OKLAHOMA
State Department
of Health

Delivery via email to: Ronnie.Stringer@Legendseniorliving.com

June 27, 2022

License Number: AL1103

Mr. Ronnie Stringer, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

Survey Event ID: DZO011

Dear Mr. Stringer:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **June 23, 2022**. 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 Digitally signed by Katie Stagner
Date: 2022.06.27 15:43:13 -05'00'

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Legend at 71st Street**
Address: **701 W 71st South**
City, State, Zip: **Tulsa, OK 74132**
Provider #: **AL1103**
Complaint #: **OK00059027**
Investigation Dates: **06/21/22-06/23/22**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents' were free from neglect to prevent elopement and ensure resident safety.	**US**
2. The center failed to ensure residents had adequate supervision to prevent injury.	**US**
3. The center failed to maintain resident records.	**US**
4. The center failed to ensure residents were appropriate for placement in the assisted living center.	**US**

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

An unannounced on-site investigation was initiated on 06/21/2022 at 1:30 p.m.

A sample of six residents including any identified residents, 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 neglect to prevent elopement and ensure resident safety was conducted.

Residents, who were identified by the staff as having the potential to wander/did wander, were all observed in the locked memory care unit. The doors to exit the memory care unit were observed to be locked with a key pad. During the survey, residents in the assisted living area of the center were not observed to exit seek and/or attempt elopement. Staff throughout the center were observed to monitor and provide supervision to the residents.

Staff were interviewed about supervision to prevent elopement. They were knowledgeable of the residents' needs. The staff at the front desk, by the front door, and administration stated the front door was monitored seven days a week from 8:00 a.m. until 8:00 p.m. to ensure residents did not exit the center unsafely and ensure residents/visitors signed out on a log if they desired to leave the center. Residents who were interviewed were aware of the need to sign out for offsite visits. Family members were interviewed and had no concerns regarding their loved ones safety at the center or the supervision provided by the staff.

Review of sampled residents' records revealed interventions were implemented if a resident was exit seeking or went through the doors of the facility to the sidewalk when it was out of character for them to do so. Sampled residents who had left the facility had been signed out on the sign out log by their visitors. Review of state reportable incident reports revealed any missing residents had been reported to the appropriate parties.

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

An investigation specific to adequate supervision to prevent injury was conducted. Residents were observed to have fall interventions in place. Staff were observed to safely transfer sampled residents.

Residents were interviewed and stated staff safely assisted them with transfers and implemented interventions to prevent falls. They stated, if they had fallen, staff were prompt to respond and intervene. Staff were knowledgeable of fall interventions and the transfer status of sampled residents.

Review of sampled residents' clinical records revealed interventions in place for falls. Residents were sent to the hospital and/or received treatment for any injuries related to falls in a timely manner. Incident reports and skin assessments were reviewed and documented information to prevent falls/injuries.

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

An investigation specific to maintaining resident records was conducted.

Resident records were observed in three locations, the first floor, the second floor, and the memory care unit chart rooms.

Staff were knowledgeable when asked how they accessed the residents' charts. Administrative staff stated a core staff member was the lead staff member on every shift to ensure agency staff had access to the code for the rooms with charts if needed.

Sampled residents' charts were reviewed and the information needed to conduct investigations was available.

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

An investigation specific to appropriate placement in the assisted living center was conducted.

Residents were observed to be well groomed, supervised, and monitored. Staff were observed to provide the required assistance with transfers and implement fall interventions specific to the sampled residents' needs.

Staff were interviewed and were knowledgeable of sampled residents' required care. Administrative staff stated residents were assessed quarterly, with any significant change, and as needed for required care. The center allowed residents to age in place as part of their treatment plan.

Review of the sampled residents' clinical records did not indicate the residents required more care than the center was providing.

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.

Jennifer Johnson RN

Jennifer Johnson RN

Date report completed: 06/24/2022

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
	AL1103	A. BUILDING: _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT 71ST STREET	701 W 71ST SOUTH TULSA, OK 74132

(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 (#OK00059027) was conducted from 06/21/22 through 06/23/22. No deficiencies were cited.	C 000		

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