OKLAHOMA
State Department
of Health

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

January 5, 2024

License Number: AL5548

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

Survey Event ID: 779311

Dear Ms. Saggese:

On **November 20, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
(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 a 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Stonecreek Assisted Living and Memory Care
Address: 17701 North Western Avenue
City, State, Zip: Oklahoma City, Ok 73012
Provider #: AL5548
Complaint #: OK00061321
Investigation Date(s): 11/17/23 and 11/20/23

ALLEGATION(S)

1.The center failed to ensure adequate supervision and treatment was provided in a timely manner for a resident who encountered a fall.
2.The center failed to provide adequate staff to provide supervision and meet the needs of the residents.

An unannounced on-site investigation was initiated 11/17/2023 at 5.00 a.m.

A sample of 3 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 records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at various times through the survey. Staff were observed providing incontinent care in a timely manner. Staff were observed rounding in a timely manner.

Resident records were reviewed including assessments, physician notes, physician orders, hospice notes, service plans, incontinent care, fall risk assessments, skin assessments, incident reports, state reportable, resident council minutes and nursing notes. Facility policy and procedures were reviewed. Grievance records were reviewed. Resident charts records and MARS/TARS were reviewed. Visitor check-in logs were reviewed. Staff schedules were reviewed.

Residents were interviewed related to the provision of incontinent care, pain, staff/resident interaction, safety, staff ensuring adequate supervision and treatment in a timely manner and wondering residents.

Staff members were interviewed regarding the facility's policy on activities of daily living, pain in-service, incidents/accidents, abuse, neglect and resident falls.

Residents were observed receiving care as physician ordered. Residents were observed for incontinent care in a timely manner. Residents were observed for signs of pain. Residents were observed for fall risk prevention methods as physician ordered. Residents were observed for care related to adequate staffing and supervision.

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: 11/21/2023

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 _____	C 11/20/2023

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 complaint investigation (OK00061321) was conducted on 11/17/23 and 11/20/23.	C 000		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

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 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1912	Continued From page 1	C1912		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the center failed to submit an incident report to OSDH for unknown injury [orbital left laceration] for one [#3] of one resident reviewed for incidents.

The Wellness Director identified 91 residents resided in the facility.

Findings:

An undated "Accidents/Incidents-Resident and Visitor" policy, read in parts, "...Whenever an occurrence or event leads to unintentional consequences and an unfortunate happening to a resident, visitor or staff member on the grounds of an Incident/Accident Report must be completed...When in Doubt -complete the form..."

On 11/20/23 at 10:25 a.m., LPN#1 stated Resident #3 had a fall incident on 08/31/23 at 1:47 a.m.

On 11/20/23 at 11:56 a.m., CNA#1 stated Resident #3 was bleeding and they notified the nurse and CMA #1. The incident reports were to be done by the CMA#1. They stated, "I didn't or they didn't fill out an incident report".

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

January 17, 2024

License Number: AL5548

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

Survey Event ID: 779311

Dear Ms. Saggese:

On **November 20, 2023,** a complaint investigation was 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 will be corrected and you will be in substantial compliance by **January 8, 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

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 11/20/2023

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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C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 1/10/24

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 11/20/2023

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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C1912	Continued From page 1	C1912		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the center failed to submit an incident report to OSDH for unknown injury [orbital left laceration] for one [#3] of one resident reviewed for incidents.

The Wellness Director identified 91 residents resided in the facility.

Findings:

An undated "Accidents/Incidents-Resident and Visitor" policy, read in parts, "...Whenever an occurrence or event leads to unintentional consequences and an unfortunate happening to a resident, visitor or staff member on the grounds of an Incident/Accident Report must be completed...When in Doubt -complete the form..."

On 11/20/23 at 10:25 a.m., LPN#1 stated Resident #3 had a fall incident on 08/31/23 at 1:47 a.m.

On 11/20/23 at 11:56 a.m., CNA#1 stated Resident #3 was bleeding and they notified the nurse and CMA #1. The incident reports were to be done by the CMA#1. They stated, "I didn't or they didn't fill out an incident report".

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/10/2024** **Facility Name:** StoneCreek Assisted Living and Memory Care **License Number:** AL5548 **Survey Event ID:** 11/20/2023 **Date Survey Completed: 11/20/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1912	Based on: record review and interview the center failed to submit an incident report to OSDH for unknown injury for one of one resident reviewed for incidents.

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?	A report has been submitted to OSDH on 1/10/2024
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 incidents of unknown origin will be submitted to OSDH
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?	An education on unknown origin incidents was completed for all parties involved in incident report
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.	Monitoring by ED, WD and QA: a. Weekly review of incidents and reportables to OSDH to be completed for compliance b. Weekly monitoring to be submitted to the QA committee for review and compliance c. Maintain logs until compliance is satisfied through the QA committee
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kimberly Saggese, NHA** OAC 310:663-25-4(F)	**Date 1/10/2024**

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.

C1921 PLAN OF CORRECTION LOG

Week of: _____ Incidents reviewed: Reportables: Compliant: Nurse Sign Off: E.D. Sign Off:

Date submitted to QA for review: _____.

OKLAHOMA
State Department
of Health

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

January 17, 2024

License Number: AL5548

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

Survey Event ID: 779311

Dear Ms. Saggese:

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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.

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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

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 11/20/2023

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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Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 1/10/24

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 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1912	Continued From page 1	C1912		

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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: 1/10/2024** **Facility Name:** StoneCreek Assisted Living and Memory Care **License Number:** AL5548 **Survey Event ID:** 11/20/2023 **Date Survey Completed: 11/20/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1912	Based on: record review and interview the center failed to submit an incident report to OSDH for unknown injury for one of one resident reviewed for incidents.

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
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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 incidents of unknown origin will be submitted to OSDH
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?	An education on unknown origin incidents was completed for all parties involved in incident report
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.	Monitoring by ED, WD and QA: a. Weekly review of incidents and reportables to OSDH to be completed for compliance b. Weekly monitoring to be submitted to the QA committee for review and compliance c. Maintain logs until compliance is satisfied through the QA committee
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kimberly Saggese, NHA** OAC 310:663-25-4(F)	**Date 1/10/2024**

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.

C1921 PLAN OF CORRECTION LOG

Week of: _____ Incidents reviewed: Reportables: Compliant: Nurse Sign Off: E.D. Sign Off:

Date submitted to QA for review: _____.

OKLAHOMA
State Department of Health

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

January 30, 2024

License Number: AL5548

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

Survey Event ID: 779312

Dear Ms. Saggese:

On **January 26, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 20, 2023,** have now been corrected effective **January 8, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5548	A. BUILDING: _____ B. WING _____	R-C 01/26/2024

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 01/26/24. 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

OKLAHOMA State Department of Health

Oklahoma State Department of Health
Long Term Care
123 Robert S Kerr Ave, Suite 1702
Oklahoma City, OK 73012-6406
p. (405) 426-8200
f. (405) 900-7594

Assisted Living Informal Dispute Resolution Request Form

In Accordance with the Continuum of Care and Assisted Living Act

Assisted Living Centers must complete this form to dispute cited deficiencies. If you have any questions, contact the IDR Coordinator by telephone at (405) 426-8200 or via e-mail at IDRCoordinator@health.ok.gov.

Submission

Complete this form, attach all documentary evidence relevant to each disputed deficiency and submit within **ten (10) calendar days** of receiving the official Statement of Deficiencies. Submit this form to Oklahoma State Department of Health, Long Term Care, Attention: IDR Coordinator, 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102-6406. **An IDR will not be granted when a request form is incomplete or inaccurate. Documentary evidence submitted past the required timeframe will not be considered.**

IDR Type: (Check One) Face-to-Face Meeting ☐ Record Review ☐ Telephone/Virtual Conference ☑

Facility Name: StoneCreek Assisted Living and Memory Care

Facility ID: AL5548

Facility Administrator: Kimberly Saggese

E-mail: ed@stonecreek-al.com

Mailing Address: 17701 N Western Ave

Telephone Number: ( ) 330-5020

City: Edmond Zip Code: 73012

Facsimile Number: ( ) 330-5044

Date Statement of Deficiencies Received: 01 /05 /2024

Survey Exit Date: 11 /20 /2023

Dispute Description

Tag Number **Explanation of Dispute** (Why is facility disputing the deficiency? List reason for each.)

A separate sheet may be attached, but must clearly identify the following: facility name, ID, survey exit date, tag number, and the explanation of the dispute. All documentary evidence submitted must also identify these items.

1. C1912 The facility was not required to report to OSDH. The injury was not unknown. The left orbital inury occurred on 8/15/23 and an incident report was completed.
2.
3.
4.

Submitted by: Kimberly Saggese

Date: 01 /10 /2024

OKLAHOMA
State Department
of Health

January 18, 2024

VIA EMAIL

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

Re: Informal Dispute Resolution Notification
License Number: AL5548

Dear Ms. Saggese:

We have received your request for an Informal Dispute Resolution (IDR) concerning the deficiencies cited at your facility during the complaint investigation of November 20, 2023. The meeting has been scheduled for **Monday, February 9, 2024 at 1:00pm** via Microsoft TEAMS. Please download Microsoft TEAMS to your desktop or portable device prior to your meeting.

The Informal Dispute Resolution meeting is informal. It is regulation that attorneys do not attend. Testimony is not presented under oath and documentary evidence is submitted without formality.

If you wish to withdraw your IDR request, we must receive written notification at least seventy-two (72) hours prior to the meeting date. If you have any questions or need additional information, please contact me at (405) 271-6868 or email idrcoordinator@health.ok.gov.

Sincerely,

Clorissa Nubine

Clorissa Nubine
IDR Coordinator
Long Term Care
Protective Health Services

c: William Whited, Ombudsman
Facility File
LaTrina Frazier
Shayla Spriggs
Rae Belt
Survey Team
Lindsey Jeffries, Nurse Aide Registry

OKLAHOMA
State Department
of Health

February 9, 2024

VIA EMAIL

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

Re: Stonecreek Assisted Living And Memory Care - Informal Dispute Resolution Determination Report License Number: AL5548

Dear Ms. Saggese:

Thank you for participating in the Informal Dispute Resolution (IDR) panel process of the Oklahoma State Department of Health concerning the survey conducted at your facility on November 20, 2023. The facility, the IDR Panel and all relevant persons were present at the meeting. The disputed deficiencies are discussed in the attached determination report.

A copy of this determination has been forwarded to the State Survey Agency for review.

Sincerely,

Kelly Bowers RN

Kelly Bowers
Chairperson
IDR Decision Making Panel
Protective Health Services

cn

Enclosure

c: LaTrina Frazier
IDR Panel
Survey Team
Facility File

IDR
Informal Dispute Resolution
Impartial Decision Making Panel
Determination Report
Today's Date: 02-09-2024

Facility Name:
Stonecreek Assisted Living
& Memory Care

Facility ID:
AL5548

Survey Date:
11-20-23

IDR Date:
02-09-24

Tags Disputed:
1. C1912 s/s=D

Status Change *
Tag Removed

Panel Members:
Kelly Bowers, Chairperson
Adam Stephens
Emilie Creswell
Carole Kimbrough
Sheila McLeod, OSDH

Determination Report: The panel feels that the tag should be rescinded because the State did not give enough supporting evidence to support the tag.

Signature____Kelly Bowers RN_____
Chairperson, Impartial Decision Making Panel

OKLAHOMA
State Department
of Health

February 9, 2024

VIA EMAIL

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

Subject: State Survey Agency Informal Dispute Resolution Determination
Re: AL5548, Stonecreek Assisted Living And Memory Care February 9, 2024 Informal Dispute Resolution

Dear Ms. Saggese:

The Department of Health has received the determination of the Informal Dispute Resolution (IDR) Decision Making Panel concerning the November 20, 2023 complaint investigation conducted at Stonecreek Assisted Living And Memory Care. The findings of the IDR Decision Making Panel have been reviewed. It is the determination of the State Survey Agency to uphold the Decision Making Panel's determination. The amended State Statement of Deficiencies (Form CMS-2567) is enclosed. If applicable, further instructions regarding the impact of these changes on any previous enforcement action will be forthcoming from the Long Term Care Enforcement office.

The facility is encouraged to submit an amended plan of correction on the enclosed Statement of Deficiencies. The amended Statement of Deficiencies must be signed, dated, and indicate the signee's title in the appropriate spaces on page one (1). Return the amended Statement of Deficiencies with your plan of correction to:

LTCEnforcement@health.ok.gov

The amended copy of the Statement of Deficiencies (Form CMS-2567) will be the releasable copy *only* when a signed amended plan of correction is provided by the facility. The original Form CMS-2567 is disclosable if a signed amended plan of correction is not submitted by the facility. [Chapter 7, State Operations Manual §7212]

Sincerely,

LATRINA FRAZIER (Feb 9, 2024 15:46 CST)
LaTrina Frazier, Ph.D., MHA, RN
Deputy Commissioner
Quality Assurance & Regulatory

cn

c: William Whited, Ombudsman
Lindsey Jeffries, Nurse Aide Registry
IDR Decision Making Panel
Shayla Spriggs
Rae Belt
Survey Team
Facility File

IDR Meeting Attendees Sign-In Sheet

02-09-2024

Microsoft Teams Meeting

Stonecreek Assisted Living and Memory Care

Survey Date: 01-12-2024

Name	Organization	Title
Sheila McLeod	Panel – OSDH	CHF Surveyor
Adams Stephens	Panel	Administrator
Emilie Creswell	Panel	Administrator
Carole Kimbrough	Panel	Administrator
Kelly Bowers	Panel – Chairperson	DON
Rae Belt	OSDH	Preventative Medical Consult
Kim Saggese	Facility	Executive Director
Frank Gscheidle	Facility	Wellness Director
Franklin Calvin	OSDH	CHF Surveyor
Robert Stephens	Facility	Director

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 _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMOF	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 complaint investigation (OK00061321) was conducted on 11/17/23 and 11/20/23. The 2567 has been amended based on a determination resulting from an Informal Dispute Resolution (IDR) removing C1912 s/s=D	C 000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/10/24