OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingpc.com

December 22, 2021

License Number: AL6004

Ms. Tara Chill, Administrator
The Renaissance Of Stillwater-Memory Care
1450 East McElroy
Stillwater, OK 74075

Survey Event ID: O91F11

Dear Ms. Chill:

On **December 10, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on 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 will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 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,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Renaissance of Stillwater-Memory Care**
Address: **1450 East McElroy**
City, State, Zip: **Stillwater, OK 74075**
Provider #: **AL6004**
Complaint #: **OK00055150**
Investigation Date(s): **12/08/21 and 12/10/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide services according to residents' contracts.	S

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

An unannounced on-site investigation was initiated on Wednesday, December 8, 2021 at 3:20 p.m.

A sample of five residents including any identified resident, 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 C1304 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.

Billie Seeman, RN

Date report completed: 12/14/2021

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Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Renaissance of Stillwater-Memory Care**
Address: **1450 East McElroy**
City, State, Zip: **Stillwater, OK 74075**
Provider #: **AL6004**
Complaint #: **OK00057273**
Investigation Date(s): **12/08/21 and 12/10/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to conduct an appropriate assessment of residents' appropriateness for placement, and to conduct assessments after significant changes in condition.	**US**
2. The center failed to administer medication in a safe manner.	**US**

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

An unannounced on-site investigation was initiated on Wednesday, December 8, 2021 at 3:20 p.m.

A sample of three residents including any identified resident, 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 assessment of the residents for admission and assessment with significant changes was conducted.

The residents were observed to have memory impairments. The staff were observed assisting the residents with activities of daily living. The residents were not above the level of care the center could provide.

The staff stated the center was always staffed with at least two staff members to accommodate the residents who required two person assistance.

Family members stated the center provided the residents assistance with activities of daily living.

Contracts, assessments, service agreements, hospice records and physician's orders were reviewed.

At the time of the survey no deficient practice related to assessment for placement or significant changes was found.

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

An investigation specific to medication administration was conducted.

Residents were observed to be awake during waking hours. Residents were observed to sleep at appropriate times. The residents were observed participating in activities, sitting in the common areas of the building, walking around the building, and eating in the dining room.

Staff stated they had not observed residents who were over sedated. Staff stated some residents were up at night and slept during the day at times. The staff from the center stated the family was notified when a medication change was made.

Hospice staff stated they notified the family if medication changes were made and documented the family was notified in the residents' hospice records. The hospice staff stated they had not witnessed residents being over-medicated or over sedated.

Family members were interviewed and stated they did not have any concerns related to medication or the sleeping/waking habits of the residents or the care provided by the staff.

Clinical records, hospice records, physician's orders, and incident reports were reviewed and revealed the center discontinued or lowered medication dosages when indicated due to falls or excessive sleepiness during waking hours. The records documented the family was notified when medication changes were made.

At the time of the survey no deficient practice was found related to medication administration.

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.

Billie Seeman, RN, Clinical Health Facility Surveyor

Date report completed: 12/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6004	A. BUILDING: _____ B. WING _____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-MEMORY CARE	1450 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 complaint investigation (#OK00055150 and #OK00057273) was conducted on 12/08/21 and 12/10/21.	C 000		
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 observation, interview and record review, the center failed to ensure routine maintenance was provided according to the contract for three (#4, 5 and #6) and failed to ensure the resident rooms were free from offensive odors for two (#1 and #3) of five sampled residents whose rooms were observed for maintenance and cleanliness. The registered nurse (RN)/Health and Wellness Director identified 19 residents who resided in the center. Findings:	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6004	A. BUILDING: _____ B. WING _____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-MEMORY CARE	1450 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 1 An undated, "Housekeeping" policy, read in parts, "...Residents deserve a safe, clean...place to live...Daily...Maintain the residence for the residents' comfort...Tips...Ask housekeepers to inspect each room...daily..." An undated, "Physical Plant Log" policy, read in parts, "...Encourage residents and staff to report any concerns they might have about the physical environment...The maintenance and housekeeping staff monitor and maintain the physical environment..." The center's contract, dated 05/13/11, read in part, "...Basic Rate Includes...Basic weekly housekeeping with linen service...Apartment maintenance..." 1. Resident (Res) #4 and #5 had service agreements which documented the basic service package included apartment maintenance. The agreement documented the staff would repair and maintain the fixtures and equipment in the unit. On 12/08/21 at 3:43 p.m., the toilet tank lid was missing in Res #5's bathroom. The housekeeper attempted to flush the toilet, the toilet would not flush and the base of the toilet moved. The housekeeper stated the toilet wiggled when she leaned against it. At 4:13 p.m., a metal piece was on the floor in Res #6's bathroom. The RN stated the metal piece was from the broken toilet paper holder. The toilet paper holder was missing from the wall. On 12/10/21 at 10:42 a.m., Res #4's bathroom light fixture was missing the cover and had a build	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6004	A. BUILDING: _____ B. WING _____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-MEMORY CARE	1450 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 2	C1304		

up of debris on the vented area of the light fixture. A small section of baseboard was missing near the bathroom entrance.

At 12:44 p.m., the administrator stated the center had an employee who was responsible for maintenance. The administrator stated the center had a maintenance request log book. She stated families, residents or staff could report maintenance requests.

The administrator was asked about Res #5's toilet. She stated the staff were instructed to turn the water off to obtain a stool sample. The administrator stated the resident must have removed the lid from the tank to try and flush it. She stated the base of the toilet needed to be tightened.

The administrator stated the repairs needed in Res #4 and Res #6's room had not been reported.

2. Resident #1 had diagnosis which included dementia and cognitive communication deficit.

An annual assessment, dated 06/25/21, documented the resident was oriented to self, was forgetful, required assistance with dressing, and was incontinent of bladder at times.

A service agreement, dated 06/29/21, documented the resident would have basic housekeeping and laundry service every day.

On 12/08/21 at 3:38 p.m., upon entering the residents room, a strong odor of urine was present. The residents bed had a comforter on the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6004	A. BUILDING: _____ B. WING _____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-MEMORY CARE	1450 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 3 At 3:50 p.m., the RN stated she could smell the urine but did not know where it was coming from. The RN lifted the comforter from the bed and the mattress was wet and had a urine odor. The mattress did not have sheets on the bed. The RN stated the certified nurse aides were responsible for making the beds. At 4:31 p.m., the activity coordinator stated Res #1 may have put the blanket over the mattress to hide the fact she was incontinent. Res #3 had diagnosis which included dementia. A service agreement, dated 05/12/21, documented the resident would be provided with dressing, grooming, and toileting assistance. The service agreement documented the resident would be provided basic housekeeping services. A significant change assessment, dated 05/12/21, documented the resident was confused oriented to self only and had fair judgment. The assessment documented the resident required assistance of one person for bathing, dressing, toileting, and was incontinent of bladder. On 12/08/21 at 4:15 p.m., Res #3 had a urine odor in his room. The odor was near his wheelchair. A bed sheet was found on the floor. The RN stated the smell was not coming from the bed sheet. The resident was observed sitting in his recliner in his room. On 12/10/21 at 8:44 a.m., Res #3 had a urine odor in his room. At 11:08 a.m., a family member of Res #3 stated they had visited a couple of times and had smelled a urine odor in the residents room. The	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6004	A. BUILDING: _____ B. WING _____	C 12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-MEMORY CARE	1450 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 4 family member also stated they came to visit another time and the bedding was wet with urine. At 12:44 p.m., the administrator stated the urine odor in Res #3's room had been reported to her. She stated the urine odor could be coming from the mattress. The administrator stated routine maintenance and housekeeping was a service provided in the contract.	C1304		

OKLAHOMA
State Department
of Health

Delivery via email to: executivedirector@renlivingpc.com

January 5, 2022

License Number: AL6004

Ms. Tara Chill, Administrator
The Renaissance Of Stillwater-Memory Care
1450 East McElroy
Stillwater, OK 74075

Survey Event ID: O91F11

Dear Ms. Chill:

On **December 10, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 17, 2022**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2022.01.05 09:18:13 -06'00'

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/30/2021** **Facility Name:** The Renaissance Assisted Living- Memory Care **License Number:** AL6004 **Survey Event ID:** O91F11 **Date Survey Completed: 12/10/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304	Based on: observation, interview and record review, the center failed to ensure routine maintenance was provided according to the contract for three (#4, #5, and #6) and failed to ensure the resident rooms were free from offensive odors for two (#1 and #3) of five sampled residents whose rooms were observed for maintenance and cleanliness.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: 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?	1. Housekeeping and Maintenance staff will be inserviced on importance of ensuring routine maintenance is reported and performed as necessary. 2. Staff will be inserviced on importance of reporting items needing maintenance, and ensuring resident rooms are free from offensive odors.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Every resident residing in community had 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?	Maintenance Director, Executive Director, and/or designee will perform random checks of resident apartments and common areas within community to ensure they are odor free and to ensure routine maintenance requests have been reported and repaired.
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.	Maintenance Director and/or Executive Director will be responsible for sustained compliance. Executive Director and/or designee will maintain monitoring records. Tracking and Trending will be reported and reviewed during the QA meeting.

	Monitoring records will be attached to the QA meeting minutes, and will be maintained by the Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/17/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tara R. Chill** OAC 310:663-25-4(F)	**Date 12/30/2021**

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

December 30, 2022

License Number: AL6004

Ms. Tara Chill, Administrator
The Renaissance of Stillwater-Memory Care
1450 East McElroy
Stillwater, OK 74075

Survey Event ID: O91F12

Dear Ms. Chill:

On **December 28, 2022,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 10, 2021,** have now been corrected effective **January 17, 2022.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL6004	A. BUILDING: _____ B. WING _____	R 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RENAISSANCE OF STILLWATER-MEMORY CARE	1450 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 An offsite/paper revisit was conducted on 12/28/22. The facility was in substantial compliance.	{C 000}		

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