OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingpc.com; executivedirector@renlivingsw.com

May 10, 2024

License Number: AL6002

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

RE: Survey Event ID: 12F411

Dear Ms. Chill:

On **April 26, 2024**, agents from our office concluded a State Licensure survey 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 **April 26, 2024**.

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 (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 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 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 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,

Clorissa Nubine

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Renaissance of Stillwater Assisted Living**
Address: **1400 East McElroy**
City, State, Zip: **Stillwater, OK, 74075**
Provider #: **AL6002**
Complaint #: **OK00064052**
Investigation Date(s): **04/25/24-04/26/24**

ALLEGATION(S)
The center failed to ensure assistance with incontinent care and meal delivery was provided in a timely manner and according to the contract and plan of care
The center failed to ensure residents were treated with dignity and respect and failed to ensure a clean, comfortable, and homelike environment.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 05/25/2023 at 7:30 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Observations of the facility were made upon entry and randomly throughout survey. Residents were observed receiving incontinent care and meal services. Staff were observed interacting with residents during care and individual pursuits.
Records were reviewed including contracts, assessments, menus, progress notes, physician orders, policies, and schedules.
Interviews were conducted with staff and residents regarding incontinent care, meal delivery, dignity and respect, and adequate staffing.

The attached State form, Statement of Deficiencies, 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: 04/29/2024

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 _____	C 04/26/2024

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 relicensure survey was conducted from 04/25/24 through 04/26/24. A complaint investigation (#OK00064052) was conducted in conjunction with the survey. Facility Census: 27 The following abbreviations are used throughout the document: MAR - medication administration record mg - milligram Res - resident	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored in accordance with Chapter 257 relating to food service establishments. The administrator identified all 27 residents received nutrition from the kitchen. Findings: An initial tour of the kitchen was conducted on 04/25/24 at 08:23 a.m. The following was observed during the tour: a. two gallons of milk with expiration dates of 04/21/24 and 04/23/24 in the two door upright	C 391		

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 _____	C 04/26/2024

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

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C 391	Continued From page 1 refrigerator, b. a one gallon bag half full of cooked bacon without a date or label in the two door upright refrigerator, c. opened bag of ham sandwich meat without a date or label in the two door upright refrigerator, d. opened bag of sliced provolone cheese without a date or label in the two door upright refrigerator, e. a container of low-fat yogurt opened without a date in the two door upright refrigerator, f. an open five pound container of chicken base with an expiration date of 04/04/24 in the two door upright refrigerator, g. one half block of Velveeta in original foil wrapping with a hole in one side of the original wrapping not sealed, labeled, or dated in the two door upright refrigerator, h. a bag of sliced cheddar cheese without a date or label in the two door upright refrigerator, i. a box of 20 inch fettuccini noodles open to air and undated in the dry food storage area, and j. a box of small oranges with several covered in a white and green fuzzy substance. On 04/25/24, at 08:43 a.m., cook #1 stated the refrigerators and storage is to be checked for expired food weekly on truck days. They stated they were not sure when the last time it was completed. They stated the food in the two door refrigerator should have been sealed, dated, and labeled. They stated the oranges should have	C 391		

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 _____	C 04/26/2024

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

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C 391	Continued From page 2 been thrown away.	C 391		
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		

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 _____	C 04/26/2024

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
C1505	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered as ordered and orders to discontinue a medication was completed for two (#3 and #4) of eight sampled residents reviewed for medications. The administrator identified 26 of 27 residents received medications. Findings: 1. Res #3 had diagnoses which included hypertension. A physician order, dated 08/29/23, documented to administer metoprolol 25 mg one and a half tabs by mouth twice daily for hypertension. A fax communication to the physician, dated 03/19/24 documented Res #3's blood pressure medication had been consistently held due to low blood pressures. The communication was returned with an order to discontinue the metoprolol on 03/20/24. The metoprolol was discontinued 04/19/24. On 04/25/24 at 4:10 p.m., the administrator stated the medication should have been discontinued as soon as the order was received, but no later than the next business day. 2. Res #4 had diagnoses which included migraines.	C1505		

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 _____	C 04/26/2024

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
C1505	Continued From page 4 A physician order, dated 03/18/24, documented to administer Aimovig injection once per month for migraines. A MAR for March 2024 documented the Aimovig injection was to be administered on 03/25/24 but was not given. A MAR for April 2024 documented the Aimovig injection was to be given on 04/22/24 but was not given. On 04/25/24 at 3:40 p.m., the administrator stated the nurse had stated the injection was not given. They stated the nurse was not aware it was due.	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.	C1923		

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 _____	C 04/26/2024

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

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C1923	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication administration documentation was accurate and complete for one (#1) of eight sampled residents reviewed for medications. The administrator identified 26 of 27 residents received medications. Findings: Res #1 had diagnoses which included diabetes. A physician order, dated 04/04/24, documented to administer insulin aspart 12 units twice per day. A physician order, dated 04/05/24, documented to administer insulin detemir 30 units twice per day. A MAR for April 2024 documented blanks for two of 40 administrations of the insulin aspart. A MAR for April 2024 documented blanks for two of 40 administrations of the insulin detemir. On 04/25/24 at 3:34 p.m., the administrator stated the blanks on the MAR were a documentation error, they stated there was no way the medication was missed and it just did not get documented.	C1923		

OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingpc.com; executivedirector@renlivingsw.com

June 7, 2024

License Number: AL6002

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

Survey Event ID: 12F411

Dear Ms. Chill:

On **April 26, 2024,** a Licensure survey with 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 **June 26, 2024**.

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/22/2024

Facility Name: The Renaissance of Stillwater- Assisted Living

License Number: AL6002

Survey Event ID: 12F411

Date Survey Completed: 4/26/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation and interview, the facility failed to ensure food was stored in accordance with Chapter 257 relating to food service establishments.

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?	Culinary team in-serviced on food storage requirements in accordance with Chapter 257 relating to food service establishments.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	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.
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?	1. Audit will be performed daily x2 weeks, and randomly afterwards to ensure that food items are stored as required in accordance with Chapter 257 relating to food service establishments.
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.	Director of Culinary Services and/or ED will be responsible for sustained compliance. ED and/or designee 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.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/26/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill Executive Director** **Date 5/22/2024**

OAC 310:663-25-4(F)

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/22/2024** **Facility Name:** The Renaissance of Stillwater- Assisted Living **License Number:** AL6002 **Survey Event ID:** 12F411 **Date Survey Completed: 4/26/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to ensure medications were administered as ordered and orders to discontinue a medication was completed for two (#3 and #4) of eight sampled residents reviewed for 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?	Nurse and Med Techs in-serviced on resident rights of medication administration and order processing checklist.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	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.
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?	1. Audit will be performed daily x2 weeks, and randomly afterwards to ensure that medications are being administered as ordered, and discontinued timely according to physician orders.
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.	Nurse and/or ED will be responsible for sustained compliance. ED and/or designee 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.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/26/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill Executive Director**	**Date 5/22/2024**

OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/22/2024** **Facility Name:** The Renaissance of Stillwater- Assisted Living **License Number:** AL6002 **Survey Event ID:** 12F411 **Date Survey Completed: 4/26/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: record review and interview, the facility failed to ensure medication documentation was accurate and complete for (#1) of eight sampled residents reviewed for 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?	Nurse and medaides inserviced on seven rights of medication administration, including documentation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	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.
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?	1. EMAR will be audited daily x3 weeks, and randomly afterwards to ensure that documentation of medication administration is accurate.
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.	Nurse and/or ED will be responsible for sustained compliance. ED and/or designee 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.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/26/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill Executive Director** OAC 310:663-25-4(F)	**Date 5/22/2024**

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.			

OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingpc.com; executivedirector@renlivingsw.com

July 29, 2024

License Number: AL6002
Survey Event ID: 12F412

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

Dear Ms. Chill:

On **July 24, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **July 24, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **June 26, 2024**.

If you have any questions concerning the information in this letter, 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

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
	AL6002	A. BUILDING: _____ B. WING _____	R-C 07/24/2024

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 07/24/24, an offsite/revisit was conducted. The deficiencies from 04/26/24 were cleared.	{C 000}		

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