OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingsw.com

March 14, 2022

License Number: AL3601

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

RE: Survey Event ID: FBQ711

Dear Ms. Chill:

On **March 2, 2022**, agents from our office concluded a State Licensure survey in conjunction with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on March 2, 2022.

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 Digitally signed by Katie Stagner
Date: 2022.03.14 15:39:59 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Renaissance of Ponca City**
Address: **2616 Turner Street**
City, State, Zip: **Ponca City, Ok 74604**
Provider #: **AL3601**
Complaint #: **OK00058475**
Investigation Date(s): **02/28/22, 03/01/22 and 03/03/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure resident property was not misappropriated.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/28/2022 at 09:20 a.m.

A sample of 9 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, 1970, 1504 and 1917 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Mary Cooper By Edas

Mary Cooper RN/CHFS

Date report completed: 03/07/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Renaissance of Ponca City**
Address: **2616 Turner Street**
City, State, Zip: **Ponca City, Ok 74604**
Provider #: **AL3601**
Complaint #: **OK00056019**
Investigation Date(s): **02/28/22, 03/01/22 and 03/03/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide medications as contracted/ordered by the physician.	**US**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/28/2022 at 09:20 a.m.

A sample of 3 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to administration of medications as ordered by the physician was conducted. Residents were interviewed regarding receiving medications as ordered by the physician. Medication Administration Records were reviewed for documentation of medications administered and compared to medications as ordered by the physician. A medication observation pass was completed with no concerns. Staff were interviewed regarding any concerns about residents not receiving medications as ordered by the physician. No concerns were voiced. At the time of investigation there was no deficient practice related to medication administration as ordered by the physician.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Mary Cooper By Ed Rcm

Mary Cooper RN/CHFS

Date report completed: 03/07/2022

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 _____	03/02/2022

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 and complaint investigation [OK00058475 and OK00056019] was completed on 02/28/22, 03/1/22 and 03/02/22. The following abbreviations may have been used in the writing of this report. CNA=Certified Nursing Assistant ED=Executive Director K=Thousand MAT=Medication Administration Technician OSDH=Oklahoma State Department of Health POA=Power of Attorney Res=Resident RCD=Resident Care Director	C 000		
C1504 SS=E	310:663-15-1 & 63 OS 1-1918(B)(4) RESIDENT RIGHTS - Finances 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)(4) (4) Every resident shall have the right to manage such resident's own financial affairs, unless the resident delegates the responsibility, in writing, to the facility. The resident shall have at least a quarterly accounting of any personal financial transactions undertaken in the resident's behalf by the facility during any period of time the resident has delegated such responsibilities to the facility;	C1504		

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C1504	Continued From page 1	C1504		

This REQUIREMENT is not met as evidenced by:
Based on interview, and record review the center failed to ensure quarterly statements were provided to family representatives or residents for three (#1, 2, and #3) of seven sampled residents reviewed for financial transactions made on behalf of the resident by the center.

The Executive Director identified seven residents who had funds managed by the center.

Findings:

The center had no policy in place for resident funds prior to the following incident.

An Oklahoma State Department of Health, "Incident Report" dated 12/14/21, read in part, "...Several resident funds accounts' balance sheets are not accurate with funds missing and unaccounted for...Residents at [facility name] are

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C1504	Continued From page 2 offered to keep up to $200 in main office safe. When funds are deposited or withdrawn we require two employees signatures and a receipt to be kept to validate spending...Several resident funds sheets are not adding up, missing receipts, and only have one signature..." A document titled, "Resident Funds Form" for resident #1 documented, to notify the resident when the funds are low. A document titled, "Resident Funds Form" for residents, #2 and #3, read in part, "...Notify Residents' representative when the balance of funds reaches [dollar amount] or less..." On 02/28/22 at 4:05 p.m., the ED was asked how often the cash box was audited and did the family or residents get monthly statements. She replied, it was not audited and the family/residents were not sent statements. The ED was asked what the policy was for management of resident funds. She stated, "We don't have one." At 4:45 p.m., Res #2's POA was asked if she received any statements regarding the personal funds account. She replied, she had not receive any statements regarding Res #2's account. On 03/02/22 at 11:40 p.m., Res #1 was asked if she received a statement for her personal funds kept by the center. She replied, no. At 1:20 p.m., Res #3's POA was asked if they got monthly or quarterly statements. The POA stated, "No."	C1504		
C1917 SS=E	310:663-19-(g) REPORTS TO THE DEPARTMENT	C1917		

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C1917	Continued From page 3 (g) Content of Incident Report (1) The preliminary report shall at the minimum include: (A) who, what, when, and where; and (B) measures taken to protect the resident(s) during the investigation. (2) The follow-up report shall at the minimum include: (A) preliminary information; (B) the extent of the injury or damage if any; and (C) preliminary findings of the investigation. (3) The final report shall, at the minimum, include preliminary and follow-up information and: (A) a summary of the investigative actions; (B) investigative findings and conclusions based on findings; (C) corrective measures to prevent future occurrences; and (D) if items are omitted, why the items are omitted and when they will be provided. This Rule is not met as evidenced by: Based on interview, and record review the center failed to complete an thorough investigation of misappropriation of funds for two (#8 and #9) of nine sampled residents for misappropriation of funds. The Executive Director identified 27 resident who resided in the center.	C1917		

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C1917	Continued From page 4 Findings: A document titled, "Resident Protection and Abuse Prevention", revised 3/20, read in part, "...Investigation Steps: The Executive Director will initiate and direct investigations for abuse allegations and ensure residents are maintained in a safe environment...Executive Director/Designee ensures the investigation is prompt and confidential via private interviews with residents, witnesses and employees..." An OSDH, "Incident Report", dated 09/26/21, read in part, "...Part B:Resident's family informed staff that residents are missing $30,000 cash... Part C: Residents and family stated that [Res #9] carries a large amount of cash on them at all times. They said that [Res #9] had three bundles of $10,000 in her purse when she moved in on 09/16/21...Family and residents have so far located 10K of the original reported 30K missing..." The incident report did not document any interviews were conducted with other residents or staff regarding the missing money. An OSDH, "Incident Report", dated 10/26/21, read in part, "...Residents notified staff that they could not locate [Res #9's] wallet. They stated that they believed someone had stolen the wallet while they were sleeping...Part C [Res #8 and Res #9] moved out of the community. Investigation continues with [City] Police Dept..." The incident report did not document any interviews were conducted with other residents or staff regarding the missing wallet and contents. On 02/28/22 at 4:25 p.m., the ED was asked if	C1917		

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C1917	Continued From page 5 she interviewed other residents about missing money, items or wallet during the investigation on 10/26/21. She replied, no. She was asked if she interviewed staff regarding the missing wallet/ money on 10/26/21. She replied, I think it is in the chart. On 03/01/22 at 09:20 a.m., the ED provided one written staff statement regarding the incident on 10/26/21. The statement by CNA #4, documented, " I [CNA#4] helped look for [Res #8 and Res #9] wallet on this day Oct. 26, 2021. Along with two other employees [CNA #2 and RCD] and found nothing that day." On 03/01/22 at 5:10 p.m., CNA #1 was asked how the facility investigates allegations of misappropriation of funds. She stated, "I don't think they look into it or take it seriously...people taking money." On 03/02/22, at 2:20 p.m., the ED was asked if she interviewed other residents in relation to the missing money on 09/26/21. She replied, no. She was asked if she interviewed any staff. She replied, yes but did not provide any interviews of staff regarding the incident. The ED was asked if she interviewed other residents in relation to the missing wallet and contents on 10/26/21. She replied, no. She was asked if she interviewed any staff. She replied, yes.	C1917		
C1970 SS=E	310:663-19-4(a) POLICIES (a) Each assisted living center shall have a written policy statement that expressly prohibits the abuse or neglect of residents or misappropriation of resident property it serves. The policy shall include the facility's investigative	C1970		

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C1970	Continued From page 6 procedures and actions to be taken when incidents of abuse or neglect of residents or misappropriation of resident's property occur. This Rule is not met as evidenced by: Based on interview, and record review the center failed to ensure a policy was in place to prevent misappropriation of funds for seven (#1 through #7) of seven sampled residents reviewed for misappropriation of personal funds. The Executive Director identified seven residents who had funds managed by the center. Findings: The center had no policy in place for resident funds prior to the following incident. An OSDH, "Incident Report" dated 12/14/21, read in part, "...Several resident funds accounts' balance sheets are not accurate with funds missing and unaccounted for ...Residents at [facility name] are offered to keep up to $200 in main office safe. When funds are deposited or withdrawn we require two employees signatures and a receipt to be kept to validate spending...Several resident funds sheets are not adding up, missing receipts, and only have one signature..." An attachment to the OSDH incident report, dated 12/14/21, documented the following:	C1970		

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C1970	Continued From page 7 1. "...[Res #1]-We determined she is missing $197.00. Records show that she deposited $297 on 7/31/21. [Res#1] confirmed that she withdrew $100 during August 2021. [Res #1] stated that the remaining withdraws had her name forged, and that she did not withdraw the money..." 2. "...[Res #2]- $245 total determined to be missing ..." 3. "...[Res #3]-Total of $555 without receipts to match funds forms, nor could be confirmed by hairdresser..." 4. "...[Res #4's] funds form showed that she should have $20 remaining in account. There was zero dollars and no change remaining. After review of her records, we determined that he is missing $85 dollars..." 5. "...[Res #5]-Determined to be missing $320 total. Fund forms showed $150 still in account. However it was empty..." 6. "...[Res #6]-Determined to be missing $420 total. Funds forms showed that resident should still have $35 in account. However, no change not cash remained in account..." 7. "...[Res #7]-$540 determined to be missing. Funds form showed $15 remaining, but account is empty. Several dated stated that funds had been used for supplies/[store] ...She did not have any receipts to validate spending at [store] or for supplies..." Resident fund forms for Res #1 through #7 were reviewed from 04/24/19 through 11/30/21. Documentation showed discrepancies as reported.	C1970		

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C1970	Continued From page 8 The OSDH incident report did not identify Res #4, but included her information in the attachment. A document titled, "Resident Funds Form" for resident #1 documented, to notify the resident when the funds are low. A document titled, "Resident Funds Form" for six residents, #2 through #7, read in part, "...Notify Residents' representative when the balance of funds reaches [dollar amount] or less..." On 02/28/22 at 4:05 p.m., the ED was asked how often the cash box was audited and did the family or residents get monthly statements. She replied, it was not audited and the family/residents were not sent statements. The ED was asked what the policy was for management of resident funds She stated, "We don't have one." At 4:45 p.m., Res #2's POA was asked if she received any statements regarding the personal funds account. She replied, she had not receive any statements regarding Res #2's account. On 03/02/22 at 11:40 p.m., Res #1 was asked if she received a statement for her personal funds kept by the center. She replied, no. She was asked if she signed the funds form when she took money out of her account. She stated, "Sometimes...sometimes not." At 2:20 p.m., the OSDH attachment, dated 12/14/21, was reviewed with the ED. She acknowledged the amounts misappropriated for each resident as documented. The ED acknowledged there was no resident funds policy in place prior to the incident involving the misappropriation of resident funds, and there is	C1970		

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C1970	Continued From page 9 no written policy in place at this time.	C1970		

OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingpc.com

April 6, 2022

License Number: AL3601

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

RE: Survey Event FBQ711

Dear Ms. Chill:

On **March 2, 2022,** agents from our office completed an Assisted Living Center survey in conjunction with a complaint 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:

- The Plan of Correction does not address tags C1917 or C1970.

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

Sincerely,

Katie Stagner
Digitally signed by Katie Stagner
Date: 2022.04.06 14:49:59 -05'00'

Katie Stagner, Enforcement Reviewer
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/23/2022** **Facility Name:** The Renaissance of Ponca City **License Number:** AL3601 **Survey Event ID:** FBQ711 **Date Survey Completed: 3/2/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1504	Based on: interview, and record review the center failed to ensure quarterly statements wereprovided to family representatives or residents forthree (#1, 2, and #3) of seven sampled residents reviewed for financial transactions made onbehalf of the resident by the center.

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?	Business Office Manager in-serviced on importance of ensuring that all residents that have delegated management of any resident funds will have a statement sent to them quarterly each year.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Seven residents residing in the community that had delegated management of resident funds had the potential to be affected by deficient practice.
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?	Executive Director or Business Office Manager will audit all resident funds accounts weekly at a minimum.
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.	Executive Director and/or Business Office Manager will be responsible for sustained compliance. Executive Director and/or Business Office Manager will maintain monitoring records. Tracking and Trending will be reported and reviewed during the QA meeting. Monitoring records will be attached to the QA meeting minutes, and will be maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill** OAC 310:663-25-4(F)	**Date 3/25/2022**

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

Delivery via email to: executivedirector@renlivingpc.com

April 7, 2022

License Number: AL3601

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

RE: Survey Event FBQ711

Dear Ms. Chill:

On **March 2, 2022**, a Licensure inspection and a Complaint investigation were 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.

Please disregard the POC Reject NOTICE we sent to your facility on April 7, 2022 at approximately 2:51pm; there were technical difficulties and the survey team was not able to review the submitted POC in its entirety, and thought part of it was missing.

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 **April 15, 2022**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2022.04.07 11:06:35 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/23/2022** **Facility Name:** The Renaissance of Ponca City **License Number:** AL3601 **Survey Event ID:** FBQ711 **Date Survey Completed: 3/2/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1504	Based on: interview, and record review the center failed to ensure quarterly statements wereprovided to family representatives or residents forthree (#1, 2, and #3) of seven sampled residents reviewed for financial transactions made onbehalf of the resident by the center.

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?	Business Office Manager in-serviced on importance of ensuring that all residents that have delegated management of any resident funds will have a statement sent to them quarterly each year.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Seven residents residing in the community that had delegated management of resident funds had the potential to be affected by deficient practice.
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?	Executive Director or Business Office Manager will audit all resident funds accounts weekly at a minimum.
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.	Executive Director and/or Business Office Manager will be responsible for sustained compliance. Executive Director and/or Business Office Manager will maintain monitoring records. Tracking and Trending will be reported and reviewed during the QA meeting. Monitoring records will be attached to the QA meeting minutes, and will be maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill** OAC 310:663-25-4(F)	**Date 3/25/2022**

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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: 3/23/2022** **Facility Name:** The Renaissance of Ponca City **License Number:** AL3601 **Survey Event ID:** FBQ711 **Date Survey Completed: 3/2/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1917	Based on: interview, and record review the center failed to complete an thorough investigation of misappropriation of funds for two (#8 and #9) ofnine sampled residents for misappropriation of funds.

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?	Executive Director and Business Office Manager in-serviced on importance of ensuring that thorough investigations are completed and documented for any misappropriation of funds.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Every resident residing in community had the potential to be affected by deficient practice.
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?	Executive Director and/or designee will audit incident reports to ensure that thorough investigations are completed and documented on any misappropriation of funds.
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.	Executive Director and/or Business Office Manager will be responsible for sustained compliance. Executive Director and/or designee will maintain monitoring records. Tracking and Trending will be reported and reviewed during the QA meeting. Monitoring records will be attached to the QA meeting minutes, and will be maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill**	**Date 3/25/2022**

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.			
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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: 3/23/2022

Facility Name: The Renaissance of Ponca City

License Number: AL3601

Survey Event ID: FBQ711

Date Survey Completed: 3/2/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1970	Based on: interview, and record review the center failed to ensure a policy was in place to prevent misappropriation of funds for seven (#1 through#7) of seven sampled residents reviewed formisappropriation of personal funds.

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?	Policy will be in place for any resident that has delegated management of funds to prevent misappropriation of funds.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Seven residents that had delegated management of funds had the potential to be affected by deficient practice.
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?	Resident funds policy will be in place for residents that have delegated management of funds to prevent misappropriation of funds.
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.	Executive Director and/or Business Office Manager will be responsible for sustained compliance. Resident funds policy will be reviewed twice monthly to ensure effectiveness. Tracking and Trending will be reported and reviewed during the QA meeting. Monitoring records will be attached to the QA meeting minutes, and will be maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill** OAC 310:663-25-4(F)	**Date 3/25/2022**

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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OKLAHOMA
State Department
of Health

REPORT REVISED

Delivery via email to: JR.Gutierrez@TheRegencyOK.com;
Linda.Pearce@BridgesOK.com

July 15, 2022

CCN: 375508
Survey Event ID: N5G511

Mr. J.R. Gutierrez, Administrator
The Regency Skilled Nursing And Therapy
1610 North Bryan Avenue
Shawnee, OK 74804-4158

Dear Mr. Gutierrez:

On **June 28, 2022**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **July 5, 2022**.

The original 2567 report has been revised during administrative review of this case. A copy of the corrected 2567 report is included. Deficiencies identified during the investigation are not affected by these corrections and a new plan of correction is not required. The corrected 2567 report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.07.15 09:16:46 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375508	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REGENCY SKILLED NURSING AND THERAPY	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 07/14/22, after administrative review the 2567 was admended. A complaint investigation (#OK00059000) was conducted on 06/28/22. A List of abbrevations included are as follows: # - Number CNA - Certified Nurse aide DON - Director of Nursing FM - Family Member Res - Resident RN - Registerd Nurse	F 000		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to prevent neglect for two (#1 and #2) of three residents sampled for neglect.	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/13/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375508	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REGENCY SKILLED NURSING AND THERAPY	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1	F 600		

a. Resident #1 was left on a bedpan in their bed for multiple hours resulting in the resident feeling "neglected and embarrased."

b. Resident #2 was left naked, cold, uncovered, and crying in their bed for multiple hours.

The DON reported seven residents required assistance with activities of daily living.

Findings:

1. Res #1 was admitted with diagnoses which included a fracture of the left tibia, and kidney failure.

An initial assessment, dated 06/20/22, documented Res #1 was cognitively intact and required assistance with activities of daily living.

A care plan, dated 06/22/22, documented Res #1 required assistance of one staff member with toileting.

On 06/28/22 at 11:40 a.m., Res #1 reported, approximately one week ago, the staff had left them on the bed pan for two to three hours. Res #1 stated the staff reported they had gotten busy and forgotten about them. Res #1 stated they felt neglected and embarrassed at the time.

On 06/28/22 at 11:41 a.m., FM #1 reported Res #1 had informed them of the incident. FM #1 also reported they had informed the charge nurse.

On 06/28/22 at 1:35 p.m., CNA #3 reported staff should stay with a resident while on the bed pan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375508	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REGENCY SKILLED NURSING AND THERAPY	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

On 06/28/22 at 1:45 p.m., RN #1 reported if the resident was placed on the bed pan staff should have checked on them within a few minutes.

On 06/28/22 at 3:38 p.m., the DON reported being unaware of a resident being left on a bed pan.

2. Res #2 was admitted to the facility with diagnoses which included Cushing's disease and morbid obesity.

An initial assessment, dated 06/08/22, documented Res #2 was cognitively intact and required extensive assistance with activities of daily living.

A care plan, initiated on 06/09/22, read in parts...."personal hygiene....1 staff participation with personal hygiene...."

On 06/28/22 at 12:42 p.m., FM #2 reported the staff had left Res #2 naked and uncovered for two hours or so. FM #2 stated the staff were preparing to bathe Res #2, undressed the resident, left the room, and did not leave a call light in reach. FM #2 stated Res #2 was scared and screaming for staff to help them. FM #2 stated they had informed the administrator of the incident.

On 06/28/22 at 3:30 p.m., CNA #1 reported they were informed of the incident the next morning by CNA #2.

On 06/28/22 at 3:32 p.m., CNA #2 reported on the night of the occurrence, at the beginning of the shift, they observed Res #2 in bed, crying,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375508	A. BUILDING _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REGENCY SKILLED NURSING AND THERAPY	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 naked, and without any covering on them. CNA #2 reported Res #2 reported to them the staff were preparing to be give them a bed bath, left the room, and did not return. CNA #2 reported they had reported the occurrence to the charge nurse. On 06/28/22 at 3:40 p.m., the DON stated, "I am unaware of any resident being naked and crying". On 06/28/22 at 3:45 p.m., the administrator reported they were unaware of the occurrence.	F 600		

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
	NH630101	A. BUILDING: _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REGENCY SKILLED NURSING AND THERAPY	1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
LL000	Initial Comments A complaint investigation was conducted on 06/28/22 for complaint #OK00059000.	LL000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/13/22

OKLAHOMA
State Department of Health

Delivery via email to: executivedirector@renlivingpc.com

December 30, 2022

License Number: AL3601

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

RE: Survey Event FBQ712

Dear Ms. Chill:

On **December 29, 2022,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 2, 2022,** have now been corrected effective **April 15, 2022.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3601	A. BUILDING: _____ B. WING _____	R 12/29/2022

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 An offsite/paper revisit was conducted on 12/29/22. The facility was in substantial compliance.	{C 000}		

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