Oklahoma State Department of Health
Creating a State of Health

September 26, 2019

License Number: AL3601

Ms. Tara Chill, Administrator
The Renaissance Of Ponca City
2616 Turner Road
Ponca City, OK 74604

RE: Survey Event ID: 40TC11

Dear Ms. Chill:

On **August 29, 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 August 29, 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,

Lisa Calvin

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
	AL3601	A BUILDING _____ B WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF PONCA CITY	2616 TURNER ROAD PONCA CITY, OK 74604

(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 08/28/19 and 08/29/19. The resident census was 22. The following deficient practices were 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 REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the center failed to ensure a comprehensive assessment was complete after a significant in condition for 1 (#7) of 1 sampled resident who had a significant change in condition. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #7's record included an assessment dated, 10/02/18. The assessment documented the resident was ambulatory with a walker, only needed standby assistance for transfers and toileting and was incontinent of both bowel and bladder at times. It also documented the resident was able to eat independently and was on a regular diet. A report from the resident care coordinator was received from the resident care coordinator on 08/28/19. She described the resident as wheel	C 522		

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C 522	Continued From page 1 chair bound, had a Foley catheter and was incontinent of bowel. She stated the resident had a decline recently. On 08/29/19, the resident was observed in the dining room for lunch. She was sitting in a high back wheel chair, parked at a table. Staff was observed to serve her one course of finely chopped food at a time, and it took much one-on-one encouragement from staff to get her to eat. At 1:35 p.m., the administrator stated there was not a significant change assessment completed, but the resident should have had one completed.	C 522		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure registered nurse supervision of the skilled nursing intervention of taking and noting physician orders was done only by a licensed nurse for 6 (#1, 2, 3, 5, 6 and #7) of 8 sampled residents who had physician's orders for care and/or treatment. This	C 911		

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C 911	Continued From page 2 failed practice had the potential for more than minimal harm, at a pattern. Findings: Resident #1's record included a fax sent to the physician on 08/13/19 advising the physician the resident was confused and hallucinating and that the resident's urine was cloudy. The fax suggested a urinalysis test and requested advisement. The physician responded back to the center to obtain a urine sample and fax the results back to the physician's office. CMA (certified medication aide) #1 noted the order on 08/14/19. The RN (registered nurse) noted the order on 08/21/19, one week later. Resident #2's record included a fax to the resident's physician's office, dated 07/17/19. The fax requested an order for home health due to falls. The physician's office faxed the order for home health back to the center on the same day. CMA #1 noted the order, entered it in the resident's EMAR (electronic medical record) and faxed the order to home health on the same day. The RN noted the order on 07/24/19, eight days later. Resident #3's record included a fax from the resident's physician on 05/31/19, for the center to stop enalapril (blood pressure medication) and send one week of blood pressure readings back to the physician. CMA #1 noted the order, entered it in the EMAR and sent it to the home health on the same day. The order was never noted by a licensed nurse. Resident #5's record included a fax to the resident's physician on 08/17/19, requesting to change the resident's diet from chopped food back to a regular diet. The physician faxed back that was fine as long as the resident was not	C 911		

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C 911	Continued From page 3 having trouble chewing and swallowing. CMA #5 noted the order on 08/15/19. The RN noted the order on 08/21/19, six days later. Resident #5's record also included a new physician's order, dated 07/24/19, to continue the compression wraps to the resident's lower extremities and to change the "u" shaped felt pad in the dressings to the resident's lower legs every other day for two weeks. CMA #5 noted the order and faxed it to home health on 07/25/19. The order was noted by the RN on 07/30/19, five days later. Resident #6's record included a new prescription from the resident's physician on 06/14/19 for diflucan (anti-fungal) 150 mg to be given by mouth one tablet every other day for two weeks. CMA #5 noted the order and entered it in the EMAR on 06/19/19. The order was never noted by a licensed nurse. The record for resident #6 included a request faxed to his physician, on 07/08/19, to change the Linzess (for constipation) from routine to an as needed basis The physician's office faxed back with an order to change the Linzess to daily as needed. CMA #5 noted and entered the order in the EMAR on 07/09/19. The order was noted by the RN on 07/17/19, eight days later. The record for resident #6 included a fax sent to the resident's physician on 07/15/19, stating the resident was requesting to have his Myrbetriq (for overactive bladder) changed to daily. The physician's office faxed back with an order to change the Myrbetriq to daily. CMA #1 noted the order and entered it into the EMAR on 07/15/19. The RN noted the order 07/17/19, two days later.	C 911		

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	AL3601	A. BUILDING _____ B. WING _____	08/29/2019

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C 911	Continued From page 4	C 911		

Resident #6's record also included a fax sent to the resident's physician on 07/31/19 to inform the physician the resident refused his Symbicort inhaler. The physician faxed back that he wanted the resident to continue with the Symbicort. The resident could refuse it if he wanted, but the physician wanted it to be offered daily. CMA #5 noted the order on 08/01/19. The RN noted the order 08/07/17, six days later.

Again, on 08/06/19, the center sent a fax to resident #6's physician the resident had refused his Norco (narcotic) and Symbicort inhaler and requested advisement. The physician faxed the center back on 08/07/19 stating for the center to please stop notifying him when the resident refused his medications and to just keep trying CMA #5 noted the order on 08/07/19. The order was never noted by a licensed nurse.

Resident #7's record included a fax to the resident's physician on 06/13/19 requesting an order for an anti-anxiety medication because the resident was very anxious, repeating herself all the time and stated she was scared. The physician faxed back stating to increase the resident's venlafexine to 25 mg twice daily and that these behaviors were typical for dementia and the resident needed reassured and redirected. CMA #5 noted the order and entered it in the EMAR on 06/17/19.

Resident #7's record also included a fax to the resident's physician on 06/10/19 that the resident had red, irritated, itchy eyes. The physician faxed the center back with an order for Patanol eye drops 1 drop twice daily for five days. CMA #5 noted the order and entered it in the EMAR on 06/11/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 911	Continued From page 5 On 08/29/19 at 10:00 a m., the administrator stated the nurse only came in once a week and could not note the orders as they came in. She also said the CMAs communicated with the doctors then informed the nurse of any changes in the residents' orders	C 911		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL3601	THE RENAISSANCE OF PONCA CITY

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. 36967	08/28/2019	08/29/2019	0.25	0.00	9.00	0.00	3.00	3.75
2.								
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**

SEP 26 2019

Oklahoma State Department of Health
Creating a State of Health

October 10, 2019

License Number: AL3601

Ms. Tara Chill, Administrator
The Renaissance Of Ponca City
2616 Turner Road
Ponca City, OK 74604

RE: Survey Event 40TC11

Dear Ms. Chill:

On August 29, 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 **October 15, 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/3/2019** **Facility Name:** The Renaissance of Ponca City **License Number:** AL3601 **Survey Event ID:** 40TC11 **Date Survey Completed: 8/29/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522 SS=D	Based on: observation, interview and record review it was determined the center failed to complete the comprehensive assessment promptly after a significant change for one (#7) of one sampled resident. This resulted in the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	Registered Nurse or physician, with information received from observing and interviewing, completed a comprehensive assessment on resident #7.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Director of Health and Wellness and/or designee will conduct audit of current resident assessments to verify if significant change in condition has occurred and notify Registered Nurse so that comprehensive assessment can be completed.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Director of Health and Wellness conducted in-service training regarding this practice. Current residents with a significant change will be discussed during daily stand up and Registered Nurse will complete comprehensive assessment promptly.
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.	Registered Nurse and/or Director of Health and Wellness will be responsible for sustained compliance. Executive Director and/or Director of Health and Wellness will complete random audits of resident comprehensive assessments to validate compliance. Residents identified with significant change in condition requiring an updated comprehensive assessment will be noted at the community quality assurance meeting. Tracking and trending will be reported and reviewed by QA Committee. Monitoring records will be maintained by Executive Director or designee as evidence of correction.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/15/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara Chill, Executive Director OAC 310:663-25-4(F)			**Date 10/3/2019**
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.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/3/2019** **Facility Name:** The Renaissance of Ponca City **License Number:** AL3601 **Survey Event ID:** 40TC11 **Date Survey Completed: 8/29/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C911 SS=E	Based on: interview and record review, it was determined the center failed to ensure registered nurse supervision of the skilled nursing intervention of taking and noting physician orders was done only by a licensed nurse for 6 (#1, 2, 3,5, 6 and #7) of 8 sampled residents who had physician's orders for care and/or treatment. This failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	Registered nurse completed a review of healthcare provider orders for resident #1, 2, 3, 5, 6, and 7.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Director of Health and Wellness and community nurses will utilize a three way stamp on HCP orders to document noting HCP orders with their name, licensure, date and time. License Nurses will take, document, sign, date and time HCP orders.
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?	Director of Health and Wellness, Resident Care Director, and med aides in-service training conducted to review the requirement of licensed nurses take, note healthcare provider orders and use of the three way stamp to demonstrate compliance with noting HCP orders.
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.	Director of Health and Wellness will be responsible for sustained compliance. Director of Health and Wellness and/or designee will conduct random weekly audits to ensure orders for care and/or treatment are noted by licensed nurse. Director of Health and Wellness will produce audits to be reviewed and discussed during QA meeting to validate compliance. Monitoring records will be attached to the QA meeting documents and maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		10/10/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara Chill, Executive Director OAC 310:663-25-4(F)			**Date 10/3/2019**
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.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/3/2019** **Facility Name:** The Renaissance of Ponca City **License Number:** AL3601 **Survey Event ID:** 40TC11 **Date Survey Completed: 8/29/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1439	Based on: interview and record review, it was determined the center failed to ensure a certified med aide did not take and note physician's orders for 6 (#1, 2, 3, 5, 6, and 7) of 8 sampled residents who had physician's ordrs for care and/or treatment. This failed practice had the minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists, or that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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? OSDH Response: Element accepted Yes ☐ No ☐	Licensed nurse completed a review of all physician's orders for care and/or treatment for resident #1, 2, 3, 5, 6, and 7.
2. How will other residents having the potential to be affected by the same deficient practice be identified? OSDH Response: Element accepted Yes ☐ No ☐	All residents residing in community are subject to this practice to ensure physicians orders are taken and noted by licensed nurse.
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 ☐	Health and Wellness Director, Resident Care Coordinator, and med aides inserviced regarding certified medication aide scope of practice. All physician's orders for care and/or treatment will be taken and noted by licensed nurse only.
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. OSDH Response: Element accepted Yes ☐ No ☐	Director of Health and Wellness will be responsible for sustained compliance. Director of Health and Wellness and/or designee will complete random weekly audits to ensure that all orders for care and/or treatment are taken and noted by licensed nurse. Director of Health and Wellness will produce audits during QA meeting to validate compliance. Record of audits will be attached to QA meeting and maintained by the Health and Wellness Director and/or Executive Director to ensure compliance.

5. On what date will corrective action be completed?		10/10/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara Chill OAC 310:663-25-4(F)			**Date 10/3/2019**
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.			

5:

Oklahoma State Department of Health
Creating a State of Health

December 13, 2019

License Number: AL3601

Ms. Tara Chill, Administrator
The Renaissance Of Ponca City
2616 Turner Road
Ponca City, OK 74604

RE: Survey Event 40TC12

Dear Ms. Chill:

On **November 15, 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 **August 29, 2019,** have now been corrected effective **October 15, 2019.**

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

Sincerely,

Lisa Calleri

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

SD/ldc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3601	A BUILDING _____ B WING _____	R 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF PONCA CITY	2616 TURNER ROAD PONCA CITY, OK 74604

(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
{N 000}	Initial Comments A follow up survey was completed on 11/15/19. Census was 22. All deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow up survey was completed on 11/15/19. Census was 22. All deficient practice was cleared.	{C 000}		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL3601	THE RENAISSANCE OF PONCA CITY

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. 36967	11/15/2019	11/15/2019	0.00	0.00	0.00	0.00	0.00	0.00
2. 41872	11/15/2019	11/15/2019	0.25	0.00	2.25	0.00	5.25	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**