OKLAHOMA
State Department
of Health

Delivery via email to: tina.aston@primroseretirement.com;
kelly.anderson@primroseretirement.com

March 6, 2024

License Number: AL6009

Ms. Tina Aston, Administrator
Primrose Retirement Community Of Stillwater
832 S Range Road
Stillwater, OK 74074

RE: Survey Event ID: KR4S11

Dear Ms. Aston:

On **February 12, 2024**, 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 **February 12, 2024**.

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

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

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

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Clorissa Nubine

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6009	A. BUILDING: _____ B. WING _____	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF STI	832 S RANGE ROAD STILLWATER, OK 74074

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 02/07/24 through 02/09/24 and on 02/12/24. Facility Census: 46 Listed below are the abbreviations that will be used throughout the report: CMA - certified medication aide DM - dietary manager DON - Director of Nurses LPN - Licensed Practical Nurse RN - Registered Nurse	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: Based on observation, record review and interview, the facility failed to ensure: a. left over foods in the refrigerator was dated with preparation date; b. staff monitored refrigerator, freezer, and dish machine temperatures and chemicals; and c. a hair restraint policies for facial hair was in place. The facility census was 46. Findings: A "Dietary Policy" dated 09/13/18, read in parts, "...Establish a date marking system...to include a label with the product name, the day and date it	C 391		

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C 391	Continued From page 1	C 391		

was prepared or opened...Serve or discard...potentially hazardous foods within 7 days...designated employee will check refrigerators daily to verify that foods are date marked and that foods exceeding the 7-day period are not being used or stored...Check Temperature Log to ensure proper procedures are being followed and sign off on these logs every day..."

A "Dietary Policy" dated 10/08/18, read in parts, "...uniform expectations...Hairnet and/or Approved Black Skull Cap or approved...Baseball Hat..."

On 02/07/24 at 2:35 p.m., during the initial tour of the kitchen, the following were observed:
a. The temperature log for the commercial freezer did not contain a month or year. The temperature log contained instructions, "...Temperature should be taken twice daily during "off-peak" usage..." The log did not contain entries for the dates 25 through 28 or on 31. On two days, the temperatures were documented twice each day.

b. The Temperature log for the commercial refrigerator did not contain a month or year. "...Temperature should be taken twice daily during "off-peak" usage..." The log did not contain entries for the dates of 26 through 28. On two days, the temperatures were documented twice a day.

c. A zip bag of ground meat, inside the refrigerator, was labeled "sausage - prepared 01/26/24". The DM was asked how long left over foods are kept in the refrigerator. They stated, the date on the package is the date the food was received on the truck delivery. The DM was

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C 391	Continued From page 2 asked how it would be determined when the food was prepared. They stated, "We only use the date of delivery." c. A temperature log was not located for the dish machine. Cook #2 demonstrated the routine checking of the dish machine. The sanitizer test strips expiration date was June 2022. The Chemical test strips expiration date was October 2021. Cook #2 stated they were unaware the strips had expiration dates. Cook #2 was asked if there was a place the test strips and temperatures for the dish machine were documented. They stated, "No." On 02/09/24 at 10:35 a.m., Cook #3 and dietary aide #1 were observed to have facial hair without a hair restraint. They were asked what was the policy to cover facial hair. They stated they only were informed to wear a hat or hair net, they did not know if there was a policy for facial hair to be covered.	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident assessments were coordinated and signed by a Registered Nurse, the residents physician, and the resident or their representative for five (#1, 3, 6, 7 and #8) of eight sampled residents reviewed for assessments.	C 542		

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C 542	Continued From page 3 Census: 46 Findings: 1. Resident #1 was admitted to the facility on 11/21/22. A "Resident Evaluation", dated 11/22/22, was not signed by an RN, or the resident's physician. An LPN signature was dated 01/25/23, sixty-four days after the assessment completion date. A resident signature was dated 2/1/23, seventy days after the assessment completion date. A "Resident Evaluation", dated 12/07/22, was not signed by an RN, or the resident's physician. An LPN signature, dated 01/25/23, was signed thirty-eight days after the assessment documented as completed. The resident signature was dated 02/01/23, forty-four days after the assessment was completed. A "Resident Negotiated Service Plan With Schedule", dated 12/07/22, was signed by the resident on 02/01/23, forty-four days after the assessment was completed. A "Recommended Assisted Living Resident assessment form", dated 07/18/23, was not signed by an RN, or the resident's physician, the resident or resident representative. A "Resident Negotiated Service Plan With Schedule", dated 07/18/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Evaluation", dated 08/30/23, was not signed by the resident, resident representative,	C 542		

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C 542	Continued From page 4 an RN, or the resident's physician. On 02/12/24, at 4:35 p.m., the Administrator and DON stated evaluations, assessments, and service plans should be signed within 30 days. The Administrator stated Resident #1's documents that were signed, were signed late. 2. Resident #3 was admitted to the facility on 08/06/22. A "Resident Evaluation", dated 12/12/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Significant Change Assessment", dated 12/12/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Evaluation", dated 12/12/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Negotiated Service Plan", dated 12/12/23, was not signed by the resident, resident representative, an RN, or the resident's physician. On 02/12/24 at 4:30 p.m., the Administrator stated the required documents did not get completed. 3. Resident #6 was re-admitted to the facility on 01/05/20. An "Annual Assessment", dated 10/09/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Evaluation," dated 10/09/23, was not signed by the resident, resident representative,	C 542		

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C 542	Continued From page 5 an RN, or the resident's physician. A "Resident Negotiated Service Plan", dated 10/09/23, was not signed by the resident, resident representative, an RN, or the resident's physician. On 02/12/24, at 4:23 p.m., the Administrator stated the required information had not been completed. 4. Resident #7 was readmitted to the facility on 02/17/21. A "Significant Change Assessment", dated 11/20/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Evaluation", completed on 11/20/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Negotiated Service Plan", dated 11/20/23, was not signed by the resident, resident representative, an RN, or the resident's physician. On 02/12/24, the administrator stated there were no signatures on the assessments or the plan of care. 5. Resident #8 was admitted to the facility on 02/29/15. A "Significant Change Assessment", dated 09/22/23, was not signed by the resident, resident representative, an RN, or the resident's physician. A "Resident Evaluation", dated 09/22/23, was not signed by the resident, resident representative, an RN, or the resident's physician.	C 542		

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C 542	Continued From page 6 A "Resident Negotiated Service Plan", dated 09/22/23, was not signed by the resident, resident representative, an RN, or the resident's physician. On 02/12/24 at 4:20 p.m., the administrator stated the required forms had not been completed.	C 542		
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 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.	C1505		

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C1505	Continued From page 7	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure:
a. contracts were fully completed for two (#2 and #5) of eight sampled residents reviewed for contracts, and
b. the facility had and implemented a policy to prevent cross contamination for the use of a shared blood pressure cuff for two (#9 and #10) of five residents observed to have a blood pressure obtained during medication administration.

Census: 46

Findings:

A "Clostridium difficile Infection (CDI) Prevention and Treatment of Residents" policy, dated 08/2020, read in part, "...If single use...equipment is not available, shared equipment must be cleaned and disinfected immediately after use and between residents..."

1. On 02/09/24 at 8:20 a.m., CMA #1 was observed to obtain a blood pressure for Resident #9. The blood pressure cuff was returned to the top of the medication cart without cleaning or sanitizing. CMA #1 sanitized their hands, obtained the ordered medications for Resident #9, and administered oral medications.

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C1505	Continued From page 8 On 02/09/24 at 8:35 a.m., CMA #1, obtained the used blood pressure cuff from the top of the medication cart, then used the unclean blood pressure cuff to obtain a blood pressure for Resident #10. Without cleaning or sanitizing the blood pressure cuff, CMA #1 placed the blood pressure cuff on top of the medication cart, sanitized their hands, obtained the ordered medications for Resident #10 and administered the oral medications. On 02/09/24 at 8:55 a.m., CMA #1 was asked when the blood pressure cuff should be cleaned or sanitized. CMA #1 stated the blood pressure cuff is sanitized at the beginning and end of the shift. CMA #1 was asked what was the facility policy for cleaning or sanitizing the blood pressure cuff. They stated, "I don't know." On 02/09/24 at 10:15 a.m., the DON provided a policy titled,"Clostridium difficile Infection (CDI) Prevention and Treatment of Residents". The DON stated this is the only infection control policy found that has instructions for cleaning the blood pressure cuffs between residents. The DON was asked what the expected practice was for cleaning or sanitizing blood pressure cuffs. The DON stated, the blood pressure cuff should be cleaned or sanitized before and after the use of a resident. 2. Resident #2 as admitted to the facility on 08/31/18, and the resident contract was updated on 09/09/22. The "Resident Occupancy Agreement", dated 09/09/22, contained "Appendix A-1", for the documentation of the type of apartment, rent, and optional service charges. The form was not	C1505		

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C1505	Continued From page 9 completed to include the specific charges for rent, level of care services, or optional services. 3. Resident #5 was admitted to the facility on 01/31/24. The "Resident Occupancy Agreement", dated 01/25/24 did not contain signatures. On 02/12/24 at 4:10 p.m., the Administrator and DON were asked if the contract for Resident #5 had been signed. They stated, "No." The surveyor requested a copy of the unsigned contract.	C1505		