

Delivery via email to: executivedirector@renlivingpc.com

April 4, 2023

License Number: AL6002

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

RE: Survey Event ID: MKXZ11

Dear Ms. Chill:

On **March 16, 2023**, agents from our office concluded a State Licensure survey in conjunction with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 16, 2023**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;

- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may

be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Renaissance of Stillwater Assisted Living
Address: 1400 East McElroy
City, State, Zip: Stillwater Ok 74075
Provider #: AL6002
Complaint #: OK00060035
Investigation Dates: 03/13/23 through 03/16/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure adequate staff to provide care for dependent residents.	S

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/13/2023 at 7:54 p.m.

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

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:

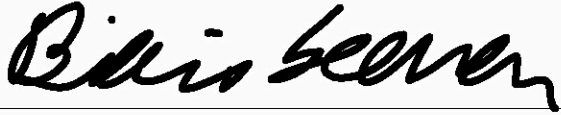
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C961 and C962 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "Billie Seeman", written over a horizontal line.

Billie Seeman, RN

Date report completed: 03/22/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/16/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 relicensure survey was conducted from 03/13/23 through 03/16/23. A complaint investigation (#OK00060035) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CNA - Certified Nurse Aide LPN - Licensed Practical Nurse MAR - Medication Administration Record MAT - Medication Administration Technician mg - milligrams RCD - Resident Care Director RN - Registered Nurse	C 000		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to update/develop the care plan based on the resident assessment to include: a. transferring assistance of two staff with the use of a mechanical lift for one (#1) of two sampled residents who utilized mechanical lifts for transfers and	C 552		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 552	Continued From page 1 b. hip precautions for one (#4) of one sampled resident who had a history of hip dislocations. The RN identified two residents who required a mechanical lift for transfers and one resident who had history of hip dislocation. Findings: An undated policy for "Mechanical Lifts", read in parts, "...Always have two caregivers assisting during the transfer of a resident using a mechanical lift..." 1. Resident #1 had diagnoses which included transient ischemic attack, tendonitis, and plantar fascitis. A significant change assessment, dated 03/14/22, documented the resident was oriented to person, place, and time, was ambulatory with staff assist and required two person assistance for transfers. A care plan/service agreement, dated 03/14/22, read in parts, "...Service Type: Transfers: Assist...Staff will assist with transfers..." The care plan/service agreement did not document the required two person assistance for transfers or the use of the mechanical lift. On 03/13/23 at 7:55 p.m., CNA #2 stated Resident #1 required two person assistance for transfers. On 03/13/23 at 8:03 p.m., CNA #3 was observed assisting Resident #1. A mechanical lift was observed in Resident #1's room. CNA #3 transferred Resident #1 from the recliner to the wheelchair and from the wheelchair to the bed	C 552		

Oklahoma State Department of Health

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C 552	Continued From page 2 with one person and without using the mechanical lift. On 03/13/23 at 8:25 p.m., CNA #3 stated they had not used the mechanical lift because it had not been working correctly. On 03/14/23 at 3:03 p.m., LPN #1 stated the service agreement was considered the care plan. The LPN stated the care plan did not document how many staff were needed to assist with transferring Resident #1 or the use of the mechanical lift. The LPN stated the care plan documented, "Staff to assist with transfers." The LPN was asked how the staff would know how much assistance to provide. They stated they would not know based on the care plan. 2. Resident #4 had diagnoses which included right hip dislocation. A preadmission assessment, dated 08/05/22, documented the resident was oriented to person, had poor gait and mobility and required staff assistance of two for ambulation and transfer of short distances. The service agreement/care plan, dated 08/05/22, read in parts, "....Service Type: Alerts: Monitor...Resident's right hip has a history of dislocation. Staff to listen for a "pop" and alert nurse and hospice..." There were no interventions documented on the care plan to prevent the right hip from becoming dislocated. Hospital discharge instructions, dated 02/22/23, read in parts, "...Hip Dislocation...Prevent another hip dislocation: Follow these precautions for 6 weeks after your injury or as directed...Sit with your back straight and your feet flat on the floor.	C 552		

Oklahoma State Department of Health

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C 552	Continued From page 3 Do not cross your legs. Do not lean forward when you sit in a chair...Keep your knees apart. Place a pillow or wedge between your knees when you sit or lie. Do not twist your knees. Do not lift your knees higher than your hips...Do not sit in a low chair...Use armrests and your upper body strength to push yourself up from a sitting position...Do not bend at the waist to pick up an object, or use a tool to pick it up..." An emergency room note, dated 02/23/23, read in parts, "...presents with right hip pain. Patient thinks he might have dislocated his hip again. He said it pops out frequently. Patient was just seen here yesterday by myself and had a conscious sedation and a closed right hip reduction...Patient underwent conscious sedation and gentle traction was applied and the hip was successfully reduced..." On 03/14/23 at 12:12 p.m., Resident #4 stated their hip had dislocated multiple times since they had been admitted the the center. Resident #4 stated they had a history of their right hip becoming dislocated through the years. Resident #4 stated some of the staff did not know how to assist them with transferring. On 03/15/23 at 1:01 p.m., CNA #4 was asked if they had assisted Resident #4 when the resident's hip became dislocated. They stated, "Yes." CNA #4 stated they had assisted Resident #4 in the shower and the resident's hip had dislocated. CNA #4 stated Resident #4 had stood up and reached down to pull his pants up and then stated their hip "popped" out. CMA #4 was asked if they had transferred Resident #4 with one person. They stated, "Yes." On 03/15/23 at 1:30 p.m., the RN was asked if	C 552		

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STATE FORM

Oklahoma State Department of Health

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C 961	Continued From page 5 Based on record review, observation, and interview, the center failed to ensure adequate staff was on duty to meet the needs of the residents for three (#1, 2, and #4) of three sampled residents who required two person assistance for transfers. The RN identified three residents who required two person assistance for transfers and two residents who required the use of a mechanical lift. Findings: The "Staffing" policy, dated 12/12/22, read in parts, "...Each community is to provide for a sufficient number of staff to...Provide care required in each resident's written record of care...Ensure the health, safety, comfort, and supervision of the residents...Adequate trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents..." An undated policy for "Mechanical Lifts", read in parts, "...Always have two caregivers assisting during the transfer of a resident using a mechanical lift..." 1. Resident #1's significant change assessment, dated 03/14/22, documented the resident was alert and oriented to person, place, and time, required the assistance of two staff members for transferring, required total assistance for toileting, and was unable to ambulate without extensive assistance. The service agreement/care plan, dated 03/14/22, documented staff would provide assistance with transfers.	C 961		

Oklahoma State Department of Health

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C 961	Continued From page 6 On 03/13/23 at 7:55 p.m., CNA #2 stated Resident #1 required two person assistance for transfers. On 03/15/23 at 9:50 a.m., Resident #1 stated one staff member had assisted them with transfers. Resident #1 was asked how many staff members provided assistance when the mechanical lift was used. They stated one. 2. Resident #2 was admitted on 07/23/21 and had diagnoses which included dementia. A "Resident Incident Report", dated 03/09/22 at 6:33 p.m., read in parts, "...[Resident #2]...Unwitnessed Fall...when I walked past his room i [sic] seem [sic] him on the floor between his chair and his kitchen sink...asked the resident what happen [sic] and he couldn't tell m [sic]...notified my nurse, hospice and family...family showed...before i [sic] could get help to get him off the floor so the family helped me..." A significant change assessment, dated 08/16/22, documented Resident #2 required two person assist with a mechanical lift for transfers and two person assist with toileting. A service agreement/care plan, dated 08/16/22, read in parts, "...Transfers...[mechanical lift] and X2 staff assist with transfers when needed...Transfers...Assist...needs X2 staff assist with transfers..." A plan of accommodation, dated 08/16/22, read in parts, "...Description of Services Provided... [mechanical] lift x 2 staff assist, transfers x 2 staff assist. Hospice has provided [mechanical] lift for	C 961		

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C 961	Continued From page 7 all transfers..." On 03/14/23 at 11:02 a.m., Resident #2's family member stated Resident #2 had fallen and there was only one staff member in the building. They stated they had to help get Resident #2 up from the floor. On 03/15/23 at 8:08 a.m., Resident #2 was observed sitting on the edge of their recliner with the foot rest up. Resident #2's legs were off of the foot rest. CNA #5 attempted to transfer Resident #2 to the wheelchair. CNA #5 was unable to transfer Resident #2 to the wheelchair. No other staff members who were qualified to provide resident care were in the building. CNA #5 went to get the business office manager to assist with Resident #2. The business office manager was unable to encourage Resident #2 to be transferred with the assist of one person. On 03/15/23 at 8:13 a.m., CNA #4 came from the memory care center to assist CNA #5 with Resident #2. CNA #4 stated they had been in the other building helping with a resident. 3. Resident #4 had diagnoses which included right hip dislocation. A preadmission assessment, dated 08/05/22, documented the resident was oriented to person, had poor gait and mobility and required staff assistance of two for ambulation and transfer of short distances. The service agreement/care plan, dated 08/05/22, read in parts, "...Must be physically taken to nearest exit...Service Type: Alerts: Fall Risk...[Resident #4] has a history of falls and is	C 961		

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C 961	Continued From page 8 high risk for continued falls...Service Type: Transfers: 2 Person Assist...Resident requires 2 person assistance for transfers in residents room and other locations as needed..." On 03/15/23 at 5:17 a.m., CNA #1 was observed working in the building without any other staff members. CNA #1 stated they typically worked the 11:00 p.m. to 7:00 a.m. shift by themselves. CNA #1 was asked if they had to get any residents up in the mornings. They stated yes, and identified Resident #1 and Resident #2. CNA #1 stated Resident #1 was transferred with a mechanical lift. On 03/15/23 at 7:39 a.m., CNA #5 was observed assisting Resident #4 out of bed without assistance of another staff member. There were no other staff members qualified to provide care in the building. On 03/15/23 at 10:44 a.m., CNA #4 stated they had clocked in around 7:08 a.m., and had gone to the memory care center and helped get residents up for the day. On 03/15/23 at 1:35 p.m., the RN was made aware of the observations of staffing. The RN was asked if the center had provided the staff to meet the needs of the residents. They stated, "No."	C 961		
C 962 SS=F	310:663-9-6(b) MINIMUM STAFF FOR SERVICES (b) A continuum of care facility or assisted living center that has only one direct care staff member on duty shall: (1) Disclose the one-person staffing and the	C 962		

Oklahoma State Department of Health

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C 962	Continued From page 9 plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure one-person staffing, and a plan to deal with emergent situations was disclosed to the residents and their representatives for all 25 residents who resided at the center and failed to ensure the plan was submitted to the OSDH. The "Assisted Living Resident Condition and Care Overview" report, dated 03/14/23, documented 10 residents were not capable of responding to emergency situations without physical assistance from the staff or were not capable of self preservation and 25 residents resided in the center. The RN identified three residents who required two person assistance for transfers.	C 962		

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C 962	Continued From page 10 Findings: The "Staffing" policy, dated 12/12/22, read in parts, "...Each community is to provide for a sufficient number of staff to...Provide care required in each resident's written record of care...Ensure the health, safety, comfort, and supervision of the residents...Adequate trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents..." On 03/14/23 at 11:16 a.m., Resident #2's family member was asked if they had been informed the center had one direct care staff on duty at times. They stated they did not remember being told there would only be one staff on duty. Resident #2's family stated Resident #2 had fallen in the past and they had to help get the resident up from the floor. They stated there was only one staff member in the building and they were not sure how long the resident had been in the floor. On 03/15/23 at 5:17 a.m., CNA #1 was observed working in the building without another staff member. CNA #1 stated they usually worked alone in the building Monday through Wednesday from 11:00 p.m. to 7:00 a.m. On 03/15/23 at 7:39 a.m., CNA #5 was the only direct care staff working in the building qualified to provide resident care. On 03/16/23 at 1:28 p.m., the business office manager stated the center had not notified the residents or their families of one direct care staff on duty and had not submitted a plan to the OSDH for approval.	C 962		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 11	C1304		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to provide contracted services to ensure a. residents were provided transfer assistance of two staff members for two (#1 and #4) of three sampled residents who required two person assistance for transfers; b. residents were provided incontinent care, and housekeeping for one (#1) of three residents reviewed for incontinent care; and c. loose broken tiles were repaired for one (#9) of eight sampled residents. The RN identified 26 residents who resided in the center, three residents who required two person	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 12 assistance, and nine residents who were incontinent. Findings: The contract for resident #1, #4, and #9 documented the residents would be provided assistance with personal care, housekeeping, transfer or ambulation and the assistance with the use of any assistive devices as detailed in the assessment/service plan. The contract documented the basic rate included apartment maintenance. 1. Resident #1 had diagnoses which included transient ischemic attack, tendonitis, and plantar fasciitis. A significant change assessment, dated 03/14/22, documented the resident was oriented to person, place, and time, was ambulatory with staff assist, required two person assistance for transfers, and was incontinent of bladder, required total assistance with toileting and wore an incontinent brief. A care plan/service agreement, dated 03/14/22, read in parts, "...Basic Housekeeping will be provided...Staff will provide basic laundry service...CNA, Medaide [sic] will assist resident with incontinence..." A "Service Checkoff List", dated 03/01/23 through 03/13/23, documented Resident #1 was frequently incontinent and to assist resident with incontinence. The check off list for p.m. shift was not signed out as completed on 03/01/23 through 03/13/23. On 03/13/23 at 7:55 p.m., CNA #2 stated	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 13 Resident #1 required two person assistance for transfers. On 03/13/23 at 8:03 p.m., CNA #3 was observed assisting Resident #1. Resident #1's apartment had a strong urine odor. CNA #3 lifted Resident #1 out of the recliner and the resident's pants were observed to be wet and smelled of urine. The recliner was wet and had a urine odor. CNA #3 then transferred Resident #1 from the wheelchair to the bed. Resident #1's wheelchair was observed to be wet and have odor of urine. CNA #3 was observed to change Resident #1's pants and incontinent brief. The pants were wet with urine, and the brief was saturated with urine. A mechanical lift was observed in Resident #1's room. CNA #3 transferred Resident #1 from the recliner to the wheelchair and from the wheelchair to the bed with one person and without using the mechanical lift. On 03/13/23 at 8:23 p.m., CNA #3 was asked when the last time the resident had been provided incontinent care. They stated the resident was dry before dinner. On 03/13/23 at 8:39 p.m., CNA #2 stated the residents had eaten dinner at 5:00 p.m. On 03/14/23 at 3:03 p.m., LPN #1 was asked how often they expected the staff to provide incontinent care to Resident #1. They stated the staff usually made rounds every two hours. LPN #1 was made aware of the observations of the urine odors and the wet pants and soaked incontinent brief. LPN #1 was asked if they had provided Resident #1 care according to their service agreement/contract. They stated, "No."	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 14 On 03/16/23 at 12:04 p.m., Resident #1's apartment was observed with the maintenance technician. A strong urine odor was present in the apartment. A pair of jeans with a wet area on the back of the pants was found lying on the floor in the resident's closet. 2. Resident #4 had diagnoses which included right hip dislocation. A preadmission assessment, dated 08/05/22, documented the resident was oriented to person, had poor gait and mobility and required staff assistance of two for ambulation and transfer of short distances. The service agreement/care plan, dated 08/05/22, read in parts, "....Service Type: Alerts: Fall Risk...[Resident #4] has a history of falls and is high risk for continued falls...Service Type: Transfers: 2 Person Assist...Resident requires 2 person assistance for transfers in residents room and other locations as needed..." On 03/15/23 at 7:39 a.m., CNA #5 was observed assisting Resident #4 out of bed without assistance of another staff member. There were no other staff members qualified to provide care in the building. 3. Resident #9 had diagnoses which included hemiplegia and hemiparesis. A significant change assessment, dated 10/02/22, documented Resident #9 was alert and oriented to person, place, and time, had limited range of motion and utilized a wheelchair for ambulation. On 03/16/23 at 11:30 a.m., Resident #9's tile in	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 15 front of their apartment door was observed to be broken and loose. On 03/16/23 at 4:08 p.m., the business office manager was shown the tile. They stated the center was responsible for the maintenance of the building. On 03/16/23 at 4:40 p.m., Resident #9 was asked how long the tile had been broken. They stated approximately nine to 12 months.	C1304		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were administered as ordered by the physician for three (#1, 2, and #5) of eight sampled residents who had orders for medications. The RN identified 26 residents who resided in the center. Findings: The "Medication Administration" policy, dated 02/2019, read in parts, "...Nurse/Medication Aide administers assists with administration, followed by documentation of medication administration/assistance on the MAR/eMAR. If medication is omitted or not given, the MAR/eMAR is circled and an explanation for the omission is documented on the MAR/eMAR..." 1. Resident #1 had diagnoses which included hypertension, coronary artery disease, and dry eyes. Physician's order, dated 10/26/21, documented to administer Lipitor 40 mg daily at bedtime.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 17 Physician's order, dated 08/30/22, documented to administer Refresh eye gel at bedtime. Physician's order, dated 09/02/22, documented to administer Seroquel 12.5 mg, Myrbetriq 50 mg, and Melatonin at bedtime, Metoprolol Tart 25 mg, Eliquis 5 mg, and fish oil capsule two times a day. A MAR, dated 01/01/23 through 01/31/23, documented to administer Lipitor, Seroquel, and Refresh eye drops daily at 8:00 p.m., The medications were not signed out as administered on 01/06/23 and 01/14/23. A MAR, dated 03/01/23 through 03/31/23, documented the Myrbetriq ER, Seroquel, Refresh eye gel, Melatonin, Metoprolol, Eliquis, and fish oil capsule were not signed out as administered on 03/04/23 at 8:00 p.m. 2. Resident #2 had diagnoses which included dementia and peripheral neuropathy Physician's orders, dated 07/23/21, documented to administer Gabapentin 300 mg two times a day for neuropathy and multivitamin daily. Physician's order, dated 11/19/21, documented to administer Cephalexin 500 mg daily for prophylactic. Physician's order, dated 03/08/22, documented to administer Furosemide 20 mg daily for edema. A service agreement/care plan, dated 08/16/22, read in parts, "...Staff to reorder medications per physician's orders ...Staff will give [Resident #2] his medication ..."	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 18 A MAR, dated 02/01/23 through 02/28/23, documented Cephalexin capsule 500 mg, Furosemide 20 mg, multivitamin, and Gabapentin 300 mg were not administered on 02/21/23 due to being unavailable. 3. Resident #5 had diagnoses which included chronic pain, GERD, seizures, and chronic kidney disease. Physician's orders, dated 04/17/22, documented to administer Calcium Acetate capsule 667 mg for chronic kidney disease, Dilantin 100 mg for seizures, and Sodium Bicarb tablet 650 mg for GERD three times a day. A service agreement/care plan, dated 05/18/22, documented the staff would reorder and administer medications per physician's orders. A MAR, dated 02/01/23 through 02/28/23 documented Calcium Acetate 667 mg, sodium bicarb tablet 650 mg and Dilantin 100 mg were to be administered three times daily. The MAR documented two doses of the Calcium Acetate were not administered on 02/26/23 and 02/27/23, and three doses were not administered on 02/28/23 due to being unavailable. The MAR documented two doses of the sodium bicarb were not administered on 02/26/23, 02/27/23, and 02/28/23 due to being unavailable. The MAR documented one dose of Dilantin was not administered on 02/26/23, two doses were not administered on 02/27/23, and 02/28/23 due to being unavailable. On 03/15/23 at 12:39 p.m., the RN was asked about the medications not signed out as	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 19 administered and the medications not administered due to being unavailable. The RN stated the MATs were supposed to monitor the medications daily and reorder the medications when needed. The RN stated the staff were supposed to click a button indicating the medications were administered in the electronic medication administration record. The RN stated if the medications were not initialed there would not be away to know if the medications had been administered.	C1505		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review, observation, and	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 20 interview, the center failed to ensure accurate documentation of medication administered for one (#5) of eight sampled resident reviewed for medication administration. The RN identified 26 residents who were administered medications and five residents who were administered injections. 1. Resident #5 had diagnoses of diabetes. A MAR, dated 03/01/23 through 03/14/23, documented Lantus (insulin) 60 units was administered at 8:00 a.m., on 03/01/23 through 03/14/23, and Lantus 60 units was administered at 8:00 p.m., on 03/01/23, 03/02/23, 03/03/23, 03/05/26, 03/06/23, 03/08/23 through 03/11/23, 03/13/23, and 03/14/23. On 03/15/23 at 8:28 a.m., Resident #5 was administered Humalog 75/25 insulin 46 units. The resident was not administered Lantus. On 03/15/23 at 12:39 p.m., the RN stated the physician had written an order to increase Lantus to 60 units twice a day, and the center called and clarified the order because Resident #5 was not on Lantus. They stated the resident had not been administered Lantus. The RN stated the Lantus was documented incorrectly on the MAR.	C1923		
C5020 SS=D	63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up 3. The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation and shall include the assisted living center and	C5020		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE RENAISSANCE OF STILLWATER-ASSISTED LIVING

1400 EAST MCELROY
STILLWATER, OK 74075

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to ensure the plan of accommodation was reviewed quarterly for one (#2) of two sampled residents who had a plan of accommodation.

Oklahoma State Department of Health

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C5020	Continued From page 22 The RCD identified two residents who had a plan of accommodation. Findings: The "Allowable Health Conditions" policy, dated 05/18/22, read in parts, "...If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria...All accommodations or additional services shall be described in a written plan of accommodation...The plan of accommodation shall be reviewed at least quarterly by a licensed health care professional..." Resident #2 was admitted on 07/23/21 and had diagnoses which included dementia. A significant change assessment, dated 08/16/22, documented Resident #2 required two person assist with a mechanical lift for transfers. A plan of accommodation, dated 05/23/22, read in parts, "...Description of Services Provided... [mechanical] lift x 2 staff assist, transfers x 2 staff assist. Hospice has provided [mechanical] lift for all transfers..." A plan of accommodation, dated 08/16/22, read in parts, "...Description of Services Provided... [mechanical] lift x 2 staff assist, transfers x 2 staff assist. Hospice has provided [mechanical] lift for all transfers..." There were no other reviews of the plan of accommodation. On 03/14/23 at 4:33 p.m., the RCD stated the last review of the plan of accommodation was done	C5020		

Oklahoma State Department of Health

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C5020	Continued From page 23 on 08/16/22. The RCD was asked why Resident #2 had a plan of accommodation. They stated because the staff transferred the resident using a [mechanical] lift at times. The RCD stated the plan of accommodation should have been reviewed quarterly.	C5020		

Delivery via email to: executivedirector@renlivingpc.com

April 19, 2023

License Number: AL6002

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

Survey Event ID: MKXZ11

Dear Ms. Chill:

On **March 16, 2023**, a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 31, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2023.04.19 10:29:38 -05'00'

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

enc



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/13/2023

Facility Name: The Renaissance of Stillwater

License Number: AL6002

Survey Event ID: MKXZ11

Date Survey Completed: 3/16/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552

Based on: Based on record review, observation, and interview, the center failed to update/develop the care plan based on the resident assessment to include: a. transferring assistance of two staff with the use of a mechanical lift for one (#1) of two sampled residents who utilized mechanical lifts for transfers and b. hip precautions for one (#4) of one sampled resident who had a history of hip dislocations.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Nurse will be in-serviced on ensuring assessment is used to update/develop the care plan based on the resident assessment, to include the hip precautions for resident with history of hip dislocations, and also transfer assistance needed for residents requiring two person assistance and/or mechanical lifts.

Two residents residing in the community had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

Care plans will be audited and updated to ensure that care plans have required components of hip dislocation and transfer assistance, including two-person assistance and mechanical lifts.

RN/DHW will be responsible for sustained compliance.

ED and/or designee will maintain monitoring records.

Tracking and trending will be reported during the QA Meeting.

Monitoring records will be attached to QA Minutes and maintained by Executive Director to ensure compliance.

5/25/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)			Date 4/14/2023
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/13/2023

Facility Name: The Renaissance of Stillwater

License Number: AL6002

Survey Event ID: MKXZ11

Date Survey Completed: 3/16/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C961

Based on: record review, observation, and interview, the center failed to ensure adequate staff was on duty to meet the needs of the residents for three (#1, 2, and #4) of three sampled residents who required two person assistance for transfers.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Tara R. Chill

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Adequate number of staff will be on duty to meet the needs of residents that require two person assistance with transfers. DHW and nurse in-serviced on importance of ensuring adequate staff are on duty to meet resident's needs.

Five residents had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

ED and/or designee will ensure that adequate staff will be on duty when residents require two person assistance with transfers. Staff in-serviced on this regulation.

ED and/or DHW will be responsible for sustained compliance.

ED and/or designee will review staffing and will maintain monitoring records.

Tracking and trending will be reported and reviewed during QA Meeting.

Monitoring records will be in POC Binder and maintained by Executive Director to maintain compliance.

4/16/2023

Date 4/16/2023

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

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/13/2023

Facility Name: The Renaissance of Stillwater

License Number: AL6002

Survey Event ID: MKXZ11

Date Survey Completed: 3/16/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C962

Based on: Based on record review, observation, and interview, the center failed to ensure one-person staffing, and a plan to deal with emergent situations was disclosed to the residents and their representatives for all 25 residents who resided at the center and failed to ensure the plan was submitted to the OSDH.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Plan for one-person staffing and plan to deal with emergent situations will be submitted to OSDH. After approval, plan will be disclosed to residents and their representatives.

All residents residing in the community had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

ED and BOM in-serviced on this regulation.

ED and/or BOM will be responsible for sustained compliance.

ED and/or BOM will maintain monitoring records.

Tracking and trending will be reported during QA Meeting.

Monitoring records will be maintained in the POC Binder.

5/25/2023

Administrator's Signature Tara R. Chill

OAC 310:663-25-4(F)

Date 4/14/2023

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License Number: AL6002

Survey Event ID: MKXZ11

Date Survey Completed: 3/16/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304

Based on: record review, observation, and interview, the center failed to provide contracted services to ensure: a. residents were provided transfer assistance of two staff members for two (#1 and #4) of three sampled residents who required two person assistance for transfers; b. residents were provided incontinent care, and housekeeping for one (#1) of three residents reviewed for incontinent care; and c. loose broken tiles were repaired for one (#9) of eight sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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;

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Staff will be in-serviced on importance of ensuring two staff members provide assistance with transfers that require two person assistance.
2. Staff will be in-serviced on importance of ensuring incontinence care is provided as contracted, and also ensuring housekeeping services are provided as contracted.
2. Maintenance team will be in-serviced on importance of ensuring that maintenance services are provided as contracted.

All residents residing in the community had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

Maintenance Director, ED, and/or designee will perform random checks of resident apartments and common areas to ensure that housekeeping and maintenance services are provided as contracted.
Audits will also be performed randomly while staff is providing assistance with residents requiring two person assistance.

Maintenance Director, ED, and/or designee will be responsible for sustained compliance.

Maintenance Director, ED, and/or BOM will maintain monitoring records.

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.		Tracking and trending will be reported and reviewed during QA Meeting. Monitoring records will be placed in POC binder, and will be maintained by ED to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/25/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 4/14/2023	
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License Number: AL6002

Survey Event ID: MKXZ11

Date Survey Completed: 3/16/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: Based on record review and interview, the center failed to ensure medications were administered as ordered by the physician for three (#1, 2, and #5) of eight sampled residents who had orders for medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Medication aides will be in-serviced on Medication Administration and Refill policies.

All residents residing in community have the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings.

- 1. EMAR/MAR will be audited daily x1 month and weekly afterwards to ensure that medication administration is documented on EMAR/MAR.
- 2. DHW and/or designee will complete weekly audit x4 weeks and bi-weekly afterwards to ensure that medications are filled timely to ensure compliance.

DHW and/or ED will be responsible for sustained compliance.

ED and/or designee will maintain monitoring records.

Tracking and trending will be reviewed and recorded during QA Meeting.

Monitoring records will be placed in POC binder and maintained by ED to ensure compliance.

5/31/2023

Administrator's Signature Tara R. Chill

Date 4/14/2023

OAC 310:663-25-4(F)

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