
Delivery via email to: executivedirector@renlivingsw.com

July 12, 2023

License Number: AL6004

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

RE: Survey Event ID: REC511

Dear Ms. Chill:

On **June 23, 2023**, 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.

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,



Lisa Calvin, 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: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 EAST MCELROY STILLWATER, OK 74075		
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/22/23 through 06/23/23. Listed below are abbreviations that will be used throughout this document. CNA- Certified Nurse Aide DHW - Director of Health and Wellness ER - emergency room ED - executive director LPN- Licensed Practical Nurse F- Fahrenheit IJ- immediate jeopardy MAT - Medication Administration Technician MC - memory care mg - milligrams OSDH - Oklahoma State Department of Health	C 000		
C 391 SS=F	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, record review, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure: a. the kitchen was clean and sanitary; b. the dish machine was working properly; and c. flour and rice were stored in a sealed container.	C 391		

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 391	Continued From page 1 The "Assisted Living Resident Condition and Care Overview" report, dated, 06/22/23 documented 19 residents resided in the center. Findings: "...310:257-5-37 Food storage...food shall be protected from contamination by storing the food...Where it is not exposed to splash, dust, or other contamination ...310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a)...Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." A "Quarterly Dietitian" report, dated 05/31/23, documented the flour was not sealed. The dish machine testing log for June 2023 was reviewed and revealed there were no documented temperatures or sanitizer readings on 06/20/23 through 06/22/23. On 06/22/23 at 11:20 a.m. a tour of kitchen was conducted with cook #1. The following was observed: a. The oven was dirty with black dried on food and debris; b. One large plastic container with the lid not closed tightly contained an unsealed sack of flour.	C 391		

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C 391	Continued From page 2 c. One large plastic container with the lid not closed tightly contained an unsealed sack of rice. d. The dish machine was out of sanitizer solution. On 06/22/23 at 11:20 a.m., Cook #1 stated the dish machine sanitizing solution was empty. Cook #1 was asked if they had tested the dish machine that morning on 06/22/23. They stated, "No." Cook #1 hooked up a new container of sanitizing solution to the dish machine. Cook #1 tested the dish machine again. The dish machine chemical sanitizing strips did not change colors to indicate the dish machine was sanitizing the dishes with the correct concentration. On 06/22/23 at 12:36 p.m., the dietary manager was asked about the dish machine. They stated they primed the chemical sanitizer in the dish machine and tested it again. The dietary manager stated when they tested the machine the chemical sanitizer strips had not changed to indicate the dish machine was sanitizing the dishes. They stated they called the representative. The dietary manager was asked about the oven. The dietary manager stated the oven did not look clean. They wiped out the oven with a cloth and a black substance was on the cloth. The dietary manager stated the flour and rice containers should have been sealed.	C 391		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards	C 701		

Oklahoma State Department of Health

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C 701	Continued From page 3 set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure hot water temperatures did not exceed 115 degree F. The "Assisted Living Resident Condition and Care Overview" report, dated 06/22/23, documented 19 residents resided in the center. Findings: A review of the hot water temperature logs revealed the hot water temperatures were checked in three rooms on 04/24/23 and in five rooms on 06/12/23. There were no other hot water temperature logs provided. On 06/22/23 at 12:14 p.m, hot water temperatures were obtained with housekeeper #1. The following temperatures were obtained: At 12:14 p.m., room #700's bathroom sink temperature was 125.0 degrees F. At 12:20 p.m., room #610's sink temperature was 124.1 degrees F. At 12:22 p.m., the temperature in the bathroom sink was 120.7 degrees F.	C 701		

Oklahoma State Department of Health

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C 701	Continued From page 4 On 06/22/23 at 2:45 p.m., the maintenance director stated the maximum hot water temperature was supposed to be 110.0 degrees F. The maintenance director stated they usually checked the water temperatures in random rooms weekly. They stated they had not checked the water temperatures in two weeks.	C 701		
C1505 SS=K	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 5 This REQUIREMENT is not met as evidenced by: On 06/22/23 at 3:00 p.m., the OSDH confirmed the existence of an immediate jeopardy situation related to a broken door lock on the medication/laundry room door, allowing residents who have memory and/or cognitive impairments access to the medication and laundry room where chemicals were within reach of the residents. Resident #1 was observed to enter the medication room, where there were chemicals in unlabeled containers. At 3:02 p.m., the administrator was informed of the existence of the immediate jeopardy. A request was made for an acceptable plan to remove the immediacy. On 06/22/23 at 4:57 p.m., the plan of removal was accepted by the OSDH. The plan of removal was as follows: "Process to correct the IJ on 6/22/23 in MC 1. DHW was immediately assigned to remain in room to ensure residents do not enter. Staff will remain present in this room until door locking mechanisms are repaired and locked. 2. Maintenance team was immediately instructed to repair locking mechanisms on doors. 3. Staff on duty also immediately in-serviced on	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 6 importance of keeping doors locked to medication room and also on the importance of ensuring all chemicals are appropriately labeled and kept out of resident's reach. ALL staff immediately notified of these requirements via phone communication. 4. Chemicals will be removed and/or labeled immediately. 5. ED, DHW, and/or designee will randomly monitor doors to ensure they are staying locked and always secured. 6. This will be completed today by 5pm." On 06/22/23 from 5:07 p.m. through 6:00 p.m., and 06/23/23 from 11:30 a.m. through 12:00 p.m., interviews were conducted with staff regarding in-service information pertaining to the immediate jeopardy plan of removal. The staff stated they had been in-serviced and were able to verbalize understanding of the information provided. The medication room/laundry room door locks were repaired on both doors leading into the medication room/laundry room. The doors were locked and a code was required to enter the room. The chemicals that were not in their original containers and not labeled were discarded. The chemicals left in the laundry room and medication room were labeled and in the original containers. Based on observation, record review, and interview, the center failed to ensure: a. the medication/laundry room was locked and chemicals were labeled and not within reach of residents who had dementia, Alzheimer's Disease, or who had cognitive impairments; b. resident at risk for skin breakdown was assessed and monitored one (#1) of one sampled resident who was observed for incontinent care	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 7 which resulted in an open wound to the coccyx; and c. medication was administered as ordered for two (#6 and #9) of 12 sampled residents observed during a medication administration pass. The "Assisted Living Resident Condition and Care Overview" report, dated 06/22/23, documented 19 residents resided in the center and had a diagnosis of dementia. Findings: The center's "Impaired Skin" policy, dated 06/03/20, read in parts, " ...The Director of Health and Wellness/Designee will communicate resident skin care and service needs ...Care employees are responsible for assisting, directing and providinghygiene as indicated on the resident's assessment and service plan ... updates when resident skin impairment occurs ...Interim Service Plans are implemented when a change is identified or reported ... Care employees s will communicate resident skin changes to the nurse ...Scheduled skin documentation is completed in the resident record ...A skin assessment is performed anytime skin breakdown ...occurs ..." 1. A "Maintenance Audit", dated 06/21/23, documented the nurses' station keypad door lock was missing buttons and not functioning and the electric panel inside the nurses' station (medication room) was missing screws and the lock. On 06/22/23 at 11:49 a.m., during an observation of the medication administration pass, the staff	C1505		

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C1505	Continued From page 8 were observed entering and leaving the medication room without locking and unlocking the doors. On 06/22/23 at 1:22 p.m., MAT #1 was asked about the medication room door. They stated the door did not lock. MAT #1 was asked how they kept the residents from entering the medication and laundry room if the door did not lock. They stated there was usually a staff member in the medication room who would redirect the residents. On 06/22/23 at 1:25 p.m., the keypad door lock to the medication room was observed. The keypad lock was missing the number five and the number eight. On 06/22/23 at 1:30 p.m., an observation was made of the medication room, there was a spray bottle with green liquid sitting on the top of a file cabinet next to a drinking glass, 91% isopropyl alcohol, hand sanitizer, and wound cleanser were in the unlocked cabinet. On 06/22/23 at 1:50 p.m., Resident #1 was observed opening the medication room door, there was not a staff member in the medication room. The resident was able to get the door open and get their walker inside the door way. There was no staff present in the medication room to redirect the resident. On 06/22/23 at 2:00 p.m., Resident #1 entered the medication room. There was no staff present to redirect the resident. On 06/22/23 at 2:03 p.m., MAT #1 was asked if there were any residents who attempted to enter the medication room/laundry room. They stated,	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 9 "Yes." MAT #1 identified Resident #1 and Resident #10. MAT #1 was asked how long the keypad lock to the medication room had been broken. They stated for at least four months. On 06/22/23 at 2:12 p.m., Resident #1 entered the medication room. There was no staff in the medication room to redirect the resident. On 06/22/23 at 2:14 p.m., MAT #2 was asked what the green liquid was inside the spray bottle in the medication room. They stated they did not know. On 06/22/23 at 2:16 p.m., the laundry room was observed with MAT #2. The laundry room contained a large container on the floor. The label documented it was Fabric Softener Concentrate. The label read in parts, "...KEEP OUT OF REACH OF CHILDREN DANGER ...have the product container or label with you when calling a poison control center ...if swallowed call a poison control center or doctor immediately ..." There were two large containers of laundry detergent in the laundry room, and two containers without a label with blue liquid in the containers sitting on the counter in the laundry room. MAT #2 was asked what the blue liquid was in the containers in the laundry room. They stated they thought it was laundry soap. On 06/23/23 at 12:14 p.m., the administrator was asked why the residents were admitted to the memory care. They stated the residents had memory loss, and/or cognitive impairments and needed a more safe and secure environment. The administrator was asked if the memory care residents were safe to have access to the medication and laundry room where chemicals were stored. They stated, "No." The	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 10 administrator was asked if they knew what had been stored in the unlabeled containers. They stated the blue liquid was laundry detergent and they did not know what the green liquid was in the spray bottle. The administrator stated the chemicals in the medication and laundry room should have been labeled and the door should have been locked. The administrator stated they had done maintenance rounds on 06/21/23 and discovered the door's keypad lock had been broken. 2. Resident #1 had diagnoses of primary dementia of Alzheimer's type and benign prostatic hyperplasia with lower urinary tract symptoms. Hospital discharge note, dated 05/13/23, read in parts, "...[Resident #1] was seen in the emergency department for evaluation...has significant excoriation of his scrotum secondary to his exposure to urine in his brief. It is very important to change his briefs frequently cleanse him thoroughly and then apply barrier cream to the entire surface of his scrotum to prevent further breakdown..." A nurse's progress note, dated 05/22/23 at 1:08 p.m., documented Resident #1 was seen in the ER on 05/13/23 for complaints of testicle bleeding was found to have significant excoriation to the scrotum secondary to exposure to urine in his brief and the physician reported to change the resident's brief frequently. Resident #1's annual assessment, dated 06/07/23, documented the resident was oriented to person only, confused at times, was incontinent of bladder, required assist of one staff member for toileting, and had red areas to	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 11 bilateral lower extremities. Resident #1's service agreement/care plan, dated 06/07/23, read in parts, "Toileting: Total Incontinence ...Staff will assist with incontinence needs as needed. Staff to check for incontinence frequently and assist with changing when wet/soiled ..." The care plan did not document the resident was at risk for skin breakdown or had previous skin breakdown. On 06/23/23 at 1:36 p.m., CNA #2 was observed to provide incontinent care to Resident #1. Resident #1's room had a strong odor of urine, the resident's chair, pad, pants, and brief were wet with urine. The resident was found to have an open area on the coccyx. CNA #2 was asked when the last time Resident #1 had been provided incontinent care. They stated before lunch sometime between 10:00 a.m., and 11:00 a.m. On 06/23/23 at 2:22 p.m., LPN #1 stated they did not have any skin assessments for Resident #1. LPN #1 was asked if Resident #1 had any pressure ulcers or open wounds. They stated, "Not that I am seeing charted." LPN #1 was asked how often Resident #1 was supposed to be provided incontinent care. They stated, "Frequently." The LPN stated they expected the staff to check the resident for incontinence every two hours. On 06/23/23 at 2:50 p.m., LPN #1 observed Resident #1's coccyx. LPN #1 stated the Resident had a 1.3 cm length by 0.4 cm width open wound to the coccyx with a yellowish wound bed and pink edges. LPN #1 was asked if they knew the resident had an open area on their coccyx. They stated, "No." LPN #1 was asked if	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 12 CNA #2 had reported Resident #1 had an open area to the coccyx. They stated, "No." 06/23/23 at 4:00 p.m., the administrator was asked if the care plan/service agreement had been updated after Resident #1 was seen in the ER for an excoriated scrotum from sitting in a wet brief. They stated, "No." They were asked if the staff had done skin assessments after the resident returned from the ER on 05/13/23. They stated the RN did a full assessment on 06/07/23. The administrator stated there were no other skin assessments done after Resident #1 returned from the ER on 05/13/23. 3. Resident #6 had diagnoses which included unspecified dementia. A physician's order, dated 02/15/22, documented to administer Flomax 0.4 mg one tablet in the evening. On 06/22/23 at 7:08 p.m., during an observation of a medication administration pass, Resident #1 was not administered the Flomax. MAT #3 stated the medication was not available for administration. 4. Resident #9 had diagnoses which included dementia and insomnia. A physician's order, dated 03/13/23, documented to administer Melatonin 5 mg at bedtime. On 06/22/23 at 7:28 p.m., during an observation of a medication administration pass, Resident #9 was not administered the Melatonin. MAT #3 stated the Melatonin on hand was 10 mg and was not the correct dose ordered. The Melatonin was not administered.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 13 On 06/23/23 at 4:42 a.m., LPN #1 stated Resident #1's Flomax was not available for administration and Resident #9 had Melatonin 10 mg in the building and the order was for Melatonin 5 mg. The LPN stated the Melatonin had not been administered because of the wrong dose.	C1505		

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

August 7, 2023

License Number: AL6004

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

RE: Survey Event REC511

Dear Ms. Chill:

On **June 23, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 30, 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

Tempal Killman, Administrative Assistant II
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: 7/21/2023

Facility Name: The Renaissance of Stillwater- Memory Care

License Number: AL6004

Survey Event ID: REC511

Date Survey Completed: 6/23/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation, record review, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure: A. the kitchen was clean and sanitary; B. the dish machine was working properly; and C. flour and rice were stored in a sealed container.

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

Dietary staff in-serviced on Chapter 257 regulations.

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.

- Audit will be performed randomly to ensure kitchen is clean and sanitary.
- Dish machine will be checked every morning, and randomly to ensure that it is working properly.
- Flour and Rice will be stored in sealed containers. ED and/or designee will audit randomly.

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.

8/25/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)			Date 7/21/2023
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: 7/21/2023		
	Facility Name: The Renaissance of Stillwater- Memory Care		
	License Number: AL6004		
	Survey Event ID: REC511		
Date Survey Completed: 6/23/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C701		Based on: observation, record review, and interview, the center failed to ensure hot water temperatures did not exceed 115 degrees F.	
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?		Maintenance team inserviced on importance of ensuring water temperatures do not exceed 115 degrees F for hot water available for resident use.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		All residents 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?		Hot water temperatures will be monitored daily x1 week and bi-weekly afterwards.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED and/or designee 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?		8/30/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)			Date 7/21/2023
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: 7/21/2023

Facility Name: The Renaissance of Stillwater- Memory Care

License Number: AL6004

Survey Event ID: REC511

Date Survey Completed: 6/23/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: observation, record review, and interview, the center failed to ensure: A. an immediate jeopardy (IJ) was determined to exist due to the center's failure to ensure the medication room/laundry room was locked and chemicals were labeled and not within reach of residents who had dementia, Alzheimer's Disease, or who had cognitive impairments. B. Resident at risk for skin breakdown was assessed and monitored for one (#1) of one sampled resident who was observed for incontinent care which resulted in an open wound to the coccyx. C. Medication was administered as ordered for two (#6 and #9) of 12 sampled residents observed during a medication administration pass.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A. Staff in-serviced on importance of keeping doors locked to medication room, and also on the importance of ensuring all chemicals are appropriately labeled and kept out of resident's reach. Chemicals were removed and/or labeled immediately.
B. Nurse's in-serviced on importance of ensuring skin assessments are completed and residents at risk for skin breakdown are monitored for skin breakdown.
C. Medication aides in-serviced on Medication Administration and Refill policies.

OSDH Response: Element accepted Yes ☐ No ☐

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

A. 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.
B. One resident was affected by deficient practice, and all residents had the potential to be affected.
C. Two residents 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?		A. ED, DHW, and/or designee will randomly monitor doors to ensure they are staying locked and always secured. B. Resident's skin will monitored for residents that are at risk for skin breakdown C. DHW and/or designee will complete daily audit x1 week and bi-weekly afterwards to ensure that medications are filled timely to ensure compliance	
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.		ED and/or designee 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?		8/30/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 7/21/2023	
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.			

Delivery via email to: [Tara Chill <executivedirector@renlivingpc.com>](mailto:Tara.Chill@renlivingpc.com); [Tara Chill <executivedirector@renlivingpc.com>](mailto:Tara.Chill@renlivingpc.com)

September 14, 2023

License Number: AL6004

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

RE: Survey Event ID: REC512

Dear Ms. Chill:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **September 12, 2023**. These deficiencies remain uncorrected from our original inspection conducted **June 23, 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,



OKLAHOMA
State Department
of Health

-
- 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, 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: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/12/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 revisit was conducted on 09/12/23. Listed below are abbreviations that will be used throughout this document. ACMA - Advanced Certified Medication Aide GERD - Gastroesophageal Reflux Disease LPN - Licensed Practical Nurse MAR - Medication Administration Record MAT - Medication Administration Technician mg - milligram	{C 000}		
{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

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/12/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{C1505}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered as ordered for four (#1, 11, 12, and #14) of five sampled residents who were reviewed for medication administration. The administrator identified 20 residents who resided in the facility. Findings: The facility's "Medication Refills and Medication Check In" policy, dated 10/2018, read in parts, "...Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available...When a medication is noted to have 7 or fewer days left, the Nurse/Med Aide on duty will contact the dispensing pharmacy or family/responsible party to obtain a refill. If the medication is a narcotic or the pharmacy is a mail order or [Veterans] pharmacy, the medication will be ordered a minimum of 14 days prior to running out...Medications are never allowed to run out unless directed by the physician..."	{C1505}		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/12/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{C1505}	Continued From page 2 1. Resident #1 had diagnoses which included GERD (Stomach acid or bile irritates the food pipe lining.) A physician's order, dated 03/13/23, documented to administer omeprazole 20 mg daily for GERD. A MAR, dated 09/01/23 through 09/12/23, documented the omeprazole had not been administered on 09/06/23 or 09/07/23. The MAR documented the omeprazole was on hold until the medication was available, and on hold until pharmacy filled. 2. Resident #11 had diagnoses which included restlessness and agitation. A physician's order, dated 05/22/23, documented to administer diazepam 5 mg at bedtime for restlessness and agitation. A MAR, dated 09/01/23 through 09/12/23, documented the diazepam had not been administered on 09/06/23, 09/07/23, 09/10/23, or 09/11/23. The MAR documented the medication was on hold until available. 3. Resident #12 had diagnoses which included thrombophilia (A blood disorder that makes the blood in your veins and arteries more likely to clot.). A physician's order, dated 08/30/23, documented to administer aspirin 325 mg daily for thrombophilia. A MAR, dated 09/01/23 through 09/12/23, documented the aspirin had not been administered on 09/07/23. The MAR documented the medication was on hold until it was available.	{C1505}			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/12/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{C1505}	Continued From page 3 4. Resident #14 had diagnoses which included hypertension. A physician's order, dated 03/13/23, documented to administer metoprolol succinate extended release 50 mg, one tablet daily for hypertension. On 09/12/23 at 2:02 p.m., MAT #1 stated Resident #14 had not been administered their metoprolol tablet on 09/12/23, because it had not been available. On 09/12/23 at 3:45 p.m. ACMA #1 stated the computer documented Resident #14 had not been administered their metoprolol today (09/12/23). On 09/12/23 at 4:55 p.m., MAT #2 stated Resident #14's metoprolol was not in the building for administration. On 09/12/23 at 4:54 p.m., LPN #1 stated they did not know why the medication for Resident #1, 12 and #14 had not been available for administration. LPN #1 stated they were waiting on hospice to fill the prescription for the diazepam for Resident #11. LPN #1 was asked if the residents' medications should have been available for administration. They stated, "Yes." LPN #1 was asked if the staff had followed the policy for medication refills. They stated, "No."	{C1505}		



Delivery via email to: [Tara Chill <executivedirector@renlivingpc.com>](mailto:Tara.Chill@renlivingpc.com); [Tara Chill <executivedirector@renlivingsw.com>](mailto:Tara.Chill@renlivingsw.com)

September 22, 2023

License Number: AL6004

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

RE: Survey Event REC512

Dear Ms. Chill:

On **September 12, 2023**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1505:** The Plan of Correction does not address how the deficient practice was corrected for the identified residents.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 9/18/2023	
	Facility Name: The Renaissance of Stillwater- Memory Care	
	License Number: AL6004	
	Survey Event ID: REC512	
Date Survey Completed: 9/14/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to ensure that medications were administered as ordered for four (#1, #11, #12, and #14) of five sampled residents who were reviewed for medication administration.	
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 Resident Care Director in-serviced on importance of medication cart audits and medication refill policy. Med Techs will be inservice on importance of medication refill policy.
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 the 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?		ED, nurse, and/or designee will audit medication carts twice weekly for 2 months then, monthly thereafter, to ensure medications are being ordered and received timely to sustain compliance.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED, nurse, and/or designee will be responsible for sustained compliance.
a. How the correction will be evaluated for effectiveness;		ED and/or designee will maintain monitoring records.
b. How the correction will be incorporated into the center's quality assurance system; and		Monitoring records will be reported and reviewed during quarterly QA meeting.
c. How monitoring records will be kept to evidence the correction.		Monitoring records will be placed 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?		11/1/2023
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Tara R. Chill		Date 9/18/2023
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.
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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.](#)

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

October 2, 2023

License Number: AL6004

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

RE: Survey Event REC512

Dear Ms. Chill:

On **September 12, 2023**, a Licensure follow-up inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 10, 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

Tempal Killman, Administrative Assistant II
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: 9/27/2023	
	Facility Name: The Renaissance of Stillwater- Memory Care	
	License Number: AL6004	
	Survey Event ID: REC512	
Date Survey Completed: 9/14/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to ensure that medications were administered as ordered for four (#1, #11, #12, and #14) of five sampled residents who were reviewed for medication administration.	
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?		Medication refill request was submitted to pharmacy. Medication obtained and administered according to physician orders. Nurse and Resident Care Director in-serviced on importance of medication cart audits and medication refill policy. Med Techs also in-serviced on importance of medication administration policy.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		All residents 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?		ED, nurse, and/or designee will audit medication carts twice weekly for x1 month then, once weekly x1 month, and monthly thereafter, to ensure medications are being ordered and received timely to sustain compliance.
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.		ED, nurse, and/or designee will be responsible for sustained compliance. ED and/or designee will maintain monitoring records. Tracking and trending will be reported and reviewed during quarterly QA meeting. Monitoring records will be placed 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?		11/10/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Tara R. Chill OAC 310:663-25-4(F)		Date 9/27/2023	
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.			

FINAL DETERMINATION NOTICE
USPS Tracking #7021 2720 0002 0354 1662

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

December 22, 2023

License Number: AL6004

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

Survey Event ID: REC513

Dear Ms. Chill:

An offsite/paper revisit conducted **December 19, 2023**, revealed that your facility corrected deficiencies effective **November 10, 2023**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

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

Respectfully,



Lisa Calvin, Enforcement Analyst II
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: AL6004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/19/2023
NAME OF PROVIDER OR SUPPLIER THE RENAISSANCE OF STILLWATER-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 12/19/23. 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