OKLAHOMA
State Department
of Health

Delivery via email to: wd@stonecreek-al.com

July 13, 2023

License Number: AL5548

Ms. Kimberly Saggese, Administrator
Stonecreek Assisted Living And Memory Care
17701 North Western Avenue
Edmond, OK 73012

RE: Survey Event ID: 9G9H11

Dear Ms. Saggese:

On **June 15, 2023**, agents from our office concluded a State Licensure survey with 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 June 15, 2023.

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: STONECREEK ASSISTED LIVING AND MEMORY CARE
Address: 17701 NORTH WESTERN AVENUE
City, State, Zip: EDMOND, OK, 73012
Provider #: AL5548
Complaint #: OK00058861
Investigation Date(s): 06/13/23-06/15/23

ALLEGATION(S)
The facility failed to ensure the residents were free from abuse.
The center failed to promote the care for the residents in a manner that maintains the resident's dignity and self-esteem.
The center failed to ensure the physician's orders were followed.
The center failed to protect the residents from misappropriation of property.
The center failed to promote care for the residents in a manner that enhances each resident's dignity and their individuality.
The center failed to provide an ongoing program of activities designed to meet the psychosocial well-being of each resident

An unannounced on-site investigation was initiated 06/13/2023 at 11:03 a.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:

A tour of the facility was conducted upon entrance and at other times throughout the survey. Resident halls, bedrooms, showers, bathrooms, and activities' areas were observed. The kitchen and dining rooms were observed. Medication administration, various staff members and residents were also observed.

Residents were interviewed regarding staff treating them with dignity and respect, care provided by staff, loss of personal items, and scheduled activities. Staff members were interviewed relating to facility policies and procedures on dignity and respect for residents, giving medications as ordered, residents' lost items, and provision of care and activities to residents.

Residents' records reviewed included assessments, physician's orders, care plans, care provided sheets, hospice and home health records, and progress notes. Facility policies and procedures were also reviewed.

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: 06/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5548	A. BUILDING: _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMORY CAR	17701 NORTH WESTERN AVENUE EDMOND, OK 73012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/13/23 through 06/15/23. A complaint investigation (#OK00058861) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: AWD - Assistant Wellness Director CMA - Certified Medication Aide etc - and so on F - Fahrenheit Feb - February MAR - Medication Administration Record mg - milligram prep - preparation tab - tablet WD - Wellness Director	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure dietary staff wore hair nets to prevent contamination of foods for two (Cook #2 and Dietary Aide #1) of three dietary staff observed during the lunch meal preparation. The "Resident List," received 06/13/23, documented 82 residents resided in the facility. The WD identified all residents received services from the kitchen.	C 391		

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(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 391	Continued From page 1 Findings: An "Employee Hygiene" policy, undated, read in part, "...Exposed hair must be covered with hairnet, hat..." On 06/13/23 at 12:40 p.m., Cook #2 and Dietary Aide #1 were observed preparing and plating food. They were not wearing hairnets. On 06/13/23 at 2:00 p.m., Dietary Aide #1 stated they were never told they needed to wear a hair covering. On 06/13/23 at 2:19 p.m., Cook #2 stated they were never told they needed to wear a hairnet. On 06/15/23 at 9:28 a.m., the Dietary Manager was asked what the policy was for hairnets in the kitchen. They stated staff were required to wear hairnets. The Dietary Manager was informed of observations made on the initial kitchen tour.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours.	C 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5548	A. BUILDING: _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMORY CAR	17701 NORTH WESTERN AVENUE EDMOND, OK 73012

(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 393	Continued From page 2 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to: a. have food items in the refrigerator and in the dry storage area labeled and dated, b. ensure leftovers of potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous foods were disposed of in 48 hours, and c. ensure food items stored in the refrigerator and in the dry storage area were maintained at proper manufacturer recommended temperatures. The "Resident List", received 06/13/23, documented 82 residents resided in the facility. The WD acknowledged all residents received services from the kitchen. Findings: A "Storage of Refrigerated and Dry Foods" policy, undated, read in parts, "...Food being returned to storage after cooking or preparation must be covered...All containers must be labeled with the contents and date food item was placed in storage...Previously cooked foods can be held in refrigeration of 41 degrees F or lower for up to 7 days and then must be discarded...All dry foods must be dated and stored in a temperature controlled environment ...There will be a rotation system for the storage of dry foods. New supplies are to be placed behind the old so that the old is used first..." On 06/13/23 at 12:40 p.m., an initial tour of the kitchen and food preparation area was	C 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5548	A. BUILDING: _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMORY CAR	17701 NORTH WESTERN AVENUE EDMOND, OK 73012

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C 393	Continued From page 3 conducted. The following was observed in the walk-in refrigerator: a. One half of a large uncovered, uncooked pepperoni pizza with no label or date, b. A plastic container ¾ full labeled Meat Sauce- prep date 05/29- use by 06/03, c. A plastic container ¾ full labeled Baked Beans- prep date 05/29- use by 06/03, d. A plastic container ½ full labeled Marinara dated 06/03, e. A small packaged, unfrozen, boneless ham with no label or date, f. A large opened bag of pepperonis with no label or date, g. A large opened bag of grilled chicken strips with no label or date, h. A large opened bag of rib patties with no label or date, i. Several unopened cases, labeled biscuit dough, french fries, and potato medley, sitting on the floor next to the door of the walk-in refrigerator. Each of the cases read, "...Keep Frozen. Store at 0 (+/-) -10 degrees F..." The following was observed in the dry storage area: a. Two ½ full bags of elbow pasta with no label or date opened, b. No items were labeled with the date they were received, c. A gallon jug of Malt Vinegar with small amount remaining, labeled 'Feb 2022- opened', d. A gallon jug of Barbecue Sauce with more than ½ remaining, labeled 'opened 06/09'. Manufacturer's label on the jug read in part, "...refrigerate after opening..." On 06/13/23 at 2:25 p.m., Cook #1 was asked	C 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 393	Continued From page 4 what the process/policy was for food storage in the walk-in refrigerator. They stated to label and date everything. Cook #1 was shown the observations made in the walk-in refrigerator. Cook #1 verified items were not dated or labeled. They acknowledged items past their 'use-by' date should have been disposed of and the cases of food sitting in the walk-in refrigerator had not been properly stored. On 06/13/23 at 2:59 p.m., Cook #2 was observed in the dry goods area removing newly delivered food items from cases and, without dating them, placing them on shelves in front of the items that were already there. Cook #2 was asked what the process/policy was for maintaining dry food storage. They stated they were new and they were just told to unpack the boxes. On 06/15/23 at 9:28 a.m., the Dietary Manager was informed of the observations made in the walk-in refrigerator, in the dry storage area, and of Cook #2. The Dietary Manager was asked if food items in the refrigerator were properly covered, labeled, and dated. They stated, "No." The Dietary Manager was asked if food items in the dry storage area had been dated and rotated. They stated, "No." The Dietary Manager was asked if leftovers of potentially hazardous and non-hazardous foods had been disposed of properly. They stated, "No." The Dietary Manager was asked if food items stored in the refrigerator and in the dry storage area had been maintained at their proper recommended temperatures. The Dietary Manager stated, "No."	C 393		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION	C1921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5548	A. BUILDING: _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMORY CAR	17701 NORTH WESTERN AVENUE EDMOND, OK 73012

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C1921	Continued From page 5 (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were not administered after they were discontinued for one (#13) of ten sampled residents observed during medication pass. The "Resident List," received 06/13/23, documented 82 residents resided in the facility. Findings: A "Medication Administration" policy, undated, read in part, "...Designated Staff will follow a consistent workflow to ensure medication orders and medication administration records (MAR) are up to date..." Resident #13 had diagnoses which included dementia with behavior disturbance. A physician's order for Res #13, dated 06/06/23, read in part, "...Discontinue Celexa..." An MAR for Res #13, dated June 2023, documented Celexa was administered 'Upon Rising' on 06/14/23. On 06/14/23 at 9:50 a.m., CMA #2 was observed to administer Celexa 20 mg tab to Res #13 during medication pass.	C1921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1921	Continued From page 6 On 06/15/23 at 10:05 a.m., CMA #2 acknowledged that Celexa had been discontinued for Res #13 earlier this month. CMA #2 stated they gave the Celexa in error because it was on the paper MAR they used to administer medications today while the Internet was down. On 06/15/23 at 10:16 a.m., the AWD was asked what the facility procedure was for CMA's administering medications when the electronic MAR could not be accessed. The AWD explained paper MAR's were printed at the beginning of each month and kept updated by the WD or AWD for use by the CMA when the Internet was down. The AWD was asked if Res #13's paper MAR had been updated with the order to discontinue Celexa on 06/06/23. They stated no and acknowledged a medication error had been made.	C1921		

OKLAHOMA
State Department
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Delivery via email to: ed@stonecreek-al.com

July 21, 2023

License Number: AL5548

Ms. Kimberly Saggese, Administrator
Stonecreek Assisted Living And Memory Care
17701 North Western Avenue
Edmond, OK 73012

Survey Event ID: 9G9H11

Dear Ms. Saggese:

On **June 15, 2023,** a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **June 16, 2023**.

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

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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: 7/22/2013** **Facility Name:** StoneCreek Assisted Living and Memory Care **License Number:** AL5548 **Survey Event ID:** 9G9H11 **Date Survey Completed: 6/15/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: Observation, record review, and interview, the facility failed to ensure dietary staff wore hair nets to prevent contamination of food for two (cook #2 and dietary aid #1) of three dietary staff observed during the lunch meal preparation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	All dietary staff were educated on 6/15/23 regarding hairnets to prevent contamination of food during meal preparation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents have the potential to be affected.
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?	The Dietary Manager is monitoring that all dietary staff are wearing hairnets during meal preparation.
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.	Plan: Weekly review of the daily monitoring with Dietary Manager and ED began the week of 6/19/23 Monitoring logs to be reviewed weekly and submitted to the QA committee A log was created for monitoring and will provide evidence by the Dietary Manager
OSDH Response: Element accepted Yes ☐ No ☒	
5. On what date will corrective action be completed?	6/16/2023
OSDH Response: Element accepted Yes ☒ No ☒	

Administrator's Signature **Kimberly Saggese** OAC 310:663-25-4(F)	**Date 7/17/2023**

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
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/22/2013
Facility Name: StoneCreek Assisted Living and Memory Care
License Number: AL5548
Survey Event ID: 9G9H11
Date Survey Completed: 6/15/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C393	Based on: observation and interview, the facility failed to: a. have food items in the refrigerator and in the dry storage area labeled and dated, b. ensure leftovers of potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous foods were disposd of in 48 hours, and c. ensure food items stored in the refrigerator and in the dry storage area were maintained at proper manufacturer recommended temperatures.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	All dietary staff were educated on 6/15/23 regarding labeling and dating, disposal of foods, and food item storage.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents have the potential to be affected.
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?	The entire cold and dry storage spaces were corrected on 6/14/23 and Dietary Manager monitoring was implemented to ensure that food are labeled, disposed of timely, and stored appropriately.
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.	Enter methods to ensure corrections are sustained: Weekly review of the daily monitoring with Dietary Manager and ED began the week of 6/19/23 Monitoring logs to be reviewed weekly and submitted to the QA committee A log was created for monitoring and will provide evidence by the Dietary Manager
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/16/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kimberly Saggese** **Date 7/17/2023**
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.

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
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Protective Health Services
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/22/2013
Facility Name: StoneCreek Assisted Living and Memory Care
License Number: AL5548
Survey Event ID: 9G9H11
Date Survey Completed: 6/15/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1921	Based on: observation, record review, and interview, the facility failed to ensure medications were not administered after they were discontinued.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Wellness management were educated on 6/15/23 regarding discontinue medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents who receive medication administration have the potential to be affected.
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?	A new MAR was printed on 6/15/23 that reflected all changes in medications including discontinued medications. A weekly review of the backup MAR will occur by Wellness management.
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.	Enter methods to ensure corrections are sustained: Weekly review of the MAR and new or discontinued orders began the week of 6/19/23 Monitoring logs to be reviewed weekly and submitted to the QA committee A log was created for monitoring evidence
OSDH Response: Element accepted Yes ☒ No ☐	
5. On what date will corrective action be completed?	6/16/2023
OSDH Response: Element accepted Yes ☒ No ☐	

Administrator's Signature **Kimberly Saggese** **Date 7/17/2023**
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.

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: ed@stonecreek-al.com

August 25, 2023

License Number: AL5548

Ms. Kimberly Saggese, Administrator
Stonecreek Assisted Living And Memory Care
17701 North Western Avenue
Edmond, OK 73012

RE: Survey Event 9G9H12

Dear Ms. Saggese:

On **August 24, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 15, 2023,** have now been corrected effective **June 16, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5548	A. BUILDING: _____ B. WING _____	R-C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMORY CAR	17701 NORTH WESTERN AVENUE EDMOND, OK 73012

(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 08/22/23 and 08/24/23. 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