OKLAHOMA
State Department
of Health

Delivery via email to: june.rose@legendseniorliving.com

June 11, 2025

License Number: AL1404

Ms. June Rose, Administrator
The Gardens At Rivermont
750 Canadian Trails Drive
Norman, OK 73072

Survey Event ID: OUCZ11

Dear Ms. Rose:

On **June 2, 2025, r**epresentatives 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 no 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 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 will be completed for each violation; and
(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 a 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: IDRCoordinator@health.ok.gov

or mail 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Gardens at Rivermont
Address: 750 Canadian Trails Drive
City, State, Zip: Norman, OK 73072
Provider #: AL1404
Complaint #: OK00083004
Investigation Date(s): 06/02/25

ALLEGATION(S)
The facility failed to assess, monitor, and intervene in a timely manner for a resident who experienced a fall and sustained injuries
The center failed to ensure residents were treated with dignity and respect
The center failed to provide dependent residents with ADL assistance
enter text
enter text

An unannounced on-site investigation was initiated 06/02/2025 at 9:00 a.m.

A sample of 3 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: An initial tour of the center showed residents were dressed and groomed appropriately. Observations of vulnerable, dependent, and independent residents were made. Staff and resident interactions and staff assistance with personal care were observed. Resident health records, incident reports, policies, nurse's notes, and resident assessments were reviewed. Interviews were conducted with residents, families, and staff.

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: 06/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1404	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT RIVERMONT	750 CANADIAN TRAILS DRIVE NORMAN, OK 73072

(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 survey (#OK00083004) was conducted on 06/02/25. Deficiencies were cited as a result of the survey. Facility Census: 51 Listed below are abbreviations that will be used throughout this document. DON- director of nursing OSDH - Oklahoma State Department of Health RN - registered nurse	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 record review and interview, the center failed to ensure an annual comprehensive assessment was signed/coordinated by an RN or physician for 1 (#1) of 3 sampled residents reviewed for assessments coordinated by a RN or physician. The DON identified 51 residents resided in the center. Findings:	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1404	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT RIVERMONT	750 CANADIAN TRAILS DRIVE NORMAN, OK 73072

(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 1 A "14-day Comprehensive Assessment," dated 04/28/25, showed Resident #1 had diagnoses which included traumatic brain injury, hypertension, and seizures. The assessment did not show it was signed/coordinated by an RN or physician. On 06/02/25 at 11:45 a.m., the DON was asked if there a copy of the assessment with signatures. The DON stated, "No, I didn't get signatures on it."	C 542		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a personal interview between the resident and/or the resident's representative for 1 (#1) of 3 residents sampled for comprehensive assessments. The DON identified 51 residents resided in the center. Findings:	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1404	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT RIVERMONT	750 CANADIAN TRAILS DRIVE NORMAN, OK 73072

(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 543	Continued From page 2 A "14-day Comprehensive Assessment," dated 04/28/25, showed Resident #1 had diagnoses which included traumatic brain injury, hypertension, and seizures. The assessment did not show it was signed by the resident and/or the resident's representative. On 06/02/25 at 11:45 a.m., the DON was asked if there a copy of the assessment with signatures. The DON stated, "No, I didn't get signatures on it."	C 543		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1404	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT RIVERMONT	750 CANADIAN TRAILS DRIVE NORMAN, OK 73072

(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
C1912	Continued From page 3 treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the OSDH for 1 (#1) of 3 sampled residents reviewed for incident reports. The DON identified 51 residents resided in the center. Findings: A "14-day Comprehensive Assessment," dated 04/28/25, showed Resident #1 had diagnoses which included traumatic brain injury, hypertension, and seizures. An incident report, dated 05/25/25, showed Resident #1 sustained a hip fracture from a fall on 05/25/25. There was no fax confirmation the incident report was sent to the OSDH.	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1404	A. BUILDING: _____ B. WING _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT RIVERMONT	750 CANADIAN TRAILS DRIVE NORMAN, OK 73072

(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
C1912	Continued From page 4 On 06/02/25 at 11:17 a.m., the DON was asked if the center submitted the incident report to the OSDH. The DON stated, "Oh, Yes." The DON was asked for the fax confirmation sheet. The DON stated, "I'll get it." On 06/02/25 at 11:46 a.m., the DON stated, "We didn't receive a fax confirmation for the incident report."	C1912		

OKLAHOMA
State Department of Health

Delivery via email to: june.rose@legendseniorliving.com

June 30, 2025

License Number: AL1404

Ms. June Rose, Administrator
The Gardens At Rivermont
750 Canadian Trails Drive
Norman, OK 73072

Survey Event ID: OUCZ11

Dear Ms. Rose:

On **June 2, 2025,** 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 in a timely manner. **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 **July 8, 2025**.

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
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: 6/26/2025** **Facility Name:** The Gardens at Rivermont **License Number:** AL1404-1404 **Survey Event ID:** OUCZ11 **Date Survey Completed: 6/2/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542	Based on: record review and interview, the centerfailed to ensure an annual comprehensiveassessment was signed/coordinated by an RN orphysician for 1 (#1) of 3 sampled residentsreviewed for assessments coordinated by a RNor physician

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Unable to correct #1. Resident moved out. All residents will have a Comprhensive Assestment by the RN and/or Doctor on move in, significant change and yearly
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 Health Care Director has been inserviced on Comprehensive assessments. All Comprehensive Assessments will be reviewed by the RD after completion for signatures and timeliness
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.	All Comprehensive Assessments will be reviewed by the RD For signatures Review of the Conprehensive Assessment will go in writing weekly and taken throught the QA committee for review and recommendations x four weeks then monthly thereafter. Weekly audits of the Comprehensive Assessments to assure Signatures Findings from the audits will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **June Rose** JRose OAC 310:663-25-4(F)	**Date 6/26/2025**

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: 6/26/2025
Facility Name: The Gardens at Rivermont
License Number: AL1404-1404
Survey Event ID: OUCZ11
Date Survey Completed: 6/2/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543	Based on: record review and interview, the centerfailed to include a personal interview between theresident and/or the resident's representative for 1(#1) of 3 residents sampled for comprehensiveassessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Each resident and/or their representiative will have a personal interview with the Nurse when completing a Comprehensive Assessment on a resident.
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?	All Comprehensive Assessments will be reviewed by the RD to assure a personal interview is done. The Health Care Director has been in-servided on the requirements for a Comprhensive aassessment.
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.	All Comprehensive Assessments will be reviewed by the RD For personal interviews Review of the Conprehensive Assessment will go in writing weekly and taken throught the QA committee for review and recommendations x four weeks then monthly thereafter. Weekly audits of the Comprehensive Assessments to assure personal interviews Findings from the audits will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **June Rose** June Rose **Date 6/26/2025**
OAC 310:663-25-4(F)

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

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

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: 6/26/2025** **Facility Name:** The Gardens at Rivermont **License Number:** AL1404-1404 **Survey Event ID:** OUCZ11 **Date Survey Completed: 6/2/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1912	Based on: on record review and interview, the centerfailed to submit an incident report to the OSDHfor 1 (#1) of 3 sampled residents reviewed forincident reports.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 report has been sent to the OSDH on the reportable incisdent. All reportables will be sent to OSDH and to the the OKDHS and the OK. Nurse Aide if neccessary
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in 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?	Incident reports will be reviewed daily by the RD and HCD and audits will be placed in writing. The Administrator and Health Care Director have been inserviced. has been in-service on reporting requirements.
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.	Incident and accidents will be reviewed daily for compliance. The Residence Director or designee will audit incident reports for compliance daily. Findings of the daily audits will be placed in writing and taken to the QA weekly x 4 weeks then monthly thereafter Review of the audited incident reports will be incorporated into the QA meeting and the need for any additional intervention will be put into place. Record of the documention will be kept with the QA minutes
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **June Rose** June Rose OAC 310:663-25-4(F)	**Date 6/26/2025**

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.

LEGEND SENIOR LIVING

Training & In-Service Attendance Time Sheet

Survey Event ID: OHCZ11

Course Name: Annual Comprehensive Assessment Requirements **Date:** 06.11.2025

Instructor(s): Christy Gilmore

Location: The Gardens at Rivermont **Hours:** .30

No.	Name	Title	Community Name (Ex: Legend at Rivendell)	Time In	Time Out	Eval. Given Y/N
1	June Rose	Admin	Rose			
2	Vickie Simpson	Health Care Director	VS			
3						
4						
5						

OKLAHOMA
State Department of Health

Delivery via email to: june.rose@legendseniorliving.com

July 15, 2025

License Number: AL1404

Ms. June Rose, Administrator
The Gardens At Rivermont
750 Canadian Trails Drive
Norman, OK 73072

Survey Event ID: OUCZ12

Dear Ms. Rose:

On **July 11, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your complaint survey on **June 2, 2025,** have now been corrected effective **July 8, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
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
	AL1404	A. BUILDING: _____ B. WING _____	R-C 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT RIVERMONT	750 CANADIAN TRAILS DRIVE NORMAN, OK 73072

(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 07/11/25. 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