OKLAHOMA
State Department
of Health

Delivery via email to: codye@wslm.biz

August 2, 2022

License Number: AL6010

Mr. Cody Erikson, Administrator
Legacy Village Of Stillwater
5601 N Washington St
Stillwater, OK 74075

Survey Event ID: QLO411

Dear Mr. Erikson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **July 25, 2022**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Lisa Calvin

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Legacy Village of Stillwater**
Address: **5601 N. Washington St.**
City, State, Zip: **Stillwater, OK, 74075**
Provider #: **AL6010**
Complaint #: **OK00059245**
Investigation Date(s): **07/25/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure a safe, sanitary environment.	**US**

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

An unannounced on-site investigation was initiated on 07/25/2022 at 8:30 a.m.

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

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 unsubstantiated related to this allegation.

An investigation specific to the facility failing to ensure a safe, sanitary environment was conducted.

Tours were conducted throughout the survey. Resident rooms and bathrooms were observed to be clean and without odor.

A review of records documented the facility had a plumbing company out to the facility twice to ensure the facility had functional plumbing.

Residents stated they had no issues with their rooms/bathrooms.

Staff stated the maintenance takes care of small, routine plumbing issues, but contacts a plumber if they are not able to resolve the problem. The maintenance supervisor and the administrator stated they were made aware they had a clogged line, a plumber was contacted immediately and came out that same day. This plumber was unable to fix the issue. The next day, the facility contacted a commercial plumbing company who came out that day and corrected the problem. The maintenance supervisor and administrator stated they are able to call any professional service the facility may need to ensure the residents have a safe, sanitary environment.

Staff stated the residents had access to functional private bathrooms and bathing facilities at all times.

At the time of the investigation, there was no deficient practice related to the facility failing to ensure a safe, sanitary environment.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

*Rae Belt, RN*_____

Rae Belt, RN, CHFS

Date report completed: 07/26/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6010	A. BUILDING: _____ B. WING _____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY VILLAGE OF STILLWATER	5601 N WASHINGTON ST STILLWATER, OK 74075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00059245) was conducted on 07/25/22 .No deficiencies were cited.	C 000		

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