OKLAHOMA
State Department
of Health

Delivery via email to: riley.loving@legendseniorliving.com

October 24, 2025

License Number: AL5517

Riley Loving, Administrator
The Legend At Jefferson's Garden
15401 North Penn Avenue
Edmond, OK 73013

RE: Survey Event ID: NNE511

Dear Riley Loving:

On **October 9, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 9, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5517	A. BUILDING: _____ B. WING _____	10/09/2025

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted on 10/09/25. Facility Census: 41 Listed below are abbreviations that will be used throughout this document. RN - registered nurse	C 000		
C 391 SS=D	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure food was stored, labeled, and dated according to center policy for 1 of 1 refrigerator observation. The resident director identified 41 residents resided in the center. Findings: On 10/09/25 at 8:45 a.m., three plastic wrapped plates containing croissant sandwiches were observed during the initial kitchen observation with the culinary coordinator. A policy titled "Storage of foods," dated 06/01/20, read in part, "Wrap, cover or seal all refrigerated	C 391		

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	AL5517	A. BUILDING: _____ B. WING _____	10/09/2025

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C 391	Continued From page 1 foods and label with the preparation date." On 10/09/25 at 8:45 a.m., The culinary coordinator stated they were prepared yesterday, and should have been dated. On 10/09/25 at 3:54 p.m., the resident director stated any food that was in the refrigerator should be covered, labeled, and dated.	C 391		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on record review and interview, the center	C 532		

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	AL5517	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGEND AT JEFFERSON'S GARDEN	15401 NORTH PENN AVENUE EDMOND, OK 73013

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C 532	Continued From page 2	C 532		

failed to ensure resident assessments accurately reflected the resident status for 2 (#2 and #6) of 8 sampled residents reviewed for assessment accuracy.

The resident director identified 41 residents resided in the center.

Findings:

A facility policy titled "Resident Assessments," dated 07/01/12, read in part, "conducting assessments of the resident to determine appropriateness of residency, to determine the care and services needed and/or desired by the resident, and to determine certain risks the resident might experience in order to plan appropriately to meet resident needs."

1. Resident #2's 14 day initial assessment, dated 09/16/24, showed Resident #2 was independent with bathing, dressing, eating, transferring, toileting, and ambulation.

Resident #2's level of service and financial charges document, dated 09/15/24, showed Resident #2 was described and charged as being a level 2 based on requiring assistance from staff for bathing and nutrition.

2. Resident #6's annual assessment, dated 09/15/25, showed Resident #6 was independent with bathing, dressing, eating, transferring, toileting, and ambulation.

Resident #6's level of service and financial charges document, dated 09/15/25, showed Resident #6 was described and charged as being a level 3 based on requiring assistance from staff for nutrition, bathing, dressing, mobility, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5517	A. BUILDING: _____ B. WING _____	10/09/2025

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 532	Continued From page 3 toileting. On 10/09/25 at 1:12 p.m., the health care director was asked why Resident #2 was being charged as a level 2 if they were independent with all of their functionality. The health director stated the initial assessment was incorrectly coded for their functionality. They were asked why Resident #6 was being charged as a level 3 if they were independent in their functionality. The health director stated the annual assessment for Resident #6 was also coded incorrectly for their functionality. The health care director stated they were the one that completed all of those forms, and could not tell me why they were coded incorrectly. On 10/09/25 at 3:53 p.m., the resident director stated the expectation was that assessments should be coded accurately.	C 532		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure required assessments were signed/coordinated by an RN or physician for 3 (#1, 2, and #3) of 8 sampled residents reviewed for assessments.	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5517	A. BUILDING: _____ B. WING _____	10/09/2025

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 542	Continued From page 4 The resident director identified 41 residents resided in the facility. Findings: 1. Resident #1's annual assessment, dated 11/20/24, did not have a signature from an RN or a physician. 2. Resident #2's 14 day admission assessment, dated 09/16/24, did not have a signature from an RN or a physician. 3. Resident #3's preadmission assessment, dated 09/19/25, did not have a signature from an RN or a physician. On 10/09/25 at 1:20 p.m., the health care director stated they did not believe preadmission assessments required an RN or a physician signature, but they did agree the documents did not contain an RN or physician signature. On 10/09/25 at 3:53 p.m., the residence director stated that the assessments should have been signed by an RN or a physician.	C 542		
C 703 SS=F	Hot Water - Laundry - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot water at a temperature of 160 degree Fahrenheit shall be available for use in the laundry at all times. The required temperature of 160 degrees shall be that measured in the washing machine and shall be supplied so that	C 703		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5517	A. BUILDING: _____ B. WING _____	10/09/2025

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 703	Continued From page 5 this temperature may be maintained over the entire wash and rinse period. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident's laundry was washed at an appropriate temperature for sanitization to occur on 2 of 2 washing machines checked for temperature. The resident director identified 41 residents resided in the center. Findings: On 10/09/25 at 1:38 p.m., two of the three washing machines in the facility were checked to see if the machine reached the appropriate temperature of 160 degrees to ensure sanitization of resident clothes. Both of the washing machines registered at 112 degrees when checked by the maintenance director. On 10/09/25 at 1:50 p.m., the maintenance director stated they thought the machines should reach at least 120-140 degrees. They stated the machines were older and they guessed the machines did not reach temperature because they had a hot/cold cycle instead of just a hot cycle. On 10/09/25 at 3:53 p.m., the resident director stated they believed laundry could be cleaned using chemicals to sanitize.	C 703		

OKLAHOMA
State Department
of Health

Delivery via email to: riley.loving@legendseniorliving.com

November 7, 2025

License Number: AL5517

Riley Loving, Administrator/Residence Director
The Legend At Jefferson's Garden
15401 North Penn Avenue
Edmond, OK 73013

RE: Survey Event NNE511

Dear Riley Loving:

On **October 9, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **October 10, 2025**.

We will conduct a revisit for your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/5/2025** **Facility Name:** Jefferson Gardens **License Number:** AL5517 **Survey Event ID:** NNE511 **Date Survey Completed: 10/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation, record review, and interview, the center failed to ensure food was sotred, labeled, and dated according to center policy for 1 of 1 refrigerator observation.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All Resident food items were removed, inspected and properly labeled and or discarded. Dining staff were instructed to lable all resident food items with date opened. The Residence Director (RD) , Chef or Designee will inspect the refrigerator, freezer and dry storage weekly to ensure proper lableling and storage after 30 days will do monthly and then resume to quarterly audits after compliance is met.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Care staff were trained on proper labeling procedures. Correction will be monitored at QA meeting.
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?	Dining Service Associates were inserviced on the storage of Food Policy in compliance with 310-663-3-8(a) Food Storage, preparation and service. The Residence Director, Chef or designess will provide ongoing in-service training and education to all appropriate Dietary staff on proper labeling and storage.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RD, Dietary Manager, or designee will conduct weekly audits of all food storage areas, including refrigerators, freezers, and dry storage, to ensure all food items are properly labeled and dated in accordance with facility policy and Oklahoma State Department of Health requirements Audit results will be recorded on the Food Storage Audit Form and maintained in the Quality Assurance (QA) binder. All audits and related documentation will be reviewed and discussed during QA meetings to identify any patterns of noncompliance and determine if retraining or corrective measures are necessaryb) the audits and related documentation will be discussed at QA meetings and will be documented in QA file

	The RD, Registered Dietician will review audit records Quarterly to verify ongoing compliance and provide follow-up as needed. Documentation of these reviews will be kept on file in the dietary consult report.c) The audit will be maintained with the QA file and updated quarterly QA/Dietician Quartlery review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/10/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Riley Loving RD** Riley Loving RD OAC 310:663-25-4(F)	**Date 11/5/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/5/2025** **Facility Name:** Jefferson Gardens **License Number:** AL5517 **Survey Event ID:** NNE511 **Date Survey Completed: 10/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C532	Based on: Record review and interview, the center failed to ensure resident assessments accurately reflected the resident status for 2 of 8 sampled residents reviewed for assessment accuracy.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The 14-day initial assessment has been reviewed, corrected, and updated on the official Oklahoma State Department of Health (OSDH) assessment form to accurately reflect the information documented in the resident's electronic record. The correction was completed by the Health Care Director (HCD) and reviewed by the Administrator for accuracy and compliance. All current resident records have been audited to ensure that assessment documentation matches between the OSDH form and the electronic health record. Ongoing audits will be conducted monthly and then quarterly by the RD, HCD or designee to ensure continued compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Health Care Director (HCD) reviewed all current resident records to identify any other residents who may not have had a 14-day initial assessment completed or documented accurately. This review included cross-checking the electronic health record and OSDH assessment forms for each resident. Any missing or incomplete assessments identified during this audit were immediately corrected by the Registered Nurse (RN) or physician.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Health Care Director (HCD) and Registered Nurse (RN) have implemented a tracking and monitoring system to ensure all new residents receive their 14-day initial assessment within the required timeframe. The system includes: A tracking log maintained by the HCD to monitor due dates for all assessments.HCD inservice on OSDH timelines and documentation requirements for all assessments. The Administrator or designee will audit a random sample of resident charts monthly to ensure continued compliance with assessment requirements. Findings will be reviewed

	during the facility's Quality Assurance meetings, and any identified gaps will be immediately corrected.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Health Care Director (HCD) or designee will conduct monthly audits of newly admitted residents to verify that all 14-day initial assessments are completed, signed, and accurately documented on the OSDH form and in the electronic health record Audit results will be documented and reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings quarterly. The Health Care Director (HCD) or designee will complete a monthly audit form verifying that all new residents have a completed and signed 14-day assessment Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Riley Loving RD OAC 310:663-25-4(F)	Riley Loving RD	**Date 11/5/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/3/2025** **Facility Name:** Jefferson Gardens **License Number:** AL5517 **Survey Event ID:** NNE511 **Date Survey Completed: 10/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C542	Based on: record review and interview , the facility failed to ensure required assessments were signed/coordinated by and RN or physician for 3 of 8 sampled residents reviewed for assessments

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: # 3 of this tag is not correct- Oklahoma Administrative Code (OAC 310:663-5)) requires admission Assessment, Comprehensive Assessment: Within 14 days after admission, Care Plan (Service Plan). No requirement for RN or physician signature on preadmission.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All resident assessments identified as missing an RN signature have been reviewed and signed by the facility's Registered Nurse (RN) to verify accuracy and compliance with OSDH requirements. Each assessment was reviewed in full to confirm that the information documented accurately reflects the resident's current condition.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Health Care Director (HCD) has verified that all required assessments are now properly signed and filed in each resident's record. A verification log has been implemented to track all future assessments and ensure completion prior to filing.
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?	A signature verification process has been implemented to ensure that all required resident assessments are reviewed and signed by the Registered Nurse (RN) prior to being finalized or filed. The Health Care Director (HCD) or designee will review all completed assessments Monthly to confirm RN signatures are present and properly dated. A tracking and checklist system has been established for all new assessments to verify that the RN signature is obtained within the required time frame. HCD have been inserviced on the requirement for RN review and signature on all assessments prior to completion. Additionally, the Administrator will include review of RN-signed assessments as part of the facility's Quality

	Assurance (QA) process, discussed quarterly to ensure sustained compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Health Care Director (HCD) or designee will perform monthly audits of resident assessment records to ensure all required assessments are reviewed and signed by the Registered Nurse (RN). The audits will include verification that signatures and dates are complete, accurate, and timely. Audit findings will be documented on a monitoring log and presented during the facility's Quality Assurance and Performance Improvement (QAPI) meetings. Any deficiencies identified during these audits will result in immediate correction and staff re-education. The Administrator will review and sign off on all monthly audit summaries to ensure ongoing compliance and accountability. Monitoring documentation will be maintained for at least 12 months. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Riley Loving RD OAC 310:663-25-4(F)	**Date 11/5/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/5/2025** **Facility Name:** Jefferson Gardens **License Number:** AL5517 **Survey Event ID:** NNE511 **Date Survey Completed: 10/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C703	Based on: observation and interview the facility failed to ensure residents laundry was washed at an appropriate temperature for sanitization to occur on 2 of 2 washing machines checked for temperature

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A licensed plumber was contacted and has adjusted and recalibrated the hot water system servicing the laundry area to ensure the washing machines reach and maintain a minimum temperature of 160°F, as required for proper sanitation. The Maintenance Director verified the correction by testing and recording water temperatures at the washing machine during a full wash cycle. On 10/21/25, an inservice was completed for all staff responsible for maintenance and laundry services. The training covered state regulatory requirements for hot water temperature (minimum 160°F for laundry sanitation), proper recording procedures, and immediate reporting protocols for out-of-range temperatures. Attendance was documented and filed in the training records The RD and Maintenance Director have confirmed that the water temperature consistently meets state requirements. A temperature log has been implemented for laundry staff to record weekly wash temperatures for 30 days and then monthly ongoing audits will resume. Any reading below 160°F will be reported immediately to the Maintenance Department for correction.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Maintenance Director inspected and tested all washing machines throughout the facility to ensure that each unit reaches the required 160°F sanitizing temperature during operation. This review confirmed that all equipment is now functioning properly and delivering the correct water temperature. Because laundry services support all residents, this corrective action benefits the entire facility population.

	Ongoing monitoring and temperature logging will ensure that all residents continue to be protected from potential sanitation concerns
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?	A monitoring system has been implemented to ensure that all washing machines consistently reach and maintain the required 160°F sanitizing temperature. Laundry staff are now responsible for recording daily wash temperatures using a calibrated thermometer and documenting results on a Laundry Temperature Log. The Maintenance Director will review these logs weekly to verify compliance and ensure equipment is functioning properly. If temperatures fall below 160°F, the issue will be immediately reported to the Administrator and corrected by maintenance or a licensed plumber. Maintenance staff have been Inserviced on OSDH temperature requirements and the importance of accurate monitoring and documentation
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Maintenance Director or designee will conduct monthly audits of laundry temperature logs and perform direct temperature checks on washing machines to confirm water temperatures reach at least 160°F during the wash cycle. Audit results will be documented and maintained in the facility's Quality Assurance (QA) binder under the "Housekeeping" section. The Administrator and Health Care Director (HCD) will review audit findings during monthly QA meetings to verify continued compliance and address any identified deficiencies immediately. All monitoring records will be kept for a minimum of 12 months. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/10/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Riley Loving RD OAC 310:663-25-4(F)	Riley Loving RD	**Date 11/5/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department of Health

Delivery via email to: riley.loving@legendseniorliving.com

November 19, 2025

License Number: AL5517

Riley Loving, Administrator
The Legend At Jefferson's Garden
15401 North Penn Avenue
Edmond, OK 73013

RE: Survey Event NNE512

Dear Riley Loving:

On **November 12, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 9, 2025,** have now been corrected effective **October 10, 2025.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5517	A. BUILDING: _____ B. WING _____	R 11/12/2025

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 11/12/25. The facility was in substantial compliance.	{C 000}		

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