
Delivery via email to: codye@wslm.biz

January 3, 2023

License Number: AL6010

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

RE: Survey Event ID: 50XL11

Dear Mr. Erikson:

On **December 9, 2022**, agents from our office concluded an initial State Licensure survey along with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **December 9, 2022**.

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

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

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;

- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT LICENSURE

Facility: Legacy Village of Stillwater
Address: 5601 N. Washington Street
City, State, Zip: Stillwater OK 74075
Facility ID #: AL6010
Complaint #: OK00059720
Investigation Dates: 11/28/22 through 11/30/22, and 12/09/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure a safe, sanitary and homelike environment.	US
2. The center failed to provide nutritious, palatable food in sufficient quantity.	US

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 11/28/2022 at 10:00 a.m.

A sample of 10 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to pest control was conducted.

Clinical records, incident reports, maintenance logs, grievances, and resident council minutes were reviewed at the time of the survey.

No evidence of rodents including snakes was found at the time of the survey. No gaps in doors or trash was found near the kitchen. No entry doors were left open.

One staff member stated they saw a snake the night shift had put in a cup. They stated it was found near the assisted living side of the building. Staff stated the pest control company was notified there may have been a snake in the building. The staff stated the grounds were inspected and no snake was located. The memory care staff denied seeing a snake. The assisted living residents denied seeing a snake.

At the time of the survey no deficiencies were found related to pest/rodent control.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to sufficient, palatable, nutritious meals was conducted.

Clinical records, menus, grievances, and resident council minutes, policies, and procedures were reviewed during the survey.

Sufficient amount of food was observed in the kitchen. The menus were posted and alternate menu items of the same nutritious value were available. The kitchen served chicken strips rather than roasted chicken from the menu on one day of the survey. No residents complained about the substituted food item served.

Residents stated they could get an alternate food item if they did not like what the center was serving. Residents stated they were not aware of the kitchen running out of food. Residents stated if they had a special request the center attempted to provide them the food item. Staff stated they had not had any complaints from the residents about not having nutritious, palatable meals available.

At the time of the survey no deficiencies related to sufficient, palatable, nutritious meals were found.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. 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.



Billie Seeman, RN

Date report completed: 12/22/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/09/2022
NAME OF PROVIDER OR SUPPLIER LEGACY VILLAGE OF STILLWATER		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 N WASHINGTON ST STILLWATER, OK 74075		
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C 000	INITIAL COMMENTS An initial licensure survey was conducted from 11/28/22 through 11/30/22, and 12/09/22. A complaint investigation (#OK00059720) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CNA - Certified Nurse Aide D - depth EMAR - Electronic Medication Administration Record F - Fahrenheit L - length LPN- Licensed Practical Nurse MAR - Medication Administration Record MAT - Medication Administration Technician RN - Registered Nurse TAR - Treatment Administration Record W - width x - times	C 000		
C 329 SS=F	310.663-3-3(a)(9) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.	C 329		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 329	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the center failed to include the provisions for evacuation of the building structure and staff to meet the evacuation needs of residents in the residency agreements/contract for 10 (#1 through #10) of 10 sampled residents. The Executive Director identified 81 residents resided in the center. Findings: On 12/09/22 at 4:30 p.m., the residents' agreement/contracts were reviewed with the administrator, who was asked to locate the provision for evacuation of the building structure and staff to meet the evacuation needs of residents in the residency agreement/contracts. They stated they had gone back and forth with the office concerning the contracts and did not think that was in the agreements/contracts.	C 329		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure:	C 391		

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C 391	Continued From page 2 a. Cleaning and sanitation to prevent contamination in the memory care dining/kitchenette area; b. Food was covered, labeled, and dated when stored in the refrigerator; c. Food was covered during holding and transportation; and d. Gloves were used for a single task. The Executive Director identified 41 residents who resided in the assisted living center, 23 residents who resided in the memory care #1, and 19 residents who resided in the memory care lower level. The Executive Director identified all of the residents received their nutrition from the kitchen. Findings: The undated, "Food Receiving and Storage" policy, read in parts, "...Food Services, or other designated staff, will maintain clean food storage areas at all times...All foods stored in the refrigerator or freezer will be covered, labeled and dated..." The undated, "Food Preparation and Service" policy, read in parts, "...Food service employees shall prepare and serve food in a manner that complies with safe food handling practices...Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness..." 1. "...310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a)...Equipment food-contact surfaces and	C 391		

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C 391	Continued From page 3 utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." On 11/29/22 at 12:00 p.m. a tour of the level one memory care kitchenette/dining area was conducted. The following was observed: a. The microwave was observed to have food splatters on all sides of the inside of the microwave. b. The oven was dirty with black dried on food; c. A sheet pan with dried on food was stored in a drawer; and d. Food crumbs were observed in a drawer. 2. "...310:257-5-60. Ready-to-eat, Time/Temperature Control for Safety Food, date marking... (e) of this Section, refrigerated, ready-to-eat, Time/Temperature Control for Safety Food prepared and held in a food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of seven (7) days..." On 11/29/22 at 12:00 p.m. a tour of the level one kitchenette/dining area and servery was conducted. The following was observed: a. The refrigerator contained an undated bag with strawberries with mold on them; b. An undated green salad with mold on the	C 391		

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C 391	Continued From page 4 lettuce; c. cold compress was located in the freezer; d. A cup with a straw in it not labeled with a name or date was in the door of the refrigerator; e. A yogurt cup not labeled or dated; f. A bag with beef sticks not labeled or dated in the refrigerator; and d. a bowl of ice cream uncovered was in the freezer inside the servery. On 11/29/22 at 12:02 p.m., server #1 stated they were not responsible for cleaning the appliances in the memory care area. Server #1 stated they were told they did not have to clean the appliances in the memory care kitchen/dining area. On 11/29/22 at 12:10 p.m., MAT # 1 stated the microwave was dirty with food splatter, and the food was not labeled in the refrigerator. MAT #1 stated the kitchen staff were responsible for cleaning the area. At 12:14 p.m., server #1 stated the salad in the refrigerator belonged to a resident and it had mold on it. Server #1 identified the strawberries and stated they had mold on them and should have been thrown out. On 11/29/22 at 12:30 p.m., a tour of the lower level memory care kitchenette/dining area and servery was conducted. The following was observed: a. The microwave had food splatters on all sides; and b. The oven had black food drippings On 11/29/22 at 12:30 p.m., CNA #2 stated the microwave was dirty with splashes of soup and coffee, and the oven looked like something had	C 391		

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C 391	Continued From page 5 dripped during cooking. CNA #2 stated the servers were responsible for cleaning the appliances in the memory care. On 11/29/22 at 4:01 p.m., the Food Service Director stated the servers were responsible for serving the food, picking up the dishes, and cleaning the dining room. The Food Service Director stated the servers were not responsible for cleaning the appliances in the memory care kitchenette area. 3. 310:257-5-45. Miscellaneous sources of contamination Food shall be protected from contamination that may result from a factor or source not specified under OAC 310:257-5-21 through OAC 310:257-5-44..." On 11/29/22 at 12:00 p.m., staff were observed to deliver food trays to resident rooms. The food trays were not covered as they were transported to the resident rooms. On 11/29/22 at 4:01 p.m., the Food Service Director stated they expected the staff to cover the food before it was transported to the resident rooms. On 11/30/22 at 11:42 a.m., 10 bowls of caprese salad were observed in the assisted living servery uncovered. No staff was observed in the servery. On 11/30/22 at 11:49 a.m., server #2 entered the servery and covered the salad. Server #2 stated they forgot to cover the salad. On 11/30/22 at 6:17 p.m., CNA #3 was observed delivering trays to the residents on the second floor of the assisted living. The bread pudding	C 391		

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C 391	Continued From page 6 was not covered. CNA #3 stated the desserts were not covered because they would not fit under the plate covers. 4. 310:257-5-34. Gloves, use limitation (a)...single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. On 11/30/22 at 12:07 p.m., the lunch service was observed in the assisted living dining room/servery. At 12:08 p.m., the hot box containing the lunch meal was observed in the servery. At 12:19 p.m. the Food Service Director put the food from the hot box on the steam table. At 12:24 p.m., the Food Service Director touched their mask and the front of their apron shirt with their gloved hands. At 12:27 p.m. the Food Service Director was observed handling the serving utensils with the same gloved hands and then picking up the potatoes from the steam table with their gloved hands. The Food Service Director obtained the rolls from the hot box with the same gloved hands. The Food Service Director continued to plate the food. They touched the potatoes with the same gloved hands that touched the hot box and the serving utensils. The Food Service Director used his gloved hands to pick up the potatoes, they used the serving utensil and one gloved hand to place the cauliflower on the plate, and touched the	C 391		

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C 391	Continued From page 7 pulled pork with their gloved hands after putting the pulled pork on the plate. Server #2 was observed to enter the servery pick up a plate of food and place a roll on the plate with their gloved hands and deliver the food to a resident and then return to the servery with the same gloved hands and pick up another plate and place a roll on the plate and deliver the plate to a resident in the dining room. The Food Service Director touched the serving utensils, plates, ready to eat cooked food, and the rolls after touching the hot box used to transport the food to the assisted living servery without changing gloves. On 11/30/22 at 12:35 a.m., the Food Service Director stated the utensils had been sanitized and they had washed their hands three times. The Food Service Director was asked if they were aware gloves were to be used for a single task in the kitchen. They stated, "Good to know."	C 391		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.)	C 701		

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C 701	Continued From page 8 This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure hot water temperatures did not exceed 115 degrees F in memory care. The Executive Director identified 23 residents who resided in the memory care. Findings: An undated, "Environmental Services" policy, read in parts, "...Hot water temperatures will be maintained between 105-120 degrees Fahrenheit in resident areas..." On 11/30/22 the hot water temperatures were obtained in the memory care with the maintenance director. The following temperatures were obtained: At 10:58 a.m., room 1321's sink temperature was 127.5 degrees F and the shower temperature was 124 degrees F. At 11:00 a.m., room 1311's sink temperature was 126.7 degrees F and the shower temperature was 124.0 degrees F. At 11:07 a.m., the temperature in the bathroom on the first floor memory care was 131.0 degrees F. On 11/30/22 at 11:08 a.m., the maintenance director stated the maximum hot water temperature was supposed to be 115.0 degrees F. At 11:10 a.m., the lower level memory care	C 701		

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C 701	Continued From page 9 bathroom temperature in the sink was 130.8 degrees F. The residents in memory care have access and use this bathroom. At 11:15 a.m., room 308's sink temperature was 127.4 degrees F. At 11:19 a.m., room 307's sink temperature was 124.8 degrees F and the shower was 121.0 degrees F. The maintenance director stated a company had been in the center working on the boiler. The maintenance director was asked if they had checked the hot water temperatures this week. They stated no.	C 701		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN for eight (#1, 2, 3, 5, 6, 8, 9 and #10) of ten sampled residents reviewed for monthly medication reviews. The Executive Director identified 74 residents were administered medication by the staff and	C 921		

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(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 921	Continued From page 10 seven residents self-administered their medications. Findings: An undated, "Review of Resident Medication" policy, read in parts, "... The Resident Care Coordinator or a licensed healthcare professional will review all resident medications..." Resident #1, 2, and #6's clinical record did not contain a monthly medication review for April, July, or September 2022. Resident # 3 and #5's clinical record did not contain a monthly medication review for June, July, September, or October 2022. Resident #8's clinical record did not contain a monthly medication review for April, June, July, or October 2022. Resident #9's clinical record did not contain a monthly medication review for October 2022. Resident #10's clinical record did not contain a monthly medication review for April, July, September, or October 2022. On 12/09/22 at 12:43 p.m., the Executive Director stated they could not find the monthly medication reviews done by the RN.	C 921		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 11 and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure: a. Medications were administered as ordered by	C1505		

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C1505	Continued From page 12 the physician for one (#12) of nine sampled residents who were observed during two medication administration passes; b. the blood pressure cuff was cleaned in between residents for one (#13) of two sampled residents who were observed to have their blood pressure obtained during a medication administration pass; and c. PPE was properly disposed of when leaving a resident room who was COVID-19 positive and on transmission based precautions for one (#15) of two sampled resident who were on transmission based precautions. The Executive Director identified three residents who were on transmission based precautions for COVID-19 and 81 residents who resided in the center. Findings: An undated, "Pharmacy Services" policy, read in parts, "...If the community is administering medications, the community shall coordinate and obtain medications...The community's preferred pharmacy will provide the following...Routine and emergency delivery..." 1. Resident #12 had diagnoses which included Atrial Fibrillation. A service plan, dated 10/26/22, read in parts, "...Medication Assistance...Significant Total Assist...Legacy will order medication from pharmacy. Nurse or Medtech will administer medication per Physician order..." A current physician's order, dated 11/14/22,	C1505		

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C1505	Continued From page 13 documented to administer Eliquis 2.5 mg one tablet twice a day at 9:00 a.m., and 8:00 p.m. A MAR, dated 11/01/22 through 11/30/22, documented the Eliquis was not administered due to "No Refills-Awaiting MD Authorization" and "New Order- Awaiting Pharmacy Delivery" four out of 60 opportunities. On 11/29/22 at 9:39 a.m., MAT #5 was observed to prepare medications for Resident #12. MAT #5 stated Resident #12 was out of Eliquis 2.5 mg. MAT #5 stated the staff member who worked the overnight shift was responsible for reordering medications. MAT #5 did not administer the Eliquis. On 11/29/22 at 4:33 a.m., LPN #1 stated they have had problems with medication reordering and have designated a few staff members to reorder the medications. LPN #1 was asked if they had been notified Resident #12 was out of their Eliquis. They stated no. 2. On 11/29/22 at 8:55 a.m., MAT #4 obtained Resident #14' blood pressure with a wrist blood pressure machine. At 9:02 a.m., MAT #4 placed the wrist blood pressure cuff on top of the medication cart without cleaning the cuff. At 9:05 a.m., MAT #4 obtained Resident #13's blood pressure with the same wrist blood pressure cuff used on Resident #14. MAT #4 had not cleaned the blood pressure cuff before it was used for Resident #13. On 11/29/22 at 9:09 a.m., MAT #4 stated they cleaned the blood pressure cuff before they	C1505		

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C1505	Continued From page 14 started the medication pass and would clean it after every third resident. On 11/29/22 at 4:33 p.m., LPN #1 stated the staff should clean the blood pressure machine in between each resident. 3. On 11/29/22 at 9:26 a.m., MAT #5 donned PPE and entered Resident #15's room to administer medications. MAT #5 stated Resident #15 was on isolation due to COVID-19. On 11/29/22 at 9:32 a.m., MAT #5 was observed as they left Resident #15's room, they removed the isolation gown, wadded it up, and placed it under their arm and disposed of the gown in the medication room. On 11/29/22 at 9:35 a.m., MAT #5 was asked if they had training in procedures for residents on transmission based precautions. They stated, "Not really." On 11/29/22 at 4:33 p.m., LPN #1 stated once the staff had taken off their PPE, they should have put it in a bag and disposed of it in the biohazard trash.	C1505		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's	C1923		

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C1923	Continued From page 15 condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure an accurate medication administration record was maintained for one (#13) of nine sampled residents reviewed during medication administration. The Executive Director stated 81 residents resided in the assisted living facility. Findings: The undated "Medication Administration Record" policy, read in parts, "...Medication Administration Records are the only thing that should be used to document which medications have and have not been administered. An EMAR is treated as a record...Each section of the EMAR must be appropriately completed during each medication pass..." Resident #13 had diagnoses which included diabetes, hypertension, hyperlipidemia, prostate cancer, and a history of cataract surgery. A current physician's order, dated 11/14/22,	C1923		

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C1923	Continued From page 16 documented to administer Preservision AREDS one capsule daily at 8:00 a.m., and Osteo Bi-Flex one tablet daily at 8:00 a.m. A MAR, dated 11/29/22, documented the Preservision and the Osteo Bi-Flex had been administered. On 11/29/22 at 9:05 a.m., MAT #4 was observed as they administered Resident #13's medications. MAT #4 did not administer the Preservision or the Osteo Bi-Flex. On 11/29/22 at 1:10 p.m., LPN #2 was asked if they could look in the MAR and determine the exact time the morning medications were signed out as administered. LPN #2 stated the Preservision and the Osteo-Bi-Flex were signed at 9:05 a.m., the same time the other morning medications had been signed out. On 12/09/22 at 11:01 a.m., MAT #4 was asked why they had initialed the MAR indicating they administered the Preservision and the Osteo Bi-Flex. They stated they thought they documented they were not administered. MAT #4 was asked why they had not administered the medications. They stated because the medications were not labeled.	C1923		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act.	C5010		

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C5010	Continued From page 17 B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to coordinate care with the home health company to ensure wound care was completed as ordered by the physician for one (#9) of one resident who had a wound and was on home health. The Executive Director identified 16 residents who were receiving home health services. Findings:	C5010		

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C5010	Continued From page 18 Resident #9 had diagnoses which included a non healing wound to the left second toe. A TAR for the wound to the left second toe, dated 11/18/22 through 11/30/22, read in parts, "...Left 2ND TOE REMOVE OLD DRESSING IF PRESENT, CLEAN WITH SOAP AND WATER, USE ENDOFORM AS PRIMARY DRESSING, USE HYDROFERA BLUE AS SECONDARY DRESSING, COVER WITH ABSORBENT PAD, WRAP WITH GAUZE, HOLD WITH TAPE DAILY...HOME HEALTH TO DO AND FACILITY TO PERFORM ON DAYS HOME HEALTH IS NOT SCHEDULED..." The TAR documented circled initials on 11/24/22 through 11/26/22 indicating the wound care had not been completed by the center's staff, the TAR was blank for 11/27/22 through 11/30/22. There was no documentation the wound care had been completed by the center's staff, wound care clinic, or the home health company on 11/24/22, 11/25/22, 11/27/22, and 11/30/22. A wound care clinic note, dated 11/29/22, read in parts, "...Wound...Location...Left 2nd toe...Diagnoses: Non pressure chronic ulcer...of left foot with fat layer exposed...Measurement L: 0.50 cm x W: 0.30 cm x D: 0.15 cm...Skin condition...intact: No...erythema: yes...Drainage: present...Drainage amount: moderate...Color: serosanguineous..." A physician's order, dated 11/29/22, documented to perform the following wound care daily: Remove old dressing from left second toe, clean with soap and water, place endoform as primary dressing, hydrofera blue as secondary dressing, cover dressing with absorbent pad, wrap with gauze and tape.	C5010		

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C5010	Continued From page 19 A home health vital signs flow sheet, documented an LPN from the home health company signed the flow sheet on 11/22/22, 11/28/22, 12/03/22, 12/04/22, and 12/05/22. A TAR, dated 12/01/22 through 12/09/22, documented circled initials on 12/01/22 indicating the wound care to the left second toe had not been completed by the center's staff. The TAR for 12/02/22 through 12/09/22 was blank. There was no documentation the wound care had been completed by the center's staff, wound care clinic, or the home health company on 12/01/22, 12/02/22, 12/06/22, 12/07/22, and 12/08/22. On 12/09/22 at 12:57 p.m., the Executive Director stated home health was performing Resident #9's wound care three times a week to the toe. The Executive Director was asked how they coordinated care with the home health company. They stated the nurse filled out a third party provider note. The Executive Director stated the RN reviewed the notes when they were available and the LPN reviewed the third party notes the rest of the time. On 12/09/22 at 1:32 p.m., LPN #1 was asked if they had done Resident 9's wound care. They stated no, home health had been changing the dressings. LPN #1 stated they had not changed Resident #9's dressing and did not know how often home health changed the dressing. On 12/09/22 at 1:35 p.m., Resident #9's dressing was observed on their toe with LPN #1. There was no date on the bandage. Resident #9 stated the home health nurse was the last person who had changed the dressing and they could not	C5010		

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C5010	Continued From page 20 remember the day. Resident #9 stated to LPN #1 the home health nurses came on the weekends, and they thought the staff at the center was supposed to change the dressing during the week. LPN #1 stated to Resident #9 they would have to check because they thought home health was doing it. On 12/09/22 at 1:40 p.m., LPN #1 looked through the home health logs and stated 12/05/22 was the last day home health had changed Resident #9's dressing. On 12/09/22 at 3:00 p.m., the Executive Director stated they were not aware the center's LPN had not been changing Resident #5's dressing on the days home health was not scheduled.	C5010		

Delivery via email to: codye@wslm.biz

January 24, 2023

License Number: AL6010

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

RE: Survey Event 50XL11

Dear Mr. Erikson:

On **December 9, 2022**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **ALL TAGS:** This POC is not accepted the completion date is more than 60 days from the notice of the violation dated 01/03/23. The corrective action completion dates shall not exceed sixty (60) calendar days from receipt of notice of violation.

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

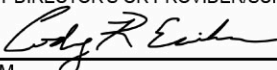
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C 000	INITIAL COMMENTS An initial licensure survey was conducted from 11/28/22 through 11/30/22, and 12/09/22. A complaint investigation (#OK00059720) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CNA - Certified Nurse Aide D - depth EMAR - Electronic Medication Administration Record F - Fahrenheit L - length LPN- Licensed Practical Nurse MAR - Medication Administration Record MAT - Medication Administration Technician RN - Registered Nurse TAR - Treatment Administration Record W - width x - times	C 000	The provider submits the following plan of correction in good faith and to comply with Oklahoma State Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusion stated in the statement of deficiencies.	
C 329 SS=F	310.663-3-3(a)(9) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.	C 329		

Oklahoma State Department of Health

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

TITLE

(X6) DATE



Executive Director

1/16/2023

Oklahoma State Department of Health

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C 329	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the center failed to include the provisions for evacuation of the building structure and staff to meet the evacuation needs of residents in the residency agreements/contract for 10 (#1 through #10) of 10 sampled residents. The Executive Director identified 81 residents resided in the center. Findings: On 12/09/22 at 4:30 p.m., the residents' agreement/contracts were reviewed with the administrator, who was asked to locate the provision for evacuation of the building structure and staff to meet the evacuation needs of residents in the residency agreement/contracts. They stated they had gone back and forth with the office concerning the contracts and did not think that was in the agreements/contracts.	C 329	The center administration adopted the current Residency Agreement in good faith upon it's review, revision and eventual acceptance by the OSDH Licensing Division prior to opening in 2020. Upon the findings of this survey, the center will include wording in the Residency Agreement to include information on evacuation of the building structure as well as staff required to meet the evacuation needs of residents. The updated residency agreement will replace the current version in all new move in documents. All residents in the AL and MC had the potential to be affected by this practice, however, no residents were harmed as a result of this practice. --Center will submit corrections to OSDH Licensing Division for review and inclusion in the community's profile.	3/01/2023
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure:	C 391		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGACY VILLAGE OF STILLWATER

5601 N WASHINGTON ST
STILLWATER, OK 74075

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

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C 391	Continued From page 3 utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." On 11/29/22 at 12:00 p.m. a tour of the level one memory care kitchenette/dining area was conducted. The following was observed: a. The microwave was observed to have food splatters on all sides of the inside of the microwave. b. The oven was dirty with black dried on food; c. A sheet pan with dried on food was stored in a drawer; and d. Food crumbs were observed in a drawer. 2. "...310:257-5-60. Ready-to-eat, Time/Temperature Control for Safety Food, date marking... (e) of this Section, refrigerated, ready-to-eat, Time/Temperature Control for Safety Food prepared and held in a food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of seven (7) days..." On 11/29/22 at 12:00 p.m. a tour of the level one kitchenette/dining area and servery was conducted. The following was observed: a. The refrigerator contained an undated bag with strawberries with mold on them; b. An undated green salad with mold on the	C 391		

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C 391	Continued From page 4 lettuce; c. cold compress was located in the freezer; d. A cup with a straw in it not labeled with a name or date was in the door of the refrigerator; e. A yogurt cup not labeled or dated; f. A bag with beef sticks not labeled or dated in the refrigerator; and d. a bowl of ice cream uncovered was in the freezer inside the servery. On 11/29/22 at 12:02 p.m., server #1 stated they were not responsible for cleaning the appliances in the memory care area. Server #1 stated they were told they did not have to clean the appliances in the memory care kitchen/dining area. On 11/29/22 at 12:10 p.m., MAT # 1 stated the microwave was dirty with food splatter, and the food was not labeled in the refrigerator. MAT #1 stated the kitchen staff were responsible for cleaning the area. At 12:14 p.m., server #1 stated the salad in the refrigerator belonged to a resident and it had mold on it. Server #1 identified the strawberries and stated they had mold on them and should have been thrown out. On 11/29/22 at 12:30 p.m., a tour of the lower level memory care kitchenette/dining area and servery was conducted. The following was observed: a. The microwave had food splatters on all sides; and b. The oven had black food drippings On 11/29/22 at 12:30 p.m., CNA #2 stated the microwave was dirty with splashes of soup and coffee, and the oven looked like something had	C 391		

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C 391	Continued From page 5 dripped during cooking. CNA #2 stated the servers were responsible for cleaning the appliances in the memory care. On 11/29/22 at 4:01 p.m., the Food Service Director stated the servers were responsible for serving the food, picking up the dishes, and cleaning the dining room. The Food Service Director stated the servers were not responsible for cleaning the appliances in the memory care kitchenette area. 3. 310:257-5-45. Miscellaneous sources of contamination Food shall be protected from contamination that may result from a factor or source not specified under OAC 310:257-5-21 through OAC 310:257-5-44..." On 11/29/22 at 12:00 p.m., staff were observed to deliver food trays to resident rooms. The food trays were not covered as they were transported to the resident rooms. On 11/29/22 at 4:01 p.m., the Food Service Director stated they expected the staff to cover the food before it was transported to the resident rooms. On 11/30/22 at 11:42 a.m., 10 bowls of caprese salad were observed in the assisted living servery uncovered. No staff was observed in the servery. On 11/30/22 at 11:49 a.m., server #2 entered the servery and covered the salad. Server #2 stated they forgot to cover the salad. On 11/30/22 at 6:17 p.m., CNA #3 was observed delivering trays to the residents on the second floor of the assisted living. The bread pudding	C 391		

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C 391	Continued From page 6 was not covered. CNA #3 stated the desserts were not covered because they would not fit under the plate covers. 4. 310:257-5-34. Gloves, use limitation (a)...single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. On 11/30/22 at 12:07 p.m., the lunch service was observed in the assisted living dining room/servery. At 12:08 p.m., the hot box containing the lunch meal was observed in the servery. At 12:19 p.m. the Food Service Director put the food from the hot box on the steam table. At 12:24 p.m., the Food Service Director touched their mask and the front of their apron shirt with their gloved hands. At 12:27 p.m. the Food Service Director was observed handling the serving utensils with the same gloved hands and then picking up the potatoes from the steam table with their gloved hands. The Food Service Director obtained the rolls from the hot box with the same gloved hands. The Food Service Director continued to plate the food. They touched the potatoes with the same gloved hands that touched the hot box and the serving utensils. The Food Service Director used his gloved hands to pick up the potatoes, they used the serving utensil and one gloved hand to place the cauliflower on the plate, and touched the	C 391		

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C 391	Continued From page 7 pulled pork with their gloved hands after putting the pulled pork on the plate. Server #2 was observed to enter the servery pick up a plate of food and place a roll on the plate with their gloved hands and deliver the food to a resident and then return to the servery with the same gloved hands and pick up another plate and place a roll on the plate and deliver the plate to a resident in the dining room. The Food Service Director touched the serving utensils, plates, ready to eat cooked food, and the rolls after touching the hot box used to transport the food to the assisted living servery without changing gloves. On 11/30/22 at 12:35 a.m., the Food Service Director stated the utensils had been sanitized and they had washed their hands three times. The Food Service Director was asked if they were aware gloves were to be used for a single task in the kitchen. They stated, "Good to know."	C 391		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.)	C 701	On the date the surveyor was in the building, contractors were present to perform calibration on a newly installed supplemental boiler. When water temps read higher than usual, it was discovered the the work being performed had caused the bypass of a thermostatic mixing valve. Temperature logs show a history of water being within a few degrees warmer or cooler than 115. The center recognizes, based on the surveyor's findings that efforts should be taken to eliminate large temperature fluctuations, particularly hotter than usual while work is being performed. All residents in the MC building had the potential to be affected. No residents were harmed as a result of this occurrence.	

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C 701	Continued From page 8 This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure hot water temperatures did not exceed 115 degrees F in memory care. The Executive Director identified 23 residents who resided in the memory care. Findings: An undated, "Environmental Services" policy, read in parts, "...Hot water temperatures will be maintained between 105-120 degrees Fahrenheit in resident areas..." On 11/30/22 the hot water temperatures were obtained in the memory care with the maintenance director. The following temperatures were obtained: At 10:58 a.m., room 1321's sink temperature was 127.5 degrees F and the shower temperature was 124 degrees F. At 11:00 a.m., room 1311's sink temperature was 126.7 degrees F and the shower temperature was 124.0 degrees F. At 11:07 a.m., the temperature in the bathroom on the first floor memory care was 131.0 degrees F. On 11/30/22 at 11:08 a.m., the maintenance director stated the maximum hot water temperature was supposed to be 115.0 degrees F. At 11:10 a.m., the lower level memory care	C 701	--Center will continue to routinely test water temperatures at random locations throughout the MC community and record readings in the water temperature log. --Community maintenance staff will ensure the thermostatic mixing valve is not bypassed during system repairs or maintenance. If bypass is necessary and temperatures cannot be maintained during maintenance or repair, maintenance staff will temporarily shut off hot water while repairs are made. --The water temperature policy will be amended to include provision for ensuring safe water temperature during repairs. --Water temperature logs will be reviewed at the community QA meetings.	03/1/2023 03/01/2023 03/01/2023 03/10/2023

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C 701	Continued From page 9 bathroom temperature in the sink was 130.8 degrees F. The residents in memory care have access and use this bathroom. At 11:15 a.m., room 308's sink temperature was 127.4 degrees F. At 11:19 a.m., room 307's sink temperature was 124.8 degrees F and the shower was 121.0 degrees F. The maintenance director stated a company had been in the center working on the boiler. The maintenance director was asked if they had checked the hot water temperatures this week. They stated no.	C 701		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN for eight (#1, 2, 3, 5, 6, 8, 9 and #10) of ten sampled residents reviewed for monthly medication reviews. The Executive Director identified 74 residents were administered medication by the staff and	C 921	74 Residents in the AL and MC had the potential to be affected by this practice. Executive Director verified that all residents' medication orders were reviewed by the community RN in December and January. --AL Director, MC Director or Wellness Director will audit past three months of medication orders for RN review. The PCP will be notified for those without completed reviews in that time frame. --ED, AL Director or designee will monitor the monthly medication orders to ensure timely review by RN. --Ongoing compliance will be monitored and reported to the QA committee.	3/1/2023 3/1/2023 3/10/2023

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C 921	Continued From page 10 seven residents self-administered their medications. Findings: An undated, "Review of Resident Medication" policy, read in parts, "... The Resident Care Coordinator or a licensed healthcare professional will review all resident medications..." Resident #1, 2, and #6's clinical record did not contain a monthly medication review for April, July, or September 2022. Resident # 3 and #5's clinical record did not contain a monthly medication review for June, July, September, or October 2022. Resident #8's clinical record did not contain a monthly medication review for April, June, July, or October 2022. Resident #9's clinical record did not contain a monthly medication review for October 2022. Resident #10's clinical record did not contain a monthly medication review for April, July, September, or October 2022. On 12/09/22 at 12:43 p.m., the Executive Director stated they could not find the monthly medication reviews done by the RN.	C 921		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1505		

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C1505	Continued From page 11 and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure: a. Medications were administered as ordered by	C1505		

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C1505	Continued From page 12 the physician for one (#12) of nine sampled residents who were observed during two medication administration passes; b. the blood pressure cuff was cleaned in between residents for one (#13) of two sampled residents who were observed to have their blood pressure obtained during a medication administration pass; and c. PPE was properly disposed of when leaving a resident room who was COVID-19 positive and on transmission based precautions for one (#15) of two sampled resident who were on transmission based precautions. The Executive Director identified three residents who were on transmission based precautions for COVID-19 and 81 residents who resided in the center. Findings: An undated, "Pharmacy Services" policy, read in parts, "...If the community is administering medications, the community shall coordinate and obtain medications...The community's preferred pharmacy will provide the following...Routine and emergency delivery..." 1. Resident #12 had diagnoses which included Atrial Fibrillation. A service plan, dated 10/26/22, read in parts, "...Medication Assistance...Significant Total Assist...Legacy will order medication from pharmacy. Nurse or Medtech will administer medication per Physician order..." A current physician's order, dated 11/14/22,	C1505	All residents in AL and MC have the potential to be impacted by this practice. A. Medication Pass --Wellness Director/RN will verify that the PCP was notified of missed medication. If not already reported, the RN will report to resident PCP. --Wellness Director/RN will conduct in-service training on medication administration and reordering. --Wellness Director/RN or designee will randomly audit and observe medication passes and record results of observation. --Results of audits and observations will be reported to the QA committee. B. BP cuff cleaning and PPE disposal. No residents were identified to have been harmed by this practice. --Wellness Director/RN or designee will conduct in-service training for all direct care staff on infection control and PPE use. --Wellness Director/RN or designee will randomly audit PPE use in the community and report findings to the QA committee.	03/01/2023 03/01/2023 03/01/2023 03/10/2023 03/01/2023 03/10/2023