Oklahoma State Department of Health
Creating a State of Health

August 15, 2019

License Number: AL7241

Ms. Kimberly Crenshaw, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event ID: W50M11

Dear Ms. Crenshaw:

On **July 19, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on July 19, 2019.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc
Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7241	A. BUILDING _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HOUSE ASSISTED LIVING & MEMOR'	2450 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012

(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 07/18/19 and 07/19/19 a re-licensure survey was conducted. The census was 109. The following deficient practice was cited.	C 000		
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 Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to complete the comprehensive assessments as required for 1 (# 1) of 11 sampled residents. This resulted in the potential for more than minimal harm. Findings: RESIDENT #1 Resident #1 moved into the center on 09/21/18. There was no 14 day comprehensive assessment found in her records. On 07/19/19 at 2:30 p.m., assessments records	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7241	A BUILDING _____ B WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HOUSE ASSISTED LIVING & MEMOR'	2450 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012

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C 522	Continued From page 1 were reviewed and there was no 14 day comprehensive assessment available as required for resident #1. Registered nurse /director of nursing (RN/DON) stated she could not find the assessment and did not know where the assessment was at the time of survey.	C 522		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7241	PRAIRIE HOUSE ASSISTED LIVING & MEMORY CARE

Type of Survey (select all that apply)

[2] [ ] [ ] [ ] [ ]

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

Extent of Survey (select all that apply)

[A] [ ] [ ] [ ] [ ]

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 32888	07/18/2019	07/19/2019	0.50	0.00	12.75	0.00	4.00	3.00
2. 18273	07/18/2019	07/19/2019	0.50	0.00	3.50	0.00	1.50	0.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

AUG 16 2019 jm

Oklahoma State Department of Health
Creating a State of Health

September 4, 2019

License Number: AL7241

Ms. Kimberly Crenshaw, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event W50M11

Dear Ms. Crenshaw:

On July 19, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 28, 2019**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

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

LC/KS

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
	AL7241	A. BUILDING: _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HOUSE ASSISTED LIVING & MEMORY CARE	2460 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012

(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 07/18/19 and 07/19/19 a re-licensure survey was conducted. The census was 109. The following deficient practice was cited.	C 000	Plan of Correction is Being Submitted Using the Optional Template	
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 by: Based on interview and record review, it was determined the center failed to complete the comprehensive assessments as required for 1 (# 1) of 11 sampled residents. This resulted in the potential for more than minimal harm. Findings: RESIDENT #1 Resident #1 moved into the center on 09/21/18. There was no 14 day comprehensive assessment found in her records. On 07/19/19 at 2:30 p.m., assessments records were reviewed and there was no 14 day comprehensive assessment available as required for resident #1. Registered nurse /director of nursing (RN/DON) stated she could not find the assessment and did not know where the assessment was at the time of survey.	C 522		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly B. Cleveland — TITLE: dhso — (X6) DATE: 8/16/19

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 8/27/2019
	Facility Name: Prairie House Assisted Living and Memory Care
	License Number: AL7241
	Survey Event ID: W50M11
	Date Survey Completed: 7/19/2019

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 522	Based on: interview and record review, it was determined the center failed to complete the comprehensive assessments as required for 1 (#1) of 11 sampled residents. This resulted in the potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is being submitted pursuant to the applicable state regulations. Nothing contained herein shall be construed as an admission that the facility violated any federal or state regulation or failed to follow any applicable standard of care. Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the the statement of deficiencies. The plan of correction is prepared and executed soley because it is required by State Regulations.

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 comprehensive resident assessment was completed on Resident #1.
OSDH Response: Element accepted Yes No	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit will be conducted of all resident charts to ensure that all residents residing in the facility have a completed comprehensive assessment per state regulations.
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?	It is the policy of this facility to comply with Oklahoma State regulatory requirements by timely completing a comprehensive resident assessment on all residents admitted to and residing in the facility. The facility RN (responsible for completing assessments) has been in-serviced on both the Oklahoma State regulatory and the facility policy requirement(s) for timely completion of resident comprehensive assessments. Additionally, the Executive Director will ensure compliance with Oklahoma State regulatory requirements for completing all comprehensive resident assessments and ensure the completion is timely and in accordance with regulatory requirements by completing scheduled chart audits for assessment compliance.
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;	The Executive Director will ensure that the RN has timely completed a comprehensive resident assessment within fourteen (14) days after admission; once every twelve (12) months thereafter; and promptly after a significant change in the resident's condition.

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.	a. The Executive Director will audit resident comprehensive assessments for completion each day for a period of one week; three times per week for a period of two weeks; one time per week for a period of four weeks until substantial compliance is achieved. b. The Executive Director will continue to monitor assessments for compliance and report monthly for a period of three (3) consecutive months to the Quality Assurance Committee, and returning to quarterly reporting thereafter. c. A binder will be maintained with the following information: A copy of the completed resident assessment on resident one; a copy of all resident chart audits completed, with corresponding resident's name and date and signature of the person completing the audit and a copy of the in-service training provided to the RN by the Executive Director. There will also be a signature sheet of training provided to each employee trained and the signature of the individual providing the training. This in-service documentation will also include a copy of the Oklahoma State regulatory requirements regarding comprehensive assessments as well as the facility policy; including a copy of each QA committee meeting minutes where this survey is discussed and the plan of correction documentation is reviewed. This will be completed for the next 3 months and quarterly thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/28/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Kimberly A Allen	**Date 8/27/2019**

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

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

Items Below Are For OSDH Use Only

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

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

Prairie House Assisted Living and Memory Care

Record of Inservice

Date 7/19/2019 Time In: 1630 Time Out: 1700

Instructors Kimberly Crenshaw, Executive Director Kimberly Crenshaw

Topics
1 company policy re:
2 comprehensive assessments
3 state regulations re:
4 comprehensive assessments
5
6
7
8

Attendance

Printed Name	Signature/Title	Printed Name	Signature/Title
1 JANIE PIERRE	RN RCP	18	
2		19	
3		20	
4		21	
5		22	
6		23	
7		24	
8		25	
9		26	
10		27	
11		28	
12		29	
13		30	
14		31	
15		32	
16		33	
17		34	
Instructors Signature / Title			

Protective
Health Services
Oklahoma State
Department of Health

Long Term Care
1000 Northeast Tenth Street
Oklahoma City, OK 73117
Phone (405) 271-6868

Recommended Assisted Living
Resident Assessment Form

All Areas Must Be Addressed, "N/A" if not applicable. **** Denotes Items required for Admission Assessment.***

Admission Date_____

Facility Name_____ **Assessment Date**_____

***Resident Name**_____ **Room #:** _____ **Date of Birth:** _____

Assessment Type (*circle one*): Preadmission 14 day Annual Significant Change

***Disease Diagnoses and Medically Defined Conditions:**

_____

_____

***History of Infections and Prior Medical History:**

_____

***List All Current Medications and dosages (list additional medications on separate page if needed):**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

***Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) *(circle one)*:**

Alert / Non-Alert / Oriented x ___ Confused / Confused at Times / Forgetful Judgment: G / F / P

_____

***Mental Health History / Mental Retardation or Developmental Disabilities:**

_____

***Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):**

Mobility: G / F / P Strength: G / F / P Gait: G / F / P

Range of Motion: Full / Limited / Contractures (describe) _____

Weight Bearing: Yes / No (describe) _____

Ambulatory Without Assistance / With Staff Assistance (describe)

_____

Bedfast / Chair fast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

***List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:**

Bathing_____ Eating_____ Dressing_____ Transferring_____ Toileting_____ Ambulation_____

Devices/Restraints (Describe):

Side rails used? Yes / No

Restraint Devices (Describe)_____ Utilized When and Why (describe)_____

Assisted Living Resident Assessment Form

Oral / Nutritional Status:

Diet Order: _____ Height: _____Weight: _____ Weight Changes (loss or gain)_____

Abnormalities: Swallowing Problems Yes / No Nausea / Vomiting (describe)_____

Ability to Eat: Independent / Meal Set Up & Cueing / Assistance to Use Utensils/ Supervision / Must be Fed

Oral Status: Own Teeth / Partial Teeth / Dentures / No Teeth / Condition of Teeth (describe)_____

Tube Feeding: Gastrostomy / Nasogastric (describe) _____

***Toileting Ability/Elimination:**

Bladder: Continent / Incontinent / Incontinent at times (describe) / Urinary Catheter – Indwelling / Other

Bowel: Continent / Incontinent / Incontinent at times (describe)_____

Toileting Ability: Independent / Assist / Total Assist / Adult Briefs / B&B Restoration / Toileting Schedule

Customary Routine (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Sleep habits: G / F / P How Many Hours in 24? _____ Sleep Problems (describe) _____

Meals: In Dining Room / In Room / Other Location / Eats Out (describe frequency) _____

Bathing: Prefers bath / Prefers shower / Preferred schedule (describe)_____

Usual time to rise_____ Usual bedtime_____ Naps during day?_____

Psychosocial Status: (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Ability to communicate: G / F / P Interviewable: Yes / No. If No describe:_____

Usual Mood: Calm / Fearful / Agitated / Anxious_____

History of Mood Disorder / Depression:_____

History of Abnormal Behaviors: Agitation / Anger Outburst /Crying / Aggressive / Combative / Elopement Risk

Family / Friends Involvement: Yes / No (describe) _____

Skin Condition (G=Good, F=Fair, P=Poor, if fair or poor, describe):

General Condition: G / F / P _____Turgor: G / F / P _____

Describe Color, Texture and Appearance: _____

Describe Abnormalities: _____

Wounds (Describe All: location, size, color, drainage, treatment): _____

_____

Special Treatments and Procedures (i.e. wound care, respiratory therapy, physical therapy, restorative, etc.):

_____

Sensory and Physical Impairments (i.e. vision, hearing, etc.):

_____

_____ _____ _____

Signature of Resident or Representative Interviewed *Participating Health Professional* *Date*

_____ _____ _____ _____

**Signature (R.N. or Physician), Title* *Date* *Participating Health Professional* *Date*

INITIAL RESIDENT ASSESSMENTS

POLICY: Conduct assessments on all Residents prior to move-in to establish a baseline for each Resident and to determine if the Resident is appropriate for the Community.

PROCEDURES:

1. The Resident Care Director or designated staff member must conduct an assessment on each Resident prior to move-in, using the Resident Assessment form.

2. The initial assessment should document health issues communicated by the Resident or Responsible Party and incorporate all needs identified during the assessment into the Resident's Service Plan.

3. File the Resident's Assessment form in the Resident's file. Determine if the potential Resident is qualified for residency in the Community.

4. Conduct reassessments of a Resident when a change of condition occurs (or at least on an annual basis).

directly into a glass from a milk dispenser or container.

(2) **Powdered or evaporated milk.** Powdered or evaporated milk products approved under the U.S. Department of Health and Human Services' Grade "A" Pasteurized Milk Ordinance (2003 Revision), may be used only as additives in cooked foods. This does not include the addition of powdered or evaporated milk products to milk or water as a milk for drinking purposes. Powdered or evaporated milk products may be used in instant desserts and whipped products or for cooking. When foods, in which powdered or evaporated milk has been added, are not cooked the foods shall be consumed within twenty-four (24) hours.

(3) **Milk Temperature.** Milk for drinking shall be stored at a temperature of 41° F. or below and shall not be stored in a frozen state.

(4) **Eggs.** 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.

(e) **Food service training.** All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department.

(f) **Applicability.** This section shall only apply to food prepared or served by the assisted living center within the licensed assisted living center.

[**Source:** Added at 24 Ok Reg 2007, eff 6-25-2007; Added at 25 Ok Reg 2460, eff 7-11-2008(see editor's note)]

SUBCHAPTER 5. RESIDENT ASSESSMENTS

310:663-5-1. Assessments required

Each assisted living center shall use the admission and comprehensive assessment designated by the Department.

[**Source:** Added at 15 Ok Reg 2605, eff 6-25-98]

310:663-5-2. Timeframes for completing assessment

(a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission.

(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.

[**Source:** Added at 15 Ok Reg 2605, eff 6-25-98]

310:663-5-3. Description of resident assessment form

(a) The admission assessment form shall include but not be limited to the following:

(1) resident's identification;

(2) disease diagnosis/infections;

(3) mental health history, and mental retardation or developmental disability;

(4) physical functioning which includes the numbers of persons needed to assist with activities of daily living;

(5) incontinence;

(6) medications;

(7) special treatment and procedures;
(8) cognitive function; and
(9) signatures and dates.

(b) The comprehensive assessment includes the following information:
(1) physical functional status;
(2) mental functional status;
(3) customary routine;
(4) disease diagnosis;
(5) oral/nutritional status;
(6) medications;
(7) devices and restraints;
(8) special treatments;
(9) skin condition;
(10) psychosocial status;
(11) sensory and physical impairments; and
(12) medically defined conditions and prior medical history.

[**Source**: Added at 15 Ok Reg 2605, eff 6-25-98]

310:663-5-4. Conduct of assessment

(a) The assessments shall be completed by appropriate participation of health professionals trained in the assessment process.
(b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.
(c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.
(d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following:
(1) the resident;
(2) the resident's personal physician;
(3) the resident's representative; and
(4) the Department.

[**Source**: Added at 15 Ok Reg 2605, eff 6-25-98; Amended at 17 Ok Reg 422, eff 11-1-99 (emergency); Amended at 17 Ok Reg 1605, eff 5-25-00]

310:663-5-5. Use of assessment

The assisted living center shall use the results of the resident's assessment for the following:
(1) to assist in determining the appropriateness of the resident's placement in the assisted living center in compliance with 310:663-3; and
(2) to develop a care plan for the resident, in consultation with the resident.

[**Source**: Added at 15 Ok Reg 2605, eff 6-25-98]

SUBCHAPTER 7. PHYSICAL PLANT DESIGN

310:663-7-1. 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.
(b) The design of the assisted living center shall be appropriate to

PRAIRIE HOUSE ASSISTED LIVING & MEMORY CARE
QUALITY ASSURANCE
DATE:

RESIDENT CARE

POINT OF INTEREST	ACTION PLAN	PROGRESS
1. Comprehensive Nursing Assessments	Use Nursing Care Plan and Assessment tracking tool and send updated copy to Executive Director with every change	Complete and ongoing
2. Care Plans	Use Nursing Care Plan and Assessment tracking tool and send updated copy to Executive Director with every change	Complete and ongoing
	Random audits done monthly to ensure assessments complete	Ongoing
	Ensure all care plans have all required signatures.	Complete and ongoing

SEP – 5 2019

Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: AL7241

Ms. Kimberly Crenshaw, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event W50M12

Dear Ms. Crenshaw:

On **October 1, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **July 19, 2019,** have now been corrected effective **August 27, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL7241	A. BUILDING: _____ B. WING _____	R 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HOUSE ASSISTED LIVING & MEMOR'	2450 NORTH STONE RIDGE DRIVE BROKEN ARROW, OK 74012

(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 follow-up survey was conducted on 10/01/19. The census was 110. All deficient practice was cited.	{C 000}		

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

Oklahoma State Department of Health
Creating a State of Health

REPORT REVISED

December 19, 2019

License Number: AL7241

Ms. Kimberly Crenshaw, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event W50M12

Dear Ms. Crenshaw:

Enclosed is a corrected statement of deficiencies revised to correct the initial comment statement to state that deficiencies are cleared. On **October 1, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **July 19, 2019** have now been corrected effective **September 28, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 10/01/19. The census was 110. All deficient practice was cleared. After administrative review, this survey was amended on 12/18/19. Lisa McAlister, BSN, RN Manager of Survey and Compliance	{C 000}		

Oklahoma State Department of Health

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STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7241	PRAIRIE HOUSE ASSISTED LIVING & MEMORY CARE

Type of Survey (select all that apply)

2	D			

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 32388 JL	10/01/2019	10/01/2019	0.25	0.00	1.00	0.00	2.00	1.00
2. 18273 CK	10/01/2019	10/01/2019	0.25	0.00	1.00	0.00	2.00	0.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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