OKLAHOMA
State Department of Health

Delivery via email to: executivedirector@renlivingpc.com

February 14, 2023

License Number: AL6004

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

Survey Event ID: M33S11

Dear Ms. Chill:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **February 10, 2023**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Katie Stagner

Katie Stagner
Long Term Care Enforcement Analyst
Oklahoma State Department of Health

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 #: **OK00059955**
Investigation Date(s): **02/09/23 through 02/10/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The Center failed to assess, monitor and intervene for an injury of unknown origin.	**US**
2. The center failed to ensure residents received meals as ordered.	**US**
3. The center failed to ensure residents received care according to service contract.	**US**
4. The center failed to notify the state agency (OSDH) of an injury of unknown origin.	**US**
5. The center failed to notify the resident's representative of an injury of unknown origin.	**US**

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

An unannounced on-site investigation was initiated on 02/09/2023 at 12:45 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 the center failing to assess, monitor, and intervene for an injury of unknown origin.

Observations were made of residents receiving care throughout the survey. No observations were made of staff failing to assess monitor and intervene were made.

Records reviewed documented staff assessed, monitored, and intervened as necessary. They documented home health was consulted as needed when a resident had a wound. The records documented home health remained in place until the wound healed. There was no documentation a resident experienced a temperature which went untreated by staff.

Family members stated the facility did provide wound care when needed. They stated an outside entity was consulted for the wound care.

Staff stated they provided some wound care. They stated due to a nurse not always being on duty, they were limited on what care they could provide. They stated home health was consulted when necessary for resident wounds.

At the time of the investigation no deficient practice was found related to the center failing to assess, monitor, and intervene for an injury of unknown origin.

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

An investigation specific to the center failing to ensure residents received meals as ordered.

Observations were made of staff entering each resident room and inviting them to breakfast. When a resident refused, staff exited their room and attempted again a few minutes later and were able to assist the residents to the dining room. Staff were observed providing each resident a meal. Staff were observed assisting residents with their meal as needed. No observations were made of staff failing to offer a resident something to eat. Residents were also observed being offered snacks during the survey.

Records documented residents were to receive three meals a day as ordered.

Family members stated residents received meals as ordered. One family member assisted their loved one with their meals.

Staff stated residents received meals as ordered. They stated if a resident refused to eat, staff would attempt an alternate meal for the resident.

At the time of the investigation no deficient practice was found related to the center failing to ensure residents received meals as ordered.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failing to ensure residents received care according to the service contract.

Observations were made of residents receiving care per their service contracts. Residents were observed to be well kempt with no odors present. Residents were observed to have appropriately trimmed facial hair, and clean trimmed nails. Incontinent care was observed. No residents were observed to be overly saturated at the time the incontinent care took place.

Records reviewed documented residents received care according to their contracts.

Family members stated staff provided care per contract. Some stated the hospice agency provided bathing assistance to their family member.

Staff stated they bathed residents according to the schedule. They stated residents were checked/changed every two hours as needed. They stated nails were filed not clipped and cleaned as needed. They stated the activities coordinator also did nails once per week. They stated staff would assist residents with shaving as needed.

At the time of the investigation no deficient practice was found related to the center failing to ensure residents received care according to the service contract.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failing to notify the state agency (OSDH) of an injury of unknown origin.

Records reviewed documented the facility completed a State reportable each time a resident experienced an injury of unknown origin. They documented the physician, resident representative, and Adult Protective Services were notified when required.

Family members stated they were notified when their family member experienced a change in condition.

Staff stated they would report to the nurse any injury of unknown origin and an investigation would be completed. The investigation would include notifying physician, family and any additional entity required.

At the time of the investigation no deficient practice was found related to the center failing to notify the state agency (OSDH) of an injury of unknown origin.

Allegation #5: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failing to notify the resident's representative of an injury of unknown origin.

Records reviewed documented the facility notified the resident's family/representative each time the resident experienced an injury of unknown origin.

Family members stated they were notified when their family member experienced a change in condition.

Staff stated they would notify the nurse when a resident experienced an injury of unknown origin, and an investigation would be completed. The investigation would include notifying physician, family and any additional entity required.

At the time of the investigation no deficient practice was found related to the center failing to notify the resident's representative of an injury of unknown origin.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, 2, 3, 4, and #5. 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.

Tammy Bross, RN, CHFS

Date report completed: 02/13/2023

OKLAHOMA
State Department
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INVESTIGATIVE REPORT
LICENSURE

Facility: **The Renaissance of Stillwater- Memory Care**
Address: **1450 East Mcelroy**
City, State, Zip: **Stillwater, OK, 74075**
Provider #: **AL6004**
Complaint #: **OK00058403**
Investigation Date(s): **02/09/23 through 02/10/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care and services as contracted.	**US**
2. The center does not have and effective system to keep up with resident belongings.	**US**

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

An unannounced on-site investigation was initiated on 02/09/2023 at 12:45 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 the center failing to provide care and services as contracted.

Observations were made of residents receiving care per their service contracts. Residents were observed to be well kempt with no odors present. Residents were observed to have appropriately trimmed facial hair, and clean trimmed nails. Incontinent care was observed. No residents were observed to be overly saturated at the time the incontinent care took place. Staff were observed carrying a list and marking off residents as incontinent care was provided.

Observations were made of residents dressed in appropriately sized clothing. Residents were observed wearing their personal shoes. Resident rooms and bathrooms were observed to be clean and free of feces. Staff were observed to be cleaning resident rooms throughout the survey. Residents were observed with a personal laundry basket in their rooms for soiled items.

Records documented laundry services, housekeeping services, incontinent care and personal hygiene were all services the facility provided per service contracts.

Family members stated staff cleaned resident rooms per schedule. They stated staff were to check on their loved ones every two hours and provide incontinent care as needed. They stated if they noticed a missing item, they would report it to staff and they would look for it.

Staff stated residents' rooms and bathrooms were cleaned per schedule and as needed. They stated staff checked/changed residents every two hours as needed. They stated personal hygiene was provided throughout the day as needed. Staff stated linens and personal items were laundered on bath days and more often if needed. They stated one shift pulled the linens, one shift laundered them, and the other shift folded and put them away.

At the time of the investigation no deficient practice was found related to the center failing to provide care and services as contracted.

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

An investigation specific to the center failing to have and effective system to keep up with resident belongings.

Observations were made of residents dressed in appropriately sized clothing. Residents were observed wearing their personal shoes. Residents were observed with clothes hanging in their personal closets. No observations were made of residents wandering into another residents room and removing their personal items.

Family members stated their loved ones' clothing would at times be lost. They stated they reported it to staff and staff looked for the missing items.

Staff stated after laundering personal items, they would return the items to the residents. They stated if an item was reported missing, they would look for the missing items.

At the time of the investigation no deficient practice was found related to the center failing to have and effective system to keep up with resident belongings.

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.

Tammy Bross, RN, CHFS

Date report completed: 02/13/2023

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INVESTIGATIVE REPORT
LICENSURE

Facility: **The Renaissance of Stillwater-Memory Care**
Address: **1450 East Mcelroy**
City, State, Zip: **Stillwater, OK, 74075**
Provider #: **AL6004**
Complaint #: **OK00059083**
Investigation Date(s): **02/09/23 through 02/10/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure residents' medications were provided in a timely manner.	**US**
2. The facility failed to provide timely incontinent care, baths as scheduled and clean linens.	**US**
3. The facility failed to provide a clean, homelike environment.	**US**
4. The facility failed to ensure dependent residents were awake and assisted with meals.	**US**

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

An unannounced on-site investigation was initiated on 02/09/2023 at 12:45 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 the facility failing to ensure residents' medications were provided in a timely manner.

Records reviewed documented residents received medications as ordered by the physician. It documented when a resident refused a medication, staffed honored their right to refuse.

Family members stated the facility staff provided medications as ordered.

Staff stated they administered medications as ordered by the physician.

At the time of the investigation no deficient practice was found related to the facility failing to ensure residents' medications were provided in a timely manner.

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

An investigation specific to the facility failing to provide timely incontinent care, baths as scheduled and clean linens.

Residents were observed to be well kempt with no odors present. Incontinent care was observed. No residents were observed to be overly saturated at the time the incontinent care took place. Staff were observed carrying a list and marking off residents as incontinent care was provided. Residents were observed to be dressed appropriately for the season. Resident rooms were observed to have clean linens present. No observations were made of saturated linens throughout the survey.

Records reviewed documented residents received care according to their service contracts.

Family members interviewed stated staff were to check on their loved ones every two hours and provide incontinent care as needed. They stated staff or an outside entity provided bathing assistance. The stated laundry services were offered, but some stated their family chose to clean resident belongs at their personal homes.

Staff stated residents were bathed according to the schedule. They stated staff checked/changed residents every two hours as needed. Staff stated linens were laundered on bath days and more often if needed. They stated one shift pulled the linens, one shift laundered them, and the other shift folded and put them away.

At the time of the investigation no deficient practice was found related to the facility failing to provide timely incontinent care, baths as scheduled and clean linens.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to provide a clean, homelike environment.

Resident rooms and bathrooms were observed to be clean and free of feces. Staff were observed to be cleaning resident rooms throughout the survey. No odors were observed. Residents were observed with a personal laundry basket in their rooms for soiled items.

Records reviewed documented residents had the option of receiving housekeeping services in their service contracts.

Family members stated staff cleaned resident rooms per schedule.

Staff stated residents' rooms and bathrooms were cleaned per schedule and as needed.

At the time of the investigation no deficient practice was found related to the facility failing to provide a clean, homelike environment.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to ensure dependent residents were awake and assisted with meals.

The breakfast meal service was observed. Observations were made of staff entering each resident room and inviting them to breakfast. When a resident refused, staff exited their room and attempted again a few minutes later and were able to assist the residents to the dining room. Staff were observed providing each resident a meal. Staff were observed assisting residents with their meal as needed. No observations were made of residents sleeping through the meal service. Residents were also observed being offered snacks during the survey.

Records reviewed documented residents received meals as ordered.

Family members stated staff assisted residents with their meals as needed. One family member assisted their loved one with their meals.

Staff stated they woke each resident up for meals. They stated if a resident was noted to be sleeping, staff would intervene and assist with meals as needed.

At the time of the investigation no deficient practice was found related to the facility failing to ensure dependent residents were awake and assisted with meals.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, 2, 3, and #4. 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.

Tammy Bross, RN, CHFS

Date report completed: 02/13/2023

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 _____	02/10/2023

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 Complaint investigations (#OK00059955, OK00059083, and #OK00058403) were conducted on 02/09/23 and 02/10/23. No deficiencies were cited.	C 000		

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