



Delivery via email to: shekita.gray@legendseniorliving.com

October 18, 2021

License Number: AL5594

Ms. Shekita Gray, Administrator
Legend At Council Road
11320 North Council Road
Oklahoma City, OK 73162

Survey Event ID: R4U411

Dear Ms. Gray:

On **October 7, 2021**, 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;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action will be completed for each violation; and
- (6) Be signed by the administrator.



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

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

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

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

The IDR request must be submitted within 10 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406



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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Legend at Council Rd
Address: 11320 N Council Rd
City, State, Zip: Oklahoma City, OK 73162
Provider #: AL5594
Complaint #: OK00055317
Investigation Date(s): 10/04/21, 10/07/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to have and/or implement their abuse policy.	S
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☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/04/2021 at 8:30 a.m.

A sample of 4 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1971 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, reading "Melissa Swaim RN", written over a horizontal line.

Melissa Swaim RN

Date report completed: 10/08/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/07/2021
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LEGEND AT COUNCIL ROAD

**11320 NORTH COUNCIL ROAD
OKLAHOMA CITY, OK 73162**

(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 abbreviated survey was conducted 10/04/21 and 10/07/21 to investigate complaint #OK00055317.	C 000		
C1971 SS=D	310:663-19-4(b) POLICIES (b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: Based on interview and record review, the center failed to immediately investigate an abuse allegation for one (#1) of two sampled residents with allegations of abuse. The administrator identified 66 residents who resided in the facility. Findings: A policy titled, "Resident Abuse, Neglect and Exploitation", read in part, "...An investigation shall be conducted by the Residence Director Administrator or designee ...Report findings shall be kept in a separate file in the Residence Director's or designee's office ..." The policy, read in part, "...The written report shall contain: any corrective action taken by the employer, the name and address of any person who may have witnessed the incident..."	C1971		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5594	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/07/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGEND AT COUNCIL ROAD

**11320 NORTH COUNCIL ROAD
OKLAHOMA CITY, OK 73162**

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C1971	Continued From page 1 a. An incident report, dated an incident occurred on 03/24/20, read in part, the facility was notified on 03/25/20 of an allegation of abuse. The summary of the investigation documented statements were faxed to adult protective services (APS). On 10/08/21 at 11:08 a.m., the administrator was asked if there was an investigation of abuse which occurred on 03/24/20. She stated she could not provide documentation of the investigation. She was asked if there should have been an investigation with documentation of the investigation. She stated, "Yes".	C1971		



OKLAHOMA
State Department
of Health

Delivery via email to: shekita.anderson@legendseniorliving.com

October 27, 2021

License Number: AL5594

Ms. Shekita Anderson Administrator
Legend At Council Road
11320 North Council Road
Oklahoma City, OK 73162

Survey Event ID: R4U411

Dear Ms. Anderson:

On **October 7, 2021**, 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 30, 2021.**

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

Sincerely,

Tempal Killman

Digitally signed by Tempal
Killman
Date: 2021.10.27 10:41:34 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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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: 10/25/2021	
	Facility Name: Legend at Council Road	
	License Number: AL5549	
	Survey Event ID: R4U411	
Date Survey Completed: 10/7/2021		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: c 1971	Based on: Based on interview and record review, the center failed to immediately investigate an abuse allegation for one (#1) of two sampled residents with allegations of abuse.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. The plan of correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.		
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?		Resident #1 no longer resides at the community. The Residence Director or designee will immediately investigate any abuse allegation according to LSL policy titled, "Resident Abuse, Neglect and Exploitation" and secure documentation relevant to the the investigation according to said policy and in accordance with OSDH 310:663-19-4(b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department.
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?		The Resident Director or designee will in-service all team members on the policy titled 'Resident Abuse, Neglect and Exploitation' and OSDH Policy 310:663-19-4 (b). Residence Director or designee will investigate any allegation of abuse, neglect and exploitation and secure any documentation relevant to the investigation in the RD office according to policy titled 'Resident Abuse, Neglect and Exploitation and in accordance with OSDH 310:663.19-4(b).
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.		Documentation and report findings shall be kept with the incident report in the Incident report binder in the office of the Resident Director. Results of the documentation will be reviewed in the QA meeting for further action if needed. Staff in-serviced on LSL Policy Resident Abuse, Neglect or Exploitation and OSDH Policy 310:663-19-4(b). Monitoring records will be kept with the QA minutes.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/30/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Shekita Anderson RD OAC 310:663-25-4(F)		Date 10/25/2021	
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 Anderson RD
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.			



Delivery via email to: tomee.andrews@legendseniorliving.com

December 29, 2022

License Number: AL5594

Ms. Tomee Andrews, Administrator
Legend At Council Road
11320 North Council Road
Oklahoma City, OK 73162

Survey Event ID: R4U412

Dear Ms. Andrews:

On **December 23, 2022**, a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 7, 2021**, have now been corrected effective **November 30, 2021**.

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGEND AT COUNCIL ROAD

**11320 NORTH COUNCIL ROAD
OKLAHOMA CITY, OK 73162**

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{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 12/23/22. The facility is in substantial compliance.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE