OKLAHOMA
State Department
of Health

Delivery via email to: Sarah.Odamah@legendseniorliving.com

April 2, 2025

License Number: AL1103

Ms. Sarah Odamah, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

RE: Survey Event ID: ZHXO11

Dear Ms. Odamah:

On **March 26, 2025**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 26, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Legend at 71st Street
Address: 710 W 71st
City, State, Zip: Tulsa, OK, 74132
Provider #: AL1103
Complaint #: OK00065728
Investigation Date(s): 03/24/25, 03/25/25, and 03/26/25

ALLEGATION(S)
enter text The facility failed to ensure residents were not physically, verbally or psychosocially abused.
The facility failed to ensure residents were treated with dignity and respect.
The facility failed to ensure palatable food was served under sanitary conditions.
enter text
enter text

An unannounced on-site investigation was initiated 03/24/2025 at 2:30 p.m.

A sample of ten residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 Summary of Complaint Investigation:

Upon entrance into the facility and throughout the survey observations were made of staff interactions with the residents in public during dining observations, activities and in their rooms being treated with dignity and respect. A review of records was conducted to include residents' clinical records, physicians' orders, care plans, incident reports, abuse allegation investigations, and interviews with residents' family members along with the facility policies. Upon entrance into the kitchen sanitary precautions were being observed by all employees and the work areas were very clean also. The fresh fruit, vegetables and bread did not have any mold. A sample plate was provided and the palatable food met temperature requirements, tasteful and there were several options to choose from.

OKLAHOMA
State Department
of Health

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/26/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Legend at 71st Street
Address: 710 W 71st
City, State, Zip: Tulsa, OK, 74132
Provider #: AL1103
Complaint #: OK00079727
Investigation Date(s): 03/24/25, 03/25/25, and 03/26/25

ALLEGATION(S)
The center failed to ensure residents were not sexually, physically or psychosocially abused
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/24/2025 at 2:30 p.m.

A sample of ten residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 Summary of Complaint Investigation:

Upon entrance into the facility and throughout the survey observations were made of staff interactions with the residents in public during dining observations, activities and in their rooms. A review of records was conducted to include residents' clinical records, physicians' orders, care plans, incident reports, abuse allegation investigations, and interviews with residents family members along with the facility policies.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/26/2025

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 03/26/2025

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 relicensure survey was conducted from 03/24/25 through 03/26/25. Complaint investigations (#OK00079727 and #OK00065728) were conducted in conjunction with the survey. Facility Census: 76 Listed below are abbreviations that will be used throughout this document. HTN- hypertension LPN- licensed practical nurse RN- registered nurse	C 000		
C 391 SS=E	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 facility failed to ensure opened food items were labeled with the open and use by date in the walk in freezer, dry food storage area, and two of two refrigerators. The administrator identified 76 residents receive nutrition from the kitchen. Findings: On 03/24/25 at 2:49 p.m., the following food items were observed opened in refrigerators #1 and #2 with no labels to show the open and use by date:	C 391		

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 03/26/2025

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 391	Continued From page 1 a. a plastic bottle half full of salad dressing in refrigerator #1, b. a plastic container three quarters full of sour cream in refrigerator #1, c. three prepared salads on plates in refrigerator #1, d. a plastic container half full of chicken salad in refrigerator #2, e. a plastic bag three quarters full of cilantro in refrigerator #2, f. a plastic container half full of egg salad in refrigerator #2, g. a carton half full of liquid eggs in refrigerator #2, and h. a plastic wrap three quarters full of diced deli meat in refrigerator #2. On 03/24/25 at 2:54 p.m., following food items were observed opened in the walk in freezer with no labels to show the open and use by date: a. a plastic bag half full of blueberry scones, b. a plastic bag three quarters full of chicken nuggets, c. a plastic bag half full of french fries, d. a plastic bag half full of cookies, and e. two plastic bags three quarters full of chicken strips. On 03/24/25 at 2:59 p.m., the following food items were observed in the dry food storage area opened without a open and use by date: a. a plastic bag half full of marshmallows, b. a plastic wrap half full of spaghetti noodles, c. a plastic bag three quarters full of pecans, and d. a plastic bag half full of brown sugar. The facility "Storage of Foods Policy," dated 03/18/24, read in part, "Wrap, cover, or seal all refrigerated foods and label with the preparation date."..."Label the item with a description of the	C 391		

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 03/26/2025

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 391	Continued From page 2 product and the date it was wrapped/placed in the freezer." On 03/24/25 at 2:58 p.m., the kitchen chef was asked what was their policy on the items that were found in the refrigerators, freezer, and dry food storage area. The kitchen chef stated "Everything should be label and dated if not it needs to be thrown in the trash."	C 391		
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 record review and interview, the facility failed to ensure annual comprehensive assessments were signed/coordinated by a RN or physician for (#1 and #10) of 10 residents sampled for assessments coordinated by a RN or physician. The health care director/LPN identified 76 residents resided in the facility. Findings: A facility policy titled "The Personal Care Assessment," date 07/01/12, read in part, "The Healthcare Coordinator or designee will conduct the Personal Care Assessment." 1. Resident #1 was admitted on 10/13/22 with diagnoses which included dementia, HTN, pain,	C 542		

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 03/26/2025

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 542	Continued From page 3 hyperlipidemia, and edema. Resident #1's annual comprehensive assessment, dated 09/12/24, did not show the assessment was signed/coordinated by a RN or physician. 2. Resident #10 was admitted on 07/02/14 with diagnoses which included HTN, osteoarthritis, fibromyalgia, chronic pain, dementia, anxiety, and memory loss. Resident #10's annual comprehensive assessment, dated 10/25/24, did not show the assessment was signed/coordinated by a RN or physician. On 03/26/25 at 10:49 a.m., the health care director/LPN who was responsible for conducting assessments was asked the reason the two annual comprehensive assessments were not signed by a RN or physician. They stated, "They don't know how this happened."	C 542		

OKLAHOMA
State Department of Health

Delivery via email to: Sarah.Odamah@legendseniorliving.com

April 21, 2025

License Number: AL1103

Ms. Sarah Odamah, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

RE: Survey Event ZHXO11

Dear Ms. Odamah:

On **March 26, 2025**, a Licensure inspection with complaint investigations 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 **April 30, 2025.**

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 4/15/2025
	Facility Name: Legend At 71st Street
	License Number: AL1103
	Survey Event ID: ZHXO11
	Date Survey Completed: 3/26/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation, record review, and interview, the facility failed to ensure opened food items were labeled with the open and use by date in the walk in freezer, dry food storage area, and two of two refrigerators.

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 conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	All food items that were observed opened in refrigerators #1 and #2 with no labels to show the open and use dates were all discarded. All food items observed in the walk in freezer with no labels to show the open and use date were all discarded. All food items observed in the dry food storage area opened without an open and use date were all discarded.
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?	Dinning Service Associates were in-serviced on the Storage of Foods Policy in compliance with 310-663-3-8(a)FOOD STORAGE, PREPARATION AND SERVICE.
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.	a. Residence Director or designee will conduct an audit of food items storage and labeling in the kitchen, in accordance with 310-663-3-8(a) FOOD, STORAGE, PREPARATION ND SERVICE b. Review of the audit will be incorporated into the Quality Assurance meeting and need for any additional intervention will be put into place. Enter methods to keep monitoring records: c. Record of the documentation will be kept with the Qaulity Assurance Meeting Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date** Enter a date of signature. 04/14/2025
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: 4/15/2025** **Facility Name:** Legend At 71st Street **License Number:** AL1103 **Survey Event ID:** ZHXO11 **Date Survey Completed: 3/26/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C542	Based on: record review and interview, the facility failed to ensure annual comprehensive assessments were signed/coordinated by a RN or physician for (#1 and #10) of 10 residents sampled for assessments coordinated by a RN or physician.

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 conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Resident #1 and Resident #10 assessments are now signed by previous Registered Nurse after they were made aware.
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?	Registered Nurse and community Nurse Team were in-serviced on the annual comprehensive assesments policy in compliance with 310:663-5-4(b) CONDUCT OF ASSESSMENT
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.	a. Residence Director or designee will conduct an audit of the community's resident annual comprehensive assessments in accordance with 310:663-5-4(b) CONDUCT OF ASSESSMENT for compliance to the Annual comprehensive assessments being coordinated/signed by an RN or Physician of the resident. B. Review of the assessments to ensure all assessments completed were reviewed and signed by RN, audit will be incorporated into the Quality Assurance Meeting and need for any additional intervention will be put into place. Enter methods to keep monitoring records: c. Record of documentation will be kept with the Quality Assurance Meeting Minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 04/11/2025

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: Sarah.Odamah@legendseniorliving.com

May 8, 2025

License Number: AL1103

Ms. Sarah Odamah, Administrator
Legend At 71st Street
701 W 71st South
Tulsa, OK 74132

RE: Survey Event ZHXO12

Dear Ms. Odamah:

On **May 8, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaint investigation on **March 26, 2025,** have now been corrected effective **April 30, 2025.**

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

Respectfully,

Lisa Calvin

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1103	A. BUILDING: _____ B. WING _____	R-C 05/08/2025

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 conducted on 05/08/25. 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