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: XEBX11

Dear Ms. Saggese:

On **January 12, 2024**, 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.

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. 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 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 Ave**
City, State, Zip: **Edmond, OK, 73012**
Provider #: **AL5548**
Complaint #: **OK00061858**
Investigation Date(s): **01/11/24-01/12/24**

ALLEGATION(S)

The center failed to prevent the development of new/worsened pressure wounds.
The center failed to ensure residents' representatives were notified of a change in condition.

An unannounced on-site investigation was initiated 01/11/2024 at 9:15 a.m.

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

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 random throughout the survey. Staff and residents were observed during provision of care and during individual pursuits.
Facility records were reviewed including staff records, incident reports, and policies. Resident records were reviewed including physician orders, progress notes, third party notes, care plans, assessments, hospital records, service plans and contracts.
The staff were interviewed regarding wounds and notification of family. Residents sampled were not cognitively able to participate in interviews.

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: 01/16/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Stonecreek Assisted Living and Memory Care**
Address: **17701 North Western Ave**
City, State, Zip: **Edmond, OK, 73012**
Provider #: **AL5548**
Complaint #: **OK00061906**
Investigation Date(s): **01/11/24-01/12/24**

ALLEGATION(S)

The center failed to ensure residents were not physically, verbally, or psychosocially abused.
The center failed to ensure pain medications were administered accurately in an effort to ensure the correct dose was given according to the physicians' orders.
The center failed to ensure injuries of unknown origin were reported to the Oklahoma State Department of Health according to state law.

An unannounced on-site investigation was initiated 01/11/2024 at 9:15 a.m.

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

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 random throughout the survey. Staff and residents were observed during provision of care and during individual pursuits.
Facility records were reviewed including staff records, incident reports, and policies. Resident records were reviewed including physician orders, progress notes, third party notes, care plans, assessments, hospital records, medication administration records, narcotic records, service plans and contracts.
The staff were interviewed regarding abuse, pain medications, and reporting. Residents sampled were not cognitively able to participate in interviews.
The facility was previously cited for reporting and had an open plan of correction.

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: 01/16/2024

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INVESTIGATIVE REPORT

Facility: **Stonecreek AL & MC**
Address: **17701 North Western Avenue**
City, State, Zip: **Edmond, OK 73012**
Provider #: **AL5548**
Complaint #: **OK00061973**
Investigation Date(s): **01/11/24-01/12/24**

ALLEGATION(S)

The center failed to ensure residents were assessed after a major fall and failed to follow abuse policies and procedures related to abuse allegations.
The facility failed to report falls with head injuries to the state agency (OSDH).

An unannounced on-site investigation was initiated 05/11/2023 at 9:15 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 center was conducted upon entrance and throughout the survey. Residents were observed to be clean, dressed appropriately and free of odors. Staff were observed assisting residents with ADL's and as needed. Staff were observed treating residents with dignity and respect.

Resident records were reviewed including progress notes, incident reports, and care plans. Hospice visit notes were reviewed. Staff schedules were reviewed.

Staff were interviewed regarding the procedures for a resident after a fall.

The center has been cited in a recent previous survey and are in the process of correcting the citations.

The attached CMS 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: 01/16/2024

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 01/12/2024

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

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C 000	INITIAL COMMENTS Complaint investigations (#OK00061906, OK00061858, OK61973) were conducted on 01/11/24 and 01/12/24. Facility Census: 88 The following abbreviations are used throughout the document: CMA - certified medication aide CNA - certified nurse aide MCD - memory care director Res - resident	C 000		
C1505 SS=G	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	C1505		

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C1505	Continued From page 1 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 facility failed to develop and implement fall prevention interventions for one (#3) of four sampled residents reviewed for falls. On 01/11/24, Res #3 had a fall which resulted in a broken hip. The memory care director identified 88 residents resided in the facility, 31 of those resided on the memory care unit. Findings: Res #3 had diagnoses which included acute on chronic congestive heart failure, chronic kidney disease, vascular dementia, and depression. A care plan, dated 08/20/23, did not include interventions related to fall prevention. A comprehensive assessment and care plan, dated 10/06/23, documented the resident was alert, confused, frequently failed to request	C1505		

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C1505	Continued From page 2	C1505		

assistance with walking, did not remember to use a walker if up without staff assistance, could not ambulated without assistance, required a wheelchair, had weakness to bilateral lower extremities, and was incontinent of bowel and bladder. The services documented included night wellness checks and resident wellness checks.

A facility incident report, dated 11/07/23, documented Res #3 had a witnessed fall in the lobby and hit their head. The report documented the resident was sent to the emergency room for evaluation. The incident report documented follow up and prevention measures as fall mat provided and frequent wellness checks. The comments documented staff were educated to increase frequency of checks and to offer toileting assistance.

A hospital after visit summary, dated 11/07/23, documented the resident received a forehead contusion from a fall.

No fall risk assessment was completed after the fall on 11/07/23.

A nurse progress note, dated 11/08/23 at 6:59 a.m., documented Res #3 had a witnessed non-injury fall. It documented the resident fell from standing. The note documented the resident was sent to the hospital for evaluation and returned with a diagnosis of head contusion. The note did not document interventions or monitoring post-fall.

The routine services documentation did not list wellness checks.

A hospice skilled nurse on-call visit summary, dated 01/11/24 at 8:15 a.m., documented facility

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C1505	Continued From page 3 staff notified hospice at 6:42 a.m. of Res #3's fall. The note documented facility staff notified family prior to hospice arrival. The note documented the resident was yelling out in pain prior to their arrival but was without pain upon their arrival. The note documented Res #3 exhibited pain with palpation and the right foot was turned inwards. The note documented an x-ray was ordered. The note documented fall precautions were reviewed with facility staff. The precautions reviewed were not documented. A nurse progress note late entry, dated 01/11/24 at 9:30 p.m., documented the resident was found on the floor at approximately 6:00 a.m. by facility staff. The note documented the fall was reported to hospice who responded for a visit. The note documented when the family was notified they requested the resident be sent to the hospital. The note documented the resident was transported to the hospital. The note did not document interventions or when the resident was seen by hospice or transported to the hospital. A nurse progress note, dated 01/11/24 at 9:47 p.m., documented Res #3 returned from the hospital with a diagnosis of a hip fracture to right hip. The note documented the family and hospice were notified and decided to return the resident to the facility with comfort measures. On 01/11/24 at 10:06 a.m., Res #3 was observed in their room seated in their recliner. The resident was leaning to the left and had their hand covering their face. A high back manual wheelchair was observed in the bathroom with a cushion in place and an alarm attached to the chair. A fall mat was not observed in the room. The MCD stated the resident had a fall and was awaiting transport by ambulance to the hospital.	C1505		

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C1505	Continued From page 4 On 01/11/24 at 1:50 p.m., the MCD stated the protocol for falls was to report all falls with or without injury to them or the wellness director. They stated the staff member who finds the resident should take vitals and determine what caused the fall. They stated the staff member should notify the hospice or physician if the resident is not on hospice. They stated the hospice should come out to assess the resident. If the resident is not on hospice they stated the staff who found the resident should determine if a head injury occurred and call the family to ask if the resident should be sent to the hospital. They stated most of the people who fall on nights are on hospice. They stated if there is an extensive injury the resident should not be left alone or moved. They stated the information should be documented on an incident report. On 01/11/24 at 1:58 p.m., the MCD stated if the resident was on hospice it was the responsibility of the hospice to assess the resident after a fall. A hospital after visit summary, dated 01/11/24, documented Res #3 had a diagnosis of closed comminuted (broken in two or more places) fracture of right femur. On 01/11/24 at 3:00 p.m., the MCD stated Res #3 had broken their hip and an incident report would be completed. On 01/12/24 at 9:24 a.m., the MCD stated they were notified of the fall at 6:40 a.m. via text message from the CMA on the floor. They stated they were not informed of any obvious injuries but the resident was unable to bear weight. They stated the hospice was notified and arrived to the facility for an assessment at around 7:00 a.m. to	C1505		

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C1505	Continued From page 5 7:30 a.m. They stated the hospice ordered an x-ray after their assessment. They stated when they arrived to the facility around 9:00 a.m., they went to assess the resident and noticed they were acting out of the ordinary. They stated they notified the family who wanted to send the resident to the hospital. They stated they had not spoken with the staff member who found the resident or taken a statement about the fall yet. On 01/12/24 at 9:58 a.m., Res #3 was observed laying on their hospital bed in their room. There was a fall mat observed at bedside. There were bolsters observed on the sides of the bed. The resident's recliner had been moved to the other side of the room to accommodate the hospital bed. On 01/12/24 at 10:00 a.m., the memory care coordinator stated the resident had a bed alarm and one in their recliner and wheelchair. On 01/12/24 at 10:03 a.m., CNA #2 stated the staff carried devices that listed how much assistance the residents required to get out of bed. They stated if a resident falls they notify the nurse. On 01/12/24 at 10:06 a.m., CNA #3 stated they look on their device to see what assistance the residents need with transfers or other care. They stated they were unaware Res #3 had a fall until they went into their room to assist them up for the day. They stated they had attempted to help the resident stand to dress when the resident called out in pain and was unable to stand. They stated they were informed by CMA #1 at that time the resident had a fall the previous night. They stated they were in the room with the resident at approximately 6:50 a.m. They stated there was	C1505		

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C1505	Continued From page 6 no way to see any fall interventions on their handheld devices. They stated the resident had alarms in their bed and chairs. On 01/12/24 at 10:40 a.m., CMA #1 stated they were the staff who responded to the resident's fall. They stated the resident was observed in the floor laying on their left side in front of their recliner. They stated the bed alarm was sounding. They stated the resident was in pain when they responded. They stated they took vital signs and called the hospice. They stated they received a return call from the hospice approximately 20-25 minutes after their original call in which they were notified it would be an hour before the hospice nurse could arrive to assess the resident. They stated they were unsure if they notified the family of the fall. They stated after taking vitals and notifying hospice the resident was left in their bed without staff in the room.	C1505		
C5010 SS=D	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from	C5010		

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C5010	Continued From page 7 any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to coordinate care with a third party provider for one (#3) of four sampled residents reviewed for falls. The memory care director identified 88 residents resided in the facility, 31 of those resided on the memory care unit. Findings: Res #3 had diagnoses which included acute on chronic congestive heart failure, chronic kidney disease, vascular dementia, and depression. On 01/11/24 at 1:58 p.m., the MCD stated if the resident was on hospice it was the responsibility of the hospice to assess the resident after a fall. They stated the hospice should have notified the	C5010		

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C5010	Continued From page 8 family of the fall for Res #3. A nurse progress note, dated 01/11/24 at 9:30 p.m., documented a late entry for Res #3's fall. The note documented the resident was found on the floor at approximately 6:00 a.m. by facility staff. The note documented the fall was reported to hospice who responded for a visit. The note documented when the family was notified they requested the resident be sent to the hospital. The note documented the resident was transported to the hospital. The note did not document interventions or when the resident was seen by hospice or transported to the hospital. A nurse progress note, dated 01/11/24 at 9:47 p.m., documented Res #3 returned from the hospital with a diagnosis of a hip fracture to right hip. The note documented the family and hospice were notified and decided to return the resident to the facility with comfort measures. On 01/12/24 at 9:24 a.m., the MCD stated they were notified of the fall at 6:40 a.m. via text message from the CMA on the floor. They stated they were not informed of any obvious injuries but the resident was unable to bear weight. They stated the hospice was notified and arrived to the facility for an assessment at around 7:00 a.m. to 7:30 a.m. They stated the hospice ordered an x-ray after their assessment. They stated when they arrived to the facility around 9:00 a.m., they went to assess the resident and noticed they were acting out of the ordinary. They stated they notified the family who wanted to send the resident to the hospital. They stated they had not spoken with the staff member who found the resident or taken a statement about the fall yet. On 01/12/24 at 1:01 p.m., the MCD stated	C5010		

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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
C5010	Continued From page 9 hospice and other third party providers are supposed to complete a third party care coordination sheet after each visit. They stated they are kept at the front desk. They stated they were unable to locate the third party form for Res #3's visit on 01/11/24. They stated there was no policy available for care coordination with a third party.	C5010		

OKLAHOMA
State Department
of Health

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

February 21, 2024

License Number: AL5548

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

Survey Event ID: XEBX11

Dear Ms. Saggese:

On **January 12, 2024,** 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 **February 2, 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,

Clorissa Nubine

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

Enclosure

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 01/12/2024

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 Complaint investigations (#OK00061906, OK00061858, OK61973) were conducted on 01/11/24 and 01/12/24. Facility Census: 88 The following abbreviations are used throughout the document: CMA - certified medication aide CNA - certified nurse aide MCD - memory care director Res - resident	C 000	POC Submitted on optional template	
C1505 SS=G	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	C1505		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/1/2024** **Facility Name:** StoneCreek Assisted Living and Memory Care **License Number:** AL5548 **Survey Event ID:** XEBX11 **Date Survey Completed: 1/12/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5010	Based on: record review, and interview, the facility failed to coordinate care with a third party provider for one resident reviewed for falls.

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 Residents who have a fall incident and a third party provider will receive communication to coordinate care.
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 with fall incidents and third party providers have the potential
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?	Daily review and monitoring of all fall incidents and identification of third party provider coordination
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 with the WD/AWD of fall incidents and third party provider coordination Weekly review to be submitted for approval and review by the QA committee Weekly log to be completed and signed off by WD/AWD and ED
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/2/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 2/2/2024**

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.

C5010 PLAN OF CORRECTION LOG

Week of: _____ Falls reviewed: 3rd Party Provider: Coordination of Care: Nurse Sign Off: E.D. Sign Off:

Date submitted to QA for review: _____.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/1/2024** **Facility Name:** StoneCreek Assisted Living and Memory Care **License Number:** AL5548 **Survey Event ID:** XEBX11 **Date Survey Completed: 1/12/2024**

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 resident reviewed for falls.

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 fall risk Residents have been identified and fall prevention interventions are in place
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 new Residents will be evaluated upon admission and if determined to be a fall risk put fall interventions in place. All fall incidents will be reviewed and an intervention put in place post fall.
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?	Daily review and monitoring of fall interventions for new Residents and fall incidents that occured
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 with the WD/AWD of new Resident fall risk and interventions and fall incident that occurred and interventions Weekly review to be submitted for approval and review by the QA committee Weekly log to be completed and signed off by WD/AWD an ED
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/2/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 2/2/2024**

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.

C1505 PLAN OF CORRECTION LOG

Week of: _____ Falls reviewed: New Resident: Interventions in place: Nurse Sign Off: E.D. Sign Off:

Date submitted to QA for review: _____.

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, NHA E-mail: ed@stonecreek-al.com

Mailing Address: 17701 N Western Ave Telephone Number: ( ) 330-5020

City: Edmond Zip Code: OK Facsimile Number: ( ) 330-5044

Date Statement of Deficiencies Received: 01 /30 /2024 Survey Exit Date: 01 /12 /2024

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. C1505 Resident Rights were not violated in relation to a fall. A fall did occur and proper interventions were in place and referenced throughout the 2567 and can be supported through the record at the community. Expectations of the surveyors were SNF standatds, not ALF.

2. C5010 Coordination of Care between the facility and third party is evidenced throughout the 2567 with references regarding hospice involvement and even a reference to the communication from the date in question in the body of C1505

3. _____

4. _____

Submitted by: Kimberly Saggese Date: ____/____/____

OKLAHOMA
State Department
of Health

February 12, 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 January 12, 2024. The meeting has been scheduled for **Monday, March 4, 2023 at 10:00am** 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) 426-8200 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

OKLAHOMA
State Department
of Health

March 4, 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 January 12, 2024. 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,

JR Gutierrez
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: 03-04-2024

Facility Name:
Stonecreek Assisted Living & Memory Care

Facility ID:
AL5548

Survey Date:
01-12-2024

IDR Date:
03-04-2024

Tags Disputed:	**Status Change** *
1. C1505 s/s=G	No Change
2. C5010 s/s=D	No Change

Panel Members:
JR Gutierrez, Chairperson
Dana Sandmann
Linda Brannon
Merrideth Harper
Sheila McLeod, OSDH

Determination Report: Facility did not present adequate information to make any changes.

Signature _____
Chairperson, Impartial Decision Making Panel

OKLAHOMA
State Department
of Health

March 5, 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: Stonecreek Assisted Living and Memory Care March 4, 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 January 12, 2024 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 Statement of Deficiencies will not be amended.

Sincerely,

LATRINA FRAZIER (Mar 12, 2024 21:11 CDT)

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
Shayla Spriggs	OSDH	Manager of Survey
Jennie Lewis	OSDH	CHF Surveyor
KC Claunch	OSDH	CHF Surveyor
Kim Saggese	Facility	Executive Director
Linda Brannon	Panel	Administrator
Frank Gscheidle	Facility	Wellness Director
Robert Stephens	Facility	Assistant Wellness Director
JR Gutierrez	Panel – Chairperson	Administrator
Merrideth Harper	Panel	Administrator
Dana Sandmann	Panel	Adminitrator
Sheila McLeod	Panel – OSDH	CHF Surveyor

OKLAHOMA
State Department
of Health

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

March 12, 2024

License Number: AL5548

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

Survey Event ID: XEBX12

Dear Ms. Saggese:

On **March 8, 2024,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 12, 2024,** have now been corrected effective **February 2, 2024.**

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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 _____	R-C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK ASSISTED LIVING AND MEMOR	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 revisit was conducted from 03/08/24. All deficiencies from the 01/12/24 survey were cleared. Census: 87	{C 000}		

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

OKLAHOMA
State Department
of Health

FINAL DETERMINATION NOTICE

USPS Tracking #: 7021 2720 0002 0354 1778

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

March 14, 2024

License Number: AL5548

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

Survey Event ID: XEBX12

Dear Ms. Saggese:

A revisit conducted **March 8, 2024**, revealed that your facility corrected deficiencies effective **February 2, 2024**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Respectfully,

Tempal Killman

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

Enclosure