Oklahoma State Department of Health
Creating a State of Health

November 7, 2019

License Number: AL6002

Ms. Tara Chill, Administrator
The Renaissance Of Stillwater-Assisted Living
1400 East McElroy
Stillwater, OK 74075

RE: Survey Event ID: 87EP11

Dear Ms. Chill:

On **October 2, 2019**, agents from our office concluded a State Licensure survey and complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 2, 2019.

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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: The Renaissance of Stillwater Assisted Living
Address: 1400 East McElroy
City, State, Zip: Stillwater, OK 74075
Provider #: AL6002
Complaint #: OK00054092
Investigation Date(s): 10/01/19 and 10/02/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered according to physicians' orders and/or contract.	US
2. The center failed to ensure residents had the right to voice grievances without fear of retaliation and have the issues addressed an/or resolved.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Tuesday, October 1, 2019 at 10:30 a.m.

A sample of eight 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to medications administered as ordered by a physician was conducted.

Eight residents were observed being administered medications by the center's staff on 10/01/19. All medications were administered according the physicians' orders found in the residents' records.

The residents or their representative interviewed stated they had no concerns about how their medications were administered by the center's staff. The residents stated as far as they knew, they got their medications like the physician had ordered them to be given.

A review of the residents' medication administration records and physicians' orders confirmed medications were being administered as ordered by the physicians. New medications were available for administration in the center no more than two days after the medications were ordered by the physician.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to residents' right to voice grievances without fear of retaliation was conducted.

The residents interviewed all stated they were not afraid to go the staff or administration of the center with any problem they had. A few of them said they had gone to the current administration with problems and all of them stated they were happy with the outcome and felt like they had been heard. None of them reported any type of retaliation.

The administrator stated she and the staff would listen to any resident who had a problem and no one would suffer any type of retaliation.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Teena Cornett

Teena Cornett, RN CHFS IV

Date report completed: 10/08/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6002	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-ASSISTE	1400 EAST MCELROY STILLWATER, OK 74075

(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 re-licensure survey was conducted 10/01/19 and 10/02/19. Complaint #OK00054092 was investigated in conjunction with the re-licensure survey. Deficient following practice was cited as a result of the re-licensure survey. No deficient practice was cited as a result of the complaint investigation. Resident census was 31.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the center failed ensure registered nurse supervision of self-administration of medications for 1 (#9) of 3 sampled residents that self-administered medications. This had the potential for more than minimal harm, at a pattern. Findings: Resident #9's record documented she was admitted to the center 07/01/19 with diagnoses to include diabetes, high blood pressure, osteoporosis and irregular heartbeat. The resident had an order upon admission to self-administer her medications. The resident's care plan, dated 07/01/19, included medication	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6002	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-ASSISTE	1400 EAST MCELROY STILLWATER, OK 74075

(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 911	Continued From page 1 self-administration. Her medications ordered when she was admitted to the center were, alendronate 70 mg weekly for bone health, digoxin 250 mcg daily for irregular heartbeat, diltiazem 180 mg daily for high blood pressure, duloxetine 60 mg daily for depression, furosemide 40 mg daily for fluid retention, hydrochlorothiazide 25 mg daily for fluid retention, metformin 500 mg twice daily for diabetes, metroprolol 50 mg daily for high blood pressure, mupirocin 2% ointment three times daily for excoriation, potassium chloride 10 millequivalents daily and zinc 220 mg daily. Her record included medication self-administration assessments dated 07/01/19, 08/15/19 and 09/13/19. The 07/01/19 assessment was signed by the former RN (registered nurse) and the 09/13/19 assessment was completed by LPN (licensed practical nurse) #1. Her medication administration records for August, 2019 and September, 2019 documented the resident was self-administering her medications. On 10/01/19 at 11:20 a.m., a verbal report on the residents was received from the administrator and the LPN. It was not mentioned resident #9 self-administered her medications. At 2:10 p.m., CMA (certified medication aide)/employee #1 stated resident #9 self-administered her medications. At 3:00 p.m., medication bottles were observed in the resident's room in the presence of the administrator. The resident had a bottle of metroprolol 50 mg (milligrams), 30 day suply filled 07/11/19, (for high blood pressure) that was	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6002	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-ASSISTE	1400 EAST MCELROY STILLWATER, OK 74075

(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 911	Continued From page 2 empty. Also a partial bottle of digoxin (for irregular heartbeat) was observed. An empty bottle of metformin, 30 day supply filled 07/16/19, (for type II diabetes) was observed. There were also bottles of amiodarone and potassium that had pills in them. The resident stated those were the only medications she had. Resident #9 stated she was still taking the digoxin, amiodarone and potassium, but was not currently taking the metroprolol or the metformin. She stated her doctor was trying to get her off some of her medications. The resident said she did not have a glucometer to take her blood sugar and her blood pressure was not being monitored. At 3:10 p.m., the administrator was asked for documentation the center was monitoring the self-administration of medications for resident #9. The administrator stated she was not aware the resident was self-administering her medications and she was not aware the resident did not have all her ordered medications available to self-administer. The administrator also stated the registered nurse was new and would not know the resident was self-administering her medications. At 4:15 p.m., the LPN stated she was not aware the resident had been self-administering her medications, so there was no documentation the center had been monitoring the resident's self-administration of medications and she was not aware the resident did not have all her ordered medications.	C 911		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6002	THE RENAISSANCE OF STILLWATER-ASSISTED LIVING

Type of Survey (select all that apply)

2	3			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	10/01/2019	10/02/2019	0.50	0.00	12.00	0.00	4.50	3.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

NOV 1 2 2019

Oklahoma State Department of Health
Creating a State of Health

December 11, 2019

License Number: AL6002

Ms. Tara Chill, Administrator
The Renaissance Of Stillwater-Assisted Living
1400 East McElroy
Stillwater, OK 74075

RE: Survey Event 87EP11

Dear Ms. Chill:

On October 2, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **November 20, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/18/2019** **Facility Name:** The Renaissance of Stillwater **License Number:** AL6002 **Survey Event ID:** 87EP11 **Date Survey Completed: 10/2/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911	Based on: observation and interview, it was determined the center failed to ensure registered nurse supervision of self-administration of medications for 1 (#9) of 3 sampled residents that self-administered medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Community staff now administering Resident #9's 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?	Executive Director and Registered Nurse will review residents with physician orders to self-administer medications.
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?	Registered nurse will provide supervision and ensure monitoring of all residents that self-administer their own medications. RCD and RN in-serviced regarding this practice.
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.	RN will be responsible for sustained compliance. DHW and/or designee will maintain records of monthly monitoring of residents that self-adminster medications. Tracking and trending will be reported and reviewed during the QA meeting. Monitoring records will be attached to the QA meeting and maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/20/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara Chill** OAC 310:663-25-4(F)	**Date 11/18/2019**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health
Creating a State of Health

January 14, 2020

License Number: AL6002

Ms. Tara Chill, Administrator
The Renaissance Of Stillwater-Assisted Living
1400 East McElroy
Stillwater, OK 74075

RE: Survey Event 87EP12

Dear Ms. Chill:

On **December 30, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 2, 2019,** have now been corrected effective **November 20, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6002	A. BUILDING: _____ B. WING _____	R-C 12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-ASSISTE	1400 EAST MCELROY STILLWATER, OK 74075

(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 On 12/30/19 a follow-up survey was conducted. Census was 34. All deficient practice was cleared.	{C 000}		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6002	THE RENAISSANCE OF STILLWATER-ASSISTED LIVING

Type of Survey (select all that apply)

2	3	D		

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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Team Leader ID 1. 30875	12/30/2019	12/30/2019	0.50	0.00	0.75	0.00	2.00	0.75
2.								
3.								
4.								
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8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

JAN 14 2020 jm