

Delivery via email to: HensonZach@prairiehouseseniorliving.com

June 21, 2023

License Number: AL7241

Mr. Zachary Henson, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event ID: J1AU11

Dear Mr. Henson:

On **June 13, 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 **June 13, 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: AL7241	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/13/2023
NAME OF PROVIDER OR SUPPLIER PRAIRIE HOUSE ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 relicensure survey was conducted on 06/12/23 through 06/13/23. Listed below are abbreviations that will be used throughout this document. AFIB - atrial fibrillation BID - twice a day BPH - benign prostatic hyperplasia CAD - coronary artery disease CDM - certified dietary manager CHF - congestive heart failure CMA - certified medication aide Corp. - corporate CVA - cardiovascular accident DVT - deep vein thrombosis ER - extended release GERD - gastroesophageal reflux disease HTN - hypertension MAR - medication administration record mcg - microgram meq - milliequivalent mg - milligrams Res - Resident RN - registered nurse tab - tablet XR - extended release u/ml - units per milliliter URI - upper respiratory infection	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by:	C 391		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 Based on observation and interview, the facility failed ensure: a. the kitchen was kept clean and maintained in good repair, b. liquid products were labeled, c. handwash sinks were accessible, d. soap and paper towels were available at handwash sinks, e. handwash signs were posted at handwash sinks, and f. registering temperature indicators for measuring the dish surface temperature for the high temperature dish washer was available. The "Assisted Living Resident Condition and Care Overview" report, dated 06/12/23, documented 109 residents resided in the facility. Findings: On 06/12/23 at 11:30 a.m., a tour of the kitchen was conducted. The following observations were made: a. there were no signs notifying staff to wash their hands at the handwash sinks near the CDM's office, in the dish wash area, food preparation area, and drink station area, b. there was no soap available for staff to wash their hands at the handwash sinks in the dish wash area, food preparation area, and drink station area,	C 391		

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C 391	Continued From page 2 c. there were no paper towels available for staff to dry their hands at the handwash sinks in the dish wash area, food preparation area, and drink station area, d. there was an accumulation of black residue on the floor and walls in the dish wash area, e. there was brown residue on a ceiling tile and in a light shield in the dish wash area, f. there was no registering temperature indicator for measuring the dish surface temperature for the high temperature dish washer, g. ceiling lights were burned out and/or not working, h. there was brown residue on the storage racks in the dish wash area, i. there were two clear spray bottles of a yellow and clear liquid hanging on the rack above the three compartment sink. The bottles were not labeled, j. there was an accumulation of lint on the heat/air vents and the ceiling tiles around the vents, k. multiple spoons stored in a container in the food preparation area were stored with the food contact surface upward. They were not inverted, l. multiple plates and bowls stored on a rack across from the Continental one door reach in cooler were stored with the food contact surfaces upward. They were not inverted, m. gaskets were split on both doors on the Continental cold preparation cooler in the food	C 391		

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C 391	Continued From page 3 preparation area, n. there was an accumulation of black residue on the floor under equipment and in/on food service equipment in the food preparation area, o. there was an oven hood light burned out and/or not working, p. there was an accumulation of grease on the oven hood, filters, and fire suppression system, q. caulking was hanging loose from the oven hood, r. there was an accumulation of food, grease, and black residue on the floor, wall, and in/on food service equipment in the cook/serving area, s. gaskets were split on both doors on the Continental cold preparation cooler in the serving area, t. there was an accumulation of black residue inside the ice machine in the drink station area, u. there was an accumulation of black and brown residue on the floor under equipment in the drink station area, v. the handwash sink in the drink station area was blocked by a large carbon dioxide tank. The sink was not accessible for hand washing, w. there was lint on the ceiling near the condenser in the walk in cooler, x. there was an accumulation of food and ice on the floor in the walk in freezer, and	C 391		

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C 391	Continued From page 4 y. there was an accumulation of frost on the racks in the walk in freezer. On 06/12/23 at 12:01 p.m., the CDM asked if they had test strips for the high temperature dish washer. They stated they did not think they needed them since their dish washer was high temperature. On 06/12/23 at 12:03 p.m., the CDM was asked how staff ensured the kitchen was kept clean and maintained in good repair. They stated they had a cleaning scheduled and reported maintenance concerns to the maintenance director. They were asked what was required to be available for staff to wash their hands at the handwash sink. They stated soap, paper towels, and there should be a hand wash sign. They stated hand wash sinks should be accessible. The CDM was asked how staff identified liquids in spray bottles. They stated they should be labeled. They were asked how clean utensils and dishes were to be stored. They stated inverted. The CDM was made aware of the above findings.	C 391		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921		

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C 921	Continued From page 5 This LEVEL B is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication orders were reviewed monthly by a RN or pharmacist for eight (#1, 4, 5, 6, 7, 8, 9, and #10) of ten residents sampled for medication orders. The "Assisted Living Resident Condition and Care Overview" form, dated 06/12/23, documented 109 residents resided in the facility. Findings: 1. Res #1 was admitted to the facility on 08/25/22 with diagnoses which included GERD, CVA, AFIB, and pain. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 2. Res #5 was admitted to the facility on 10/31/22 with diagnoses which included diabetes, hypercholesterolemia, neurogenic bladder, epilepsy, depression, dementia, and coronary arteriosclerosis. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 3. Res #6 was admitted to the facility on 02/09/23 with diagnoses which included vascular dementia, hyperlipidemia, hypothyroidism, gout, HTN, diabetes, GERD, and allergic rhinitis.	C 921		

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C 921	Continued From page 6 Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 4. Res #9 was admitted to the facility on 07/17/23 with diagnoses which included history of fracture, orthostatic hypotension, diabetes, constipation, HTN, AFIB, iron deficiency anemia, BPH, CHF, depression, hypokalemia, hypothyroidism, insomnia, and myocardial infarction. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 5. Res #4 was admitted to the facility on 09/29/22 with diagnoses which included dementia, anxiety, CAD, atrial fibrillation, and depression. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 6. Res #7 was admitted to the facility on 06/22/22 with diagnoses which included HTN, diabetes, hyperlipidemia, CVA, and CHF. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 7. Res #8 was admitted to the facility on 05/11/21	C 921		

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C 921	Continued From page 7 with diagnoses which included Alzheimer's disease, anxiety, and HTN. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. 8. Res #10 was admitted to the facility on 01/19/22 with diagnoses which included diabetes, HTN, hypothyroidism, and polyneuropathy. Order summary reports were reviewed for January 2023 through June 2023. There was no documentation medications were reviewed for the months of February and March 2023 by the RN or pharmacist. On 06/12/23 at 4:00 p.m., Corp. Nurse Consult #1 was asked for the order reviews for January 2023 through June 2023. On 06/13/23 at 11:51 p.m., the health care director stated they could not find any verification of an RN or pharmacist order reviews completed for February and March 2023.	C 921		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care	C1505		

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C1505	Continued From page 8 consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were ordered as administered for nine (#1, 2, 3, 4, 5, 6, 7, 8, and #10) of ten sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" form, dated 06/12/23, documented 109 residents resided in the facility.	C1505		

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C1505	Continued From page 9 Findings: 1. Res #1 was had diagnoses which included pain. A physician order, dated 02/01/23, documented to administer diclofenac gel 1%, 2 grams topically to back and hips three times daily. A physician order, dated 04/03/23, documented to administer Tramadol 50 mg tablet, two tablets twice daily for pain until 04/28/23. A physician order, dated 04/19/23, documented to administer acetaminophen 500 mg, two tablets twice daily for pain until 05/07/23. A physician order, dated 04/26/23, documented to administer hydrocodone/apap 7.5-325 mg, one tablet every six hours for pain. A physician order, dated 04/26/23, documented to administer Biofreeze gel 4% to bilateral hips and lower back three times per day for pain. The April 2023 MAR documented the following: a. blank administration of diclofenac for the afternoon administration on 04/03/23, b. blank administration of Tramadol two out of 49 opportunities, c. diclofenac "withheld per nurses instruction" on 04/26/23 and, d. hydrocodone/apap "withheld per nurses instruction" on 04/28/23. The May 2023 MAR documented the following:	C1505		

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C1505	Continued From page 10 a. blank administration of acetaminophen for the morning administration for two of 62 opportunities, b. blank administration of Biofreeze gel for 11 of 93 opportunities, c. blank administration of hydrocodone-acet for three of 124 opportunities, d. blank administration of diclofenac gel for seven of 93 opportunities, e. diclofenac "withheld per nurses instruction" for four of 93 opportunities and, f. hydrocodone/apap "withheld per nurses instruction" for one of 124 opportunities. The June 1 through June 12 2023 MAR documented the following: a. blank administration of hydrocodone/apap for one of 47 opportunities and, c. hydrocodone/apap "withheld per nurses instruction" for two of 47 opportunities.. 2. Res #5 had diagnoses which included diabetes, epilepsy, and HTN. A physician order, dated 10/31/22, documented to apply Aspercream lidocaine 4% cream to left knee twice daily until 05/01/23. A physician order, dated 10/31/22, documented to administer insulin lispro according to sliding scale four times daily for diabetes until 05/01/23.	C1505		

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C1505	Continued From page 11 A physician order, dated 10/31/22, documented to administer lisinopril 2.5 mg daily for HTN until 05/01/23. A physician order, dated 10/31/22, documented to administer metoprolol 25 mg daily for HTN until 05/01/23. The March 2023 MAR documented the following: a. blank administration of Aspercream cream for one of 62 opportunities, b. blank administration of insulin lispro for 19 of 124 opportunities, c. lisinopril "withheld per nurses instruction" for three of 31 opportunities, d. metoprolol "withheld per nurses instruction" for three of 31 opportunities. The April 2023 MAR documented the following: A physician order, dated 04/07/23, documented to administer venlafaxine capsul 37.5 mg, one capsule twice daily for epilepsy. a. blank administration of insulin lispro for 12 of 120 opportunities, b. blank administration for Aspercream for one of 60 opportunities, c. lisinopril "withheld per nurses instruction" for six of 30 opportunities and, d. metoprolol "withheld per nurses instruction" for six of 30 opportunities.	C1505		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER PRAIRIE HOUSE ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 12 A physician order, dated 05/04/23, documented to administer insulin lispro subcutaneously four times per day according to sliding scale for diabetes. A physician order, dated 05/04/23, documented to administer lantus solostar 30 units subcutaneously in the morning for diabetes. A physician order, dated 05/04/23, documented to administer potassium chloride 10 meq once daily for supplement. The May 2023 MAR documented the following: a. blank administration of insulin lispro for 23 of 124 opportunities, b. blank administration of lantus for three of 31 opportunities, c. blank administration of potassium for one of 31 opportunities, d. blank administration of venlafaxine two of 62 opportunities, The June 2023 MAR documented the following: a. blank administration of insulin lispro six of 46 opportunities, b. blank administration of lantus for one of 12 opportunities, c. lisinopril "withheld per nurses instruction" for two of 12 opportunities and, d. metoprolol "withheld per nurses instruction" for two of 12 opportunities.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 13 A record review documented no contact to the physician, hold parameters, or orders to hold medications for any of the above instances. On 06/13/23 at 09:06 a.m., the health care director was shown the medications "withheld per nurses instruction" on Res #5's MAR. They stated there were no hold parameters for the orders and there should have been physician notification and documentation before the medication was held. On 06/13/23 at 9:52 a.m., the health care director was shown the blanks on the MAR for Res #5. They stated the blanks meant the medication was not documented as administered and there was no way to verify the resident received the medication. 3. Res #6 had diagnoses which included diabetes. A physician order, dated 03/21/23, documented to administer glimepiride tab 4 mg once daily. The May 2023 MAR documented glimepiride administration as blank for 22 of 23 opportunities. The June 1 through June 12 2023 MAR documented glimepiride administration as blank for 12 of 12 opportunities. On 06/13/23 at 1:15 p.m., the health care director stated the glimepiride was not in the medication cart or in the residents room and had not been administered. 4. Res #2 had diagnoses which included DVT and HTN.	C1505		

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C1505	Continued From page 14 A physician order, dated 03/01/23 documented Eliquis (anticoagulant) 5 mg tab by mouth twice daily. The medication was suspended 03/15/23 through 03/23/23. A physician order, dated 03/15/23, documented Eliquis 5 mg tab take two tabs (10 mg) BID by mouth for seven days. A physician order, dated 03/25/23, documented metoprolol succinate (beta blocker) 25 mg tab ER one tab by mouth every day. The March 2023 MAR was reviewed and documented the following: a. Eliquis was not administered five out of 46 opportunities. There were blanks where the medication was to be administered, and b. Eliquis 10 mg BID was administered 03/16/23 through 03/24/23. It was administered nine out of seven opportunities. The April 2023 MAR was reviewed and documented metoprolol succinate was not administered one out of 30 opportunities. There was a blank where the medication was to be administered. The May 2023 MAR was reviewed and documented metoprolol succinate was not administered one out of 31 opportunities. There was a blank where the medication was to be administered. On 06/12/23 at 3:38 p.m., the health care director was asked what blanks on the MAR indicated. They stated staff did not document they	C1505		

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C1505	Continued From page 15 administered the medication. They stated they could not verify the medication was administered to Res #2 if staff did not put their initials. They were shown the blanks on the resident's MAR. They acknowledged the findings. On 06/12/23 at 4:31 p.m., the health care director was shown the resident's MAR and asked the reason Eliquis 10 mg BID was administered for nine days instead of seven as ordered. On 06/12/23 at 4:40 p.m., the health care director stated there was no reason for the resident to have received the Eliquis beyond seven days. They stated the physician order was not followed. 5. Res #10 had diagnoses which included HTN, diabetes, hypothyroidism, GERD, and URI. A physician order, dated 01/19/22, documented carvedilol (beta blocker) 3.125 mg tab one tab by mouth twice daily. Physician orders, dated 10/28/22, documented levothyroxine sodium (hormone) 125 mcg tab take one tab by mouth once daily on Monday, Tuesday, Wednesday, Thursday, and Saturday. The order was changed on 04/19/23 to include Friday; levothyroxine sodium 125 mcg tab half tab by mouth on Sundays; and pantoprazole (proton pump inhibitor) 40 mg tab take one tab by mouth once daily. A physician order, dated 02/23/23, documented Farxiga (type 2 diabetes medication) 10 mg tab give one tab daily. The order was discontinued on 04/12/23. A physician order, dated 02/24/23, documented Lantus (diabetic medication) 100 u/ml solution	C1505		

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C1505	Continued From page 16 give eight units subcutaneous before dinner. A physician order, dated 03/19/23, documented Decadron (corticosteroid) 4 mg every day for seven days. A physician order, dated 04/12/23, documented azithromycin (antibiotic) 250 mg tab two tabs (500 mg) by mouth every day for one day. The March 2023 MAR was reviewed and documented the following: a. Decadron was not administered seven out of seven opportunities. There was no documentation the medication was ordered from the pharmacy, b. Lantus was not administered one out of 31 opportunities. There was a blank where the medication was to be administered, c. levothyroxine was documented as administered on Friday 03/17/23 and Friday 03/24/23, and d. Farxiga was not administered one out of 31 opportunities. There was a blank where the medication was to be administered. The April 2023 MAR was reviewed and documented the following: a. azithromycin was not administered one out of one opportunities. There was a blank where the medication was to be administered, b. Farxiga was documented as administered on 04/14/23 after the order was discontinued,	C1505		

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C1505	Continued From page 17 c. Lantus was not administered two out of 30 opportunities. There was a blank where the medication was to be administered, and d. levothyroxine was documented as administered on Friday 04/07/23 and Friday 04/14/23. The May 2023 MAR was reviewed and documented the following: a. carvedilol was not administered two out of 61 opportunities. It was documented withheld per nurses instructions, b. levothyroxine was not administered two out of 31 opportunities. There was a blank where the medication was to be administered, and c. pantoprazole was not administered one out of 31 opportunities. There was a blank where the medication was to be administered. On 06/13/23 at 11:43 a.m., the health care director was asked what blanks indicated on the MAR. They stated staff did not document they administered the medication and it could not be verified the medication was administered. They were asked if medications were withheld per nurses instructions should there be an order to withhold the medication. They stated there should be an order. The health care director was shown the resident's MARs where there were blanks, medications were withheld per nurses instruction with no orders to hold, and where medications were administered after the order was discontinued. They stated physician orders were not followed.	C1505		

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C1505	Continued From page 18 6. Res #3 had diagnoses which included HTN, diabetes, and cataract extraction status unspecified eye. Physician orders, dated 06/01/23, documented amlodipine (calcium channel blocker) 5 mg tab take one tab by mouth once daily; brimonidine solution (alpha adrenergic agonist) 0.15 percent instill one drop in both eyes three times a day; hydralazine (vasodilator) 100 mg tab take one tab by mouth three times daily; and insulin glargine (insulin) 100 u/ml pen inject 25 units subcutaneously every morning. The June 2023 MAR was reviewed and documented the following: a. amlodipine was not administered four out of 11 opportunities. It was documented withheld per nurses instructions, b. hydralazine was not administered 14 out of 33 opportunities. It was documented withheld per nurses instructions, c. brimondine solution not administered one out of 33 opportunities. There was a blank where the medication was to be administered, and d. insulin glargine was not administered one out of five opportunities. There was a blank where the medication was to be administered. 7. Res #4 had diagnoses which included atrial fibrillation. A physician order, dated 09/29/22, documented diltiazem (calcium channel blocker) XR 240 mg capsule one cap by mouth every day.	C1505		

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C1505	Continued From page 19 A physician order, dated 03/16/23, documented to administer Slow FE (iron) 45 mg once daily. The March 2023 MAR was reviewed and documented diltiazem was not administered seven out of 31 opportunities. It was documented withheld per nurses instructions. The April 2023 MAR was reviewed and documented diltiazem was not administered six out of 30 opportunities. It was documented withheld per nurses instructions. The May 2023 MAR was reviewed and documented diltiazem was not administered three out of 30 opportunities. It was documented withheld per nurses instructions. The June 2023 MAR was reviewed and documented diltiazem was not administered two out of 12 opportunities. It was documented withheld per nurses instructions. On 06/13/23 at 7:45 a.m., CMA #2 was observed during medication pass for Res #4. The CMA was observed administering iron 28 mg. On 06/13/23 at 9:00 a.m., the health care director was notified of the discrepancy, they stated it was a medication error and the CMA should have verified the dosage of the medication before administering the iron supplement. 8. Res #7 had diagnoses which included HTN and CHF. A physician order, dated 06/22/22, documented lisinopril (angiotensin-converting enzyme inhibitor) 2.5 mg tab one tab by mouth every day.	C1505		

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C1505	Continued From page 20 A physician order, dated 11/15/22, documented carvedilol (beta blocker) 3.125 mg tab one tab by mouth twice daily. The March 2023 MAR was reviewed and documented the following: a. carvedilol was not administered eight out of 62 opportunities. It was documented withheld per nurses instructions, and, b. lisinopril was not administered one out of 31 opportunities. It was documented withheld per nurses instructions. The April 2023 MAR was reviewed and documented the following: a. carvedilol was not administered 12 out of 60 opportunities. It was documented withheld per nurses instructions, and, b. lisinopril was not administered two out of 30 opportunities. It was documented withheld per nurses instructions. The May 2023 MAR was reviewed and documented carvedilol was not administered 12 out of 62 opportunities. It was documented withheld per nurses instructions. The June 2023 MAR was reviewed and documented the following: a. carvedilol was not administered 11 out of 23 opportunities. It was documented withheld per nurses instructions, and b. lisinopril was not administered one out of 12	C1505		

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C1505	Continued From page 21 opportunities. It was documented withheld per nurses instructions. 9. Res #8 had diagnoses which included HTN. A physician order, dated 05/11/21, documented lisinopril (angiotensin-converting enzyme inhibitor) 40 mg tab one tab by mouth once daily. A physician order, dated 11/30/22, documented hydrochlorothiazide (diuretic) 25 mg tab one tab by mouth every day. The March 2023 MAR was reviewed and documented the following: a. hydrochlorothiazide was not administered one out of 31 opportunities. It was documented withheld per nurses instructions, and b. lisinopril was not administered two out of 31 opportunities. It was documented withheld per nurses instructions. On 06/13/23 at 9:06 a.m., the health care director was asked what blanks indicated on the MAR. They stated staff did not document they administered the medication and it could not be verified the medication was administered. They were asked if medications were withheld per nurses instructions should there be an order to withhold the medication. They stated there should be an order. They were shown the blanks on the MAR for Res #3. They were shown the MARs where medications were withheld per nurses instructions with no order to hold for Res #3, Res #4, Res #7, and Res #8. They acknowledged the findings.	C1505		

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C1923	Continued From page 22	C1923		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an individual inventory sheet for a schedule II medication was maintained for one (#1) of 10 sampled residents whose medication records were reviewed. The "Assisted Living Resident Condition and Care Overview" form, dated 06/12/23, documented 109 residents resided in the facility. Findings: Res #1 had diagnoses which included pain.	C1923		

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C1923	Continued From page 23 A physician order, dated 04/26/23, documented to administer hydrocodone/apap 7.5/325 mg tab every six hours for pain. On 06/12/23 at 3:38 p.m., the health care director was asked to provide copies of individual inventory sheets for Res #1's norco. Records reviewed documented an inventory of the hydrocodone/apap from 05/12/23 through 06/12/23. On 06/13/23 at 11:51 a.m., the health care director stated no inventory sheets could be located prior to 05/12/23.	C1923		

Delivery via email to: HensonZach@prairiehouseseniorliving.com

July 17, 2023

License Number: AL7241

Mr. Zachary Henson, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event J1AU11

Dear Mr. Henson:

On **June 13, 2023**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

C0391: The deficient practice statement indicated maintenance and housekeeping concerns related to the kitchen as well as food storage and preparation. Please address all areas of concern with the required elements of your plan (Please see Letter A through Letter Y of deficient practice statement).

- a. The plan of correction should include how the correction action will be accomplished for those residents found to have been affected by the deficient practice. The POC should also address who was in-serviced, when were they in-serviced, and what changes were made to ensure compliance.
- b.
- c. The plan of correction should include what measures will be put into place, or what systemic changes made, to ensure that the deficient practice will not recur. The POC will include what system, or checks and balances, were added to your system to ensure the facility maintains compliance. Please cover all aspects of the deficient practice.
- d. The plan of correction will address how the assisted living center will monitor its performance to make sure corrections are sustained. Please provide how the correction will be evaluated for effectiveness (prior to QA); how the correction will be incorporated into the centers quality assurance system; who/what/when/where/how the facility will maintain monitoring records to provide to OSDH as evidence of correction.

C0921:

- a. The plan of correction should include when were in-services; when were the resident records reviewed; and who were the other residents' whose records were reviewed in determining the scope of deficient practice within the facility.

- b. ...
- c. The POC should include what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur and what system, or checks and balances, have you added to your system to ensure the facility maintains compliance.
- d. The plan of correction should address how the assisted living center will monitor its performance to make sure corrections are sustained. Please provide how the correction will be evaluated for effectiveness (prior to QA); how the correction will be incorporated into the centers quality assurance system; who/what/when/where/how the facility will maintain monitoring records to provide to OSDH as evidence of correction. Since the frequency of this deficient practice will likely only occur once or twice before the follow-up, please explain how will the facility monitor to ensure likely compliance (i.e. increase size of the monitored sample).

C1505:

- a. The facility's plan of correction should include when were in-services; when were the resident records reviewed; and who were the other residents' whose records were reviewed in determining the scope of deficient practice within the facility.
- b. ...
- c. The plan of correction should identify what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The POC should include what system, or checks and balances, were added to your system to ensure the facility maintains compliance.
- d. The POC will address how the assisted living center will monitor its performance to make sure corrections are sustained. Please provide how the correction will be evaluated for effectiveness (prior to QA); how the correction will be incorporated into the centers quality assurance system; who/what/when/where/how the facility will maintain monitoring records to provide to OSDH as evidence of correction.

C1923: The deficient practice was related to maintaining an accurate and complete written record of the medications administered and not just schedule II medications. Please see the regulatory text for C1923 on what is to be included in the record.

- a. The plan of correction should address when and what material was in-serviced; when was the resident's records reviewed, what other residents' records were reviewed to determine the scope of the deficient practice within the facility; and how was the review expanded to ensure the resident record was a complete and accurate record of the medications administered.
 - b. ...
-

- c. The POC should address what measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The POC should include what system, or checks and balances, you have added to your system to ensure the facility maintains compliance.
- d. The plan of correction should identify how the assisted living center will monitor its performance to make sure corrections are sustained. Please provide how the correction will be evaluated for effectiveness (prior to QA); how the correction will be incorporated into the centers quality assurance system; who/what/when/where/how the facility will maintain monitoring records to provide to OSDH as evidence of correction.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/30/2023

Facility Name: Prairie House Assisted Living and Memory Care

License Number: AL-7241

Survey Event ID: J1AU11

Date Survey Completed: 6/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation and interview, the facility failed to ensure: (a) the kitchen was kept clean and maintained in good repair (b) liquid products were labeled (c) handwash sinks were accessible (d) soap and paper towels were available at handwash sink (3) handwash signs were posted at handwash sinks, and (f) registering temperature indicators for measuring the dish surface temperature for the high temperature dish washer was available.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

An in-service of all CURRENT dietary staff and department heads on the proper preparation, storing and serving of food in compliance with 310:663-3-8(a) and in accordance with Chapter 257 of this Title (relating to food service establishments) with additional requirements.

ALL residents have the potential to be affected.

The Residence Director or designee will conduct random audits of the dietary department to ensure that food is properly prepared, stored and served in compliance with 310:663-3-8(a) and in accordance with Chapter 257 of this Title (relating to food service establishments) with additional requirements.

Enter methods to ensure corrections are sustained:

- Residence Director or designee will conduct random audits to ensure that the dietary team is in compliance with the preparation, storing and serving of food as outlined in Chapter 310:63-3-8(a) and in accordance with Chapter 257 of this Title.
- Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place.
- Record of the documentation will be kept with the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		8/8/2023
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature <i>Bochany Hiron</i> OAC 310:663-25-4(F)		Date 6/30/2023
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
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/30/2023

Facility Name: Prairie House Assisted Living and Memory Care

License Number: AL-7241

Survey Event ID: J1AU11

Date Survey Completed: 6/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: record review and interview, the facility failed to ensure medication orders were reviewed monthly by a RN or pharmacist for eight (#1, 4, 5, 6, 7, 8, 9, and #10) of ten residents sampled for medication orders.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

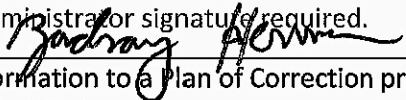
An in-service of the nursing team and residence director on monthly review of medications by a registered nurse or pharmacist in compliance with 310:663-9-2(a) MEDICATION STAFFING will be conducted. Medications for residents #'s (1,4,5,6,7,8,9, and #10) will be reviewed for accuracy and compliance.

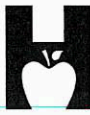
ALL residents have the potential to be affected.

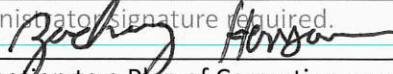
The Residence Director or designee will conduct random audits of physician orders (medications) to ensure that medications are being reviewed monthly by a registered nurse or pharmacist in compliance with 310:663-9-2(a).

Enter methods to ensure corrections are sustained:

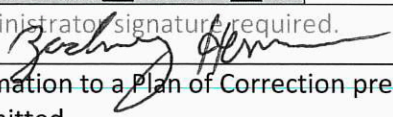
- Residence Director or designee will conduct random audits of physician orders (medications) to ensure that the nursing team is in compliance with monthly review of medications by a registered nurse or pharmacist as outlined in Chapter 310:663-9-2(a).
- Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place.
- Record of the documentation will be kept with the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/8/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date 6/30/2023	
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 Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 6/30/2023	
	Facility Name: Prairie House Assisted Living and Memory Care	
	License Number: AL-7241	
	Survey Event ID: J1AU11	
Date Survey Completed: 6/13/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on: observation, record review, and interview, the facility failed to ensure medications were ordered as administered for nine (#1, 2, 3, 4, 5, 6, 7, 8, and #10) of ten sampled residents reviewed for medications.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.		
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?		An in-service of the nursing team, care team and residence director on administration of medications as ordered in compliance with 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS – Medical Care will be conducted. Medication administration records for residents #'s (1, 2, 3, 4, 5, 6, 7, 8 and #10) will be reviewed for accuracy and 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 residents have the potential to be affected.
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 Residence Director or designee will conduct random audits of medication administration records to ensure that medications are being administered in compliance with 310:663-15-1 & OS 1-1918(B)(5) RESIDENT RIGHTS – Medical Care.
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. Residence Director or designee will conduct random audits of medication administration records to ensure that the medications are being administered in compliance as outlined in Chapter 310:663-15-1 and OS 1-1918(B)(5) RESIDENT RIGHTS – Medical Care. b. Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place. c. Record of the documentation will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐		

5. On what date will corrective action be completed?		8/8/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature		Administrator signature required.	Date 6/30/2023
OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 6/28/2023	
	Facility Name: Prairie House Assisted Living and Memory Care	
	License Number: AL-7241	
	Survey Event ID: J1AU11	
Date Survey Completed: 6/13/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1923	Based on: record review and interview, the facility failed to ensure an individual inventory sheet for a schedule II medication was maintained for one (#1) of 10 sampled residents whose medication records were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.		
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?		An in-service of the nursing team, care team and residence director on the requirement for maintenance of individual inventory sheets for Schedule II medications will be conducted in compliance with 310:663-19-2(a)(3) MEDICATION ADMINISTRATION. Resident #1 inventory sheet will be reviewed for accuracy and 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 residents have the potential to be affected.
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 Residence Director or designee will conduct random audits of individual inventory sheets for Schedule II medications to ensure records are being maintained in compliance with 310:663-19-2(a)(3).
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Enter methods to ensure corrections are sustained:
a. How the correction will be evaluated for effectiveness;		a. Residence Director or designee will conduct random audits of individual inventory sheets for Schedule II medications to ensure records are being maintained in compliance with Chapter 310:661-19-2(a)(3).
b. How the correction will be incorporated into the center's quality assurance system; and		b. Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place.
c. How monitoring records will be kept to evidence the correction.		c. Record of the documentation will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		8/8/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date 6/30/2023	
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.
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If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

Delivery via email to: zach.henson@legendseniorliving.com

August 2, 2023

License Number: AL7241

Mr. Zachary Henson, Administrator
Prairie House Assisted Living & Memory Care
2450 North Stone Ridge Drive
Broken Arrow, OK 74012

RE: Survey Event J1AU11

Dear Mr. Henson:

On **June 13, 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. After a second review, 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 **August 8, 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

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Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/30/2023

Facility Name: Prairie House Assisted Living and Memory Care

License Number: AL-7241

Survey Event ID: J1AU11

Date Survey Completed: 6/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation and interview, the facility failed to ensure: (a) the kitchen was kept clean and maintained in good repair (b) liquid products were labeled (c) handwash sinks were accessible (d) soap and paper towels were available at handwash sink (3) handwash signs were posted at handwash sinks, and (f) registering temperature indicators for measuring the dish surface temperature for the high temperature dish washer was available.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

An in-service of all CURRENT dietary staff and department heads on the proper preparation, storing and serving of food in compliance with 310:663-3-8(a) and in accordance with Chapter 257 of this Title (relating to food service establishments) with additional requirements.

ALL residents have the potential to be affected.

The Residence Director or designee will conduct random audits of the dietary department to ensure that food is properly prepared, stored and served in compliance with 310:663-3-8(a) and in accordance with Chapter 257 of this Title (relating to food service establishments) with additional requirements.

Enter methods to ensure corrections are sustained:

- Residence Director or designee will conduct random audits to ensure that the dietary team is in compliance with the preparation, storing and serving of food as outlined in Chapter 310:63-3-8(a) and in accordance with Chapter 257 of this Title.
- Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place.
- Record of the documentation will be kept with the QA minutes.