OKLAHOMA
State Department
of Health

Delivery via email to: greg.hendrix@legendseniorliving.com

January 31, 2024

License Number: AL1410

Mr. Greg Hendrix, Executive Director
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: 6QU411

Dear Ms. Riggs:

On **January 25, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your assisted living facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in 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:

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: **Legend at Rivendell**
Address: **13200 South May Avenue**
City, State, Zip: **Oklahoma City OK 73170**
Provider #: **AL1410**
Complaint #: **OK00062185**
Investigation Dates: **01/23/24 and 01/25/24**

ALLEGATION(S)

The center failed to ensure residents were not neglected and failed to prevent new or worsening pressure wounds.

An unannounced on-site investigation was initiated 01/23/2024 at 12:03 p.m.

A sample of four 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 conducted throughout the survey of staff interactions with residents, incontinent care, and supervision of the residents. The halls and apartments were observed for lingering odors. Resident clinical records including progress notes, care plans, assessment, third party provider notes, skin assessments, incident reports, policies, and procedures were reviewed during the survey. Two third party providers, six staff members, and three family members were interviewed about care and services provided by the center.

The attached Statement of Deficiencies, Form 2567 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: 01/27/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Legend at Rivendell**
Address: **13200 South May Avenue**
City, State, Zip: **Oklahoma City OK 73170**
Provider #: **AL1410**
Complaint #: **OK00062216**
Investigation Dates: **01/23/24 and 01/25/24**

ALLEGATION(S)

The center failed to ensure residents were not physically, verbally, or psychosocially abused.
The center failed to provide adequate supervision to prevent falls.

An unannounced on-site investigation was initiated 01/23/2024 at 12:03 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 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 conducted throughout the survey of staff interactions with residents, supervision of residents, and fall interventions. Residents were observed for bruises and/or injuries. Resident clinical records including physician orders, care plans, progress notes, fall risk assessments, resident council, incident reports, policies and procedures were reviewed during the survey. Four family members, six staff members, and one third party provider were interviewed concerning abuse, staff treatment of residents, and falls.

The attached 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: 01/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1410	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL	13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170

(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 Complaint investigations (OK00062185 and OK00062216) were conducted on 01/23/24 and 01/25/24. Census: 116 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide OSDH - Oklahoma State Department of Health RN - registered nurse	C 000		
C1917 SS=D	310:663-19-(g) REPORTS TO THE DEPARTMENT (g) Content of Incident Report (1) The preliminary report shall at the minimum include: (A) who, what, when, and where; and (B) measures taken to protect the resident(s) during the investigation. (2) The follow-up report shall at the minimum include: (A) preliminary information; (B) the extent of the injury or damage if any; and (C) preliminary findings of the investigation. (3) The final report shall, at the minimum, include preliminary and follow-up information and: (A) a summary of the investigative actions; (B) investigative findings and conclusions based on findings; (C) corrective measures to prevent future occurrences; and (D) if items are omitted, why the items are omitted and when they will be provided.	C1917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1410	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL	13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170

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C1917	Continued From page 1	C1917		

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to ensure bruising of unknown origin was investigated and reported to the OSDH for one (#1) of three sampled residents reviewed for abuse.

The administrator identified 59 residents who resided in the memory care.

Findings:

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

A "Resident Outing" form, dated 11/18/23, documented Resident #1 had gone home with their family member on 11/18/23 and returned to the center on 11/19/23.

There was no documentation Resident #1 had bruising to their groin or scrotum upon return on 11/19/24 through 11/22/24.

An "Incident Occurrence" report, dated 11/23/23, read in part, "...Resident noted to have dark purple bruising to groin and scrotum area. Resident unbale (sic) to tell what happened. Spoke with associates and no incident have been reported..."

There was no documentation an investigation had been conducted for the unexplained bruising to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1410	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL	13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170

(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
C1917	Continued From page 2 Resident #1's groin and scrotum to determine the cause. On 01/25/24 at 12:25 p.m., CNA #1 was asked if bruising could be a sign of abuse. They stated yes, depending on where it was located. CNA #1 stated they had observed and reported the bruises on Resident #1 to the nurse. They stated they had not been interviewed and had not given a statement about the bruising. On 01/25/24 at 12:41 p.m., CMA #1 stated they observed the bruising on Resident #1's groin and scrotum and reported it to the RN. They stated they had not been interviewed about how the bruising occurred. On 01/25/24 at 1:05 p.m., the RN stated they had not sent in an incident report to the state for the bruising. They stated they had not assessed any other residents on that wing for bruising and had not interviewed the staff except to ask if the resident had any new falls. They stated they had not interviewed any of the other residents or their family members. On 11/25/24 at 3:20 p.m., the RN was asked how they determined an injury of unknown origin was not caused by abuse. They stated if the bruise was suspicious they would do an investigation. The RN stated they were responsible for investigating and reporting incidents to the state. The center was not aware of how the bruising occurred to Resident #1 from 11/23/23 until 11/29/23, had not conducted an investigation to determine the cause of the bruising, and had not submitted an incident report to the state.	C1917		

OKLAHOMA
State Department
of Health

Delivery via email to: greg.hendrix@legendseniorliving.com;
cristy.davis@legendseniorliving.com

February 20, 2024

License Number: AL1410

Mr. Greg Hendrix, Director/Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: 6QU411

Dear Mr. Hendrix:

On **January 25, 2024,** 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 correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 13, 2024**.

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: 2/13/2024
Facility Name: Legend at Rivendell
License Number: AL1410
Survey Event ID: 6QU411
Date Survey Completed: 1/25/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1917	Based on: record review and interview, the center failed to ensure bruising of unknown origin was investigated and reported to the OSDH for one (#1) of three sampled residents reviewed for abuse.

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?	Residence Director or designee will ensure a review of the resident record for one (#1) resident as identified on the SoD to ensure compliance with 310:663-19-1(g) Reports to the Department – Content of Incident Report
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 Residence Directors, licensed nurses and care associates will be in-serviced on Reports to the Department (Content of Incident Report) as outlined in 310:663-19-1(g) to include reporting of every bruise/injury of uknown origin.
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. The Residence Director or designee will audit a sampling of the incident reports for compliance in investigating and reporting any injury of unknown origin in accordance with 310:663-19(g) Reports to the Department (Content of Incident Report). b. Review of the audit of incident reports will be incorporated into the QA meeting and the need for any additional review will be put into place. Enter methods to incorporate into QA system: c. A 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?	3/13/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature	Administrator signature required.	**Date 2/13/2024**

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

Delivery via email to: greg.hendrix@legendseniorliving.com;
cristy.davis@legendseniorliving.com

May 1, 2024

License Number: AL1410

Mr. Greg Hendrix, Director/Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: 6QU412

Dear Mr. Hendrix:

On **April 30, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 25, 2024,** have now been corrected effective **March 13, 2024.**

If you have any questions concerning the information in this letter, please contact me 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
	AL1410	A. BUILDING: _____ B. WING _____	R-C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL	13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170

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{C 000}	INITIAL COMMENTS On 04/30/24, an offsite/revisit was conducted. The deficiencies from 01/25/24 were cleared.	{C 000}		

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