OKLAHOMA
State Department
of Health

Delivery via email to: greg.hendrix@legendseniorliving.com;
christy.gilmore@legendseniorliving.com

April 9, 2025

License Number: AL1410

Gregory Hendrix, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

RE: Survey Event ID: DGP511

Dear Mr. Hendrix:

On **March 12, 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 12, 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 Rivendell
Address: 13200 South May Ave
City, State, Zip: Oklahoma City, OK 73170
Provider #: AL1410
Complaint #: OK00068213
Investigation Date(s): 03/11/25-03/13/25

ALLEGATION(S)
The facility failed to ensure residents were free from physical and psychosocial abuse.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/11/2025 at 7:45 a.m.

A sample of 13 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: Initial tour of center showed adequate staffing on all memory care units. No odors or hazards were observed. Residents were observed to be well groomed, free of odors, and without signs of distress. Records reviewed included incident reports, policies, and resident charts. Resident to resident and staff to resident interactions were observed. Interviews conducted included staff, residents, and family members. The incident leading to allegation was isolated and center followed 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: 03/13/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Legend at Rivendell
Address: 13200 South May Ave
City, State, Zip: Oklahoma City, OK 73170
Provider #: AL1410
Complaint #: OK00074096
Investigation Date(s): 03/11/25-03/13/25

ALLEGATION(S)
The Center failed to provide adequate supervision to prevent resident to resident altercations that results in injuries.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/11/2025 at 7:45 a.m.

A sample of 13 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: Initial tour of center showed adequate staffing on all memory care units. No odors or hazards were observed. Residents were observed to be well groomed, free of odors, and without signs of distress. Records reviewed included schedules for the date of the allegation, resident charts, incident report, and policies. Interviews conducted included residents who were cognitive enough to recall event and staff members on duty the date of allegation. Adequate staffing were present on the date of allegation and interventions were implemented. No other incidents were reported.

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: 03/13/2025

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INVESTIGATIVE REPORT

Facility: Legend at Rivendell
Address: 13200 South May Ave
City, State, Zip: Oklahoma City, OK 73170
Provider #: AL1410
Complaint #: OK00078147
Investigation Date(s): 03/11/25-03/13/25

ALLEGATION(S)
The center failed to ensure residents were free from physical, verbal, and psychosocial abuse and to report to all state agencies as required per regulations
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/11/2025 at 7:45 a.m.

A sample of 13 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: Initial tour of center showed adequate staffing on all memory care units. No odors or hazards were observed. Residents were observed to be well groomed, free of odors, and without signs of distress. Records reviewed included incident reports, policies, and resident charts. Observations of resident with staff were made and interviews conducted included resident and staff. Based on record review and interview the center failed to notify local law enforcement or Adult Protective Services of abuse allegation.

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: 03/13/2025

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 03/12/2025

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 A relicensure survey was conducted from 03/11/25 through 03/13/25. Complaint investigations (#OK00068213, OK00074096, and #OK00078147) were conducted in conjunction with the survey. Facility Census: 136 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide DON AL- director of nursing assisted living DON MC- director of nursing memory care ER - extended release LPN - licensed practical nurse mg - milligram tab - tablet	C 000		
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,	C1505		

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C1505	Continued From page 1 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 incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: a. administer medications as ordered by the physician for 1 (#2); and b. ensure infection control measures were maintained during medication administration for 2 (#2 and #3) of 2 residents sampled for medication administration. The DON MC identified 71 residents resided in memory care. Findings: 1. On 03/12/25 at 10:22 a.m., CMA #2 prepared Resident #2's medication for administration and did not include metoprolol succinate (an	C1505		

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C1505	Continued From page 2	C1505		

anti-hypertensive medication) 25 mg ER TAB and did not utilize hand hygiene practices.

On 03/12/25 at 10:31 a.m., CMA #2 used a paper towel to clean up spilled coffee on the floor with their bare hands and disposed of the paper towel. CMA #2 did not utilize hand hygiene practices.

On 03/12/25 at 10:32 a.m., CMA #2 handed Resident #2 their medications in a cup with a cup of water and Resident #2 swallowed the medications.

A "Handwashing" policy, dated 11/01/12, read in part, "Staff should always thoroughly wash their hands in the following situations: Before and after the handling of any medications and/or treatment."

A policy titled "Medication Administration," dated 04/13/19, read in part, "Drugs shall be administered to each resident in accordance with a physician's written order."

Resident #2 was admitted to the center on 02/21/25 with diagnoses which included type 2 diabetes, shared psychotic disorder, depression, Alzheimer's disease, essential hypertension, atherosclerotic heart disease of native coronary artery, and heart failure.

A medication list for Resident #2, dated 03/12/25, showed the resident was prescribed metoprolol succinate 25 mg ER TAB "Take 1 tablet by mouth 2 times a day." There was no order to hold the medication based on blood pressure or any other factor.

On 03/12/25 at 10:25 a.m., CMA #2 stated, "[They] won't get this because blood pressure is

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C1505	Continued From page 3	C1505		

normal." CMA #2 was asked how they knew to not give metoprolol succinate 25 mg ER TAB. CMA #2 stated, "Because the blood pressure is normal."

On 03/12/25 at 11:20 a.m., The DON MC was asked if Resident #2 had paremeters for holding metoprolol succinate 25 mg TAB. They replied, "No." The DON MC was asked if Resident #2 was to receive the medication regardless of blood pressure reading. The DON MC stated, "Yes."

2. On 03/12/25 at 10:09 a.m., CMA #2 prepared Resident #3's medications and did not utilize hand hygiene practices before or after preparing the medications.

On 03/12/25 at 10:11 a.m. CMA #2 approached Resident #3, placed a cup of medications up to the resident's mouth and Resident #3 began chewing medications and holding them in their mouth. CMA #2 gave the resident a drink of water and asked Resident #3 if they could swallow the pills. Resident #3 stated, "No." CMA #2 instructed Resident #3 to spit out the pills into the medication cup. CMA #2 did not notify the nurse that Resident #3 did not receive their medications.

On 03/12/25 at 10:17 a.m., CMA #2 dropped the medication cup with Resident #3's chewed up medications. CMA #2 picked up the medications with their bare hands and disposed of them. CMA #2 did not utilize hand hygiene practices.

Resident #3 was admitted to the center on 02/02/25 with diagnoses to include hyperlipidemia, dementia, delusional disorders, depressive episode, anxiety disorder, parkinson's disease, atrial fibrillation, osteoporosis, and

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C1505	Continued From page 4 unspecified convulsions. On 03/12/25 at 10:33 a.m. CMA #2 was asked if they missed any opportunities for hand hygiene. They stated, "No, I already did that when I first started my med [medication] pass."	C1505		
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 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	C1912		

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C1912	Continued From page 5 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 facility failed to report an abuse incident to local law enforcement or the Department of Human Services for 1 (#8) of 6 sampled residents reviewed for incident reports. The administrator identified 136 residents resided in the center. Findings: An undated documented titled "Protective Services for the Elderly and for Incapacitated Adults Act," read in part, "Any person having reasonable cause to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation shall make a report as soon as the person is aware of the situation to: 1. The Department of Human Services; or 2. The municipal police department or sheriff's office in the county in which the suspected abuse, neglect, or exploitation occurred." A center policy title "Accident and Injury Investigation," dated 07/01/12, read in part,	C1912		

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C1912	Continued From page 6 "Follow the state mandated guidelines for reporting abuse." Resident #8 was admitted to the center on 06/25/21 with diagnoses which included vascular dementia, vascular hemostatic disorder, and hypothyroidism. An abuse incident report, dated 02/25/25, read in part, "[CMA] swatted resident's hand away while raising voice. Resident crying in pain." The incident report did not show notification to local law enforcement or the Department of Human Services. On 03/11/25 at 12:24 p.m., the DON MC was asked if there was any reason local law enforcement or the Department of Human Services was not notified of the abuse. They stated, "No." The corporate consult nurse stated, "We should have." On 03/11/25 at 1:04 p.m., the administrator was asked if law enforcement or the Department of Human Services were notified of the abuse. They stated, "We did not notify either."	C1912		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded	C1923		

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C1923	Continued From page 7 immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure accurate documentation of medication administration for 1 (#3) of 3 residents sampled for medication administration. The DON MC identified 71 residents in memory care received medications. Findings: On 03/12/25 at 10:09 a.m. CMA #2 prepared Resident #3's medication. On 03/12/25 at 10:11 a.m. CMA #2 approached Resident #3, placed a cup of medications up to the resident's mouth and Resident #3 began chewing medications and holding them in their mouth. CMA #2 gave the resident a drink of water and asked Resident #3 if they could swallow the pills. Resident #3 stated, "No." CMA #2 instructed Resident #3 to spit out the pills into the medication cup. CMA #2 did not notify the nurse that Resident #3 did not receive their medications.	C1923		

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C1923	Continued From page 8 Resident #3 was admitted to the center on 02/02/25 with diagnoses which included hyperlipidemia, dementia, delusional disorders, depressive episode, anxiety disorder, parkinson's disease, atrial fibrillation, osteoporosis, and unspecified convulsions. A medication list for Resident #3, dated 03/12/25, showed the resident was prescribed Carbidopa/Levodopa 25-100 mg TAB (a dopaminergic antiparkinsonism agent), "Take 1 tablet four times a day"..."DO NOT CRUSH"..." and Acetaminophen ER 650 mg (an analgesic), "Take 1 tablet two times a day routine"..."DO NOT CRUSH"..." On 03/12/25 at 10:18 a.m., the electronic medication administration record showed Resident #3 had taken their medications. On 03/12/25 at 10:18 a.m., CMA #2 was asked why it was documented the resident took medications when they did not. CMA #2 stated, "I documented that before I tried giving it."	C1923		
C1931 SS=E	310:663-19-2(b)(1) MEDICATION ADMINISTRATION (b) An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished. (1) The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident. This Rule is not met as evidenced by:	C1931		

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C1931	Continued From page 9 Based on observation, record review, and interview the center failed to ensure: a. medications were stored and secured inside of a locked medication cart for 1 of 1 medication cart observed; and b. medications were secured inside of an unattended, open medication room for 1 of 1 medication room observed. The DON AL identified 65 residents resided in assisted living. Findings: 1. On 03/11/25 at 8:02 a.m., an unattended and locked medication cart was observed in the South hallway. One box of albuterol sulfate inhalation solution (a bronchodilator), four cards of docusate sodium 200 mg (a laxative) with 30 pills in each card, one card of amoxicillin/clavulanate potassium 875/125 mg (an antibiotic) with 14 pills in the card, and three cards of acetaminophen 325 mg (an analgesic) with 30 pills in each card were observed lying on top of the medication cart. A "Storage of Medications," policy dated, 07/01/12, read in part, "All drugs managed by the residence shall be stored safely, securely, and properly"..."in accordance with federal and state laws and regulations." On 03/11/25 at 8:06 a.m., LPN #2 approached the medication cart and was asked what the policy was for leaving medications unattended. LPN #2 stated, "You're not supposed to." 2. On 03/11/25 at 8:11 a.m., the medication room door was observed open and the medication	C1931		

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 03/12/2025

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C1931	Continued From page 10 room was unattended with no staff visible. On 03/11/25 at 8:16 a.m., the DON AL was asked what the policy was for medication room storage. The DON AL stated, "It [medication room door] should be shut and locked."	C1931		

OKLAHOMA
State Department
of Health

Delivery via email to: Jessica.Bieger@legendseniorliving.com

April 24, 2025

License Number: AL1410

Jessica Bieger, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

RE: Survey Event DGP511

Dear Ms. Bieger:

On **March 12, 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 **May 2, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/11/25 through 03/13/25. Complaint investigations (#OK00068213, OK00074096, and #OK00078147) were conducted in conjunction with the survey. Facility Census: 136 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide DON AL- director of nursing assisted living DON MC- director of nursing memory care ER - extended release LPN - licensed practical nurse mg - milligram tab - tablet	C 000		
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,	C1505		

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C1505	Continued From page 1 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 incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: a. administer medications as ordered by the physician for 1 (#2); and b. ensure infection control measures were maintained during medication administration for 2 (#2 and #3) of 2 residents sampled for medication administration. The DON MC identified 71 residents resided in memory care. Findings: 1. On 03/12/25 at 10:22 a.m., CMA #2 prepared Resident #2's medication for administration and did not include metoprolol succinate (an	C1505		

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C1505	Continued From page 2	C1505		

anti-hypertensive medication) 25 mg ER TAB and did not utilize hand hygiene practices.

On 03/12/25 at 10:31 a.m., CMA #2 used a paper towel to clean up spilled coffee on the floor with their bare hands and disposed of the paper towel. CMA #2 did not utilize hand hygiene practices.

On 03/12/25 at 10:32 a.m., CMA #2 handed Resident #2 their medications in a cup with a cup of water and Resident #2 swallowed the medications.

A "Handwashing" policy, dated 11/01/12, read in part, "Staff should always thoroughly wash their hands in the following situations: Before and after the handling of any medications and/or treatment."

A policy titled "Medication Administration," dated 04/13/19, read in part, "Drugs shall be administered to each resident in accordance with a physician's written order."

Resident #2 was admitted to the center on 02/21/25 with diagnoses which included type 2 diabetes, shared psychotic disorder, depression, Alzheimer's disease, essential hypertension, atherosclerotic heart disease of native coronary artery, and heart failure.

A medication list for Resident #2, dated 03/12/25, showed the resident was prescribed metoprolol succinate 25 mg ER TAB "Take 1 tablet by mouth 2 times a day." There was no order to hold the medication based on blood pressure or any other factor.

On 03/12/25 at 10:25 a.m., CMA #2 stated, "[They] won't get this because blood pressure is

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C1505	Continued From page 3 normal." CMA #2 was asked how they knew to not give metoprolol succinate 25 mg ER TAB. CMA #2 stated, "Because the blood pressure is normal." On 03/12/25 at 11:20 a.m., The DON MC was asked if Resident #2 had paremeters for holding metoprolol succinate 25 mg TAB. They replied, "No." The DON MC was asked if Resident #2 was to receive the medication regardless of blood pressure reading. The DON MC stated, "Yes." 2. On 03/12/25 at 10:09 a.m., CMA #2 prepared Resident #3's medications and did not utilize hand hygiene practices before or after preparing the medications. On 03/12/25 at 10:11 a.m. CMA #2 approached Resident #3, placed a cup of medications up to the resident's mouth and Resident #3 began chewing medications and holding them in their mouth. CMA #2 gave the resident a drink of water and asked Resident #3 if they could swallow the pills. Resident #3 stated, "No." CMA #2 instructed Resident #3 to spit out the pills into the medication cup. CMA #2 did not notify the nurse that Resident #3 did not receive their medications. On 03/12/25 at 10:17 a.m., CMA #2 dropped the medication cup with Resident #3's chewed up medications. CMA #2 picked up the medications with their bare hands and disposed of them. CMA #2 did not utilize hand hygiene practices. Resident #3 was admitted to the center on 02/02/25 with diagnoses to include hyperlipidemia, dementia, delusional disorders, depressive episode, anxiety disorder, parkinson's disease, atrial fibrillation, osteoporosis, and	C1505		

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C1505	Continued From page 4 unspecified convulsions. On 03/12/25 at 10:33 a.m. CMA #2 was asked if they missed any opportunities for hand hygiene. They stated, "No, I already did that when I first started my med [medication] pass."	C1505		
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 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	C1912		

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C1912	Continued From page 5 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 facility failed to report an abuse incident to local law enforcement or the Department of Human Services for 1 (#8) of 6 sampled residents reviewed for incident reports. The administrator identified 136 residents resided in the center. Findings: An undated documented titled "Protective Services for the Elderly and for Incapacitated Adults Act," read in part, "Any person having reasonable cause to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation shall make a report as soon as the person is aware of the situation to: 1. The Department of Human Services; or 2. The municipal police department or sheriff's office in the county in which the suspected abuse, neglect, or exploitation occurred." A center policy title "Accident and Injury Investigation," dated 07/01/12, read in part,	C1912		

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C1912	Continued From page 6 "Follow the state mandated guidelines for reporting abuse." Resident #8 was admitted to the center on 06/25/21 with diagnoses which included vascular dementia, vascular hemostatic disorder, and hypothyroidism. An abuse incident report, dated 02/25/25, read in part, "[CMA] swatted resident's hand away while raising voice. Resident crying in pain." The incident report did not show notification to local law enforcement or the Department of Human Services. On 03/11/25 at 12:24 p.m., the DON MC was asked if there was any reason local law enforcement or the Department of Human Services was not notified of the abuse. They stated, "No." The corporate consult nurse stated, "We should have." On 03/11/25 at 1:04 p.m., the administrator was asked if law enforcement or the Department of Human Services were notified of the abuse. They stated, "We did not notify either."	C1912		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded	C1923		

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C1923	Continued From page 7 immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure accurate documentation of medication administration for 1 (#3) of 3 residents sampled for medication administration. The DON MC identified 71 residents in memory care received medications. Findings: On 03/12/25 at 10:09 a.m. CMA #2 prepared Resident #3's medication. On 03/12/25 at 10:11 a.m. CMA #2 approached Resident #3, placed a cup of medications up to the resident's mouth and Resident #3 began chewing medications and holding them in their mouth. CMA #2 gave the resident a drink of water and asked Resident #3 if they could swallow the pills. Resident #3 stated, "No." CMA #2 instructed Resident #3 to spit out the pills into the medication cup. CMA #2 did not notify the nurse that Resident #3 did not receive their medications.	C1923		

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C1923	Continued From page 8 Resident #3 was admitted to the center on 02/02/25 with diagnoses which included hyperlipidemia, dementia, delusional disorders, depressive episode, anxiety disorder, parkinson's disease, atrial fibrillation, osteoporosis, and unspecified convulsions. A medication list for Resident #3, dated 03/12/25, showed the resident was prescribed Carbidopa/Levodopa 25-100 mg TAB (a dopaminergic antiparkinsonism agent), "Take 1 tablet four times a day"..."DO NOT CRUSH"..." and Acetaminophen ER 650 mg (an analgesic), "Take 1 tablet two times a day routine"..."DO NOT CRUSH"..." On 03/12/25 at 10:18 a.m., the electronic medication administration record showed Resident #3 had taken their medications. On 03/12/25 at 10:18 a.m., CMA #2 was asked why it was documented the resident took medications when they did not. CMA #2 stated, "I documented that before I tried giving it."	C1923		
C1931 SS=E	310:663-19-2(b)(1) MEDICATION ADMINISTRATION (b) An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished. (1) The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident. This Rule is not met as evidenced by:	C1931		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1931	Continued From page 9 Based on observation, record review, and interview the center failed to ensure: a. medications were stored and secured inside of a locked medication cart for 1 of 1 medication cart observed; and b. medications were secured inside of an unattended, open medication room for 1 of 1 medication room observed. The DON AL identified 65 residents resided in assisted living. Findings: 1. On 03/11/25 at 8:02 a.m., an unattended and locked medication cart was observed in the South hallway. One box of albuterol sulfate inhalation solution (a bronchodilator), four cards of docusate sodium 200 mg (a laxative) with 30 pills in each card, one card of amoxicillin/clavulanate potassium 875/125 mg (an antibiotic) with 14 pills in the card, and three cards of acetaminophen 325 mg (an analgesic) with 30 pills in each card were observed lying on top of the medication cart. A "Storage of Medications," policy dated, 07/01/12, read in part, "All drugs managed by the residence shall be stored safely, securely, and properly"..."in accordance with federal and state laws and regulations." On 03/11/25 at 8:06 a.m., LPN #2 approached the medication cart and was asked what the policy was for leaving medications unattended. LPN #2 stated, "You're not supposed to." 2. On 03/11/25 at 8:11 a.m., the medication room door was observed open and the medication	C1931		

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C1931	Continued From page 10 room was unattended with no staff visible. On 03/11/25 at 8:16 a.m., the DON AL was asked what the policy was for medication room storage. The DON AL stated, "It [medication room door] should be shut and locked."	C1931		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/21/2025** **Facility Name:** Legend at Rivendell **License Number:** AL 1410 **Survey Event ID:** DGP511 **Date Survey Completed: 3/12/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, record review, and interview the facility failed to administer medications as ordered by the physician and ensure infection control measures were maintained during 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 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 medication administration records for resident #2 and ensure infection control measures are maintained during medication administration for residents #2 and #3 identified on the SOD to ensure accuracy and compliance with 310:663-15-1 & 63 OS 1-1918 (B)(5) Resident Rights-Medical Care. (1) Medications shall be administered only on a physician's order.
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 Director, Nursing Team, Certified Medication Aides and Medication Aide Techs will be inserviced on Medication Administration and Infection Control Policies as outlined in 310:663-15-1 & 63 OS 1-1918 (B)(5) Resident Rights-Medical Care. (1) Medications shall be administered only on a physician's order. The Residence Director and designee will conduct random audits and monitoring of medication records to ensure accuracy and compliance in accordance with physician orders.
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	a. The Residence Director or designee will audit a sampling of the medication administration records for accuracy per physician orders in accordance with 310:663-15-1 & OS 1-1918 (B)(5) Resident Rights-Medical Care. b. Review of the audit (sampling) of medication administration will be incorporated into the QA meeting

c. How monitoring records will be kept to evidence the correction.	and the need for any additional intervention will be put into place. c. A review of the audit (sampling) will be kept with the QA minutes. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/2/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Jessica Bregar, LNHA	**Date 4/22/2025**

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: 4/21/2025** **Facility Name:** Legend at Rivendell **License Number:** AL 1410 **Survey Event ID:** DGP511 **Date Survey Completed: 3/12/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: record review and interview, the facility failed to report an abuse incident to local law enforcement or the Department of Human Services for 1 (#8) of 6 sampled residents review for incident reports.

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 (#8) resident as identified on the SOD to ensure compliance with 310:663-19-1(b) Incidents Requiring 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 Director, licensed nurses and care associates will be in-serviced on Reporting procedure to either the local law enforcement or the Department of Human Services for any abuse incident as outlined in 310:663-19-1(b) Incidents Requiring Report.
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 incident reports for compliance in investigating and reporting abuse incidents to local law enforcement or the Department of Human Services in accordance with 310:663-19-1(b) Incidents Requiring Report. b. Review of the audit incident reports will be incorporated into the QA meeting and the need for any additional intervention will be put into place. c. A review of the audit (sampling) will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/2/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Jessica Beegle, LNHA		**Date 4/22/2025**
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: 4/21/2025** **Facility Name:** Legend at Rivendell **License Number:** AL 1410 **Survey Event ID:** DGP511 **Date Survey Completed: 3/12/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: observation, record review, and interview the facility failed to ensure accurate documentation of medication administration for one (#3) of 3 resident sampled for 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 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 medication administration records for resident #3 as identified on the SOD to ensure accuracy and compliance with 310:663-19-2(a)(3) Medication Administration.
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 Director, Nursing Team, Certified Medication Aides and Medication Aide Techs will be inserviced on Medication Administration as outlined in 310:663-19-2(a)(3) Medication Administration.
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 medication administration records for accuracy per physician orders in accordance with 310:663-19-2(a)(3) Medication Administration. b. Review of the audit (sampling) of medication administration will be incorporated into the QA meeting and the need for any additional intervention will be put into place. c. A review of the audit (sampling) will be kept with the QA minutes. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/2/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Jessica Briggs, LNHA	**Date 4/22/2025**

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			
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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: 4/21/2025** **Facility Name:** Legend at Rivendell **License Number:** AL 1410 **Survey Event ID:** DGP511 **Date Survey Completed: 3/12/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1931	Based on: observation, record review, and interview the facility failed to ensure: (a) medications were stored and secured inside of a locked medication cart for 1 of 1 medication cart observed; and (b) medications were secured inside of an unattended, open medication room for 1 of 1 medication room observed.

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 medications are stored and secured inside of a locked medication cart and medication rooms are secured as identified on the SOD to ensure compliance with 310:663-19-2(b)(1) Medication Administration.
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 Director, Nursing Team, Certified Medication Aides and Medication Aide Techs will be inserviced on securing and storing medication properly as outlined in 310:663-19-2(b)(1) Medication Administration.
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 medication carts and medication rooms in accordance with 310:663-19-2(b)(1) Medication Administration. b. Review of the audit (sampling) of medication rooms and carts will be incorporated into the QA meeting and the need for any additional intervention will be put into place. c. A review of the audit (sampling) will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/2/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required Jessica Bragg, LNHA		**Date 4/22/2025**
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			
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OKLAHOMA
State Department of Health

Delivery via email to: Jessica.Bieger@legendseniorliving.com

May 6, 2025

License Number: AL1410

Jessica Bieger, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

RE: Survey Event DGP512

Dear Ms. Bieger:

On **May 5, 2025,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaint on **March 12, 2025,** have now been corrected effective **May 2, 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
	AL1410	A. BUILDING: _____ B. WING _____	R-C 05/05/2025

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 An offsite/paper revisit was conducted on 05/05/25. 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