

Delivery via email to: tara.chill@renlivingpc.com

March 12, 2024

License Number: AL3601

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

RE: Survey Event ID: PW4311

Dear Ms. Chill:

On **February 23, 2024**, agents from our office concluded a State Licensure with Complaint inspection 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 23, 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

INVESTIGATIVE REPORT

Facility: The Renaissance of Ponca City
Address: 2616 Turner Road
City, State, Zip: Ponca City, OK 74604
Provider #: AL3601
Complaint #: OK00062132
Investigation Date(s): 02/21/24 through 02/23/24

ALLEGATION(S)

The center failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 02/21/2024 at 12:45 p.m.,

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

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 Summary of Complaint Investigation:

On entrance into the facility and throughout the survey observations were made of staff assisting residents in the facility. Medication pass was observed, and some medication was passed late, and some medication was not in the facility to administer.

Residents, families, and staff were interviewed. No complaints were voiced related to the care the residents were receiving. There were a few complaints about medications not administered on time.

Incident reports for falls, schedules, closed records, medication records, care plans, policies, and contracts were reviewed during the survey.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/26/2024

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure and complaint investigation (OK00062132) was completed on 02/21/24 through 02/23/24. Facility Census: 23 The following abbreviations may have been used in the writing of this report. BID - twice a day BP - blood pressure CAD - coronary artery disease CNA - certified nurse aide CMA - certified medication aide DHW - director of health and wellness DM - dietary manager ED - executive director HS - hour of sleep MAR - medication administration record Res - resident TID - three times a day	C 000			
C 391 SS=F	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 and interview, the facility failed to ensure food was stored, prepared, and served in a sanitary manner. The ED identified 23 residents resided in the facility.	C 391			

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 391	Continued From page 1 Findings: On 02/21/24 at 1:16 p.m., an initial tour of the kitchen was made and observed the trash can was dirty with what looked like spillage on the open lid. The DM put a liner in the large can they did not close the lid. Observed spillage in the bottom of the refrigerator red in color and sticky. A unsealed plastic bag of sliced cucumber was observed not labeled or dated in the refrigerator. A plastic bag of chicken not a seal-able and not dated and labeled in the bottom of the refrigerator. On 02/21/24 at 1:23 p.m., the DM stated they just started working at the facility. The DM stated items in the refrigerator should be labeled and dated. On 02/21/24 at 1:30 p.m., debris was observed in the bottom of a stand up freezer in the storage room. At that time the DM stated the freezer and refrigerator should be free of debris and spillage. On 02/21/24 at 1:41 p.m., the DM stated when they were using the trash can they leave the lid open in the kitchen and they were not finished clearing tables from the dining room. On 02/22/24 at 7:54 a.m., CNA #1 was observed serving drinks in the dining room. The CNA then went into the kitchen and did not wash their hands. A few minutes later, three staff members were observed to come from the kitchen with gloves on their hands. The staff did not remove their gloves and wash their hands when re-entering the kitchen. The trash can lid was observed to still be open on the large trash can. On 02/22/24 at 8:08 a.m., the activities personal	C 391		

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C 391	Continued From page 2 was in the kitchen with a hair net on which did not contain all of their hair, hair was hanging down on both sides of their face. The activities staff went in and out of the kitchen and did not wash their hands. The activities staff was observed to touch their hair, place their hands in their pockets, drink their coffee, and serve meals to the residents, go in and out of the kitchen with no hand washing observed. On 02/22/24 at 8:10 a.m., CNA #1 went into the kitchen, hand washing was not observed. CNA #1 opened the refrigerator and then took the drink cart to the dining room. On 02/22/24 at 11:00 a.m., the DM stated the staff should wash their hands when entering the kitchen. They stated the staff should also wear hair nets which contained all of the staffs hair. The DM stated they did see the staff touching their hair during breakfast service.	C 391			
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions	C 532			

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C 532	Continued From page 3 and prior medical history. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure comprehensive assessments were accurate for one (#6) of eight residents whose assessments were reviewed. The ED identified 23 resident resided in the facility. Findings: Res #6 had diagnoses which included hypothyroidism, anxiety disorder, and bipolar disorder. An annual assessment, dated 01/08/24, documented the resident was alert, forgetful, with good judgement. The assessment documented the resident was independent with dressing, toileting, and incontinent of bladder. On 02/21/24 at 2:29 a.m., observed a very strong smell of urine from the resident's room from the hall. A staff member left the room with a laundry basket at that time. On 02/21/24 at 2:35 p.m., the resident stated they just got a bath and had no issues.	C 532		

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C 532	Continued From page 4 On 02/22/24 at 7:42 a.m., the resident was observed to walk into the dining room in a shirt, a brief and slides on their feet. The resident did not have on any pants. Two staff members saw the resident and assisted the resident back to their room and at 7:46 a.m., the resident came back to the dining room with pants on. On 02/22/24 at 8:12 a.m., a resident who was eating breakfast in the dining room stated there are some residents who forget to put their clothes on and will come into the dining room. On 02/22/24 at 9:45 a.m., CNA #2 stated they lay the resident's clothes out for them in the morning but the resident had came to the dining room naked. The CNA stated the resident will not let the staff dress them at times. The CNA stated the resident can walk and toilet themselves but they would not do it most of the time. Res #6 wears briefs but will urinate sitting in their chair. On 02/22/23 at 10:14 a.m., the DHW stated they were not aware the resident was not making good judgments of coming out of their room not dressed. The DHW stated the assessment did not reflect that behavior. She stated she needed to do a change in condition for the resident. The DHW stated the resident could toilet themselves when they wanted. She stated the behavior of urination and not going to the toilet should be documented on the assessment. The DHW stated the assessment did not accurately reflect the resident's behavior. The DHW stated the resident should be assisted with dressing in the mornings.	C 532			
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT	C 543			

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C 543	Continued From page 5 (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain the signature of the resident or resident representative when completing the annual assessment for one (#6) of eight resident whose annual assessments were reviewed. The ED identified 23 resident resided in the facility. Findings: Res #6 had diagnoses which included hypothyroidism, anxiety disorder, and bipolar disorder. An annual assessment, dated 01/08/24, documented the resident was alert, forgetful, with good judgement. The assessment did not document the signature of the resident or resident's representative interview the time of the assessment. On 02/22/24 at 12:18 p.m., the ED stated the personal interview would be the signature of the resident or representative. The ED stated the resident nor a representative had signed the assessment for 01/08/24.	C 543		

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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. This REQUIREMENT is not met as evidenced	C1505		

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C1505	Continued From page 7 by: Based on observation, record review, and interview, the facility failed to develop and implement fall prevention interventions for one (#1) of two residents reviewed for falls The ED identified six resident resided in the facility who had fallen in the last 60 days. Findings: A fall "Response Procedure Policy", dated 12/12/22, read in part "...the service plan is updated as needed with interventions...if a resident is falling frequently, the Director of Health and Wellness may need to request 1:1 care if the resident is not responding to interventions. If falls continue, relocation may be necessary..." Res #1 had diagnoses which included dementia, weakness, and repeated falls. A service agreement/care plan, effective date 12/29/23, documented the resident was a fall risk with an effective date of 08/07/18. The agreement documented staff to monitor the resident regularly each shift. The resident was to be using a wheelchair until cleared by physical therapy and the physician, days scheduled on service plan do not reflect the exact day service is provided, proved frequent checks and reminders to have staff help with transfers. Ensure residents were in the middle of bed at bedtime to prevent rolling out of bed. Aide to make sure items needed were at reach for resident in recliner. Resident to be up for meals in dining area. Staff to offer toileting frequently. Offer activity to resident occasionally.	C1505			

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C1505	Continued From page 8 Res #1 had 16 falls from 12/02/23 to 02/20/24 with the incident reports documenting seven different interventions the other nine incident reports did not contain new interventions for falls. On 02/22/24 at 9:450 a.m., CNA #2 stated the staff make every two hour rounds to check on the residents in the facility. The CNA stated for resident #1 they check on them more frequently every one hour when they can. On 02/22/24 at 10:57 a.m., Res #1 was in their room in a wheelchair in front of th television a sling was observed under the resident and a lift in the room. The resident was not interviewable at that time. The bed was observed in low position did not see a fall mat by the bed. The resident did not have on any shoes or socks. On 02/22/24 at 11:10 a.m., the ED stated the resident had an increase of falls after they went on hospice. They thought it may have been the bed going from a larger bed to a hospital bed. On 02/23/24 at 11:54 a.m., the DHW stated the facility had enough staff to care for th residents. The staff check on Res #1 often because they are a high fall risk.	C1505		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order	C1921		

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C1921	Continued From page 9 This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure medication were administered as ordered for two (#1 and #9) of six residents whose's medication were observed during medication pass. The ED identified 23 resident resided in the facility. Findings: A policy, Medication Administration, dated February 2019, read in part, "...If medication is ordered BID or TID, there may be multiple medication cards for that medication. Verify the medication card includes the proper sticker for the med pass being completed. For example: If you're passing the 8am dose, the med card should have a sticker on it that states 8AM or AM Dose..." 1. Res #1 had diagnoses which included dementia, weakness, and repeated falls. A service agreement/care plan, effective date 12/29/23, read in part, "...staff to administer oral medication twice each day and any as needed medications...The agreement documented staff to re-order all medications twice per week through daughter who brings to facility. Above days may vary from what's on service agreement. The agreement documented staff may crush medications as needed if the resident is having difficulty swallowing whole...Administer medication within 60 minutes on each side of ordered time, except for medication to be administered immediately or other time-sensitive medications...Medications ordered in the AM will	C1921		

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C1921	Continued From page 10 be administered between the hours of 6am-11am. Medications ordered PM or afternoon will be administered between the hours of 4pm-7pm. HS medications will be administered between the hours of 7pm-11pm..." On 02/23/24 at 10:14 a.m., during medication pass observation, Res #1 was administered tramadol, lorazepam, clindamycin, meloxicam, ropinirole, fluoxetine, gabapentin, lisinopril, mucus relief, and fluticasone. The residents loratadine was not administered related to not having the ordered dose available. A BP was not observed taken before medication was administered. The February 2024 MAR documented tramadol, lorazepam, clindamycin, meloxicam, and ropinirole were to be administered at 8:00 a.m. The MAR documented the Mucinex was not available for administration seven times, the loratadine was not available for one administration, and the lorazepam and clindamycin for one administration. The MAR documented the resident BP was 136/72 on 02/23/24. 02/23/24 at 9:55 a.m., CMA #3 stated the resident's loratadine was a different dose and medication and they did not give it. The CMA contacted the DHW and informed them of the discrepancy. On 02/23/24 at 11:35 a.m., CMA #2 stated when there was a time documented, not just AM, the medication should be administered an hour before or after the time documented. They stated they have been having problems getting medication from the pharmacy because they had changed because of a pharmacy closing.	C1921			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL3601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/23/2024
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF PONCA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1921	Continued From page 11 On 02/23/24 at 12:20 p.m., CMA #3 stated they did not take Res #1 blood pressure before administering the lisinopril, they said they got the BP after administering the medication. 2. Res # 9 had diagnoses CAD, memory loss, and indigestion. On 02/23/24 at 9:32 a.m., medication administration for Res #9 was observed. The medications which were administered were aspirin, atenolol, COQ 10, ezetimibe, fluoxetine, glucosamine/chond, multivitamin, Myrbetriq, oxybutynin, Previgen, vitamin C and vitamin D. The February 2024 MAR documented the omeprazole was to be administered at 6:00 a.m., daily. The documentation showed seven days the medication was not administered due to the medication was not available. The memantine was not observed given during medication pass but was documented complete. The DHW stated the medication was administered at 11:09 a.m., and it was scheduled to be administered at 8:00 a.m., the DHW stated the medication was administered late. On 02/23/24 at 11:57, the ED stated the process for ordering medications was not working. On 02/23/24 at 11:46 a.m., the DHW stated they really did not know why the facility was running out of the resident medication. They stated the medication should be given an hour before or after a scheduled medication time.	C1921		

Delivery via email to: tara.chill@renlivingpc.com

April 1, 2024

License Number: AL3601

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

RE: Survey Event PW4311

Dear Ms. Chill:

On **February 23, 2024**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- The correction date is greater than 60 days from the date the notification was sent to the facility.

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

Respectfully,

Clorissa Nubine

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

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: 3/25/2024

Facility Name: The Renaissance of Ponca City

License Number: AL3601

Survey Event ID: PW4311

Date Survey Completed: 2/23/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation and interview, the center failed to ensure food was stored, prepared, and served in a sanitary manner.

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

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

Include:

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Staff in-serviced on Chapter 257 regulations, including hand-washing and hair restraint policy.

Residents residing in community have the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

- Audit will be performed daily x2 weeks, and randomly afterwards to ensure refrigerator is clean and sanitary, and that food items are stored, prepared, and served in a sanitary measure.
- Trash can will be replaced with lid that automatically shuts after being used, and will be kept clean.
- Food will be stored, prepared, and served in a sanitary measure. DCS, ED, and/or designee will audit randomly.
- Staff will be monitored frequently to ensure that hands are washed every time they enter the kitchen.

Director of Culinary Services and/or ED will be responsible for sustained compliance.

ED and/or designee will maintain monitoring records.

Tracking and trending will be reported and reviewed during QA Meeting.

Monitoring records will be in POC Binder and maintained by Executive Director to maintain compliance.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/14/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 3/25/2024	
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: 3/25/2024	
	Facility Name: The Renaissance of Ponca City	
	License Number: AL3601	
	Survey Event ID: PW4311	
Date Survey Completed: 2/23/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C532	Based on: observation, record review, and interview the facility failed to ensure comprehensive assessments were accurate for one (#6) of eight residents whose assessments were reviewed.	
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?		Comprehensive assessment for resident #6 will be updated to accurately reflect resident's needs.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Resident's comprehensive assessments will be audited to ensure resident's needs are accurately reflected. To date, no resident has experienced a negative outcome pertaining to the listed findings.
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?		Nurse and ED reviewed required information requirements for comprehensive assessments. ED and/or DHW will audit three comprehensive assessments weekly x2 weeks then quarterly thereafter to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED, nurse, and/or designee will be responsible for sustained compliance.
a. How the correction will be evaluated for effectiveness;		ED and/or designee will maintain monitoring records.
b. How the correction will be incorporated into the center's quality assurance system; and		Tracking and trending will be reported and reviewed during quarterly QA meeting.
c. How monitoring records will be kept to evidence the correction.		Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		5/14/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Tara R. Chill		Date 3/25/2024
OAC 310:663-25-4(F)		

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

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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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: 3/25/2024	
	Facility Name: The Renaissance of Ponca City	
	License Number: AL3601	
	Survey Event ID: PW4311	
Date Survey Completed: 2/23/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C543	Based on: observation, record review, and interview the facility failed to obtain the signature of the resident or resident representative when completing the annual assessment for one (#6) of eight resident whose annual assessments were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
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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?	Meeting will be scheduled with resident #6s representative to review the resident's assessment and to obtain resident representative's signature and/or verbal signature will be obtained/documented.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident's comprehensive assessments will be audited to ensure compliance with signautres of the resident/representative. To date, no resident has experienced a negative outcome pertaining to the listed findings.	
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?	Review of Comprehensive Assessment requirements completed with DHW to ensure signatures of residents or resident's representatives are obtained to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; 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.	Completed Comprehensive assessments will be reviewed weekly by ED & DHW to ensure signatures have been obtained. Completed by DHW and/or ED. Tracking and trending will be reported and reviewed during quarterly QA meeting. Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	5/14/2024	

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)			Date 3/25/2024
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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: 3/25/2024	
	Facility Name: The Renaissance of Ponca City	
	License Number: AL3601	
	Survey Event ID: PW4311	
Date Survey Completed: 02/23/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on observation, record review, and interview, the facility failed to develop and implement fall prevention interventions for one (#1) of two sampled residents.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
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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?		Fall prevention measures will be reviewed and documented to date. Nurse in-serviced on "Fall Response Procedure policy". Fall prevention measures will be updated as needed with interventions.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Six residents residing in the facility had potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.
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?		ED, Nurse, and/or designee will audit incident report to ensure implementation of fall prevention measures. Audit will occur 3x weekly for one month, then weekly thereafter.
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.		ED, nurse, and/or designee will be responsible for sustained compliance. ED and/or designee will maintain monitoring records. Tracking and trending will be reported and reviewed during quarterly QA meeting. Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.
OSDH Response: Element accepted Yes ☐ No ☐		

5. On what date will corrective action be completed?		05/14/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date: 3/25/24	
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Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/25/2024

Facility Name: The Renaissance of Ponca City

License Number: AL3601

Survey Event ID: PW4311

Date Survey Completed: 2/23/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1921

Based on: observation, record review, and interview the facility failed to ensure medication were administered as ordered for two (#1 and #9) of six residents whose medication were observed during medication pass.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Medication refill request will be submitted to pharmacy timely, obtained, and administered according to physician orders. Nurse in-serviced on importance of medication cart audits and medication refill policy. Med Techs also in-serviced on importance of medication administration and refill policy.

OSDH Response: Element accepted Yes ☐ No ☐

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

Residents residing in community have the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

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?

ED, nurse, and/or designee will audit medication pass and medication carts twice weekly x1 month then, once weekly x1 month, and monthly thereafter, to ensure medications are being administered, ordered and received timely to sustain compliance.

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and

ED, nurse, and/or designee will be responsible for sustained compliance.

ED and/or designee will maintain monitoring records.

Tracking and trending will be reported and reviewed during quarterly QA meeting.

c. How monitoring records will be kept to evidence the correction.		Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/14/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 3/25/2024	
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Facility in Compliance by: Click here to enter a date.			

Delivery via email to: tara.chill@renlivingpc.com

April 19, 2024

License Number: AL3601

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

Survey Event ID: PW4311

Dear Ms. Chill:

On **February 23, 2024**, a Relicensure survey with a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **May 14, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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: 3/25/2024

Facility Name: The Renaissance of Ponca City

License Number: AL3601

Survey Event ID: PW4311

Date Survey Completed: 2/23/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation and interview, the center failed to ensure food was stored, prepared, and served in a sanitary manner.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

Include:

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Staff in-serviced on Chapter 257 regulations, including hand-washing and hair restraint policy.

Residents residing in community have the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

- Audit will be performed daily x2 weeks, and randomly afterwards to ensure refrigerator is clean and sanitary, and that food items are stored, prepared, and served in a sanitary measure.
- Trash can will be kept clean and lid will stay closed when not in use.
- Food will be stored, prepared, and served in a sanitary measure. DCS, ED, and/or designee will audit randomly.
- Staff will be monitored frequently to ensure that hands are washed every time they enter the kitchen.

Director of Culinary Services and/or ED will be responsible for sustained compliance.

ED and/or designee will maintain monitoring records.

Tracking and trending will be reported and reviewed during QA Meeting.

Monitoring records will be in POC Binder and maintained by Executive Director to maintain compliance.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/9/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 3/25/2024	
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	License Number: AL3601	
	Survey Event ID: PW4311	
Date Survey Completed: 2/23/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C532	Based on: observation, record review, and interview the facility failed to ensure comprehensive assessments were accurate for one (#6) of eight residents whose assessments were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
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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?		Comprehensive assessment for resident #6 will be updated to accurately reflect resident's needs.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Resident's comprehensive assessments will be audited to ensure resident's needs are accurately reflected. To date, no resident has experienced a negative outcome pertaining to the listed findings.
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?		Nurse and ED reviewed required information requirements for comprehensive assessments. ED and/or DHW will audit three comprehensive assessments weekly x2 weeks then quarterly thereafter to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED, nurse, and/or designee will be responsible for sustained compliance.
a. How the correction will be evaluated for effectiveness;		ED and/or designee will maintain monitoring records.
b. How the correction will be incorporated into the center's quality assurance system; and		Tracking and trending will be reported and reviewed during quarterly QA meeting.
c. How monitoring records will be kept to evidence the correction.		Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		5/9/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Tara R. Chill		Date 3/25/2024
OAC 310:663-25-4(F)		

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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?	Meeting will be scheduled with resident #6s representative to review the resident's assessment and to obtain resident representative's signature and/or verbal signature will be obtained/documented.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident's comprehensive assessments will be audited to ensure compliance with signautres of the resident/representative. To date, no resident has experienced a negative outcome pertaining to the listed findings.	
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?	Review of Comprehensive Assessment requirements completed with DHW to ensure signatures of residents or resident's representatives are obtained to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; 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.	Completed Comprehensive assessments will be reviewed weekly by ED & DHW to ensure signatures have been obtained. Completed by DHW and/or ED. Tracking and trending will be reported and reviewed during quarterly QA meeting. Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	5/9/2024	

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)			Date 3/25/2024
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: 3/25/2024	
	Facility Name: The Renaissance of Ponca City	
	License Number: AL3601	
	Survey Event ID: PW4311	
Date Survey Completed: 02/23/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on observation, record review, and interview, the facility failed to develop and implement fall prevention interventions for one (#1) of two sampled residents.	
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?		Fall prevention measures will be reviewed and documented to date. Nurse in-serviced on "Fall Response Procedure policy". Fall prevention measures will be updated as needed with interventions.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Six residents residing in the facility had potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.
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?		ED, Nurse, and/or designee will audit incident report to ensure implementation of fall prevention measures. Audit will occur 3x weekly for one month, then weekly thereafter.
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.		ED, nurse, and/or designee will be responsible for sustained compliance. ED and/or designee will maintain monitoring records. Tracking and trending will be reported and reviewed during quarterly QA meeting. Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.
OSDH Response: Element accepted Yes ☐ No ☐		

5. On what date will corrective action be completed?		05/09/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date: 3/25/24	
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
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/25/2024

Facility Name: The Renaissance of Ponca City

License Number: AL3601

Survey Event ID: PW4311

Date Survey Completed: 2/23/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1921

Based on: observation, record review, and interview the facility failed to ensure medication were administered as ordered for two (#1 and #9) of six residents whose medication were observed during medication pass.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Medication refill request will be submitted to pharmacy timely, obtained, and administered according to physician orders. Nurse in-serviced on importance of medication cart audits and medication refill policy. Med Techs also in-serviced on importance of medication administration and refill policy.

OSDH Response: Element accepted Yes ☐ No ☐

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

Residents residing in community have the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

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?

ED, nurse, and/or designee will audit medication pass and medication carts twice weekly x1 month then, once weekly x1 month, and monthly thereafter, to ensure medications are being administered, ordered and received timely to sustain compliance.

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and

ED, nurse, and/or designee will be responsible for sustained compliance.

ED and/or designee will maintain monitoring records.

Tracking and trending will be reported and reviewed during quarterly QA meeting.

c. How monitoring records will be kept to evidence the correction.		Monitoring records will be placed in POC binder and maintained by Executive Director to maintain compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/9/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 3/25/2024	
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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Facility in Compliance by: Click here to enter a date.			

Delivery via email to: tara.chill@renlivingpc.com

May 13, 2024

License Number: AL3601
Survey Event ID: PW4312

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

Dear Ms. Chill:

On **May 9, 2024**, a Relicensure revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **February 23, 2024**, have now been corrected and your facility is in compliance with licensure standards effective **May 14, 2024**.

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

Respectfully,

Clorissa Nubine

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

Enclosure