
Delivery via email to: Nikkita Forcha <nikkita.forcha@legendseniorliving.com>

November 7, 2025

License Number: AL5594

Nikkita Bowler Forcha, Administrator
Legend At Council Road
11320 North Council Road
Oklahoma City, OK 73162

Survey Event ID: 7G9T11

Dear Ms. Bowler Forcha:

On **October 22, 2025**, 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 plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

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

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

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

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

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

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

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

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

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

IDR Coordinator
Long Term Care

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

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

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

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

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

Respectfully,



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

Enclosure

INVESTIGATIVE REPORT

Facility: Legend at Council Road
Address: 11320 North Council Road
City, State, Zip: Oklahoma City, OK 73162
Provider #: AL5594
Complaint #: OK00086767
Investigation Date(s): 10/20/25-10/22/25

ALLEGATION(S)
The center failed to ensure residents were free from abuse
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 10/20/2025 at 6:45 a.m.

A sample of 7 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation: Observations of residents and staff were made. Records of including but not limited to, resident medical records, assessments, care plans, physician's orders, staff training and center policies were reviewed. Interviews with residents, families, and staff were conducted. Based on observation, record review, and interview, it was determined the center was not in compliance with state regulations.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/22/2025

INVESTIGATIVE REPORT

Facility: Legend at Council Road
Address: 11320 North Council Road
City, State, Zip: Oklahoma City, OK 73162
Provider #: AL5594
Complaint #: OK00087085
Investigation Date(s): 10/20/25-10/22/25

ALLEGATION(S)
The center failed to ensure residents were protected from abuse
The center failed to ensure call lights were answered in a timely manner
The center failed to ensure services were provided according to the contract to prevent accidents
enter text
enter text

An unannounced on-site investigation was initiated 10/20/2025 at 6:45 a.m.

A sample of 7 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation: Observations of residents and staff were made. Records of including but not limited to, resident medical records, assessments, care plans, physician's orders, staff training and center policies were reviewed. Interviews with residents, families, and staff were conducted. Based on observation, record review, and interview, it was determined the center was not in compliance with state regulations.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/22/2025

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint investigations (#OK00086767 and #OK00087085) were conducted from 10/20/25 through 10/22/25. Deficiencies were cited as a result of the survey. Facility Census: 69 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide ADL - activities of daily living ADON - assistant director of nursing c/o - complain of CMA - certified medication aide CNA - certified nursing assistant DON - director of nursing ED - emergency department EMSA - Emergency Medical Services Authority ER - emergency room geri-psych - geriatric psychiatric IJ - immediate jeopardy med - medication mg - milligram ml - milliliter OSDH - Oklahoma State Department of Health PRN - as needed QMPI - quality management and performance improvement tab - tablet	C 000		
C 341 SS=J	310:663-3-4(b)(1) APPROPRIATE PLACEMENT (b) The resident shall not be eligible for placement in the assisted living center under one (1) or more of the following circumstances: (1) The resident needs care or services that exceed the care or services available in the	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 1 assisted living center; On 10/21/25, an immediate jeopardy situation was determined to exist when the center failed to ensure discharge of Resident #1 who did not meet the center's admission criteria as outlined in the resident care and service agreement which resulted in Resident #1 assaulting and battering Resident #2. The incident resulted in Resident #2 being sent to the hospital for treatment. On 10/21/25 at 2:30 p.m., the OSDH was notified and verified the existence of the IJ situation. On 10/21/25 at 3:12 p.m., the administrator was notified of the IJ situation related to Resident #1's mental health care exceeding the care and services available. On 10/22/25 at 1:45 p.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, "IJ #1 Plan of Removal Completion: 10/22/2025 at 3:00 p.m. On 09/03/2025, Resident #1 was immediately transferred to the emergency department for psychiatric evaluation and stabilization. Resident #1 did not return to the facility, thereby eliminating the immediate threat of harm to other residents. Current residents were assessed for safety, and no other incidents of aggression or abuse were identified. The attending physician and responsible party were notified. On 10/21/2025, a review of current residents was completed by the Regional Health Care Director to identify any individuals with psychiatric or behavioral diagnoses or changes in mood or behavior. No additional residents were found to	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 2 exhibit aggression or behaviors that posed risk to others. Service plans for residents with behavioral health diagnoses were reviewed and updated to include current interventions and monitoring. On next day worked, the Regional Health Care Director reeducated the Health Care Director on reviewing and updating service plans, abuse prevention, recognition, and mandatory reporting requirements, managing behavioral health conditions, including bipolar disorder, psychosis, and anxiety, de-escalation techniques and proper intervention documentation and procedures for prompt psychiatric notification and assessment. On 10/21/2025, clinical associates received immediate re-education on the following. Associates will complete the education prior to their next scheduled shift." ..."Abuse prevention, recognition, and mandatory reporting requirements." ..."Managing mental health conditions, including bipolar disorder, psychosis, and depression. On 10/21/2025, the Oklahoma training calendar was updated to include assignments for managing mental health conditions, including bipolar disorder, psychosis, and depression. The Health Care Director, or designee, shall review completed education weekly and report results to the QMPI Committee." The IJ was lifted, effective 10/22/25 at 3:00 p.m., when all components of the plan of removal had been verified as completed. Observations from 10/20/25 through 10/22/25 showed Resident #1 was no longer living in the center and no other residents were exhibiting aggressive behaviors. Records of staff training showed all staff, including administration, had received training in	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 3 abuse and managing mental health conditions. Records of resident assessments showed residents were re-assessed for mental health needs and safety on 10/21/25. Training records showed the DON was educated on reviewing and updating service plans, abuse prevention, recognition, and mandatory reporting requirements, managing behavioral health conditions, including bipolar disorder, psychosis, and anxiety, de-escalation techniques and proper intervention documentation and procedures for prompt psychiatric notification and assessment. Training records also showed all clinical associates were educated on managing mental health conditions, including bipolar disorder, psychosis, and depression. Records of the center's QMPI committee logs showed the center was reviewing education and the QMPI committee were meeting weekly. Interviews conducted with staff showed they had received training in abuse and managing mental health conditions. The deficiency remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the center failed to ensure a resident who did not meet the center's admission criteria as outlined in the resident care and service agreement was discharged for 1 (#1) of 1 sampled resident reviewed for appropriate placement. The administrator identified 69 residents resided in the center. Findings: A policy titled "Behavior Management," dated 07/01/12, read in part, "Purpose: To set forth the expectations for assisted living residents with	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 4 behavioral problems within the assisted living residence. Appropriate training will be provided to staff that will enable them to assist and respond appropriately to residents with behavioral issues. Among the training topics that may be addressed are: Depression, Bipolar Disorder, Anxiety Disorders." An "Admission, Discharge and Transfer Policy," dated 04/01/14, read in part, "Residents of senior living residences with one or more of the following conditions shall not be admitted or retained: Any behavioral symptom that exceeds manageability. Residents shall not be transferred or discharged unless: The safety of other individuals at the residence is endangered." A hospital inpatient "Mental Status Exam," dated 07/30/25, read in part, "[Resident #1] Alertness/Orientation: The patient is alert and oriented to person, age, date, place, circumstances, and current events. Mood: The patient is 'anxious' in mood. Speech character: slightly pressured in rate. Perceptions: Persistent delusional belief that [Resident #1] is the Devil. Dangerousness: The patient does have thoughts and intent of self-harm and homicidal thoughts and intent towards unspecified people." An "Assisted Living and Residency Agreement," dated 08/29/25, read in part, "Resident shall conduct him or herself in a manner that shall not disturb the other Resident's peaceful enjoyment or the operation of the Residence. Only those persons whose physical, mental, and psychosocial needs can be met within the accommodations and services provided shall be admitted and retained. Must not have medical records that reveal any history of violence or violent tendencies. Must not be subject to	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 5 excessive anxiety, depression, phobias, or paranoia, which may result in the possibility of endangering oneself or others." A "Comprehensive Assessment," dated 08/29/25, showed Resident #1 was admitted to the center on 08/29/25 with diagnoses to include cognitive impairment, anxiety, depression, and bipolar 1. The assessment showed Resident #1 was independent with all activities of daily living and mobility. A document titled "Active Medications for [Resident #1]," dated 08/29/25, showed Resident #1 was prescribed: a. olanzapine (an antipsychotic) 10mg one tablet at bedtime; b. olanzapine 5mg one tablet every morning; c. trazadone (an antidepressant) 25mg one tablet at bedtime; and d. ABH 1-25-1mg/0.5ml gel (a compounded medication consisting of Ativan, a benzodiazepine, Benadryl, an antihistamine, and Haldol, an antipsychotic) apply 0.5ml topically three times daily as needed. An "Observation Note," dated 08/30/25 at 3:30 p.m., read in part, "At 2:13 p.m., the [family member of Resident #1] got a strange voicemail from [Resident #1] making noises and saying [they] are the devil. This [ADON] notified ACMA to give PRN ABH. PRN ABH was given." An "Evening Shift Report," dated 08/30/25, read in part, "[Resident #1] tried to bite staff and was grabbing at us. Referred to [themselves] as a devil, stated [Resident #1] eats people." An undated "Med Pass History for [Resident #1]," showed:	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 6 a. PRN ABH gel on 8/31/25 at 12:10 a.m. for anxiety; b. PRN ABH gel on 08/31/25 at 9:26 p.m. for anxiety and agitation; c. PRN ABH gel on 09/01/25 at 2:03 p.m. for anxiety and agitation; d. PRN ABH gel on 09/01/25 at 8:16 p.m. for anxiety and agitation; e. PRN ABH gel on 09/02/25 at 12:06 p.m. for anxiety and agitation; and f. refused lorazepam on 09/03/25 at 5:41 p.m. An "Observation Note," dated 09/01/25 at 11:45 a.m., read in part, "[Family member of Resident #1] reach out to [ADON] and said, '[Family of Resident #1] spent the day with [them] yesterday. They said [their] eyes looked crazy. [Family member of Resident #1] believes [they] were discharged too soon.' Call went out to [geriatric psychiatric inpatient facility] to see about sending back out for geri-psych." An "Observation Note," dated 09/01/25 at 3:30 p.m., read in part, "At 3:22 p.m., the intake nurse for [geriatric psychiatric inpatient facility] called [ADON] and stated, 'We are at capacity and full. We have [Resident #1] on the waitlist.'" An "Observation Note," dated 09/01/25 at 9:00 p.m., read in part, "At 8:20 p.m., staff called [ADON] and told [ADON] that resident was running around the unit, making dinosaur noises, and saying [they] were the devil. [ADON] told the staff to give ABH. [ADON] talked to resident on the phone and stated, 'We can not be making loud noises and running around.' [ADON] instructed staff to notify [ADON] if anything else happens this shift and [ADON] will come up to sit with the resident."	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 7 An "Evening Shift Report," dated 09/01/25, read in part, "[Resident #1] trying to bite, chasing staff, entering other residents' rooms." A "Physician's Order," dated 09/02/25, read in part, "1. Haldol 2mg- give 1 tab by mouth every 8 hours 2. May give ABH 1-25-1mg/0.5ml (2 syringes) topically every 6 hours PRN until Haldol arrives. 3. When Haldol arrives cut back to ABH 1-25-1mg/0.5ml give 0.5ml topically every 6 hours PRN. 4. Increase Trazadone to 50mg at bedtime." An "Observation Note," dated 09/02/25 at 3:45 p.m., read in part, "Resident is making dinosaur noises. Resident is moving fast with very little impulse control. Resident c/o anxiety. PRN medications given." An "Observation Note," dated 09/02/25 at 4:15 p.m., read in part, "Resident is coming out of apartment making noises like a dinosaur and scaring other staff with noises. Resident came to [ADON] and said, 'I am feeling anxious and out of control.' Resident is having incontrollable [sic] movements of extremities. Resident is on the wait list to go back to geri-psych." An "Evening Shift Report," dated 09/02/25, read in part, "[Resident #1] came out of [their] room chasing [CMA #1 and CMA #6], trying to bite them, scaring other residents. None of PRN meds or routine Haldol were effective. [They] were saying [they] were the devil, [Resident #1] was going to eat us up like meat." An "Observation Note," dated 09/03/25 at 10:15 a.m., read in part, "The new order for Haldol is not helping resident. Resident seems very manic and is moving very fast. Resident has more motor movements, loud noises, and harder to redirect."	C 341		

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 10/22/2025
---	--	--	--

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 341	Continued From page 8 An "Observation Note," dated 09/03/25 at 11:00 a.m., read in part, "Resident was pulling [ADON] hair, tickling [ADON], pinching, yelling, and became very upset with any redirection. Resident would not keep hands to self. Resident stated, 'I am going to kill myself and everyone in here.' [ADON] immediately called 911." An "Observation Note," dated 09/03/25 at 11:15 a.m., read in part, "Resident was trying to bite EMSA workers. Resident stated, 'I am going to eat you.'" An "ED Provider Note," dated 09/03/25 at 11:55 a.m., read in part, "[Resident #1] acknowledges previous statements about wanting to harm others, including saying 'I'm going to kill some people.'" A "Physician's Order," dated 09/03/25 at 2:50 p.m., read in part, "Lorazepam [Ativan, a benzodiazepine] 0.5mg take 0.5 tablets (0.25mg) by mouth every 8 hours for 10 days." An "Observation Note," dated 09/03/25 at 4:15 p.m., read in part, "Received call from ER nurse. Nurse reports resident has been discharged with no new orders. States that resident is 'stable'. [DON] expressed concern for resident returning. ER nurse reports that resident already in transit to return to residence." An "Observation Note," dated 09/03/25 at 7:30 p.m., read in part, "Received notification around 6:35 p.m. this evening that associate found [Resident #1] on [Resident #2] scratching [Resident #2] on the face. [DON] instructed associate to remain with the resident and to call EMSA."	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 9 An "Evening Shift Report," dated 09/03/25, read in part, "[Resident #1] attacked [Resident #2]. [Resident #2] was bleeding all over [their] face and sent to the hospital. [Resident #1] was taken in police custody." On 09/04/25, OSDH received an incident report with an incident date of 09/03/25. The incident report read in part, "On the evening of September 3, 2025 around 6:35 p.m., [DON] received notification that [Resident #1] was seen on top of [Resident #2] scratching residents face. Associate entered apartment and [Resident #1] moved and ran into apartment across the hall. Both residents had an associate at bedside until EMSA arrived." On 10/20/25 at 7:24 a.m., CMA #8 was asked what they could recall about Resident #1. They stated, "During day shift [Resident #1] was quiet and stayed in [their] room except for meals. On the evening shift, 3 p.m. to 11 p.m., [they] would come out and tell staff [Resident #1] was going to eat their flesh and it made them uneasy." On 10/20/25 at 7:25 a.m., CMA #8 was asked what they could recall about the incident between Residents #1 and #2. They stated, "[Resident #1] scratched up [Resident #2] bad. [Resident #2] was transported to the hospital, family moved [them] to another facility, and then [they] passed away. [Resident #2] was defenseless." CMA #8 stated Resident #2 was bedbound and Resident #1 was independently ambulatory. On 10/20/25 at 9:07 a.m., CMA #2 stated they were working in the assisted living on 09/03/25 and stated, "I saw ambulance, police and the fire department out front. I asked what's happening	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 10 and they said one of the residents attacked the other. Nobody's really talking about it." CMA #2 was asked if they had been educated on abuse since the incident between Residents #1 and #2. They stated, "No." On 10/20/25 at 9:37 a.m., CMA #1 was asked what they could recall about the incident between Residents #1 and #2. They stated, "I came in the room and said [Resident #2] is in trouble, [Resident #1] is beating [Resident #2] all over. [Resident #2] had blood all over [their] face, [their] pillow. I saw [Resident #2] lying on the bed, lifeless. I was so traumatized. I still really am. When the police came they took [Resident #2] to the hospital, [Resident #2] was unconscious. They handcuffed [Resident #1] and as [they're] sitting in the police car [they're] saying they want to drink blood. [Resident #1] had blood all over [their] face." CMA #1 stated Resident #2 could not walk and was bedbound. They stated Resident #1 was independent with ADLs and mobility. CMA #1 stated upon return from the ED on 09/03/25, Resident #1 broke the mirror in their bathroom and was chasing staff with it. CMA #1 was asked if they were given any instruction to increase safety checks on Resident #1 upon return from the ED on 09/03/25. They stated, "No, [ADON] just said if anything happens call [them]." CMA #1 stated Resident #1 refused their lorazepam when returning to the center from the ED. On 10/20/25 at 9:55 a.m., CMA #6 was asked to recall the incident between Residents #1 and #2. They stated, "I finished helping a resident and I heard 'help'. I went to the room, saw [Resident #1] on top of [Resident #2] and blood. Blood was everywhere on [Resident #1's] face and hands." CMA #6 stated Resident #1 fled from the room and they called for help from CMA #1. CMA #6	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 11 was asked what Resident #1's normal behavior was like. They stated, "[They] were threatening. [They] would say [they] were the devil and wanted to drink our blood." On 10/20/25 at 10:11 a.m., the corporate consult nurse was asked what their process was following the incident between Residents #1 and #2. They stated, "Going forward I will be involved with all admissions from geri-psych and assessments will be thorough. I will also oversee all antipsychotic med [medicine] changes and initiations. We in-serviced all staff on abuse and brought in a counselor who's also a chaplain for staff." On 10/20/25 at 12:29 p.m., Resident #2's guardian was asked to recall their knowledge of the incident between Residents #1 and #2. They stated the center had called to notify them that another resident had scratched Resident #2 and they were being sent to the hospital to be evaluated. Resident #2's guardian stated, "I didn't go to the ER, so a doctor called me and said it was more than scratches." Resident #2's guardian stated they were "horrified" when seeing Resident #2 at the hospital and stated, "Both eyes were very swollen with blood filled bruises on both eyes. No scratches that I could see. [They] were in a neck brace and did not respond." Resident #2's guardian was asked what effects Resident #2 had from the incident. They stated Resident #2 was blind and doctors thought they would have to remove their left eye. Resident #2's guardian stated, "On the Tuesday after the attack, [they] became much more alert. [They] were having recall of everything happening. [They] were begging me to take them to the hospital and to make sure the surgeons were there, but of course [they] were in the hospital already."	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 12 Resident #2's guardian stated Resident #2 was discharged from the hospital on hospice and passed away on 09/29/25. On 10/20/25 at 2:39 p.m., the ADON stated Resident #1 was impulsive with increased agitation on 09/03/25. They stated Resident #1 was sent to the ED for evaluation and returned to the center at approximately 4:30 p.m. The ADON stated, "[Resident #1] was calm. We gave a dose of Ativan and [they] were sleeping in [their] bed when I left around 6:00 p.m. The family were getting sitters put into place." The ADON was asked what additional measures for resident safety were put into place until the sitters were hired and came to the center for Resident #1. They stated, "Just watch [Resident #1] and call me if anything changed." The ADON was asked what the frequency was for staff to watch Resident #1. They stated, "Just more often than they were." On 10/21/25 at 8:03 a.m., the family member of Resident #1 was asked to recall the day of 09/03/25. They stated, "The meds [ADON] got on board weren't working for [Resident #1]." The family member of Resident #1 was asked if Resident #1 was aggressive at the center. They stated, "Not until [they] started pulling [ADON's] hair that day [09/03/25] and then after [they] got back from the hospital." The family member of Resident #1 stated Resident #1 broke their bathroom cabinet mirror when they arrived back from the ED and they weren't sure how. The family of Resident #1 stated, "I was in the process of hiring a sitter and the sitter was going to be there at 8:00 p.m. I got the call shortly after 6:30 p.m. about the attack on the other resident." They stated the ADON and the family member had decided Resident #1 required a one on one sitter	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 13 for safety because Resident #1 was not calming down. On 10/21/25 at 9:52 a.m., CMA #8 was asked if they had any mental health training for diagnoses such as anxiety, psychosis, or bipolar. They stated, "No." CMA #8 was asked what the in-service was about that was given after the incident between Residents #1 and #2. They stated, "I don't think I was at that one because someone has to stay back here in memory care." CMA #8 was asked if they received any separate in-service or hands out about any topics from that in-service. They stated, "No, but I think I might have signed that I received it because I was told to." On 10/21/25 at 9:54 a.m., CNA #3 was asked what mental health training they had. They stated, "I'm trained in dementia, but that's it." They were asked if they had any training for bipolar, anxiety, or depression. They stated, "No, I don't." CNA #3 was asked if they were given any in-service on abuse or behaviors after the incident between Residents #1 and #2. They stated, "Not that I remember, no." On 10/21/25 at 10:04 a.m., CNA #2 was asked what they knew about the incident between Residents #1 and #2. They stated, "I wasn't here, and nobody is really talking about it. Just that one of them hurt the other." CNA #2 denied having any abuse in-service provided recently and had no training in mental health disorders. On 10/21/25 at 10:06 a.m., CNA #1 stated they were not present for the last in-service and were not provided any information regarding abuse. They denied having any mental health training.	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 14 On 10/21/25 at 10:09 a.m., CMA #4 stated they were in-serviced on abuse after the incident between Residents #1 and 2 and had mental health training through the center. They were asked what measures they were educated on to prevent behaviors. They stated, "Redirecting the resident and I would call the nurse if I couldn't handle the behaviors." On 10/21/25 at 11:56 a.m., the corporate consult nurse was asked when residents would be discharged from the center. They stated, "When they start exhibiting or experiencing harm to others." They were asked when they would not accept a resident back from the ED. They stated, "If we have a resident with multiple behaviors, we call the ED and let them know. If they are out of our care scope, we talk to families saying we can't care for them. In [Resident #1's] situation [they] were sent back from ED and was completely calm." The corporate consult nurse was asked about Resident #1 breaking their mirror. They stated they broke the mirror some time before they entered Resident #2's room. The corporate consult nurse was asked after Resident #1 returned from the ED, what measures were put into place to make sure Resident #1 and others were safe. They stated, "[ADON] stayed and talked to [Resident #1], [they] were calm. [ADON] told all care staff if anything happens let them know and we will contact family. We had care staff monitoring other residents and making sure the residents in their apartments had doors closed." On 10/21/25 at 12:15 p.m., the administrator was asked how they provide in-services. They stated, "We do it verbally and usually go over the policies that pertain to the in-service." The administrator was asked what method was used for the abuse	C 341		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 15 and behavior in-services provided on 09/11/25 and 09/25/25. They stated, "We just did it verbally." The administrator was asked if all staff were in-serviced. They stated, "We tried to get them all, but no."	C 341		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 16 or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 10/21/25, an immediate jeopardy situation was determined to exist when the center failed to ensure a resident (Resident #2) was free from being assaulted, battered, and maimed by Resident #1. The incident resulted in Resident #2 being sent to the hospital for treatment. On 10/21/25 at 2:30 p.m., the OSDH was notified and verified the existence of the IJ situation. On 10/21/25 at 3:12 p.m., the administrator was notified of the IJ situation related to the resident-to-resident abuse of Resident #2. On 10/22/25 at 1:45 p.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part,	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 17 "IJ #1 Plan of Removal Completion: 10/22/2025 at 3:00 p.m. On 9/3/2025, Resident #1 was immediately transferred to the emergency department for psychiatric evaluation and stabilization. Resident #1 did not return to the facility. A review of current residents was completed, and no additional residents were identified as exhibiting violent or aggressive behaviors toward others. Beginning 10/21/2025, current clinical associates received immediate re-education on abuse prevention, recognition, and mandatory reporting requirements, as well as tools for managing changes in mental health. Clinical associates who were not on duty on that date will complete the same training prior to their next scheduled shift. Beginning 10/21/2025, the Quality Management and Performance Improvement (QMPI) Committee will convene within 24 hours of any identified behavioral escalation to review current interventions, determine psychiatric consultation needs, and evaluate resident placement to ensure safety. Beginning 10/21/2025, the Health Care Director or designee will review incident reports daily to identify behavioral triggers or signs of aggression, ensuring timely interventions, appropriate follow-up, and documentation. Beginning 10/21/2025, the Quality Management and Performance Improvement (QMPI) Committee will review behavior-related incidents weekly for 90 days to verify that interventions are timely and effective. The QMPI Committee will analyze findings, make recommendations for	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 18 system improvement, and ensure continued compliance and resident safety." The IJ was lifted, effective 10/22/25 at 3:00 p.m., when all components of the plan of removal had been verified as completed. Observations from 10/20/25 through 10/22/25 showed Resident #1 was no longer living in the center and no other residents were exhibiting aggressive behaviors. Records of staff training showed all staff, including administration, had received training in abuse and managing changes in mental health. Records of newly implemented daily incident logs and QMPI committee logs showed the center was tracking resident incidents and behaviors daily. Review of a current resident assessment log showed residents who were identified to have mental health needs were reassessed by the corporate consult nurse. Interviews conducted with staff showed they had received training in abuse and managing changes in mental health. The deficiency remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the center failed to ensure a resident was free from abuse for 1 (#2) of 7 sampled residents reviewed for abuse. The administrator identified 69 residents resided in the center. Findings: A policy titled "Behavior Management," dated 07/01/12, read in part, "Purpose: To set forth the expectations for assisted living residents with behavioral problems within the assisted living residence. Appropriate training will be provided to staff that will enable them to assist and respond	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 19 appropriately to residents with behavioral issues. Among the training topics that may be addressed are: Depression, Bipolar Disorder, Anxiety Disorders." A policy titled "Resident Abuse, Neglect, and Exploitation," dated 04/30/19, read in part, "Purpose: To set forth policies that expressly prohibit the abuse or neglect of residents or misappropriation of resident property and define training requirements for associates." 1. A "Comprehensive Assessment," dated 08/23/24, showed Resident #2 was admitted to the center on 08/24/21 with diagnoses to include senile degeneration of the brain, anoxic brain damage, and dementia without behavioral disturbance. A "CT Head WO Contrast [Computer Tomography without contrast] Final Result," dated 09/03/25 at 9:32 p.m., read in part, "Diffuse hemorrhage and slight deformity throughout the left eye globe with dislocation of the lens concerning for open globe injury. There is also hemorrhage within the inferior right globe with slight global deformity concerning for global injury. Pattern of intraglobal hemorrhage can be seen with choroidal detachment. Hematoma along the left mandible." An "ED Provider Note," dated 09/03/25 at 11:27 p.m., read in part, "[Resident #2] presents to the ED with complaint of assault. Ophthalmology paged immediately. Facial plastic team will be involved for the lip laceration. Ophthalmology would like to take [Resident #2] to the OR [operating room]. Diagnosis: assault, traumatic injury of glove of eye, laceration of upper lip with complication, laceration of skin of left eyelid."	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 20 A "Clinical Note," dated 09/09/25 at 1:03 p.m., read in part, "[Resident #2] status post globe exploration. Assessment: bilateral conjunctival lacerations, right medial rectus avulsion, left lower eyelid avulsion, subconjunctival hemorrhage and chemosis, hyphema, vitreous hemorrhage, retinal detachment vs choroidal detachment." A "Progress Note," dated 09/03/25 at 11:29 p.m., read in part, "[Resident #2] presents to level III trauma room. Patient intubated and non-communicative." 2. A hospital inpatient "Mental Status Exam," dated 07/30/25, read in part, "[Resident #1] Alertness/Orientation: The patient is alert and oriented to person, age, date, place, circumstances, and current events. Mood: The patient is 'anxious' in mood. Speech character: slightly pressured in rate. Perceptions: Persistent delusional belief that [Resident #1] is the Devil. Dangerousness: The patient does have thoughts and intent of self-harm and homicidal thoughts and intent towards unspecified people." An "Assisted Living Residency Agreement," dated 08/29/25, for Resident #1, read in part, "Admission and Retention. Must not be subject to excessive anxiety, depression, phobias, or paranoias, which may result in the possibility of endangering oneself or others." A "Comprehensive Assessment," dated 08/29/25, showed Resident #1 was admitted to the center on 08/29/25 with diagnoses to include cognitive impairment, anxiety, depression, and bipolar 1. The assessment showed Resident #1 was independent with all activities of daily living and mobility.	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 21 A document titled "Active Medications for [Resident #1]," dated 08/29/25, showed: a. olanzapine (an antipsychotic) 10mg one tablet at bedtime; b. olanzapine 5mg one tablet every morning; c. trazadone (an antidepressant) 25mg one tablet at bedtime; and d. ABH 1-25-1mg/0.5ml gel (a compounded medication consisting of Ativan, a benzodiazepine, Benadryl, an antihistamine, and Haldol, an antipsychotic) apply 0.5ml topically three times daily as needed. An "Observation Note," dated 08/30/25 at 3:30 p.m., read in part, "At 2:13 p.m., the [family member of Resident #1] got a strange voicemail from [Resident #1] making noises and saying [they] are the devil. This [ADON] notified ACMA to give PRN ABH. PRN ABH was given." An "Evening Shift Report," dated 08/30/25, read in part, "[Resident #1] tried to bite staff and was grabbing at us. Referred to [themselves] as a devil, stated [Resident #1] eats people." An undated "Med Pass History for [Resident #1]," showed: a. PRN ABH gel on 8/31/25 at 12:10 a.m. for anxiety; b. PRN ABH gel on 08/31/25 at 9:26 p.m. for anxiety and agitation; c. PRN ABH gel on 09/01/25 at 2:03 p.m. for anxiety and agitation; d. PRN ABH gel on 09/01/25 at 8:16 p.m. for anxiety and agitation; e. PRN ABH gel on 09/02/25 at 12:06 p.m. for anxiety and agitation; and f. refused lorazepam on 09/03/25 at 5:41 p.m.	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 22 An "Observation Note," dated 09/01/25 at 11:45 a.m., read in part, "[Family member of Resident #1] reach out to [ADON] and said, '[Family of Resident #1] spent the day with [them] yesterday. They said [their] eyes looked crazy. [Family member of Resident #1] believes [they] were discharged too soon.' Call went out to [geriatric psychiatric inpatient facility] to see about sending back out for geri-psych." An "Observation Note," dated 09/01/25 at 3:30 p.m., read in part, "At 3:22 p.m., the intake nurse for [geriatric psychiatric inpatient facility] called [ADON] and stated, 'We are at capacity and full. We have [Resident #1] on the waitlist.'" An "Observation Note," dated 09/01/25 at 9:00 p.m., read in part, "At 8:20 p.m., staff called [ADON] and told [ADON] that resident was running around the unit, making dinosaur noises, and saying [they] were the devil. [ADON] told the staff to give ABH. [ADON] talked to resident on the phone and stated, 'We can not be making loud noises and running around.' [ADON] instructed staff to notify [ADON] if anything else happens this shift and [ADON] will come up to sit with the resident." An "Evening Shift Report," dated 09/01/25, read in part, "[Resident #1] trying to bite, chasing staff, entering other residents' rooms." A "Physician's Order," dated 09/02/25, read in part, "1. Haldol 2mg- give 1 tab by mouth every 8 hours 2. May give ABH 1-25-1mg/0.5ml (2 syringes) topically every 6 hours PRN until Haldol arrives. 3. When Haldol arrives cut back to ABH 1-25-1mg/0.5ml give 0.5ml topically every 6 hours PRN.4. Increase Trazadone to 50mg at bedtime."	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 23 An "Observation Note," dated 09/02/25 at 3:45 p.m., read in part, "Resident is making dinosaur noises. Resident is moving fast with very little impulse control. Resident c/o anxiety. PRN medications given." An "Observation Note," dated 09/02/25 at 4:15 p.m., read in part, "Resident is coming out of apartment making noises like a dinosaur and scaring other staff with noises. Resident came to [ADON] and said, 'I am feeling anxious and out of control.' Resident is having incontrollable [sic] movements of extremities. Resident is on the wait list to go back to geri-psych." An "Evening Shift Report," dated 09/02/25, read in part, "[Resident #1] came out of [their] room chasing [CMA #1 and CMA #6], trying to bite them, scaring other residents. None of PRN meds or routine Haldol were effective. [They] were saying [they] were the devil, [Resident #1] was going to eat us up like meat." An "Observation Note," dated 09/03/25 at 10:15 a.m., read in part, "The new order for Haldol is not helping resident. Resident seems very manic and is moving very fast. Resident has more motor movements, loud noises, and harder to redirect." An "Observation Note," dated 09/03/25 at 11:00 a.m., read in part, "Resident was pulling [ADON] hair, tickling [ADON], pinching, yelling, and became very upset with any redirection. Resident would not keep hands to self. Resident stated, 'I am going to kill myself and everyone in here.' [ADON] immediately called 911." An "Observation Note," dated 09/03/25 at 11:15 a.m., read in part, "Resident was trying to bite EMSA workers. Resident stated, 'I am going to	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 24 eat you." An "ED Provider Note," dated 09/03/25 at 11:55 a.m., read in part, "[Resident #1] acknowledges previous statements about wanting to harm others, including saying 'I'm going to kill some people.'" A "Physician's Order," dated 09/03/25 at 2:50 p.m., read in part, "Lorazepam [Ativan, a benzodiazepine] 0.5mg take 0.5 tablets (0.25mg) by mouth every 8 hours for 10 days." An "Observation Note," dated 09/03/25 at 4:15 p.m., read in part, "Received call from ER nurse. Nurse reports resident has been discharged with no new orders. States that resident is 'stable'. [DON] expressed concern for resident returning. ER nurse reports that resident already in transit to return to residence." An "Observation Note," dated 09/03/25 at 7:30 p.m., read in part, "Received notification around 6:35 p.m. this evening that associate found [Resident #1] on [Resident #2] scratching [Resident #2] on the face. [DON] instructed associate to remain with the resident and to call EMSA." An "Evening Shift Report," dated 09/03/25, read in part, "[Resident #1] attacked [Resident #2]. [Resident #2] was bleeding all over [their] face and sent to the hospital. [Resident #1] was taken in police custody." On 09/04/25, OSDH received an incident report with an incident date of 09/03/25. The incident report read in part, "On the evening of September 3, 2025 around 6:35 p.m., [DON] received notification that [Resident #1] was seen on top of	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 25 [Resident #2] scratching residents face. Associate entered apartment and [Resident #1] moved and ran into apartment across the hall. Both residents had an associate at bedside until EMSA arrived." On 10/20/25 at 7:24 a.m., CMA #8 was asked what they could recall about Resident #1. They stated, "During day shift [Resident #1] was quiet and stayed in [their] room except for meals. On the evening shift, 3 p.m. to 11 p.m., [they] would come out and tell staff [Resident #1] was going to eat their flesh and it made them uneasy." On 10/20/25 at 7:25 a.m., CMA #8 was asked what they could recall about the incident between Residents #1 and #2. They stated, "[Resident #1] scratched up [Resident #2] bad. [Resident #2] was transported to the hospital, family moved [them] to another facility, and then [they] passed away. [Resident #2] was defenseless." CMA #8 stated Resident #2 was bedbound and Resident #1 was independently ambulatory. On 10/20/25 at 9:07 a.m., CMA #2 stated they were working in the assisted living on 09/03/25. They stated, "I saw ambulance, police and the fire department out front. I asked what's happening and they said one of the residents attacked the other. Nobody's really talking about it." CMA #2 was asked if they had been educated on abuse since the incident between Residents #1 and #2. They stated, "No." On 10/20/25 at 9:37 a.m., CMA #1 was asked what they could recall about the incident between Residents #1 and #2. They stated, "I came in the room and said [Resident #2] is in trouble, [Resident #1] is beating [Resident #2] all over. [Resident #2] had blood all over [their] face, [their]	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 26 pillow. I saw [Resident #2] lying on the bed, lifeless. I was so traumatized. I still really am. When the police came they took [Resident #2] to the hospital, [Resident #2] was unconscious. They handcuffed [Resident #1] and as [they're] sitting in the police car [they're] saying they want to drink blood. [Resident #1] had blood all over [their] face." CMA #1 stated Resident #2 could not walk and was bedbound. They stated Resident #1 was independent with ADLs and mobility. CMA #1 stated upon return from the ED on 09/03/25, Resident #1 broke the mirror in their bathroom and was chasing staff with it. CMA #1 was asked if they were given any instruction to increase safety checks on Resident #1 upon return from the ED on 09/03/25. They stated, "No, [ADON] just said if anything happens call [them]." CMA #1 stated Resident #1 refused their lorazepam when returning to the center from the ED. On 10/20/25 at 9:55 a.m., CMA #6 was asked to recall the incident between Residents #1 and #2. They stated, "I finished helping a resident and I heard 'help'. I went to the room, saw [Resident #1] on top of [Resident #2] and blood. Blood was everywhere on [Resident #1's] face and hands." CMA #6 stated Resident #1 fled from the room and they called for help from CMA #1. CMA #6 was asked what Resident #1's normal behavior was like. They stated, "[They] were threatening. [They] would say [they] were the devil and wanted to drink our blood." On 10/20/25 at 10:11 a.m., the corporate consult nurse was asked what their process was following the incident between Residents #1 and #2. They stated, "Going forward I will be involved with all admissions from geri-psych and assessments will be thorough. I will also oversee all antipsychotic med [medicine] changes and	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 27 initiations. We in-serviced all staff on abuse and brought in a counselor who's also a chaplain for staff." On 10/20/25 at 12:29 p.m., Resident #2's guardian was asked to recall their knowledge of the incident between Residents #1 and #2. They stated the center had called to notify them that another resident had scratched Resident #2 and they were being sent to the hospital to be evaluated. Resident #2's guardian stated, "I didn't go to the ER, so a doctor called me and said it was more than scratches." Resident #2's guardian stated they were "horrified" when seeing Resident #2 at the hospital and stated, "Both eyes were very swollen with blood filled bruises on both eyes. No scratches that I could see. [They] were in a neck brace and did not respond." Resident #2's guardian was asked what effects Resident #2 had from the incident. They stated Resident #2 was blind and doctors thought they would have to remove their left eye. Resident #2's guardian stated, "On the Tuesday after the attack, [they] became much more alert. [They] were having recall of everything happening. [They] were begging me to take them to the hospital and to make sure the surgeons were there, but of course [they] were in the hospital already." Resident #2's guardian stated Resident #2 was discharged from the hospital on hospice and passed away on 09/29/25. On 10/20/25 at 2:39 p.m., the ADON stated Resident #1 was impulsive with increased agitation on 09/03/25. They stated Resident #1 was sent to the ED for evaluation and returned to the center at approximately 4:30 p.m. The ADON stated, "[Resident #1] was calm. We gave a dose of Ativan and [they] were sleeping in [their] bed when I left around 6:00 p.m. The family were	C1512		

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 10/22/2025
---	--	--	--

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
C1512	Continued From page 28 getting sitters put into place." The ADON was asked what additional measures for resident safety were put into place until the sitters were hired and came to the center for Resident #1. They stated, "Just watch [Resident #1] and call me if anything changed." The ADON was asked what the frequency was for staff to watch Resident #1. They stated, "Just more often than they were." On 10/21/25 at 8:03 a.m., the family member of Resident #1 was asked to recall the day of 09/03/25. They stated, "The meds [ADON] got on board weren't working for [Resident #1]." The family member of Resident #1 was asked if Resident #1 was aggressive at the center. They stated, "Not until [they] started pulling [ADON's] hair that day [09/03/25] and then after [they] got back from the hospital." The family member of Resident #1 stated Resident #1 broke their bathroom cabinet mirror when they arrived back from the ED and they weren't sure how. The family member of Resident #1 stated, "I was in the process of hiring a sitter and the sitter was going to be there at 8:00 p.m. I got the call shortly after 6:30 p.m. about the attack on the other resident." The family member of Resident #1 stated the ADON and the family member had decided Resident #1 required a one on one sitter for safety because Resident #1 was not calming down. On 10/21/25 at 9:52 a.m., CMA #8 was asked if they had any mental health training for diagnoses such as anxiety, psychosis, or bipolar. They stated, "No." CMA #8 was asked what the in-service was about that was given after the incident between Residents #1 and #2. They stated, "I don't think I was at that one because someone has to stay back here in memory care."	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 29 CMA #8 was asked if they received any separate in-service or hands out about any topics from that in-service. They stated, "No, but I think I might have signed that I received it because I was told to." On 10/21/25 at 9:54 a.m., CNA #3 was asked what mental health training they had. They stated, "I'm trained in dementia, but that's it." They were asked if they had any training for bipolar, anxiety, or depression. They stated, "No, I don't." CNA #3 was asked if they were given any in-service on abuse or behaviors after the incident between Residents #1 and #2. They stated, "Not that I remember, no." On 10/21/25 at 10:04 a.m., CNA #2 was asked what they knew about the incident between Residents #1 and #2. They stated, "I wasn't here, and nobody is really talking about it. Just that one of them hurt the other." CNA #2 denied having any abuse in-service provided recently and had no training in mental health disorders. On 10/21/25 at 10:06 a.m., CNA #1 stated they were not present for the last in-service and were not provided any information regarding abuse. They denied having any mental health training. On 10/21/25 at 10:09 a.m., CMA #4 stated they were in-serviced on abuse after the incident between Residents #1 and 2 and had mental health training through the center. They were asked what measures they were educated on to prevent behaviors. They stated, "Redirecting the resident and I would call the nurse if I couldn't handle the behaviors." On 10/21/25 at 11:56 a.m., the corporate consult nurse was asked when residents would be	C1512		

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 10/22/2025
NAME OF PROVIDER OR SUPPLIER LEGEND AT COUNCIL ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1512	Continued From page 30 discharged from the center. They stated, "When they start exhibiting or experiencing harm to others." They were asked when they would not accept a resident back from the ED. They stated, "If we have a resident with multiple behaviors, we call the ED and let them know. If they are out of our care scope, we talk to families saying we can't care for them. In [Resident #1's] situation [they] were sent back from ED and was completely calm." The corporate consult nurse was asked about Resident #1 breaking their mirror. They stated they broke the mirror some time before they entered Resident #2's room. The corporate consult nurse was asked after Resident #1 returned from the ED, what measures were put into place to make sure Resident #1 and others were safe. They stated, "[ADON] stayed and talked to [Resident #1], [they] were calm. [ADON] told all care staff if anything happens let them know and we will contact family. We had care staff monitoring other residents and making sure the residents in their apartments had doors closed." On 10/21/25 at 12:15 p.m., the administrator was asked how they provide in-services. They stated, "We do it verbally and usually go over the policies that pertain to the in-service." The administrator was asked what method was used for the abuse and behavior in-services provided on 09/11/25 and 09/25/25. They stated, "We just did it verbally." The administrator was asked if all staff were in-serviced. They stated, "We tried to get them all, but no."	C1512		

Delivery via email to: Nikkita Forcha <nikkita.forcha@legendseniorliving.com>

December 18, 2025

License Number: AL5594

Nikkita Bowler, Administrator
Legend At Council Road
11320 North Council Road
Oklahoma City, OK 73162

Survey Event ID: 7G9T11

Dear Ms. Bowler:

On **October 22, 2025**, 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 **October 23, 2025**.

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

Respectfully,



Lisa Calvin, 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: 11/12/2025		
	Facility Name: Legend at Council Road		
	License Number: AL 5594		
	Survey Event ID: 7G9T11		
Date Survey Completed: 10/22/2025			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C341		Based on: Based on "center failed to ensure resident did not meet the center admission criteria as outlined in the resident care and service agreement was discharged.	
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?		Resident was immediately discharge to ER and did not return. Eliminating the immediate harm to other residents.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		A review of current residents was completed by RHCD to identify any individuals with psychiatric diagnosis or changes in mood or behaviors that pose risks to others.	
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?		An assessment was performed of all residents in the community of any behavioral, or psychiatric diagnosis. Service plans for residents with behavioral, or psychiatric diagnosis were reviewed and updated. We immediately educated all clinical associates on 10/21/2025.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		RD, HCD and or designee will monitor, Daily and weekly behavior monitoring, daily incident review.	
a. How the correction will be evaluated for effectiveness;		Submit weekly and monthly reviews to QMPI committee. The QMPI committee will analyze findings, make recommendations for system improvement, and ensure continued compliance and resident safety.	
b. How the correction will be incorporated into the center's quality assurance system; and		Daily and Weekly Logs will be updated and submitted to QMPI for 90 days to verify interventions are timely and effective.	
c. How monitoring records will be kept to evidence the correction.		QMPI will maintain logs and minutes	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/23/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Nikkita Forcha OAC 310:663-25-4(F)			Date 11/12/2025
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: 11/12/2025

Facility Name: Legend at Council Road

License Number: AL 5594

Survey Event ID: 7G9T11

Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1512

Based on: "center failed to ensure residents were free from abuse"

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

Include:

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

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident was immediately discharged to ER and did not return. Eliminating the immediate harm to other residents. Resident 2 was sent to emergency room for treatment.

A review of current residents was completed by the RHCD to identify any individuals with psychiatric diagnosis or changes in mood or behaviors that pose risks to others.

The RHCD reeducated the HCD on reviewing and updating service plans, abuse prevention, recognition, and mandatory reporting requirements, managing behavioral health conditions, including bipolar, psychosis, and prompt psychartic notification and assessments. Clinical associated received immediate reeducation on the following: abuse prevention, recognitions and mandatory reporting requirements. Managing mental conditions, including bipolar, psychosis, and depression. The QMPI committee will convene within 24 hours of any identified behavioral escalation to review current interventions, determine psychiatric consultation needs, and evaluate resident placement to ensure safety.

RD, HCD and or designee will monitor, daily and weekly behavioral, abuse and daily incident review.

Submit Weekly and Monthly reviews to QMPI committee. The QMPI committee will analyze findings, make recommendations for system improvement, and ensure continued compliance and resident safety.

Daily and weekly review logs will be update and submitted to QMPI for 90 days to verify intervention are timely and effective.

QMPI will maintain logs and minutes