OKLAHOMA
State Department
of Health

Delivery via email to: cherylann.ledbetter@legendseniorliving.com

October 22, 2021

License Number: AL1103

Ms. Cherylann Ledbetter, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

Survey Event ID: 01J511

Dear Ms. Ledbetter:

On **September 23, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

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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

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Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Legend at 71st Street**
Address: **701 W 71st South**
City, State, Zip: **Tulsa, OK, 74132**
Provider #: **AL1103**
Complaint #: **OK00056494**
Investigation Date(s): **09/20/21 through 09/23/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate care and services in accordance with residents' contracts	**S**
2. The center failed to complete assessments as required	**S**

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

An unannounced on-site investigation was initiated 09/20/2021 at 9:40 p.m.

A sample of five 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

An investigation specific to resident assessments, service agreements, and care was conducted.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0542 for details.

An investigation specific to required assessments was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Donna Payne

Donna Payne, RN

Date report completed: 10/01/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Legend at 71st Street**
Address: **701 W 71st South**
City, State, Zip: **Tulsa, OK, 74132**
Provider #: **AL1103**
Complaint #: **OK00056827**
Investigation Date(s): **09/20/21 through 09/23/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were treated with dignity and respect	**US**
2. The center failed to provide care according to an accurate assessment and/or according to the contract	**S**

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

An unannounced on-site investigation was initiated 09/20/2021 at 9:40 p.m.

A sample of five 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 Centers for Medicare and Medicaid Services (CMS) 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 residents being treated with dignity and respect was conducted.

Upon entrance to the facility a tour was conducted. Most resident apartment doors were closed. Residents were observed to be in bed. No lingering odors were noted in the facility. In the memory care unit, two residents were observed in the common area. The residents were dressed appropriately. A staff member was observed assisting one of the residents to her room. Staff were observed to be attentive and professional.

During the course of the survey, staff were observed greeting residents, entering resident apartments, assisting residents with meals and their daily activities. Staff were observed to treat residents in a professional and respectful manner.

Interviews with residents revealed no concerns with staff treating them with respect and dignity.

The facility grievances were reviewed for the last six months with no documentation of concern regarding residents being treated with dignity and respect.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

An investigation specific to resident assessments, service agreements, and care was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action 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 federal/state regulations had occurred in relation to the allegation.

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Donna Payne

Donna Payne, RN

Date report completed: 10/01/2021

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INVESTIGATIVE REPORT

Facility: **Legend at 71st Street**
Address: **701 W 71st South**
City, State, Zip: **Tulsa, OK, 74132**
Provider #: **AL1103**
Complaint #: **OK00057744**
Investigation Date(s): **09/20/21 through 09/23/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care according to an accurate assessment and/or according to the contract	S
2. The center failed to ensure medications were obtained and administered as ordered by the physician	S

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

An unannounced on-site investigation was initiated 09/20/2021 at 9:40 p.m.

A sample of five 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

An investigation specific to resident assessments, service agreements, and care was conducted.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

An investigation specific to medication administration was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Donna Payne

Donna Payne, RN

Date report completed: 10/01/2021

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 09/23/2021

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 An abbreviated survey was conducted on 09/20/21 through 09/23/21 to investigate complaint # OK00056494, OK00056827, and OK00057744. Total residents: 62 The following is a list of abbreviations/symbols used throughout this document: CMA - certified medication aide CNA - certified nursing assistant DON - director of nursing (also known as health care director) MAR - medication administration record mg - milligram	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the 14 day resident assessment was signed by a registered nurse or the resident's personal physician for one (#1) of four sampled residents whose assessments were reviewed. The health care director identified 62 residents who resided in the facility. Findings: Resident #1 received a 14 day resident assessment, dated 04/26/21. The assessment	C 542		

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C 542	Continued From page 1 was not signed by the resident or representative interviewed, a registered nurse, or the resident's personal physician. On 09/22/21 at 1:55 p.m., the health care director was asked who was responsible to ensure the resident assessments were signed. She stated the nurse completing the assessment was responsible. She was asked why the 14 day resident assessment was not signed. She had no answer.	C 542		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the personal care assessment and/or the negotiated services agreement was signed by the resident or responsible party, for three (#1, 3, and #4) of four	C1304		

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C1304	Continued From page 2	C1304		

sampled residents whose assessments / agreements were reviewed; and services were provided based on the resident's personal care assessment/negotiated service agreement for three (#1, 2, and #3) of four sampled residents whose services were reviewed.

The health care director identified 62 residents who resided in the facility.

Findings:

The "Personal Care Assessment" policy, dated 07/01/12, read in part, " ...Purpose: To set forth guidelines for determining the medical and nonmedical care and services needed or desired by a resident ...The results of the assessment will be communicated to the prospective resident or their legal representative ...The results of the assessment will be used to develop the Negotiated Service Agreement ...The assessment will be updated within the first 30 days after admission, upon significant change of condition, and every 120 days thereafter and the Negotiated Service Agreement updated as indicated ..."

1. Resident #1 had diagnoses which included Alzheimer's disease.

A 14 day resident assessment, dated 04/26/21, documented the resident was confused at times, had fair judgement, ambulatory without assistance, continent of bladder, occasionally incontinent of bowel requiring cueing, and wore adult briefs.

An unsigned personal care assessment, dated 05/01/21, documented the resident was to receive standard housekeeping services weekly, stand by staff assistance and/or assistance of

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C1304	Continued From page 3	C1304		

one staff member for showering three times a week with staff to monitor for any changes or increased needs, staff reminders and cueing to complete hygiene and grooming tasks with staff to observe for increased needs and changes, and frequent staff reminders and cueing to go to the bathroom to remain continent with staff to observe for increased needs.

An unsigned personal care assessment, dated 05/31/21, documented the resident was to receive standard housekeeping services weekly, stand by staff assistance and/or assistance of one staff member for showering three times a week, staff reminders and cueing to complete hygiene and grooming tasks, and frequent staff reminders and cueing to go to the bathroom to remain continent with staff observation to identify any increased needs.

A review of the services delivery record, dated August 2021, revealed six documented showers.

A review of the services delivery record, dated September 2021, revealed no documented showers.

An unsigned personal care assessment and unsigned negotiated services agreement, dated 09/16/21, documented the resident was to receive standard housekeeping services more than once weekly to include bathroom cleaning with frequent checks to help maintain cleanliness, stand by staff assistance and/or assistance of one staff member for showering three times a week with staff to monitor for any changes or increased needs, staff reminders and cueing to complete hygiene and grooming tasks with frequent checks to maintain adequate hygiene, and frequent staff reminders and cueing to go to

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C1304	Continued From page 4 the bathroom with staff observation to identify any increased needs. On 09/21/21 and 09/22/21, during visits to resident #1's apartment, observed the bathroom commode to have a smear of brown material on the outside of the bowl which was visible from the bathroom doorway. On 09/22/21 at 1:55 p.m., housekeeping #1 was asked what resident rooms had been cleaned. She presented her schedule which revealed a mark on resident #1's room number. She was asked what the mark on the room number meant. She stated the mark meant the room had been cleaned. A tour of resident #1's bathroom revealed the same observation of the commode having a smear of brown material on outside of bowl. Housekeeping #1 was asked to visit resident #1's bathroom. She was asked what had been cleaned in the bathroom. She stated, "Maybe I didn't clean this room." 2. Resident #2 had diagnoses which included Alzheimer's disease and vascular dementia. A 14 day resident assessment, dated 10/08/20, documented the resident was confused at times, had fair judgement, ambulatory with staff assistance, used a walker for mobility, occasionally incontinent of bowel and bladder, and wore adult briefs. A personal care assessment and negotiated services agreement, dated 06/30/21, documented the resident was to receive standard	C1304		

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C1304	Continued From page 5 housekeeping services weekly with staff to monitor for change, assistance of one staff member for showering one-two times a week, verbal reminders and staff escort to the bathroom with staff to monitor for changes. A review of the services delivery record, dated August 2021, revealed 3 documented showers. A review of the services delivery record, dated September 2021, revealed no documented showers. On 09/21/21, 09/22/21, and 09/23/21, during visits to resident #2's apartment, observed the bathroom commode to have a brown stain running down the outside of the bowl which was visible from the bathroom doorway. Also observed a smear of brown material on the floor beside the commode. On 09/23/21 at 9:10 a.m., the maintenance/housekeeping director was asked to visit resident #2's room. Upon entry into the bathroom he stated, "Okay, this needs to be taken care of." He was informed the same observation had been made the last three days and asked why the bathroom had not been cleaned. He stated they rely on nursing to inform housekeeping when there was a cleaning need. He stated they conducted spot checks of the rooms, for cleanliness, but did not check them all. He was asked if resident #2's bathroom would have been cleaned in addition to the regularly scheduled cleaning. He stated yes, if we had known about it.	C1304		

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C1304	Continued From page 6 3. Resident #3 had diagnoses which included hemiplegia and hemiparesis affecting right dominant side. A 14 day resident assessment, dated 08/08/20, documented the resident was alert, had good judgement, ambulatory with staff assistance, continent of bowel and bladder, and independent with toileting. Unsigned personal care assessments, dated 09/09/20, and 01/08/21, documented the resident required at least one person staff assistance during bathing one-two times a week with staff to monitor for change. A review of the services delivery records, dated September 2020 through December 2020, revealed no documented baths. Resident #4 had diagnoses which included cognitive dysfunction, type two diabetes mellitus, and falls. A 14 day resident assessment, dated 08/02/21, documented the resident was forgetful, had good judgement, utilized a walker for mobility, and continent of bowel and bladder. A review of resident #4's assessments revealed the personal care assessment and negotiated services agreement, dated 09/18/21 were not signed by the resident or responsible party. On 09/22/21 at 11:21 a.m., housekeeping #1 was asked what was included when providing housekeeping services in a resident's bathroom. She stated she would clean the shower, handrails, mirror, sink, toilet, sweep, and mop the floor.	C1304		

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C1304	Continued From page 7 She was asked how she knew which resident's rooms were to be cleaned. She stated she received a schedule of rooms to be cleaned for the week, basically the same rooms were cleaned on a weekly schedule. She was asked what the procedure was for incontinent residents who had accidents or if something needed to be cleaned between scheduled cleanings. She stated nursing would let housekeeping know if housekeeping was needed. On 09/22/21 at 12 p.m., the maintenance/housekeeping director was asked how housekeeping was scheduled. He stated housekeeping was based on the resident's level of care. He was asked if housekeeping was documented on the services delivery record. He stated no. He was asked how he ensured housekeeping services were rendered. He stated by conducting spot checks. On 09/22/21 at 12:20 p.m., CNA #3 was asked how she knew which residents were scheduled for showers. She stated she checked the nurse's board daily where the shower schedule would be listed. She was asked how she knew which residents required assistance. She stated it would be posted on the nurse's board. She was asked what the procedure was if she noticed a resident's bathroom needed cleaning. She stated if she had time she would clean it,	C1304		

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LEGEND AT 71ST STREET	701 W 71ST SOUTH TULSA, OK 74132

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C1304	Continued From page 8 otherwise she would inform housekeeping. On 09/22/21 at 3:20 p.m., the health care director was asked how often the negotiated service agreement was completed. She stated every time the personal care assessment was completed. She was asked how they ensured the negotiated services agreement/personal care assessment was communicated to the resident and/or resident representative. She stated the assessment/ agreement would be signed. She was asked why personal care assessments/negotiated services agreements were not signed. She did not have an answer. She was asked who was responsible to ensure the personal care assessment/negotiated services agreement was communicated to the resident and/or resident representative and signed. She stated the nurse who completed the assessment was responsible. She was asked if the personal care assessment/negotiated services agreement was complete without the signature of the resident and/or resident representative. She stated the assessment would be accurate for our staff. She was asked who was responsible to ensure residents received a shower. She stated she was responsible. She was asked where completed showers were documented. She stated showers were documented on the services delivery record. She was asked who was responsible to ensure	C1304		

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 09/23/2021

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
C1304	Continued From page 9 showers were documented as given. She stated she was responsible. She was asked who was responsible to ensure residents received housekeeping services. She stated the maintenance director was responsible. On 09/23/21 the health care director was asked for sampled resident's service contracts. She stated the personal care assessment/negotiated service agreement was the clinical service contract.	C1304		
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	C1505		

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 09/23/2021

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
C1505	Continued From page 10 incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure adequate and appropriate medical care consistent with established medical practice standards, for one (#1) of three sampled residents whose records were reviewed for care specific to medication administration. The health care director identified 60 residents who were administered medications. Findings: Resident #1 had diagnoses which included pneumonia and history of deep vein thrombosis. Physician orders included: - Eliquis (a blood thinner) 2.5 mg to be administered twice daily; - Chest x-ray, due to congestion, dated 07/28/21; and - Z-Pak (an antibiotic) to be administered per directions, dated 07/30/21.	C1505		

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 09/23/2021

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
C1505	Continued From page 11 A review of the MAR for July, August, and September, 2021 revealed 23 missed doses of Eliquis. Twenty doses missed due to medication not being available and three doses missed due to waiting on delivery of the medication. A review of the MAR for July, 2021 did not reveal the Z-Pak, ordered 07/30/21, had been added to the MAR or administered. A review of the MAR for August, 2021 revealed Azithromycin (Z-Pak) had been added to the MAR however no doses of the antibiotic were documented as being administered and the antibiotic was discontinued 08/01/21. A review of the clinical record revealed resident #1 was seen in an urgent care facility 08/01/21 where the following issues were addressed: periorbital dermatitis, cough, and left lower lobe pneumonia. Antibiotics were prescribed. On 09/22/21 at 2:05 p.m., CMA #1 was asked what the procedure was for medication refills. She stated she would let the DON know, check to see when the medication was last refilled, and request the medication refill from the pharmacy. She was asked what the timeframe was for medication to be refilled. She stated usually within 24 hours. On 09/22/21 at 3:20 p.m., the health care director/DON was asked who was responsible to ensure ordered medications and refills were obtained timely. She stated the medication aide was responsible for medication refills with nurse oversight.	C1505		

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 09/23/2021

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
C1505	Continued From page 12 She was asked who was responsible to ensure resident #1's order for an antibiotic was completed. She stated the nurse on duty was responsible.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: cherylann.ledbetter@legendseniorliving.com

November 16, 2021

License Number:

AL1103

Ms. Cherylann Ledbetter, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

Survey Event ID: 01J511

Dear Ms. Ledbetter:

On **September 23, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 15, 2021**.

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

Sincerely,

Tempal Killman Digitally signed by Tempal Killman
Date: 2021.11.16 09:52:47 -06'00'

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: 11/1/2021

Facility Name: Legend at 71st Street

License Number: AL1103

Survey Event ID: 01J511

Date Survey Completed: 9/23/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542	Based on: interview and record review, the facility failed to ensure the 14 day resident assessment was signed by a registered nurse or the resident's personal physician for one (#1) of four sampled residents whose assessments were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. The plan of correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.

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?	The Resident Director or designee will ensure that the 14 day resident assessment for resident (#1) has been signed by a registered nurse or the resident's personal physician in accordance with 310:663-5-4(b) CONDUCT OF ASSESSMENT.
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 have the potential to be affected.
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?	The Resident Director, Health Care Director and/or Assistant Health Care Director will be in-serviced on CONDUCT OF ASSESSMENT in accordance with 310:663-5-4(b).
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.	Enter methods to ensure corrections are sustained: The Resident Director or designee will audit the 14 day resident assessments to ensure that the assessments are signed by a registered nurse or the resident's personal physician in accordance with 310:663-5-4(b) CONDUCT OF ASSESSMENT. Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place. Review of the audit will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/15/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 11-04-2021

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/1/2021** **Facility Name:** Legend at 71st Street **License Number:** AL1103 **Survey Event ID:** 01J511 **Date Survey Completed: 9/23/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: interview and record review, the facility failed to ensure adequate and appropriate medical care consistent with established medical practice standards, for one (#1) of three sampled residents whose records were reviewed for care specific to medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. The plan of correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.

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?	A medication review was completed and all physician ordered medication made available for resident (#1) to ensure adequate and appropriate medical care consistent with established medical standard practices in accordance with 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS .
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 in the community have the the potential to be affected.
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?	All resident medication orders will been reviewed for accuracy and availability. MAR to cart audits will be completed 3x per week. All staff responsible for the administration of medication will be in-serviced on medication availability, medication documentation and ordering of medication in a timely manner in accordance with . 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS.
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.	Enter methods to ensure corrections are sustained: Resident Director or designee will monitor the availability of medications and their medication administration 3x per week. Review of the documentation will be incorporated into the QA meeting and need for any additional intervention will be put into place. Record of the documentation will be kept with the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		12/15/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	11-04-2021
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/1/2021** **Facility Name:** Legend at 71st Street **License Number:** AL1103 **Survey Event ID:** 01J511 **Date Survey Completed: 9/23/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: observation, interview, and record review, the facility failed to ensure the personal care assessment and/or the negotiated services agreement was signed by the resident or responsible party, for three (#1, 3, and #4) of four sampled residents whose assessments /agreements were reviewed; and services were provided based on the resident's personal care assessment/negotiated service agreement for three (#1, 2, and #3) of four sampled residents whose services were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. The plan of correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.

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?	The personal care assessments and/or negotiated services agreement for residents (#1, 3 and 4) shall be updated and signatures shall be obtained by the resident or responsible party. The personal care assessments and/or negotiated services agreement shall be reviewed for residents (#1, 2, and #3) to ensure services are provided in accordance with 310:663-13-1(d) RESIDENT SERVICE CONTRACT.
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 in the community have the potential to be affected.
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?	The Resident Director or designee will audit a sampling of updated personal care assessments and/or negotiated services agreements to ensure that signatures have been obtained by the resident or responsible party and will review documentation to ensure services have been provided in accordance with 310:663-13-1(d) RESIDENT SERVICE CONTRACT. In-service of all care staff on documentation of services provided as outlined on the personal care assessments and/or negotiated services agreement.
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	Enter methods to ensure corrections are sustained: Resident Director or designee will audit a sampling of the personal care assessments and/or negotiated services agreements to ensure that signatures have been obtained by the resident or responsible party and will review documentation of the care staff to ensure services

c. How monitoring records will be kept to evidence the correction.	outlined on the personal care assessment and/or negotiated services agreements are being provided. Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place. Record of the documentation will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/15/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 11-04-2021

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: cara.slavens@legendseniorliving.com

December 20, 2022

License Number: AL1103

Ms. Cara Slavens, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

Survey Event ID: 01J512

Dear Ms. Slavens:

On **December 19, 2022,** an offsite/paper complaint revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 23, 2021,** have now been corrected effective **February 21, 2022.**

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

Sincerely,

Lisa Calvin

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1103	A. BUILDING: _____ B. WING _____	R-C 12/19/2022

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 An offsite/paper revisit was completed on 12/19/22. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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