

Delivery via email to: amanda.sikich@legendseniorliving.com;
kimberly.saggese@legendseniorliving.com; jennifer.benham@legendseniorliving.com;
Alicia.Webb@legendseniorliving.com

February 24, 2026

License Number: AL1410

Amanda Sikich, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: 1LH411

Dear Ms. Sikich:

On **February 13, 2026**, representatives 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 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.

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kimberly.saggese@legendseniorliving.com; jennifer.benham@legendseniorliving.com;
Alicia.Webb@legendseniorliving.com

April 22, 2026

License Number: AL1410

Amanda Sikich, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: 1LH412

Dear Ms. Sikich:

On **April 21, 2026**, an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 13, 2026**, have now been corrected effective **March 6, 2026**.

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

Respectfully,



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: AL1410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/21/2026
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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 04/21/26. 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

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 OSDH.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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Legend at Rivendell

Address: 13200 South May Ave

City, State, Zip: OKC, OK. 73170

Provider #: AL1410

Complaint #: OK00089387

Investigation Date: 02/12/26 through 02/13/26

ALLEGATION(S)	
1. The facility failed to ensure residents were free from abuse or neglect.	
enter text	

An unannounced on-site investigation was initiated 02/12/2026 at 4:00 p.m.

A sample of three participants, including any identified participants, 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 A tour of the facility was conducted upon entrance into the facility. Residents were observed for abuse and neglect, and privacy concerns. Staff were observed interacting with residents.

Records reviewed included: Residents health records, facility reported incidents, staff records, and contracts. Residents, families, and staff were asked questions regarding abuse and abuse training, transfers, and incident reporting.

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: 02/13/2026

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/13/2026
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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 A complaint investigation (#OK00089387) was conducted on 02/12/26 and 02/13/26. Deficiencies were cited as a result of the survey. Facility Census: 66 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide	C 000		
C1505 SS=D	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, 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.	C1505		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure residents were assisted off the floor appropriately for 1 (#1) of 3 sampled residents reviewed for abuse. The regional director identified 66 residents resided in the center. Findings: 1. A "Resident Assessment Form" for Resident #1, completed on 01/05/26 at admission, showed Resident #1 had diagnosed which included dementia, mood disorder, and anxiety. The assessment form showed Resident #1 was confused at times and was admitted to a memory care facility. A care plan for Resident #1, dated 01/05/26, showed Resident #1 required prompts or reminders periodically to complete daily tasks. An "Incident Report," dated 02/04/26, showed there was a video of CNA#1 pulling Resident #1 across the floor by their forearms backwards about 8 feet into their room. 2. An application for employment for CNA #1 showed their hire date was 07/08/20. A training record, dated 10/29/25, showed CNA #1 had abuse training. A training record, dated 10/31/25, showed CNA #1 had dementia care training. 3. An application for employment for CNA #2	C1505		

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March 10, 2026

License Number: AL1410

Amanda Sikich, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: 1LH411

Dear Ms. Sikich:

On **February 13, 2026**, 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 6, 2026**.

We will conduct a revisit for 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, 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: 3/6/2026

Facility Name: Legend at Rivendell

License Number: AL1410

Survey Event ID: 1LH411

Date Survey Completed: 2/13/2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: c1505

Based on: The facility failed to ensure residents were free from abuse or neglect.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All residents have the potential to be affected.

Residents who are at risk for falls have the potential to be affected.

- On 2/16/2026, C.N.A #1 was terminated due to failure to adequately to perform duties of job and failure to fill out incident report on 2/4/2026.
- Beginning 2/18/2026, Health Care Director shall verify that each clinical associate has access to a gait belt to be used as needed.
- Beginning 3/20/2026, current clinical associates re-educated on fall response, to include using a gait belt to assist residents off of the floor and calling a second associate to assist if unable to assist resident up independently.

Enter methods to ensure corrections are sustained:

- Beginning 3/20/2026, the Health Care Director will observe and complete audits on two transfers weekly for four weeks and then monthly for two months. Any deficient practices shall be corrected immediately with re-education.
- Audits shall be reviewed during the next QMPI committee, any additional recommendations shall be implemented.
- Weekly logs shall be created and kept with the QMPI Committee Meeting minutes.

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March 10, 2026

License Number: AL1410

Amanda Sikich, Administrator
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13200 South May Ave
Oklahoma City, OK 73170

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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 6, 2026**.

We will conduct a revisit for 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, 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: 3/6/2026

Facility Name: Legend at Rivendell

License Number: AL1410

Survey Event ID: 1LH411

Date Survey Completed: 2/13/2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: c1505

Based on: The facility failed to ensure residents were free from abuse or neglect.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
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Enter methods to ensure corrections are sustained:

- Beginning 3/20/2026, the Health Care Director will observe and complete audits on two transfers weekly for four weeks and then monthly for two months. Any deficient practices shall be corrected immediately with re-education.
- Audits shall be reviewed during the next QMPI committee, any additional recommendations shall be implemented.
- Weekly logs shall be created and kept with the QMPI Committee Meeting minutes.

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER LEGEND AT RIVENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure residents were assisted off the floor appropriately for 1 (#1) of 3 sampled residents reviewed for abuse. The regional director identified 66 residents resided in the center. Findings: 1. A "Resident Assessment Form" for Resident #1, completed on 01/05/26 at admission, showed Resident #1 had diagnosed which included dementia, mood disorder, and anxiety. The assessment form showed Resident #1 was confused at times and was admitted to a memory care facility. A care plan for Resident #1, dated 01/05/26, showed Resident #1 required prompts or reminders periodically to complete daily tasks. An "Incident Report," dated 02/04/26, showed there was a video of CNA#1 pulling Resident #1 across the floor by their forearms backwards about 8 feet into their room. 2. An application for employment for CNA #1 showed their hire date was 07/08/20. A training record, dated 10/29/25, showed CNA #1 had abuse training. A training record, dated 10/31/25, showed CNA #1 had dementia care training. 3. An application for employment for CNA #2	C1505		

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C1505	Continued From page 2 showed their hire date as 01/14/26. On 02/13/26 at 10:35 a.m., CNA #1 stated via phone interview staff was called to Resident #1 and #2's divided room because Resident #2 had a fall. Resident #1 was on Resident #2's side of the room attempting to help Resident #2. CNA #1 stated CNA #2 was assisting Resident #2 and they were trying to get Resident #1 to their own side of the room and allow staff to assist Resident #2. CNA #1 stated Resident #1 was trying to hit them and they lost their balance which required them to lower Resident #1 to the floor. CNA #1 stated they had their hands under Resident #1's armpits from behind the resident to try to get Resident #1 out of the way. On 02/13/26 at 11:02 a.m., CNA #2 stated via phone interview staff was called to Resident #2's room for a fall. CNA #2 stated they and CNA #1 were trying to assist Resident #2, but Resident #1 came over and was trying to help Resident #2. CNA #2 stated CNA #1 told Resident #1 staff would handle it. CNA #2 stated they went to get the blood pressure cuff and when they returned Resident #1 was on the floor. Resident #1 was saying do not touch me. CNA #2 stated they thought CNA #1 had picked Resident #1 up by themselves by putting their arms under Resident #1's arms. CNA #2 stated they could not really remember that night. On 02/13/26 at 11:36 a.m., the administrator stated the third party camera monitoring company paid for by the family called on 02/11/26 to let them know they had concerns. The administrator stated they watched the video and reported they saw Resident #1 put their arms up for help and CNA #1 pulled Resident #1 backwards by their forearms about 8 feet back into their side of the	C1505		

Oklahoma State Department of Health

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(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
C1505	Continued From page 2 showed their hire date as 01/14/26. On 02/13/26 at 10:35 a.m., CNA #1 stated via phone interview staff was called to Resident #1 and #2's divided room because Resident #2 had a fall. Resident #1 was on Resident #2's side of the room attempting to help Resident #2. CNA #1 stated CNA #2 was assisting Resident #2 and they were trying to get Resident #1 to their own side of the room and allow staff to assist Resident #2. CNA #1 stated Resident #1 was trying to hit them and they lost their balance which required them to lower Resident #1 to the floor. CNA #1 stated they had their hands under Resident #1's armpits from behind the resident to try to get Resident #1 out of the way. On 02/13/26 at 11:02 a.m., CNA #2 stated via phone interview staff was called to Resident #2's room for a fall. CNA #2 stated they and CNA #1 were trying to assist Resident #2, but Resident #1 came over and was trying to help Resident #2. CNA #2 stated CNA #1 told Resident #1 staff would handle it. CNA #2 stated they went to get the blood pressure cuff and when they returned Resident #1 was on the floor. Resident #1 was saying do not touch me. CNA #2 stated they thought CNA #1 had picked Resident #1 up by themselves by putting their arms under Resident #1's arms. CNA #2 stated they could not really remember that night. On 02/13/26 at 11:36 a.m., the administrator stated the third party camera monitoring company paid for by the family called on 02/11/26 to let them know they had concerns. The administrator stated they watched the video and reported they saw Resident #1 put their arms up for help and CNA #1 pulled Resident #1 backwards by their forearms about 8 feet back into their side of the	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/13/2026
NAME OF PROVIDER OR SUPPLIER LEGEND AT RIVENDELL			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
C1505	Continued From page 3 room. The administrator stated the camera only recorded if the resident changed planes (went from standing to on the floor). The administrator stated a gait belt should have been used along with the resident's own strength to rise from the floor.	C1505			