for COVID-19
3.The center failed to have/implement an effective infection control program to prevent COVID-19.
4.The facility failed to ensure dietary staff followed infection prevention policies and procedures and followed proper procedures for covering hair and beards.

An unannounced on-site investigation was initiated 05/24/2024 at 9:05 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the 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:

Tours of the facility were conducted throughout the survey. Staff were observed for following and implementing infection control policy and procedures, implementing nursing protocol, and interactions with residents.

Resident records were reviewed including assessments, care plans, physician orders, nursing notes, hospital records, service contracts, medication records, and third party reports.

Facility policy and procedures, incident reports, infection control tracking logs, dietary reports, grievances, and resident council meeting minutes were reviewed.

Residents and staff were interviewed related to abuse, change in condition, infection control, and dietary services.

OKLAHOMA
State Department
of Health

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: 05/31/2024

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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 relicensure survey was conducted on 05/24/24 and 05/28/24 through 05/30/24. A complaint investigation (#OK00062027) was conducted in conjunction with the survey. Facility Census: 35 Listed below are abbreviations that will be used throughout this document. ADON - assistant director of nursing COVID-19 - coronavirus disease 2019 DON - director of nursing ED - executive director OSDH - Oklahoma State Department of Health Res - resident QA - quality assurance	C 000		
C 711 SS=D	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by:	C 711		

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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 711	Continued From page 1 Based on record review and interview, the center failed to ensure an annual fire inspection was completed. The ADON identified 35 residents resided in the center. Findings: There was no documentation a fire marshall inspection had been completed in 2023. On 05/28/24 at 9:25 a.m., the ED was asked if a fire marshall inspection had been completed in 2023. They stated an inspection was not completed in 2023. The stated the last inspection was in November 2022.	C 711		
C1110 SS=D	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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
C1110	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the QA committee met on a quarterly basis. The ADON identified 35 residents resided in the center. Findings: Internal QA committee reports were reviewed from April 2023 through March 2024. There was no documentation the QA committee met October 2023 through December 2023. On 05/29/24 at 10:51 a.m., the ED stated the QA committee did not meet during October 2023 through December 2023.	C1110		
C1914 SS=E	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure incidents requiring reporting were	C1914		

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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
C1914	Continued From page 3 reported to OSDH for three (#3, 9, and #10) of six sampled residents reviewed for incidents. The ADON identified 35 residents resided in the center. Findings" A "Respiratory Disease Outbreak" policy, dated 05/17/23, read in part, "...It is the policy...to institute appropriate infection control practices to assist in preventing the spread of infections such as...COVID-19...Two cases of residents being confirmed with the same respiratory disease, such as...COVID-19...constitutes an outbreak...Notify local and state health authorities as required by regulations and follow directions for reporting..." 1. A December 2023 COVID-19 log documented Res #9 and Res #10 tested positive for COVID-19 on 12/04/23. There was no documentation the outbreak was reported to OSDH. On 05/28/24 at 2:31 p.m., the ED was asked if the COVID-19 outbreak in December 2023 was reported to OSDH. They stated it should have been. On 05/28/24 at 3:12 p.m., the DON stated the outbreak was not reported to OSDH. They stated it should have been reported. They stated they missed it. 2. A "Universal Incident/Occurrence" report, dated 11/18/23 at 11:35 p.m., documented Res #3 had an unwitnessed fall in their bedroom. They stated they hurt their back, ribs and spine.	C1914		

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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
C1914	Continued From page 4 It was documented the resident was sent to the ER. A hospital after visit summary, dated 11/19/23, documented the resident had diagnosis of closed fracture of multiple ribs of the left side, initial encounter. There was no documentation the incident was reported to OSDH. On 05/29/24 at 10:23 a.m., the DON was asked if the resident's fall on 11/18/23 with diagnosis of closed fracture of multiple ribs was reported to OSDH. On 05/29/24 at 10:29 a.m., the DON stated they did not report the incident.	C1914		

OKLAHOMA
State Department
of Health

Delivery via email to: steven.sallee@primroseretirement.com

June 17, 2024

License Number: AL6303

Mr. Steven Sallee, Administrator
Primrose Retirememt Community Of Shawnee
1905 North Bryan
Shawnee, OK 74804

RE: Survey Event 6U3X11

Dear Mr. Sallee:

On **May 30, 2024**, a Relicensure 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 **June 18, 2024.**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/7/2024
	Facility Name: Primrose Retirement of Shawnee
	License Number: AL6303
	Survey Event ID: 6U3X11
	Date Survey Completed: 5/30/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C711	Based on: Record review and interview, the center failed to ensure annual fire inspection was completed.

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?	ED contacted Fire Marshall on 5/30/2024 about the missed 2023 inspection, I was informed they overlooked the unnannounced inspection due to having only 2 inspectors for Shawnee. They stated we could call in and set up future inspections to ensure completion and compliance with 310:663-7-1(a).
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 residents would be affected by the annual inspections not being 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?	I met with PMT Robert Estes on 6/7/2024, He contacted the Fire Marshall and set the 2024 annual inspection for 6/18/2024 to ensure compliance. If the Fire Marshall has not completed their inspection by June of the current year, we will contact them and schedule an inspection.
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.	Enter methods to ensure corrections are sustained: a. PMT will contact the Fire Marshall to schedule an inspection for the current year if the inspection has not occurred by June 1st of the current year. PMT will address the status of the annual inspections in each of the monthly and quarterly QA meetings and the ED will complete an inspection of the reports. Utilize signoff sheet for the annual fire inspections and review at each QA meeting to ensure compliance. All records and reports will be kept for a minimum of 3 years.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/18/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 6/11/2024**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/7/2024
	Facility Name: Primrose Retirement of Shawnee
	License Number: AL6303
	Survey Event ID: 6U3X11
	Date Survey Completed: 5/30/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1110 Quality Assurrance Committee	Based on: record review and interview, the center failed to ensure the QA committee met on a quarterly basis.

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?	The QA committee will meet on the 3rd Wednesday of each month to ensure monthly and quarterly meeting requirements are met.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	We will ensure the completion of all monthly and quarterly QA meetings as it has the potential to affect all 35 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?	On 6/7/2024 Our QA Committee met and scheduled the meetings for the rest of 2024 to ensure they were completed each month and quarter.
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.	Enter methods to ensure corrections are sustained: QA meetings will be held, documented and filed on the above listed dates to ensure full compliance of 310:663-11-1. We will follow policy to hold monthly meetings to ensure safety measures and protocols are completed. All records will be filed and kept for a minimum of 3 years.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/7/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 6/11/2024**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/7/2024
	Facility Name: Primrose Retirement Community of Shawnee
	License Number: AL6303
	Survey Event ID: 6U3X11
	Date Survey Completed: 5/30/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1914 Reports to the Department	Based on: Record review and interview. The center failed to ensure incidents requiring reporting were reported to OSDH for three(#3,#9, and #10) of six sampled residents reviewed for incidents

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this POC is not an admission, but rather a 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?	On 5/30/2024, Our DON submitted all the reports to OSDH that were not previously submitted in order to place us in compliance.
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 state reportables will be reported promptly per 310:663-19-1(d) as this can affect each of the 35 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?	Held inservice on 5/29/24 with DON on identifying and reporting state reportables. DON will ensure that incidents that meet the requirements of a state reportable per 310:663-19-1(d) are promptly reported.
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 will meet with the DON about any incidents that occurs in the community and determine the reportability of each incident. Incidents will be discussed at each monthly QA meeting and ensure state reportables have been submitted All incident reports will be kept for at least 7 years.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 6/11/2024**

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

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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 relicensure survey was conducted on 05/24/24 and 05/28/24 through 05/30/24. A complaint investigation (#OK00062027) was conducted in conjunction with the survey. Facility Census: 35 Listed below are abbreviations that will be used throughout this document. ADON - assistant director of nursing COVID-19 - coronavirus disease 2019 DON - director of nursing ED - executive director OSDH - Oklahoma State Department of Health Res - resident QA - quality assurance	C 000		
C 711 SS=D	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by:	C 711	THE PLAN OF CORRECTION IS BEING SUBMITTED USING THE OPTION TEMPLATE.	

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
	AL6303	A. BUILDING: _____ B. WING _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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 711	Continued From page 1 Based on record review and interview, the center failed to ensure an annual fire inspection was completed. The ADON identified 35 residents resided in the center. Findings: There was no documentation a fire marshall inspection had been completed in 2023. On 05/28/24 at 9:25 a.m., the ED was asked if a fire marshall inspection had been completed in 2023. They stated an inspection was not completed in 2023. The stated the last inspection was in November 2022.	C 711		
C1110 SS=D	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110	THE PLAN OF CORRECTION IS BEING SUBMITTED USING THE OPTIONAL TEMPLATE.	

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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
C1110	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the QA committee met on a quarterly basis. The ADON identified 35 residents resided in the center. Findings: Internal QA committee reports were reviewed from April 2023 through March 2024. There was no documentation the QA committee met October 2023 through December 2023. On 05/29/24 at 10:51 a.m., the ED stated the QA committee did not meet during October 2023 through December 2023.	C1110		
C1914 SS=E	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure incidents requiring reporting were	C1914	THE PLAN OF CORRECTION IS BEING SUBMITTED USING THE OPTIONAL TEMPLATE	

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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
C1914	Continued From page 3 reported to OSDH for three (#3, 9, and #10) of six sampled residents reviewed for incidents. The ADON identified 35 residents resided in the center. Findings" A "Respiratory Disease Outbreak" policy, dated 05/17/23, read in part, "...It is the policy...to institute appropriate infection control practices to assist in preventing the spread of infections such as...COVID-19...Two cases of residents being confirmed with the same respiratory disease, such as...COVID-19...constitutes an outbreak...Notify local and state health authorities as required by regulations and follow directions for reporting..." 1. A December 2023 COVID-19 log documented Res #9 and Res #10 tested positive for COVID-19 on 12/04/23. There was no documentation the outbreak was reported to OSDH. On 05/28/24 at 2:31 p.m., the ED was asked if the COVID-19 outbreak in December 2023 was reported to OSDH. They stated it should have been. On 05/28/24 at 3:12 p.m., the DON stated the outbreak was not reported to OSDH. They stated it should have been reported. They stated they missed it. 2. A "Universal Incident/Occurrence" report, dated 11/18/23 at 11:35 p.m., documented Res #3 had an unwitnessed fall in their bedroom. They stated they hurt their back, ribs and spine.	C1914		

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 _____	C 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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
C1914	Continued From page 4 It was documented the resident was sent to the ER. A hospital after visit summary, dated 11/19/23, documented the resident had diagnosis of closed fracture of multiple ribs of the left side, initial encounter. There was no documentation the incident was reported to OSDH. On 05/29/24 at 10:23 a.m., the DON was asked if the resident's fall on 11/18/23 with diagnosis of closed fracture of multiple ribs was reported to OSDH. On 05/29/24 at 10:29 a.m., the DON stated they did not report the incident.	C1914		

OKLAHOMA
State Department
of Health

Delivery via email to: steven.sallee@primroseretirement.com

July 10, 2024

License Number: AL6303
Survey Event ID: 6U3X12

Mr. Steven Sallee, Administrator
Primrose Retirement Community Of Shawnee
1905 North Bryan
Shawnee, OK 74804

Dear Mr. Sallee:

On **July 3, 2024**, 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 **May 30, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **June 18, 2024**.

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
	AL6303	A. BUILDING: _____ B. WING _____	R-C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMEMT 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 On 07/03/24, an offsite/desk audit was conducted. The deficiencies from 05/30/24 were cleared.	{C 000}		

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