



Oklahoma State Department of Health  
Creating a State of Health

October 21, 2019

License Number: AL5517

Ms. Shekita Gray, Administrator  
The Legend At Jefferson's Garden  
15401 North Penn Avenue  
Edmond, OK 73013

**Survey Event ID: D0RK11**

Dear Ms. Gray:

On **September 10, 2019**, 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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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;

Board of Health

Gary Cox, JD  
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- (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) 271-6868 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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  
1000 N.E. 10th  
Oklahoma City, OK 73117-1299

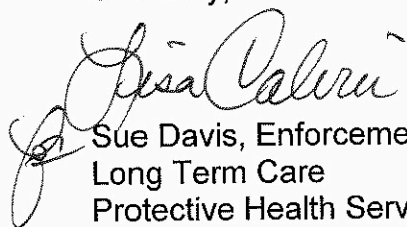
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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](mailto:IDRCoordinator@health.ok.gov), or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to [LTC@health.ok.gov](mailto:LTC@health.ok.gov) or call (405) 271-6868. 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.

Sincerely,



Sue Davis, Enforcement Coordinator  
Long Term Care  
Protective Health Services

SD/lde

Enclosure

## INVESTIGATIVE REPORT

**Facility:** The Legend at Jefferson's Garden  
**Address:** 15401 North Penn Avenue  
**City, State, Zip:** Edmond, OK 73013  
**Provider #:** AL5517  
**Complaint #:** OK00053886  
**Investigation Date(s):** 09/05/19, 09/06/19 and 09/10/19

| ALLEGATION(S)                                                           | S = SUBSTANTIATED    |
|-------------------------------------------------------------------------|----------------------|
|                                                                         | US = UNSUBSTANTIATED |
| 1. The center failed to ensure medications were properly administered.  | S                    |
| 2. The center failed to ensure the residents' rights were not violated. | S                    |

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, September 5, 2019 at 8:45 a.m.

A sample of 11 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 Description of Significant Findings Related to Each Allegation is Provided Below:**

**Allegation #1:** Deficient practice was substantiated related to this allegation, but no deficient practice was cited.

An investigation specific to residents who were administered medication from center staff was conducted.

On 07/02/19 during a resident council meeting a resident complained a night shift medication aid did not wake the resident up to take medication and observe ingestion, but left medications at bedside for the resident to take when resident awoke.

The complaint documented resident medications were found in the resident bed and on the floor.

On 09/05/19 at 11:50 a.m. during a medication pass the residents were observed to receive the correct medication and correct dose. No resident complained about receiving too much medication. No medication was found on the floor of resident rooms or in their beds. No residents were found very sleepy in the middle of



the day except those who liked taking naps after lunch, had disease processes which made residents sleepy and energy depleted, etc.

At 2:30 p.m. during record review, there was no documentation Xanax prn was given daily to the resident. The medication administration record documented the resident received Xanax prn on April 3, 4, 8, 9 of 2019; once May 31, 2019; and once June 1, 2019. The resident did not receive Xanax prn daily.

**Allegation #2:** Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505, 1511 and 1951 for details.

**Determination Summary and Follow-Up Action:**

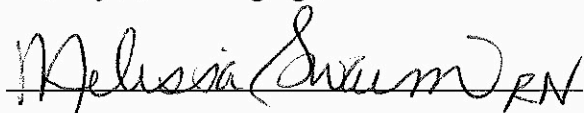
Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Melissa Swaim RN", written over a horizontal line.

Melissa Swaim RN

Date report completed: 09/11/2019

Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5517</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/10/2019</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE LEGEND AT JEFFERSON'S GARDEN</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15401 NORTH PENN AVENUE<br/>EDMOND, OK 73013</b> |
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| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| C 000                    | INITIAL COMMENTS<br><br>An abbreviated survey was conducted 09/05/19, 09/06/19 and 09/10/19, to investigate complaint #OK 00053886. Resident census was 39. Deficient practice was cited as follows.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | C 000               |                                                                                                                          |                          |
| C1505<br>SS=E            | 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care<br><br>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<br><br>63 O.S. 1-1918.(B)(5)<br>(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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined the center failed to ensure medications were: | 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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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**THE LEGEND AT JEFFERSON'S GARDEN**

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EDMOND, OK 73013**

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| C1505                    | <p>Continued From page 1</p> <p>A. administered routinely as ordered by the physician for the resident's pain for 1 (#6) of 11 sampled residents who were administered medications by the centers staff; and</p> <p>B. available and in the center for 1 (#11) of 11 residents who were administered their physician ordered eye drops by the centers staff; and administered prn (as needed) leg cramp/spasm medication after the resident requested during the night.</p> <p>This failed practice resulted in the potential for more than minimal harm, at a pattern. Findings:</p> <p><b>Resident #6</b></p> <p>On 07/30/19 resident #6 admitted to the center with a diagnosis to include osteoarthritis.</p> <p>The physician orders dated July, August and September 2019 documented the resident was to receive hydrocodone-acetaminophen 7.5-325 milligrams (mg) every four hours at 0000 (midnight or 12 a.m.), 0400 (4:00 a.m.), 0800 (8:00 a.m.), 12:00 p.m. (noon), 1600 (4:00 p.m.) and 2000 (8:00 p.m.)</p> <p>The individual narcotic record documented no pain medication was in the center and counted until 08/04/19 at 5:00 p.m.</p> <p>The resident missed 21 doses of their pain medication from the time of admission to present (19 missed doses of hydrocodone-acetaminophen to be administered by the center's staff at 4:00 a.m. and 2 missed doses of hydrocodone-acetaminophen to be administered by the center's staff at midnight). The same staff member was responsible for 20 of</p> | C1505               |                                                                                                                          |                          |

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| C1505                    | <p>Continued From page 2</p> <p>the 21 missed doses of routine pain medication not being administered as ordered. An interview was requested with the staff member, but they were not available for interview.</p> <p>On 09/06/19 at 12:45 p.m. resident #6 complained they were not getting their routine pain medication during the night shift. The resident stated the pain was rated at a 7 when either waiting for the call light to be answered or after the resident got up out of bed looking for the night shift staff to ask for the routine pain medication. When the resident was asked how they felt about it, resident #6 stated it was awful and frustrating.</p> <p>Resident #11</p> <p>On 02/23/18 resident #11 admitted to the center with diagnosis to include gait disturbances, dry eyes and ocular allergies.</p> <p>Resident #11's assessment documented the resident was alert. The resident had good judgement. The resident had limited range of motion with their right arm. The resident had good communication and was interviewable.</p> <p>The care plan, dated 06/20/19, documented all medications must be ordered by the attending physician (including over the counter medications). No medications of any kind should be left in the resident apartment without an order. The resident requires assistance with managing, supervising or administering medications.</p> <p>On 09/06/19 at 11:35 a.m. the resident mentioned self administering eye drops in the bathroom in the resident's room. Refresh Tears, lubricant eye drops, 0.5 fluid ounce bottle was observed on the</p> | C1505               |                                                                                                                          |                          |

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| C1505                    | <p>Continued From page 3</p> <p>resident's bathroom counter. The resident had a physician's order to self administer and keep at bedside since 08/28/16.</p> <p>During record review, the resident's chart did not have a self administration medication assessment.</p> <p>On 09/10/19 at 10:12 a.m. the licensed practical nurse and administrator were asked if resident #11 had a self administration medication evaluation. They both stated the resident did not self administer any of her medication; the center's staff were responsible for administering the resident's medications.</p> <p>At 11:15 a.m. the resident stated the leg cramp medication was requested during the night shift the week before last and employee #12 did not bring the resident the requested prn medication. The electronic medication administration record (eMAR) documented no leg cramp medication was administered in the month of September 2019, one time in the month of August 2019, seven times in the month of July 2019 and three times in the month of June 2019. After the resident returned from the emergency room after a fall 09/06/19 there was a new order for zanaflex to be given every 8 hours prn for pain or spasms.</p> <p>At 3:36 p.m. employee #11 was asked to retrieve the physician ordered artificial tears sterile 1.4% drops to be instilled in each eye twice a day, gentel mild to moderate, sterile 0.3% drops two drops to be instilled in the left eye as prn for allergies and the ocusoft lid scrub original medication pad to cleanse eye twice weekly on Tuesday and Thursday at 8:00 p.m. Employee #11 opened the medication cart (top drawer) and stated none of the eye related drops, etc. would</p> | C1505               |                                                                                                                          |                          |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE LEGEND AT JEFFERSON'S GARDEN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15401 NORTH PENN AVENUE<br/>EDMOND, OK 73013</b> |                                                                                                                          |                                                                    |
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| C1505                                                                       | Continued From page 4<br><br>on the medication cart because the resident self administered all of the eye drops, etc. When asked how she knew the resident self administered the artificial tears she stated she went to the room and watched the resident self administer the artificial tears and documented it was given on the eMAR.<br><br>At 3:40 p.m. the resident was asked if they self administered all of their eye drops. The resident stated, "Yeah." When asked about artificial tears sterile 1.4% drops to be instilled in each eye twice a day the resident stated, "I don't have any artificial tears; the doctor told me I didn't need them a long time ago." The resident stated the only eye drops in the resident's room were the Refresh Tears, lubricant eye drops.<br><br>There were no physician orders documenting the resident could self administer the artificial tears, gentel or the ocusoft lid scrub. The center's staff were responsible for administering artificial tears since 03/28/16, gentel and ocusoft lid scrub since 07/21/16.<br><br>The artificial tears, gentel and ocusof lid scrub were not available for administration. | C1505                                                                                        |                                                                                                                          |                                                                    |
| C1511<br>SS=E                                                               | 310:663-15-1 & 63 OS 1-1918(B)(11) RESIDENT RIGHTS - Respect/Services<br><br>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<br><br>63 O.S. 1-1918.(B)(11)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C1511                                                                                        |                                                                                                                          |                                                                    |

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| C1511                    | <p>Continued From page 5</p> <p>(11) Every resident shall have the right to receive courteous and respectful care and treatment and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and a statement of related charges, including any costs for services not covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and record review, it was determined the centers staff failed to provide residents with dignity, courteousness and respectful care and treatment for 4 (#1, #6, #10 and #11) of 11 residents who received services from the centers staff. This failed practice resulted in the potential of more than minimal harm, at a pattern. Findings:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the center 05/01/18 with diagnosis to include progressive supranuclear palsy and dizziness.</p> | C1511               |                                                                                                                          |                          |



Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5517</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/10/2019</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**THE LEGEND AT JEFFERSON'S GARDEN**

**15401 NORTH PENN AVENUE  
EDMOND, OK 73013**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| C1511                    | <p>Continued From page 6</p> <p>Resident #1 assessment, dated 05/15/19, documented the resident was alert and oriented x 2 (person and place), forgetful with good judgement. Mobility was good with full range of motion and ambulatory with staff assistance in a wheelchair per self. The resident had fair strength and poor gait requiring 2 person assist with transfers and toileting; and 1 person assist with bathing and dressing. The resident was bladder incontinent at times and bowel continent. The resident's ability to communicate was good and was interviewable.</p> <p>Resident #1 did not have full range of motion. The resident was not observed to self propel.</p> <p>On 09/05/19 at 9:59 a.m. resident #1 was asked what they thought of the staff. The resident stated they had had problems with them. Resident #1 stated there were staff who did not attend to their needs.</p> <p>Resident #1 was asked if the center's staff were rough when providing care. The resident stated, "Yes, there are a few that are." The resident was asked if they knew the names of the staff. The resident stated they could not remember the center's staff names, but stated they worked on the night shift (11-7). The resident stated, "sometimes they are rough enough to bump into me." The resident was asked if they had any other concerns or complaints. The resident stated there were center staff who did not have good attitudes when they came to the residents room with sour looks on their faces; like they didn't want to be there or to help provide the needed care and the resident dreaded to see them. The resident stated they thought the night shift staff did what they wanted the way they wanted because they didn't have any supervision.</p> | C1511               |                                                                                                                          |                          |

Oklahoma State Department of Health

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| C1511                    | <p>Continued From page 7</p> <p>Resident #6</p> <p>Resident #6 was admitted to the center 07/30/19 with diagnosis to include osteoarthritis and hypoproteinemia.</p> <p>Resident #6 assessment, dated 07/30/19, documented the resident was alert and oriented x 3 (person, place and situation) with good judgement. The resident's mobility was fair with good strength and good gait. The resident was weight bearing with full range of motion and ambulatory with staff assistance; uses a rolling walker in apartment with stand by assist, wheelchair with self propel. The resident was a 1 person assist with transferring, toileting, bathing and ambulating. The resident was continent of both bladder and bowel, but had nausea/vomiting, weighed 100 pounds at 5'2". The resident's communication was good and was interviewable with hearing aides x 2.</p> <p>On 09/06/19 at 12:45 p.m. resident #6 complained they were not getting their routine pain medication during the night shift. The resident stated the pain was rated at a 7 when either waiting for the call light to be answered or after the resident got up looking for the night shift staff for the routine pain medication. When the resident was asked how they felt about it, resident #6 stated it was awful and frustrating.</p> <p>Resident #10</p> <p>Resident #10 was admitted to the center 08/27/18 with diagnosis to include parkinson's disease, falls, subdural hematoma, weakness, insomnia and transient ischemic attack (TIA).</p> | C1511               |                                                                                                                          |                          |

Oklahoma State Department of Health

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| C1511                                                                       | <p>Continued From page 8</p> <p>Resident #10's significant change assessment, dated 05/17/19, documented the resident was oriented, but the space for how oriented was left blank. The resident had good judgment. The resident was weight bearing with limited range of motion. The resident's mobility was poor with poor strength and poor gait. The resident was ambulatory with staff assistance; "resident is unable to ambulate with or without staff assistance." Resident was unable to propel self in wheelchair; requires staff assistance. The resident was a 2 person assist with transferring, bathing and toileting. The resident was a 1 person assist with eating and dressing. The resident had a history of nausea with meal set up and cueing. The resident was continent of both bladder and bowel. The resident had good communication and was interviewable; the resident was able to answer.</p> <p>It was reported the night shift staff would ask the resident to go to the bathroom in the residents diaper and they would come back and clean the resident up later. The staff was also rough when providing care to the resident.</p> <p>Resident #11</p> <p>Resident #11 was admitted to the center 02/23/18 with diagnosis to include dizziness, gait disturbance, osteoarthritis, dry eyes and ocular allergies.</p> <p>Resident #11's assessment documented the resident was alert. The box and space for the resident being oriented and to what was left blank. The resident had good judgement. The resident had limited range of motion with their right arm. The resident's mobility was good with good strength and good gait. The resident was</p> | C1511                                                                                        |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| C1511                                                                       | <p>Continued From page 9</p> <p>weight bearing and ambulated without assistance, but required a stand by assist for transfers; and was independent when in wheelchair. The resident required a 1 person assist with transferring, dressing, toileting and bathing. The resident was continent of both bladder and bowel, but required a 1 person assist toileting. The resident had good communication and was interviewable.</p> <p>Resident #11's care plan, dated 06/20/19, documented the resident required physical assistance of one staff in the bathroom for toileting.</p> <p>On 09/05/19 at 2:00 p.m. resident #11 stated they needed help with transfers and toileting and the staff didn't like them (the resident). The resident stated they (the resident) was slow and the staff tried to rush them. The resident was asked if the staff asked them to use the bathroom in bed and they would tell them they'd come back to clean up the resident. The resident stated, employee #12 wouldn't come back.</p> <p>On 09/06/19 at 11:35 a.m. resident #11 stated they requested assistance nightly. The resident was asked if they could remember the last time employee #12 told the resident to use the bathroom in bed and left the resident waiting for night staff to come back to help. The resident stated, "Last night." The resident was asked how often it happened. She stated, "Every night when I call and (employee #12) is there it happens."</p> <p>On 09/10/19 at 11:09 a.m. the resident stated the employee had handed the resident a cup of water and requested ice; employee #12 refused to get it. The resident stated, "It doesn't cost anything." The resident stated employee #12 stated the</p> | C1511                                                                      |                                                                                                                          |  |                                                                    |

Oklahoma State Department of Health

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| C1511                                                                       | <p>Continued From page 10</p> <p>resident was too slow and told the resident to do the things the resident needed to do; employee #12 didn't stay with the resident like they're supposed to. The resident stated, "After employee #12 stated I was too slow; I help myself." The resident was asked if she had fallen because The resident was asked how they felt about it. The resident stated, "It makes me fell anxious. I need help and they don't come."</p> <p>The resident council meeting minutes, dated 03/03/19, documented the residents were concerned the pendants weren't working properly during the evening and early morning. Residents noticed the night staff watching tv and on their phones. One resident stated the night shift staff were rude to her.</p> <p>The resident council meeting minutes, dated 07/02/19, documented the third shift was slow to respond (30-45 minutes according to the residents) to pendant/call light, sometimes the center staff didn't respond at all. Floor staff discuss other residents and were overheard by residents speaking negative about other residents at the center.</p> <p>The resident council meeting minutes, dated 08/06/19, documented a resident was having problems with employee #12 stating the employee had a poor bedside manner.</p> <p>Resident's at the center who required more assistance from the center's staff had complaints about the night-shift staff employee #12.</p> | C1511                                                                                        |                                                                                                                          |                                                                    |
| C1951<br>SS=E                                                               | <p>310:663-19-3(a) MAINTENANCE OF RECORDS</p> <p>(a) There shall be an organized, accurate,</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C1951                                                                                        |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| C1951                    | <p>Continued From page 11</p> <p>clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice.</p> <p>This Rule is not met as evidenced by:<br/>Based on interview and record review, the center failed to maintain organized, accurate, clinical records for:</p> <p>A. Resident #6 who was to receive physician ordered pain medications routinely; staff documented the medication was given on the electric medication administration record (eMAR), but the narcotic was not signed out on the residents individual narcotic record;</p> <p>B. Resident #10 had a significant change, but the assessment did not include all of the significant changes of the resident and the care plan wasn't updated; and</p> <p>C. Resident #11 who had one order to self administer refresh eye drops as needed (prn), but her other physician ordered medication and eye drops were to be administered by the center's qualified staff.</p> <p>This failed practice resulted in the potential for more than minimal harm, at a pattern. Findings:</p> <p>Resident #6</p> <p>On 07/30/19 resident #6 admitted to the center with a diagnosis to include osteoarthritis.</p> | C1951               |                                                                                                                          |                          |

Oklahoma State Department of Health

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| C1951                                                                       | <p>Continued From page 12</p> <p>The physician orders dated July, August and September 2019 documented the resident was to receive hydrocodone-acetaminophen 7.5-325 milligrams (mg) every four hours at 0000 (midnight or 12 a.m.), 0400 (4:00 a.m.), 0800 (8:00 a.m.), 12:00 p.m. (noon), 1600 (4:00 p.m.) and 2000 (8:00 p.m.)</p> <p>The individual narcotic record documented no pain medication was in the center and counted until 08/04/19 at 5:00 p.m.</p> <p>The electronic medication administration record (eMAR) documented the resident had received the routine pain medication, but the medication was not signed out on the resident's individual narcotic record or given to the resident.</p> <p>The resident missed at total of 21 doses of physician ordered pain medication on:</p> <p>08/05/19 at midnight;<br/>08/05/19 at 4:00 a.m.;<br/>08/06/19 at midnight;<br/>08/10/19 at 4:00 a.m.;<br/>08/11/19 at 4:00 a.m.;<br/>08/12/19 at 4:00 a.m.;<br/>08/14/19 at 4:00 a.m.;<br/>08/15/19 at 4:00 a.m.;<br/>08/16/19 at 4:00 a.m.;<br/>08/17/19 at 4:00 a.m.;<br/>08/20/19 at 4:00 a.m.;<br/>08/22/19 at 4:00 a.m.;<br/>08/25/19 at 4:00 a.m.;<br/>08/26/19 at 4:00 a.m.;<br/>08/28/19 at 4:00 a.m.;<br/>09/02/19 at 4:00 a.m.;<br/>09/04/19 at 4:00 a.m.;<br/>09/05/19 at 4:00 a.m.;<br/>09/06/19 at 4:00 a.m.;</p> | C1951                                                                      |                                                                                                                          |                          |                                                                    |

Oklahoma State Department of Health

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| C1951                    | <p>Continued From page 13</p> <p>09/07/19 at 4:00 a.m.; and<br/>09/10/19 at 4:00 a.m.</p> <p>The resident missed 21 doses of their pain medication from the time of admission to present (19 missed doses of hydrocodone-acetaminophen to be administered by the center's staff at 4:00 a.m. and 2 missed doses of hydrocodone-acetaminophen to be administered by the center's staff at midnight). The same staff member was responsible for 20 of the 21 missed doses of routine pain medication not being administered as ordered. An interview was requested with the staff member, but employee #12 was not available for interview.</p> <p>Resident #10</p> <p>Resident #10 was admitted to the center 08/27/18 with diagnosis to include parkinson's disease, falls, subdural hematoma, weakness, insomnia and transient ischemic attack (TIA).</p> <p>A nurses note, dated 03/29/19, documented the resident had returned from hospital after a fall (03/25/19) with a pelvic fracture. The resident was alert and oriented x 3 (person, place and time) and resident was to be assisted by 2 people using a gait belt.</p> <p>A physician's order, dated 04/09/19, documented to crush medications.</p> <p>A nurses note (late entry), dated 04/24/19, documented the resident was no longer wanting to go to the dining room for meals because of the tremors in the bilateral upper extremities which caused the spilling of drinks which made the resident embarrassed and didn't want other residents to look down on.</p> | C1951               |                                                                                                                          |                          |



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**THE LEGEND AT JEFFERSON'S GARDEN**

**15401 NORTH PENN AVENUE  
EDMOND, OK 73013**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| C1951                    | <p>Continued From page 14</p> <p>There should have been a significant change after the resident returned from the hospital with the care plan updated.</p> <p>A physician's progress note, dated 05/16/19, documented the resident's parkinson's disease had progressed rapidly in the past month. The resident's tremors had increased to the point where feeding self became difficult, if not impossible. The resident experienced dysphagia (problems swallowing) both food and medication and was sleeping most of the day. The resident was transported by the center's staff in a manual wheelchair and had notable difficulty sitting upright. The resident was alert and cognitively fairly intact. The resident has become incontinent and was no longer able to alert staff as to when toileting was needed. The resident had a clasping position of the left hand and mild edema at the forearm. Tremors in both arms were notable at rest. The center's staff have to essentially help the resident with 6/6 activities of daily living (ADLs). The resident was a moderate assist for all mobility. The resident required feeding assistance. The resident has increased sleep with dysarthria (slurring of speech).</p> <p>Resident #10 significant change assessment, dated 05/17/19, documented the resident was oriented, but the space for how oriented was left blank. The resident had good judgment. The resident was weight bearing with limited range of motion. The resident's mobility was poor with poor strength and poor gait. The resident was ambulatory with staff assistance; "resident is unable to ambulate with or without staff assistance." Resident was unable to propel self in wheelchair; requires staff assistance. The resident was a 2 person assist with transferring,</p> | C1951               |                                                                                                                          |                          |

Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5517</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/10/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE LEGEND AT JEFFERSON'S GARDEN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15401 NORTH PENN AVENUE<br/>EDMOND, OK 73013</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| C1951                                                                       | <p>Continued From page 15</p> <p>bathing and toileting. The resident was a 1 person assist with eating and dressing. The resident had a history of nausea with meal set up and cueing. The resident was continent of both bladder and bowel. The resident had good communication and was interviewable; the resident was able to answer.</p> <p>Resident #10's significant change assessment, dated 05/17/19, was not accurate.</p> <p>Resident #10's plan of accommodation, dated 05/24/19, documented the resident was currently a 2 person assist with transfers and all ADLs, a broda chair had been ordered due to the resident leaning and posture in the wheelchair.</p> <p>Resident #10's had not been updated since 01/24/19. Without updating the care plan at the time of the resident's significant change the center's staff would not know about the increased care the resident required since the care plan was how the center's staff was communicated the resident's needs.</p> <p>Resident #11</p> <p>On 02/23/18 resident #11 admitted to the center with diagnosis to include gait disturbances, dry eyes and ocular allérgies.</p> <p>Resident #11's assessment documented the resident was alert. The resident had good judgement. The resident had limited range of motion with their right arm. The resident had good communication and was interviewable.</p> <p>The care plan, dated 06/20/19, documented all medications must be ordered by the attending physician (including over the counter</p> | C1951                                                                                        |                                                                                                                          |  |                                                                    |

Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5517</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/10/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE LEGEND AT JEFFERSON'S GARDEN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>15401 NORTH PENN AVENUE<br/>EDMOND, OK 73013</b>                             |                          |                                                                    |
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| C1951                                                                       | <p>Continued From page 16</p> <p>medications). No medications of any kind should be left in the resident apartment without an order. The resident requires assistance with managing, supervising or administering medications.</p> <p>On 09/06/19 at 11:35 a.m. the resident mentioned self administering eye drops in the bathroom in the resident's room. Refresh Tears, lubricant eye drops, 0.5 fluid ounce bottle was observed on the resident's bathroom counter. The resident had a physician's order to self administer and keep at bedside since 08/28/16.</p> <p>During record review, the resident's chart did not have a self administration medication assessment.</p> <p>On 09/10/19 at 10:12 a.m. the licensed practical nurse and administrator were asked if resident #11 had a self administration medication evaluation. They both stated the resident did not self administer any of her medication; the center's staff were responsible for administering the resident's medications.</p> <p>At 3:36 p.m. employee #11 was asked to retrieve the physician ordered artificial tears sterile 1.4% drops to be instilled in each eye twice a day, gentel mild to moderate, sterile 0.3% drops two drops to be instilled in the left eye as prn for allergies and the ocusoft lid scrub original medication pad to cleanse eye twice weekly on Tuesday and Thursday at 8:00 p.m. Employee #11 opened the medication cart (top drawer) and stated none of the eye related drops, etc. would on the medication cart because the resident self administered all of the eye drops, etc. When asked how she knew the resident self administered the artificial tears she stated she went to the room and watched the resident self</p> | C1951                                                                      |                                                                                                                          |                          |                                                                    |

Oklahoma State Department of Health

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| C1951                                                                       | <p>Continued From page 17</p> <p>administer the artificial tears and documented it was given on the eMAR.</p> <p>At 3:40 p.m. the resident was asked if they self administered all of their eye drops. The resident stated, "Yeah." When asked about artificial tears sterile 1.4% drops to be instilled in each eye twice a day the resident stated, "I don't have any artificial tears; the doctor told me I didn't need them a long time ago." The resident stated the only eye drops in the resident's room were the Refresh Tears, lubricant eye drops.</p> <p>There were no physician orders documenting the resident could self administer the artificial tears, genteal or the ocusoft lid scrub. The center's staff were responsible for administering artificial tears since 03/28/16, genteal and ocusoft lid scrub since 07/21/16.</p> <p>The artificial tears, genteal and ocusoft lid scrub were not available for administration, but the center's staff documented the artificial tears and ocusoft lid scrub had been administered routinely.</p> | C1951                                                                      |                                                                                                                          |                          |                                                                    |

# STATE WORKLOAD REPORT

|                                    |                                                            |
|------------------------------------|------------------------------------------------------------|
| Provider/Supplier Number<br>AL5517 | Provider/Supplier Name<br>THE LEGEND AT JEFFERSON'S GARDEN |
|------------------------------------|------------------------------------------------------------|

Type of Survey (select all that apply)

|   |  |  |  |  |
|---|--|--|--|--|
| 3 |  |  |  |  |
|---|--|--|--|--|

- |                           |                         |                     |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification   |
| B Dumping Investigation   | F Inspection of Care    | J Sanctions/Hearing |
| C Federal Monitoring      | G Validation            | K State License     |
| D Follow-up Visit         | H Life Safety Code      | L CHOW              |
| M Other                   |                         |                     |

Extent of Survey (select all that apply)

|  |  |  |  |  |
|--|--|--|--|--|
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- A Routine/Standard Survey (all providers/suppliers)  
 B Extended Survey (HHA or Long Term Care Facility)  
 C Partial Extended Survey (HHA)  
 D Other Survey

## SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

| Surveyor ID Number<br>(A) | First<br>Date<br>Arrived<br>(B) | Last<br>Date<br>Departed<br>(C) | Pre-Survey<br>Preparation<br>Hours<br>(D) | On-Site<br>Hours<br>12am-8am<br>(E) | On-Site<br>Hours<br>8am-6pm<br>(F) | On-Site<br>Hours<br>6pm-12am<br>(G) | Travel<br>Hours<br>(H) | Off-Site Report<br>Preparation<br>Hours<br>(I) |
|---------------------------|---------------------------------|---------------------------------|-------------------------------------------|-------------------------------------|------------------------------------|-------------------------------------|------------------------|------------------------------------------------|
| Team Leader ID            |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 1. <i>MS</i> 34460        | 09/05/2019                      | 09/10/2019                      | 0.75                                      | 0.00                                | 20.25                              | 0.00                                | 3.50                   | 8.00                                           |
| 2. <i>JM</i> 42023        | 09/05/2019                      | 09/10/2019                      | 0.25                                      | 0.00                                | 13.50                              | 0.00                                | 2.00                   | 0.00                                           |
| 3.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 4.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 5.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 6.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 7.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 8.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 9.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 10.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 11.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 12.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 13.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 14.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours.....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

OCT 24 2019 *jm*



Oklahoma State Department of Health  
Creating a State of Health

October 29, 2019

License Number: AL5517

Ms. Shekita Gray, Administrator  
The Legend At Jefferson's Garden  
15401 North Penn Avenue  
Edmond, OK 73013

**Survey Event ID: D0RK11**

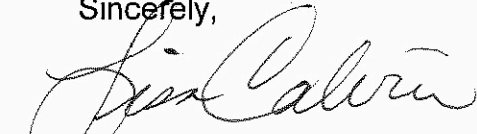
Dear Ms. Gray:

On **September 10, 2019**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1511:** We do not accept this POC because the center was cited C1511 and the POC documented correction for C1911.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,



Sue Davis, Enforcement Coordinator  
Long Term Care  
Protective Health Services

SD/lde

Enclosure

Board of Health

Gary Cox, JD  
Commissioner of Health

Timothy E Starkey, MBA (*President*)  
Edward A Legako, MD (*Vice-President*)  
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO  
Terry R Gerard II, DO  
Charles W Grim, DDS, MHSA

R Murali Krishna, MD  
Ronald D Osterhout  
Charles Skillings

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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:** 10/23/2019

**Facility Name:** Legend at Jefferson's Garden

**License Number:** 5517

**Survey Event ID:** D0RK11

**Date Survey Completed:** 9/10/2019

RECEIVED

OCT 25 2019

HRDS

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505

Based on: Based on observation, interview and record review, it was determined the center failed to ensure, a) Self Medication assessment not completed for 1 (#11) of 11 sampled residents. b) Medication not given per Physician Orders for 1 (#11) of 11 sampled residents who received medications. c. Medication not available per physician order for 1 (#11) of 11 sampled residents.

### 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?

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #11: A self medication assessment was completed.

Resident #11: Resident medication review completed and all physician ordered medication available.

Resident #6: No longer resides in community.

OSDH Response: Element accepted Yes ☐ No ☐

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

Residents residing in the community have the potential to be affected.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

All resident medication orders have been reviewed for accuracy and availability.

MAR to cart audits will be completed 1 x per week

Medication administration will be observed by the HCD or designee 2 x per week and results documented.

RD and HCD in-serviced on Self Administration Assessment regulation

All Medication Aides in-serviced on Medication availability, Medication documentation and Medication ordering

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;

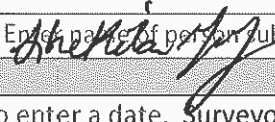
Results of the documentation will be reviewed in the QA meeting.

QA team will recommend and put in place additional interventions if needed.

RECEIVED

OCT 25 2019

LONG TERM CARE

|                                                                                                                                                                  |                           |                                                               |                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. |                           | Record of the documentation will be kept with the QA minutes. |                                                                                                                              |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                         |                           |                                                               |                                                                                                                              |
| 5. On what date will corrective action be completed?                                                                                                             |                           | 11/23/2019                                                    |                                                                                                                              |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                         |                           |                                                               |                                                                                                                              |
| <b>Administrator's Signature</b> <b>Shekita Gray</b><br><small>OAC 310:663-25-4(F)</small>                                                                       |                           | <b>Date 10/23/2019</b>                                        |                                                                                                                              |
| 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.            |                           |                                                               |                                                                                                                              |
| <b>Addendum Date</b>                                                                                                                                             | Enter a date of addendum. | <b>Submitted by</b>                                           | Enter name of person submitting addendum.  |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                         |                           |                                                               |                                                                                                                              |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                           |                           |                                                               |                                                                                                                              |



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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|  <p>Oklahoma State<br/>Department of Health<br/>Creating a State of Health</p> <p>Protective Health Services<br/>Long Term Care Service</p> | <b>OPTIONAL PLAN OF CORRECTION TEMPLATE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|                                                                                                                                                                                                                              | <b>Current Date:</b> 10/23/2019                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
|                                                                                                                                                                                                                              | <b>Facility Name:</b> Legend at Jefferson's Garden                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                              | <b>License Number:</b> 5517                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
|                                                                                                                                                                                                                              | <b>Survey Event ID:</b> D0RK11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| <b>Date Survey Completed:</b> 9/10/2019                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <b>SUMMARY OF DEFICIENCY CITED BY OSDH</b>                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| ID Prefix Tag: C 1911                                                                                                                                                                                                        | Based on: Based on observation, interview and record review, it was determined the center failed to provide residents with dignity, courteousness, respect during care and treatment for 4 (#1, 6, 10, 11) out of 11 sampled residents.                                                                                                                                                                                                                                                                                                     |  |
| <b>ASSISTED LIVING CENTER'S PLAN OF CORRECTION</b>                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <b>REQUIRED ELEMENTS OF A PLAN</b>                                                                                                                                                                                           | <b>ASSISTED LIVING CENTER'S PLAN ELEMENTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?                                                                                                 | <p>Resident #1, 11: State Assessments updated for accuracy . #10 no longer resides at the community</p> <p>Resident #10: Significant change assessment – Resident not longer resides at the community</p> <p>Resident #11: Physician ordered medication reviewed for availability and accuracy. Resident #10 no longer resides at the community. Resident #6 no longer resides at the community.</p> <p>RD and HCD in-serviced on State Assessments and Significant change regulations.</p> <p>All staff in-serviced on resident rights</p> |  |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified?                                                                                                                | Residents residing in the community have the potential to be affected.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?                                                                                                       | <p>RD will review and respond to resident council meetings every month and document.</p> <p>RD and/or HCD will make random rounds and 11-7 visits and document findings.</p> <p>All resident medication orders have been reviewed for accuracy and availability.</p> <p>MAR to cart audits will be completed 1x per week</p> <p>Medication administration will be observed by the HCD or designee 2 x per week and results documented.</p>                                                                                                  |  |

|                                                                                                                                                                                                                                                                                                                                                                                                              |                           |                                                                                                                                                                                                                          |                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                              |                           | All Medication Aides in-serviced on Medication availability, Medication documentation and Medication ordering                                                                                                            |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                           |                                                                                                                                                                                                                          |                                           |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: <ul style="list-style-type: none"> <li>a. How the correction will be evaluated for effectiveness;</li> <li>b. How the correction will be incorporated into the center's quality assurance system; and</li> <li>c. How monitoring records will be kept to evidence the correction.</li> </ul> |                           | Results of the documentation will be reviewed in the QA meeting.<br><br>QA team will recommend and put in place additional interventions if needed.<br><br>Record of the documentation will be kept with the QA minutes. |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                           |                                                                                                                                                                                                                          |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                                                                                                                                                                                                         |                           | 11/23/2019                                                                                                                                                                                                               |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                           |                                                                                                                                                                                                                          |                                           |
| <b>Administrator's Signature</b> <b>Shekita Gray</b><br><small>OAC 310:663-25-4(F)</small>                                                                                                                                                                                                                                                                                                                   |                           | <b>Date</b> <b>10/23/2019</b>                                                                                                                                                                                            |                                           |
| 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.                                                                                                                                                                                                                                                        |                           |                                                                                                                                                                                                                          |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                                                                                                                                                                                                         | Enter a date of addendum. | <b>Submitted by</b>                                                                                                                                                                                                      | Enter name of person submitting addendum. |
| <i>Shekita Gray</i>                                                                                                                                                                                                                                                                                                                                                                                          |                           |                                                                                                                                                                                                                          |                                           |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                                                                                                                                                                                                                     |                           |                                                                                                                                                                                                                          |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.<br>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:** 10/23/2019

**Facility Name:** Legend at Jefferson's Garden

**License Number:** 5517

**Survey Event ID:** D0RK11

**Date Survey Completed:** 9/10/2019

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1951

Based on: Based on observation, interview and record review, it was determined the center failed to ensure, a) resident Significant change assessment not accurate (#10). b) Physician ordered Medication not available for 1 (#11) of 11 residents. c) physician ordered medication not administered per physician orders for 1 (#6) of 11 sampled residents.

### 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?

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #10: No longer resides in the community.

Resident #6: No longer resides in the community.

Resident #11: Physician ordered medication reviewed for availability and accuracy

OSDH Response: Element accepted Yes ☐ No ☐

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

Residents residing in the community have the potential to be affected.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

All resident medication orders have been reviewed for accuracy and availability.

MAR to cart audits will be completed 1 x per week and results documented.

Medication administration will be observed by the HCD or designee 2 x per week and results documented.

RD and HCD in-serviced on accuracy of Significant changes.

All Medication Aides in-serviced on Medication availability, Medication documentation and Medication ordering

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

Results of the documentation will be reviewed in the QA meeting.

QA team will recommend and put in place additional interventions if needed.

Record of the documentation will be kept with the QA minutes.

|                                                                                                                                                       |                           |                        |                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------|-------------------------------------------|
| c. How monitoring records will be kept to evidence the correction.                                                                                    |                           |                        |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                              |                           |                        |                                           |
| 5. On what date will corrective action be completed?                                                                                                  |                           | 11/23/2019             |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                              |                           |                        |                                           |
| Administrator's Signature <b>Shekita Gray</b><br>OAC 310:663-25-4(F)                                                                                  |                           | Date <b>10/23/2019</b> |                                           |
| 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. |                           |                        |                                           |
| <b>Addendum Date</b>                                                                                                                                  | Enter a date of addendum. | <b>Submitted by</b>    | Enter name of person submitting addendum. |
| Items Below Are For OSDH Use Only                                                                                                                     |                           |                        |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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

November 4, 2019

License Number: AL5517

Ms. Shekita Gray, Administrator  
The Legend At Jefferson's Garden  
15401 North Penn Avenue  
Edmond, OK 73013

**Survey Event ID: D0RK11**

Dear Ms. Gray:

On September 10, 2019, 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 **November 23, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin  
Long Term Care Enforcement Reviewer  
Oklahoma State Department of Health

LC/ks

Board of Health

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Commissioner of Health

Timothy E Starkey, MBA (*President*)  
Edward A Legako, MD (*Vice-President*)  
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Jenny Alexopoulos, DO  
Terry R Gerard II, DO  
Charles W Grim, DDS, MHSA

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Long Term Care Service

#### OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/23/2019

Facility Name: Legend at Jefferson's Garden

License Number: 5517

Survey Event ID: D0RK11

Date Survey Completed: 9/10/2019

#### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1511

Based on: Based on observation, interview and record review, it was determined the center failed to provide residents with dignity, courteousness, respect during care and treatment for 4 (#1, 6, 10, 11) out of 11 sampled residents.

#### 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?

##### ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #1, 11: State Assessments updated for accuracy . #10 no longer resides at the community

Resident #10: Significant change assessment – Resident not longer resides at the community

Resident #11: Physician ordered medication reviewed for availability and accuracy. Resident #10 no longer resides at the community. Resident #6 no longer resides at the community.

RD and HCD in-serviced on State Assessments and Significant change regulations.

All staff in-serviced on resident rights

OSDH Response: Element accepted Yes ☐ No ☐

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

Residents residing in the community have the potential to be affected.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

RD will review and respond to resident council meetings every month and document.

RD and/or HCD will make random rounds and 11-7 visits and document findings.

All resident medication orders have been reviewed for accuracy and availability.

MAR to cart audits will be completed 1x per week

Medication administration will be observed by the HCD or designee 2 x per week and results documented.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |                           |                                                                                                                                                                                                                          |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | All Medication Aides in-serviced on Medication availability, Medication documentation and Medication ordering                                                                                                            |                                   |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                           |                                                                                                                                                                                                                          |                                   |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained?<br>Include: <ul style="list-style-type: none"> <li>a. How the correction will be evaluated for effectiveness;</li> <li>b. How the correction will be incorporated into the center's quality assurance system; and</li> <li>c. How monitoring records will be kept to evidence the correction.</li> </ul> |                           | Results of the documentation will be reviewed in the QA meeting.<br><br>QA team will recommend and put in place additional interventions if needed.<br><br>Record of the documentation will be kept with the QA minutes. |                                   |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                           |                                                                                                                                                                                                                          |                                   |
| 5. On what date will corrective action be completed?                                                                                                                                                                                                                                                                                                                                                            |                           | 11/23/2019                                                                                                                                                                                                               |                                   |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                           |                                                                                                                                                                                                                          |                                   |
| Administrator's Signature Shekita Gray                                                                                                                                                                                                                                                                                                                                                                          |                           | Date 10/23/2019                                                                                                                                                                                                          |                                   |
| 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                                                                                                                                                                                                             | Shekita Gray submitting addendum. |
| Items Below Are For OSDH Use Only                                                                                                                                                                                                                                                                                                                                                                               |                           |                                                                                                                                                                                                                          |                                   |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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

December 12, 2019

License Number: AL5517

Ms. Shekita Gray, Administrator  
The Legend At Jefferson's Garden  
15401 North Penn Avenue  
Edmond, OK 73013

**Survey Event ID: D0RK12**

Dear Ms. Gray:

On **November 26, 2019**, 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.

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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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;

Board of Health

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Commissioner of Health

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Jenny Alexopoulos, DO  
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Charles W Grim, DDS, MHSA

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- (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) 271-6868 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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  
1000 N.E. 10th  
Oklahoma City, OK 73117-1299

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](mailto:IDRCoordinator@health.ok.gov), or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to [LTC@health.ok.gov](mailto:LTC@health.ok.gov) or call (405) 271-6868. 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.

Sincerely,



 Sue Davis, Enforcement Coordinator  
Long Term Care  
Protective Health Services

SD/lde

Enclosure

# STATE WORKLOAD REPORT

 Provider/Supplier Number  
 AL5517

 Provider/Supplier Name  
 THE LEGEND AT JEFFERSON'S GARDEN

Type of Survey (select all that apply)

|   |   |  |  |  |
|---|---|--|--|--|
| 3 | D |  |  |  |
|---|---|--|--|--|

 A Complaint Investigation  
 B Dumping Investigation  
 C Federal Monitoring  
 D Follow-up Visit  
 M Other

 E Initial Certification  
 F Inspection of Care  
 G Validation  
 H Life Safety Code

 I Recertification  
 J Sanctions/Hearing  
 K State License  
 L CHOW

Extent of Survey (select all that apply)

|  |  |  |  |  |
|--|--|--|--|--|
|  |  |  |  |  |
|--|--|--|--|--|

 A Routine/Standard Survey (all providers/suppliers)  
 B Extended Survey (HHA or Long Term Care Facility)  
 C Partial Extended Survey (HHA)  
 D Other Survey

## SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

| Surveyor ID Number<br>(A) | First<br>Date<br>Arrived<br>(B) | Last<br>Date<br>Departed<br>(C) | Pre-Survey<br>Preparation<br>Hours<br>(D) | On-Site<br>Hours<br>12am-8am<br>(E) | On-Site<br>Hours<br>8am-6pm<br>(F) | On-Site<br>Hours<br>6pm-12am<br>(G) | Travel<br>Hours<br>(H) | Off-Site Report<br>Preparation<br>Hours<br>(I) |
|---------------------------|---------------------------------|---------------------------------|-------------------------------------------|-------------------------------------|------------------------------------|-------------------------------------|------------------------|------------------------------------------------|
| Team Leader ID            |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 1. <i>jm</i> 42023        | 11/26/2019                      | 11/26/2019                      | 0.50                                      | 0.00                                | 3.00                               | 0.00                                | 1.00                   | 1.50                                           |
| 2.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 3.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 4.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 5.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 6.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 7.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 8.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 9.                        |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 10.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 11.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 12.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 13.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |
| 14.                       |                                 |                                 |                                           |                                     |                                    |                                     |                        |                                                |

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours.....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

 DEC 16 2019 *jm*



Oklahoma State Department of Health  
Creating a State of Health

December 20, 2019

License Number: AL5517

Ms.. Shekita Gray, Administrator  
The Legend At Jefferson's Garden  
15401 North Penn Avenue  
Edmond, OK 73013

**Survey Event ID: D0RK12**

Dear Ms.. Gray:

On November 26, 2019, 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 **December 30, 2019**.

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) 271-6868.

Sincerely,

Sue Davis  
Long Term Care Enforcement Reviewer  
Oklahoma State Department of Health

SD/jt

Board of Health

Gary Cox, JD  
Commissioner of Health

Timothy E Starkey, MBA (*President*)  
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Ronald D Osterhout  
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|                                                                                                                                                                                                                                               |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <p>Oklahoma State<br/>Department of Health<br/>Creating a State of Health</p> <p>Protective Health Services<br/>Long Term Care Service</p>                  | <b>OPTIONAL PLAN OF CORRECTION TEMPLATE</b>                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                               | Current Date: 12/16/2019                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                               | Facility Name: Legend at Jefferson's Garden                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                               | License Number: 5517                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                               | Survey Event ID: DORK11                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                      |
| Date Survey Completed: 11/26/2019                                                                                                                                                                                                             |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>SUMMARY OF DEFICIENCY CITED BY OSDH</b>                                                                                                                                                                                                    |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| ID Prefix Tag: C 1505                                                                                                                                                                                                                         | Based on: Based on observation, interview and record review, it was determined the center failed to ensure, a) Medication not available per physician order for 1 (#1) of 4 sampled residents. |                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>ASSISTED LIVING CENTER'S PLAN OF CORRECTION</b>                                                                                                                                                                                            |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| Assisted Living Center's Comments:                                                                                                                                                                                                            |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>REQUIRED ELEMENTS OF A PLAN</b>                                                                                                                                                                                                            |                                                                                                                                                                                                | <b>ASSISTED LIVING CENTER'S PLAN ELEMENTS</b>                                                                                                                                                                                                                                                                                                                                        |
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?                                                                                                                  |                                                                                                                                                                                                | Resident #1: Resident medication review completed and all physician ordered medication available.                                                                                                                                                                                                                                                                                    |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                      |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified?                                                                                                                                 |                                                                                                                                                                                                | Residents residing in the community have the potential to be affected. RD and HCD will review and oversee all medications are available.                                                                                                                                                                                                                                             |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                      |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?                                                                                                                        |                                                                                                                                                                                                | <p>All resident medication orders have been reviewed for accuracy and availability.</p> <p>MAR to cart audits will be completed 2x per week.</p> <p>Medication administration will be observed by the HCD or designee 1 x per week and results documented.</p> <p>All Medication Aides in-serviced on Medication availability, Medication documentation and Medication ordering.</p> |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                      |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:                                                                                                                               |                                                                                                                                                                                                | Results of the documentation will be reviewed in the QA meeting.                                                                                                                                                                                                                                                                                                                     |
| <p>a. How the correction will be evaluated for effectiveness;</p> <p>b. How the correction will be incorporated into the center's quality assurance system; and</p> <p>c. How monitoring records will be kept to evidence the correction.</p> |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                      |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |
| 5. On what date will corrective action be completed?                                                                                                                                                                                          |                                                                                                                                                                                                | 12/30/2019                                                                                                                                                                                                                                                                                                                                                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                      |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                      |