OKLAHOMA
State Department
of Health

Delivery via email to: judy.kirkland@legendseniorliving.com; donna.robison@legendseniorliving.com

February 20, 2025

License Number: AL1405

Ms. Judy Kirkland, Administrator
Arbor House Assisted Living Center
4501 West Main Street
Norman, OK 73072

Survey Event ID: EJH711

Dear Ms. Kirkland:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **February 12, 2025**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: ARBOR HOUSE ASSISTED LIVING CENTER
Address: 4501 WEST MAIN STREET
City, State, Zip: NORMAN, OK, 73072
Provider #: AL1405
Complaint #: OK00073446
Investigation Date(s): 02/11/2025 and 02/12/2025

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to have and/or implement an effective grievance policy and procedure.
The center failed to have and/or implement an effective pest control program.

An unannounced on-site investigation was initiated 02/11/2025 at 4:00 p.m.

A sample of six residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Observations were made of staff and resident interactions. Residents were observed receiving assistance with care in a non-aggressive manner. Residents rooms were observed for pest and no signs of pest were observed including bed bugs.

Residents were asked about treatment from staff including any staff identified in the allegations. Residents were asked about abuse and who to report it and how the facility resolved any problems and grievances. They were asked about the pest control the facility has and if there were any problems with pests, including bed bugs.

Staff were asked about their knowledge of the abuse policy and how to identify abuse. They were asked about the care they have observed being provided by other staff including those identified in the allegations. The staff were asked how problems and grievances were resolved and addressed.

Abuse policy, grievances policy, and pest control policy were reviewed. Resident council minutes, grievances, employee files, pest control invoices, abuse investigations, and employee training records were all reviewed.

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: 02/12/2025

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
	AL1405	A. BUILDING: _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING CENTER	4501 WEST MAIN STREET 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 investigation (#OK00073446) was conducted on 02/11/25 through 02/12/25. No deficiencies were cited. Facility Census: 45	C 000		

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