OKLAHOMA
State Department
of Health

Delivery via email to: codye@wslm.biz; baleighm@wslm.biz

August 21, 2024

License Number: AL6010

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

Survey Event ID: 1TCW11

Dear Mr. Erikson:

On **August 8, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Legacy Village of Stillwater**
Address: **5601 N Washington St**
City, State, Zip: **Stillwater, OK, 74075**
Provider #: **AL6010**
Complaint #: **OK00065920**
Investigation Date(s): **08/07/24 and 08/08/24**

ALLEGATION(S)
The center failed to protect the resident from physical abuse.

An unannounced on-site investigation was initiated 08/07/2024 at 09:30 a.m.

A sample of 3 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:

Tours of the facility were conducted upon entry and throughout the survey. Resident hallways were observed for staff assistance with resident care needs. The memory care unit was observed for security and the supervision of residents. Staff were observed providing interaction and assisting residents. Residents were observed participating in activities in the dining and commons area.

Resident medical records were reviewed including physician orders, medication administration records, progress notes, plans of care, assessments, and physician progress notes. Policy and procedures regarding abuse and incident reporting were reviewed. Incident reports, including state reportable incidents were reviewed. Employee files were reviewed. In-services related to abuse prevention training were reviewed.

Residents were interviewed related to their safety and the care they received. Staff were interviewed related to abuse prevention, abuse detection, and incident reporting procedures.

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: 08/09/2024

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	AL6010	A. BUILDING: _____ B. WING _____	C 08/08/2024

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LEGACY VILLAGE OF STILLWATER	5601 N WASHINGTON ST STILLWATER, OK 74075

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C 000	INITIAL COMMENTS A complaint investigation (#OK00065920) was conducted on 08/07/24 and 08/08/24. Facility Census: 92 Listed below are the abbreviations that will be used throughout this document. ACMA - advanced certified medication aide ED - executive director MC - memory care ODH - Oklahoma Department of Health Pcp - primary care physician Res - resident	C 000		
C1512 SS=E	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 Statues, 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	C1512		

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C1512	Continued From page 1 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 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: Based on observation, record review, and interview, the center failed to ensure the staff	C1512		

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C1512	Continued From page 2	C1512		

reported suspected instances of abuse immediately for one (#1) of three residents reviewed for abuse/neglect.

The wellness director identified 92 residents who resided in the center.

Findings:

A "Freedom from Abuse, Neglect and Exploitation" policy, undated, read in parts, "...Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, impairment or mental anguish...You are obligated to report any suspected instances of Abuse, Neglect or Misappropriation immediately to the appropriate personnel..."

Res #1 had diagnoses which included dementia and diabetic neuropathy.

The medical record documented Res #1 was oriented to person only, dependent with care needs, and resided on the secured memory care unit of the center.

A "Resident Skin Report" dated 07/15/24, documented bruising on Res #1's left forearm that was not there on Friday.

A "Hospice Resident Services Visit note" dated 07/15/24 at 4:00 p.m., documented a large bruise observed to Res #1's left forearm.

An initial incident report, ODH form 283, dated 07/15/24, read in part, "...On 07/15/24 Staff notified the clinical team of a bruise to the left forearm of resident. Bruise was light pink to purple in color and went around the lower arm

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C1512	Continued From page 3	C1512		

near the wrist. Spouse claimed that bruising was the result of an incident between (ACMA #1) and resident. Investigation opened due to abuse allegations. Pcp, hospice, and executive director notified of allegation. (ACMA #1) was suspended pending the outcome of the investigation. Investigation ongoing at the time of this initial report ..."

A staff #1 witness statement, dated 07/16/24, documented on 07/14/24 Res #1 had been heard stating "If you twist my arm like that again" to ACMA #1. The statement documented ACMA #1 was observed to have grabbed Res #1 underneath the armpit and walked them to their room.

A staff #2 witness statement, dated 07/16/24, documented on 07/14/24 they witnessed ACMA #1 take Res #1's arm from his armpit and take them down the hallway super-fast. They stated ACMA #1 was moving the resident a lot faster than normal.

A final incident report, ODH form 283, dated 07/18/24, read in part, " ...Investigation completed. Police report filed. Abuse substantiated after ED and MC director interview with employee. Termination following suspension. Form 718 updated and sent to reflect termination status ...Spouse notified of investigation and resolution ..."

On 08/07/24 at 1:00 p.m., Res #1 was observed in the secured memory care unit ambulating independently with a walker. Res #1 was unable to answer questions upon interview due to cognition.

On 08/07/24 at 1:38 p.m., Res #1's spouse stated

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C1512	Continued From page 4 they had observed a large bruise on Res #1's forearm on the morning of 07/15/24. They stated the bruise had not been there prior to that day. Res #1's spouse stated an unnamed staff member had told them the bruise had been caused by ACMA #1 grabbing the resident's arm in anger the night before. Res #1's spouse stated they had contacted the wellness director immediately to notify them of the bruise and allegation of abuse. On 08/08/24 at 9:45 a.m., the wellness director was asked when the suspected abuse of Res #1 was reported. The wellness director stated the staff had reported observation of the bruise on 07/15/24. They stated the center had not been made aware of ACMA #1's actions on 07/14/24 until witness statements were completed on 07/16/24. The wellness director stated the staff who witnessed the suspected abuse should have notified them immediately and not waited until an abuse investigation had been started. On 08/08/24 at 11:07 a.m., the memory care director stated Res #1's spouse had contacted them regarding the bruise and allegation of abuse on 07/15/24. They stated the staff members who witnessed the incident on 07/14/24 should have notified administration immediately of the suspected abuse but did not.	C1512		

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Delivery via email to: codye@wslm.biz; baleighm@wslm.biz

September 18, 2024

License Number: AL6010

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

Survey Event ID: 1TCW11

Dear Mr. Erikson:

On **August 8, 2024,** 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 **September 25, 2024**.

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

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

Enclosure

Oklahoma State Department of Health

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C1512 SS=E	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 Statues, 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	C1512	All residents residing in the Memory Care Level where this associate was assigned to work had the potential to be affected by the actions of this associate. Upon allegation of abuse, the named associate was immediately placed on suspension and removed from the building pending full investigation. Residents in the areas where associate was assigned to work had skin assessments completed to ensure there were no signs of bruising or indication of abuse. Associates who worked with the named associate were interviewed along with residents who may have been able to verbalize any wrongdoing as a part of the full investigation. No other residents were identified to have been affected by this action.	

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C1512	Continued From page 1 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 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: Based on observation, record review, and interview, the center failed to ensure the staff	C1512	--In-service was scheduled for 8-22-24 to re-train staff on "Recognizing signs of Abuse, Neglect and Misappropriation and the Proper Reporting Requirements". All staff unable to attend the initial training will be re-trained in separate sessions. --Abuse, Neglect and Misappropriation training materials will be updated to more specifically focus on reporting requirements and time frames. --Assisted Living Director, Memory Care Director or their designee will audit the training binder monthly to ensure all staff have been trained in the Abuse, Neglect and Misappropriation process and procedure. --Training records will be reviewed in community QA meeting to ensure full compliance and attendance. And initial Abuse, Neglect and Misappropriation training materials will be reviewed to ensure the most updated version is being used.	9-25-2024 9-25-2024 9-25-2024 9-25-2024

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C1512	Continued From page 2 reported suspected instances of abuse immediately for one (#1) of three residents reviewed for abuse/neglect. The wellness director identified 92 residents who resided in the center. Findings: A "Freedom from Abuse, Neglect and Exploitation" policy, undated, read in parts, "...Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, impairment or mental anguish...You are obligated to report any suspected instances of Abuse, Neglect or Misappropriation immediately to the appropriate personnel..." Res #1 had diagnoses which included dementia and diabetic neuropathy. The medical record documented Res #1 was oriented to person only, dependent with care needs, and resided on the secured memory care unit of the center. A "Resident Skin Report" dated 07/15/24, documented bruising on Res #1's left forearm that was not there on Friday. A "Hospice Resident Services Visit note" dated 07/15/24 at 4:00 p.m., documented a large bruise observed to Res #1's left forearm. An initial incident report, ODH form 283, dated 07/15/24, read in part, "...On 07/15/24 Staff notified the clinical team of a bruise to the left forearm of resident. Bruise was light pink to purple in color and went around the lower arm	C1512		

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LEGACY VILLAGE OF STILLWATER	5601 N WASHINGTON ST STILLWATER, OK 74075

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C1512	Continued From page 4 they had observed a large bruise on Res #1's forearm on the morning of 07/15/24. They stated the bruise had not been there prior to that day. Res #1's spouse stated an unnamed staff member had told them the bruise had been caused by ACMA #1 grabbing the resident's arm in anger the night before. Res #1's spouse stated they had contacted the wellness director immediately to notify them of the bruise and allegation of abuse. On 08/08/24 at 9:45 a.m., the wellness director was asked when the suspected abuse of Res #1 was reported. The wellness director stated the staff had reported observation of the bruise on 07/15/24. They stated the center had not been made aware of ACMA #1's actions on 07/14/24 until witness statements were completed on 07/16/24. The wellness director stated the staff who witnessed the suspected abuse should have notified them immediately and not waited until an abuse investigation had been started. On 08/08/24 at 11:07 a.m., the memory care director stated Res #1's spouse had contacted them regarding the bruise and allegation of abuse on 07/15/24. They stated the staff members who witnessed the incident on 07/14/24 should have notified administration immediately of the suspected abuse but did not.	C1512		

OKLAHOMA
State Department
of Health

Delivery via email to: codye@wslm.biz; baleighm@wslm.biz

October 9, 2024

License Number: AL6010

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

Survey Event ID: 1TCW12

Dear Mr. Erikson:

On **October 8, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **August 8, 2024,** have now been corrected effective **September 25, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6010	A. BUILDING: _____ B. WING _____	R-C 10/08/2024

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 An offsite/paper revisit was conducted on 10/08/24. The facility was in substantial compliance.	{C 000}		

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