OKLAHOMA
State Department
of Health

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

December 5, 2025

License Number: AL3601

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

RE: Survey Event ID: F5HM11

Dear Ms. Chill:

On **October 29, 2025**, agents from our office concluded a State Licensure survey 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 **October 29, 2025**.

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: IDRCoordinator@health.ok.gov

Or mail 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,

Tempal Killman

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

Enclosure

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: **The Renaissance of Ponca City**
Address: **2616 Turner Road**
City, State, Zip: **Ponca City, Ok. 74604**
Provider #: **AL3601**
Complaint #: **OK000**
Investigation Date: **10/27/25 through 10/29/25**

ALLEGATION(S)
1.The center failed to have and/or implement an effective pest control program.

An unannounced on-site investigation was initiated 10/27/2025 at 9:00 a.m.

A sample of eight participants, including any identified participants, 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: A tour of the facility was conducted upon entrance into the center. Residents were observed for environmental concerns, personal care concerns, staffing concerns, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and pest control record. Residents and staff were asked questions safety and abuse and neglect.

The attached State form, Statement of Deficiencies, 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: 10/29/2025

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ALLEGATION(S)
1.The center failed to have adequate staffing to meet residents' needs
2. The center failed to ensure residents are treated with dignity and respect.
3. The center failed to follow infection control policies and procedures.
4. The center failed to ensure care and services were provided as per physicians' orders and plan of care.
5. The center failed to ensure dependent residents received assistance with ADLS.
6. The center failed to ensure residents required level of care was appropriate for assisted living centers.
7. The center failed to provide adequate supervision to prevent residents from violating the privacy of other residents.

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	AL3601	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 000	INITIAL COMMENTS A relicensure survey with complaint (#OK00078453, OK00078475, and #OK00086956) was conducted from 10/27/25 through 10/29/25. Deficiencies were cited as a result of the survey. Facility Census: 31 Listed below are abbreviations that will be used throughout this document. ED - executive director DON - director of nursing CNA - certified nursing assistant CMA - certified medication aide	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 kitchen staff utilized beard covers for 3 of 3 observations. The ED identified 31 residents received nutrition from the kitchen. Findings: On 10/27/25 at 9:05 a.m., cook #1 was observed	C 391		

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C 391	Continued From page 1 to have a short beard. They were observed cleaning up after breakfast and did not have a beard cover. On 10/27/25 at 12:05 p.m., cook #1 was observed in the kitchen serving lunch without a beard cover. On 10/28/25 at 9:25 a.m., cook #1 was observed in the kitchen without a beard cover. A facility policy titled "Management and Personnel Hair Restraint," dated 03/2023, read in part, "Employees shall effectively restrain their hair in all food production areas in order to effectively keep hair from contacting exposed food; clean equipment, utensils and linens and unwrapped single-service - use articles while they are working." On 10/27/25 at 12:05 p.m., cook #1 stated, "I don't have a hair net, because I am bald. I don't need one for my beard, it is short. If I have to wear a beard net, I will just shave it." On 10/28/25 at 9:27 a.m., the dietary manager stated, "All staff are to wear a hair or beard nets in the kitchen."	C 391		
C 910 SS=F	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing	C 910		

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C 910	Continued From page 2 shall be provided or arranged: This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to provide sufficient staff to meet the services in the assisted living center's contract for resident care needs and evacuation for 5 residents identified as not capable of responding to emergency situations without physical assistance from staff. The ED identified 31 residents resided in the facility. On 10/28/25 at 8:02 a.m., two different seating areas for dining services were observed with a total of twelve residents in both areas. There were two residents who received assistance from family members with their meal, one staff member was present in the dining areas going back and forth between both sides serving plates	C 910		

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C 910	Continued From page 3	C 910		

and drinks. Three residents were observed to be in wheelchairs and four had rolling walkers.

A "Resident Rental Agreement," signed 12/06/23, read in part, "Supervision and assistance shall be for the safety of and assistance to all residents during any emergency, including evacuation."

The "Assisted Living Resident Sample," dated 10/27/25, identified five residents that were chairfast.

An "Assisted Living Resident Condition and Care Overview," completed 10/27/25, showed 10 residents with dementia and five residents not capable of responding to emergency situations without physical assistance from staff of the facility or were not capable of self-preservation.

A "Resident Care and Information" form, dated 10/27/25, showed four residents needed special assistance with evacuation (wheelchair bound, bed bound, limited mobility).

On 10/28/25 at 3:00 p.m., a review of the pendant call history (the call light system for residents), dated 10/06/25 through 10/27/25, showed 61 out of 249 call light responses were answered over 20 minutes after activation.

On 10/29/25 at 2:30 p.m. the ED stated they did not have an evacuation policy they could locate.

On 10/29/25 at 3:30 p.m., a review of staff schedules for October 2025 showed two clinical staff members scheduled for each day shift, evening shift and night shift. There were partial clinical staff member shifts scheduled for day and evening shifts for the month of October.

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C 910	Continued From page 4 On 10/28/25 at 9:05 a.m., Resident #10 was asked about staffing and call light response. The resident stated they pushed their pendant and sometimes no one even came. They stated they were not sure why they never respond, but felt like it was due to not having many staff present, and some residents needed a lot of help. On 10/29/25 at 1:01 p.m. family member #1 was asked about the care their family member received. They stated their family member received good care. Most of the time call lights were answered when needed. Family Member #1 stated the response time varied, but they had audio and video in their room. The staff responded to them calling out for help better than they did when they used the pendant system. Family Member #1 stated the staff watched and listened to the monitors at the nurses' desk to know when the resident needed something. On 10/29/25 at 1:15 p.m., Resident #11 was asked about staffing and the care they received. Resident #11 stated they did not use their pendant very often as it took too long for someone to answer it, if it ever responded to. Resident #11 stated they had a fall and pushed the pendant and another resident looked for staff. Resident #11 stated they were unable to locate anyone to assist. They stated the other resident helped them up and a staff member finally came in after 30 minutes or so. Resident #11 stated they felt like they had good staff, just not enough in the evenings and on weekends. Resident #11 stated the staff that were at the facility were always working with other residents. On 10/28/25 at 2:41 p.m., the DON was asked about the clinical schedule and assignments. They stated the staff assigned were responsible	C 910		

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C 910	Continued From page 5 for all resident care needs, medication administration, and laundry services. The DON stated the staff also ensured all residents were in the dining room for meals, or they get meals delivered to their rooms. The DON was asked how many residents required assistance for mobilization. They stated there were four residents that required two persons to get them up into wheelchairs, then the residents could mobilize where they needed. The DON stated there were a couple of ambulatory residents that required direction and assistance. On 10/28/25 at 3:14 p.m., CNA #4 was asked about staffing on their shift. They stated it was much better now that there had been another person added to the evening shift, even if it was only for a few hours during dinner. CNA #4 was asked if they were able to get tasks completed. CNA #4 stated they often have laundry left at end of shift on days that hospice changed bed linens for residents, but they passed it to the next shift to get caught up. CNA #4 was asked about call light response times. CNA #4 stated they did not feel like they were able to answer call lights timely as they system did not work right and they had to stare at the monitors at the desk. CNA #4 stated they had several incontinent residents they checked on every two hours with one that took 20-30 minutes to get cleaned, dressed and up for the day, as well as three that required two person assist with transfers.	C 910		
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	C1505		

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C1505	Continued From page 6 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 by: Based on observation, record review, and interview, the center failed to provide residents with privacy and confidentiality for 5 residents with camera and audio receiving monitors in the	C1505		

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C1505	Continued From page 7	C1505		

facility.

The ED identified 31 residents resided in the facility.

On 10/29/25 at 11:39 a.m., audio monitoring receiving devices were observed at the nurses' station near the walkway by the front door. Voices were heard from the monitors when standing near the nurses' station. Camera system receiving monitors were observed on the East side of the nurses' station in a secure area that was not visible to anyone who was not behind the nurses' station. Signage related to video monitoring in the facility was observed on the front door. The following rooms were identified by staff as having cameras or audio monitoring devices that they monitor. The rooms identified did not have any signage or notification of monitors or cameras in place on or near the resident's door:

a. room 101
b. room 103
c. room 106
d. room 201
e. room 404

An "Electronic Communication and Monitoring Devices" policy, dated 06/20/25 read in part, "Notice will also be placed on the resident's door."

On 10/28/25 at 1:09 p.m., CNA #3 was asked about the monitoring of residents. They stated there were four residents that had audio or video cameras in their rooms and the receivers were at the desk.

On 10/28/25 at 3:25 p.m., CNA #2 was asked about the call systems and resident checks. CNA #2 stated the call pendants did not work all the

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C1505	Continued From page 8 time and were hard to get turned off. They stated there were several residents that had audible surveillance that was in the facility and the receivers were at the nurses station. CNA #2 stated they listened for residents that may have issues or needed something when they were near the desk. On 10/29/25 at 2:20 p.m., the DON was asked about audio from resident rooms being overheard at the nurses station. The DON stated they did not believe anyone would know where the voices or conversations were coming from as far as specific residents. The DON was asked about conversations that may have names identified in them. The DON stated, "Yes, I suppose that could happen." The DON was asked about signage being posted on or near resident doors per policy. The DON stated, "I was not aware that the policy stated they needed signage."	C1505		