OKLAHOMA
State Department
of Health

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

June 10, 2025

License Number: AL6010

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

RE: Survey Event ID: 0WSU11

Dear Mr. Erikson:

On **June 2, 2025**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. 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 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 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 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 calendar 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

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**
City, State, Zip: **Stillwater, OK. 74075**
Provider #: **AL6010**
Complaint #: **OK00079973**
Investigation Date(s): **05/29/25 through 05/30/25 and 06/02/25**

ALLEGATION(S)
1. The facility failed to ensure the residents were free from abuse.
2. The facility failed to report allegations of abuse to the required state agencies.

An unannounced on-site investigation was initiated 05/29/2025 at 9:30 a.m.

A sample of 10 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: A tour of the facility was conducted on and throughout the survey. Residents and staff interactions were observed for signs of abuse. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, and facility policies. Residents were asked questions about concerns related to care and abuse. Staff were asked about resident care, identifying abuse, reporting abuse, and if any abuse concerns have been observed or reported.

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: 06/03/2025

OKLAHOMA
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of Health

INVESTIGATIVE REPORT

Facility: **Legacy Village of Stillwater**
Address: **5601 N. Washington**
City, State, Zip: **Stillwater, OK. 74075**
Provider #: **AL6010**
Complaint #: **OK00082935**
Investigation Date(s): **05/29/25 through 05/30/25 and 06/02/25**

ALLEGATION(S)
1.The center failed to ensure residents were not abused.

An unannounced on-site investigation was initiated 05/29/2025 at 9:30 a.m.

A sample of 10 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: A tour of the facility was conducted on and throughout the survey. Residents and staff interactions were observed for signs of abuse. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, and facility policies. Residents were asked questions about concerns related to care and abuse. Staff were asked about resident care, identifying abuse, reporting abuse, and if any abuse concerns have been observed or reported.

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

Thank you for bringing your concerns to our attention.

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Long Term Care Service

Date report completed: 06/03/2025

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	AL6010	A. BUILDING: _____ B. WING _____	C 06/02/2025

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 relicensure and complaint survey (#OK00079973 and #OK00082935) was conducted from 05/29/25 through 05/30/25 and on 06/02/25. Facility Census: 96 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nursing assistant MAT - medication administration tech med- medication Res - resident RN - registered nurse	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual comprehensive assessment was signed/coordinated by a RN or physician for 1 (#1) of 10 residents sampled for annual assessments coordinated by a RN or physician. The executive director identified 96 residents resided in the center.	C 542		

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C 542	Continued From page 1 Findings: An untitled undated policy, read in part, "A resident assessment is completed on each resident prior to admission and at least every (6) months there after. The assessment must be completed and signed by a licensed health care professional." Resident #1's significant change assessment, dated 03/28/25, showed the resident was admitted on 09/11/23 with diagnoses which included dementia and and osteoporosis. The assessment was not signed by the RN or physician until 05/29/25 when a copy of the assessment was requested. On 05/30/25 at 12:37 p.m., the wellness director was asked what the policy was for ensuring a RN or physician signed completed assessments. They stated they were not sure if there was a policy. The wellness director was shown Resident #1's assessment dated 03/28/25. They stated Resident #1's assessment was not signed by a RN or physician until 05/29/25.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

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C 543	Continued From page 2	C 543		

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to ensure comprehensive assessments were signed by the resident and/or resident representative for 3 (#1, #3 and #4) of 10 sampled residents reviewed for comprehensive assessments.

The executive director identified 96 residents resided in the center.

Findings:

1. Resident #1's significant change assessment, dated 03/28/25, showed Resident #1 was had diagnoses which included dementia and and osteoporosis. The assessment was not signed by the resident and/or resident's representative.

2. Resident #3's comprehensive bi-annual assessment, dated 03/25/25, showed Resident #3 had diagnoses which included dementia and hyperlipidemia. The assessment was not signed by the resident and/or resident's representative.

3. Resident #4's comprehensive bi-annual assessment, dated 02/14/25, showed Resident #4 had diagnoses which included history of stroke and hypertension. The assessment was not signed by the resident and/or resident's representative.

On 05/30/25 at 12:37 p.m., the wellness director was asked what the policy was for ensuring a resident and/or resident representative participated in an assessment. They stated they

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C 543	Continued From page 3 were not sure if there was a policy. The wellness director was shown Resident #1, #3, and #4's assessments. They stated the assessments were not signed by the residents or their representatives.	C 543		
C1512 SS=G	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 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		

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C1512	Continued From page 4 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 record review and interview, the center failed to prevent resident abuse for 1 (#2) of 3 sampled residents reviewed for abuse. The executive director identified 96 residents resided in the center. Findings: An undated policy titled "Admin. 57-Reporting Resident Abuse," read in part, "Abuse may	C1512		

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C1512	Continued From page 5	C1512		

consist of verbal abuse, sexual abuse, involuntary seclusion, mental abuse."

1. Resident #2's comprehensive annual assessment, dated 04/30/25, showed they were admitted on 07/10/23 with diagnoses which included type 2 diabetes and osteopenia. The assessment showed the resident was alert and oriented to person and place and their memory was intact.

A final incident report form 283, dated 05/22/25, read in part, "med aide came into Res room to give medication at approx. [approximately] [4:45 p.m.] and found Res. sitting on the bed with no clothes on and a [gender withheld] resident standing in front of [them] near bed naked from the waist down and attempting to put on [their] clothes."..."I asked [Resident #2] what happened and [they] described unwanted and uninvited touches and advances."

Resident #2's nurses note, dated 05/22/25, showed a med aide went into Resident #2's room at 4:40 p.m. to administer medication and observed Resdient #2 on the bed with no clothes on and Resident #3 standing at Resident #2's bed side partially dressed. The note showed Resident #2 nodded their head at the aide and voiced,"I don't want [them] in here." The note showed Resident #3 voiced to the aide to not say anything and this would be their secret. The note showed the medication aide instructed Resident #3 to leave Resident #2's apartment. The not showed Resident #2 reported Resident #3 forced themselves on them. The note showed the executive director, families of both residents, and the police were notified.

Resident #2's nurses note, dated 05/30/25, read

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C1512	Continued From page 6 in part, "On 05/25/25 at 12:30 staff reported the res was sitting at the dining table and just finished lunch and [they] looked at the CMA and kept saying '[they] raped me. I'm scared.' CMA walked [them] to [their] bedroom, they stopped and pointed at [Resident #3's] door and repeated '[they] raped me, I'm scared." The CMA locked the door behind [them] when they were inside the room, walked [them] to [their] bed and [they] freaked out. CMA said, 'sit on the bed. You are safe. [They] are not going to hurt you again.'..."[Resident #2] is very sad and solemn." 2. Resident #3's comprehensive bi-annual assessment, dated 03/25/25, showed Resident #3 had diagnoses which included dementia without behaviors and hyperlipidemia. The assessment showed Resident #3 was alert and oriented to person, place and time, their memory appears intact, they had no history of behavioral concerns. Resident #3's nurses notes, dated 05/22/25, showed a med aide went into Resident #2's room at 4:40 p.m. to administer medication and observed Resident #2 on the bed with no clothes on and Resident #3 standing at Resident #2's bed side partially dressed. The note showed Resident #2 nodded their head at the aide and voiced ,"I don't want [them] in here." The note showed Resident #3 voiced to the aide to not say anything and this would be their secret. The note showed the medication aide instructed Resident #3 to leave Resident #2's apartment. The note showed Resident #2 reported Resident #3 forced themselves on them. On 05/30/25 at 12:37 p.m., the wellness director stated the abuse allegation was made after the med aide reported Resident #2 was in their room	C1512		

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C1512	Continued From page 7	C1512		

in bed with no clothes and Resident #3 was standing bed side with pants around their knees. The wellness director stated they were unable to determine if sexual intercourse happened based upon the investigation. The wellness director stated Resident #2 was sent to the emergency room at the request of family for a sexual assault nurse examination. The wellness director stated they were unable to get a copy of the sexual assault nurse examination. The wellness director stated staff reported Resident #2 was shaken up when they returned from the emergency room.

On 05/30/25 at 1:25 p.m., a family representative for Resident #2 stated they were notified on 05/22/25 of an alleged sexual assault on their family at the center. They stated Resident #2 used the word "rape" when they accounted the incident to them. The family representative stated Resident #2 had been crying a lot since the incident on 05/22/25.

On 05/30/25 at 2:00 p.m., a police agency detective stated they were notified of sexual assault allegations on 05/22/25 at 4:54 p.m. and they were presenting to the district attorney a case of sexual assault.

On 05/30/25 at 2:05 p.m., Resident #2 was asked about any concerns at the facility. They stated "A [gender withheld] came into my room and raped me. It was a tough thing to go through. Every so often, I think about it and want to lock my door, but [they] are gone now."

On 05/30/25 at 2:40 p.m., CNA/MAT #2 stated Resident #2's door was propped open on 05/22/25 at around 4:30 p.m., so they went across the hall to the medication room to prepare Resident #2's medication. CNA/MAT #2 stated

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C1512	Continued From page 8 they returned around three minutes later and Resident #2's door was closed. CNA/MAT #2 stated they knocked and did not hear anything so they went in and announced their presence. CNA/MAT #2 stated they observed Resident #2 laying in their bed on their back completely unclothed. CNA/MAT #2 stated Resident #3 was standing at the bedside with their pants around their ankles and wearing a brief, and buttoning their shirt. CNA/MAT #2 stated Resident #2 mouthed, "I don't want [them] in here" to CNA #2. CNA/MAT #2 stated Resident #3 told them "this is our secret, don't tell anyone" and left the room.	C1512		

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

June 27, 2025

License Number: AL6010

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

RE: Survey Event 0WSU11

Dear Mr. Erikson:

On **June 2, 2025**, a Licensure inspection with complaint investigation was conducted at your Assisted Living Center facility. 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 **July 15, 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

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

Enclosure

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C 000	INITIAL COMMENTS A relicensure and complaint survey (#OK00079973 and #OK00082935) was conducted from 05/29/25 through 05/30/25 and on 06/02/25. Facility Census: 96 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nursing assistant MAT - medication administration tech med- medication Res - resident RN - registered nurse	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 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual comprehensive assessment was signed/coordinated by a RN or physician for 1 (#1) of 10 residents sampled for annual assessments coordinated by a RN or physician. The executive director identified 96 residents resided in the center.	C 542	The unsigned assessment identified during the survey process for the focus resident has been signed. All 96 residents in the AL and MC had the potential to be impacted by this practice. 1. Audit will be conducted by community administrator, RN or their designee to identify any assessments not signed by the RN. A tracker will be developed to track identified unsigned assessments as well as tracking when signatures are obtained. 2. Facility clinical team will attain signatures for any unsigned assessments identified during audit. 3. RN or designee will report findings and tracker updates to community QA committee. 4. RN or designee will audit annual assessments for signatures monthly for 3 months.	7-15-25 7-15-25 7-15-25 7-15-25

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 06/02/2025

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 542	Continued From page 1 Findings: An untitled undated policy, read in part, "A resident assessment is completed on each resident prior to admission and at least every (6) months there after. The assessment must be completed and signed by a licensed health care professional." Resident #1's significant change assessment, dated 03/28/25, showed the resident was admitted on 09/11/23 with diagnoses which included dementia and and osteoporosis. The assessment was not signed by the RN or physician until 05/29/25 when a copy of the assessment was requested. On 05/30/25 at 12:37 p.m., the wellness director was asked what the policy was for ensuring a RN or physician signed completed assessments. They stated they were not sure if there was a policy. The wellness director was shown Resident #1's assessment dated 03/28/25. They stated Resident #1's assessment was not signed by a RN or physician until 05/29/25.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

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C 543	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were signed by the resident and/or resident representative for 3 (#1, #3 and #4) of 10 sampled residents reviewed for comprehensive assessments. The executive director identified 96 residents resided in the center. Findings: 1. Resident #1's significant change assessment, dated 03/28/25, showed Resident #1 was had diagnoses which included dementia and and osteoporosis. The assessment was not signed by the resident and/or resident's representative. 2. Resident #3's comprehensive bi-annual assessment, dated 03/25/25, showed Resident #3 had diagnoses which included dementia and hyperlipidemia. The assessment was not signed by the resident and/or resident's representative. 3. Resident #4's comprehensive bi-annual assessment, dated 02/14/25, showed Resident #4 had diagnoses which included history of stroke and hypertension. The assessment was not signed by the resident and/or resident's representative. On 05/30/25 at 12:37 p.m., the wellness director was asked what the policy was for ensuring a resident and/or resident representative participated in an assessment. They stated they	C 543	The unsigned assessments identified during the survey process for the focus residents have been signed. All 96 residents in the AL and MC had the potential to be impacted by this practice. 1. Audit will be conducted by community administrator, RN or their designee to identify any assessments unsigned by resident or responsible party. A tracker will be developed to track identified unsigned assessments as well as tracking when signatures are obtained. 2. Facility clinical team will attain signatures for any unsigned assessments identified during audit. 3. RN or designee will report findings and tracker updates to community QA committee. 4. RN or designee will audit annual assessments for signatures monthly for 3 months.	7-15-2025 7-15-2025 7-15-2025 7-15-2025

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C 543	Continued From page 3 were not sure if there was a policy. The wellness director was shown Resident #1, #3, and #4's assessments. They stated the assessments were not signed by the residents or their representatives.	C 543		
C1512 SS=G	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 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	The accused resident was immediately placed under direct staff supervision until family arrived and took him to their home. Accused resident has moved out of the community (did not return after incident). Internal investigation was conducted, which included interviewing other residents in the immediate area to determine if anyone else had been affected. No additional residents were identified. 1. Executive Director or designee will conduct an in-service training on Abuse and Neglect. 2. All staff will continue to be trained upon new hire and at least annually on Abuse and Neglect. 3. Community will continue to screen all residents on the Sex Offenders Registry prior to move in. 4. Status of new move in sex offender screening and Abuse and Neglect screening will be reported to the community QA Committee.	7-15-2025 7-15-2025 7-15-2025 7-15-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1512	Continued From page 4 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 record review and interview, the center failed to prevent resident abuse for 1 (#2) of 3 sampled residents reviewed for abuse. The executive director identified 96 residents resided in the center. Findings: An undated policy titled "Admin. 57-Reporting Resident Abuse," read in part, "Abuse may	C1512		

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C1512	Continued From page 5 consist of verbal abuse, sexual abuse, involuntary seclusion, mental abuse." 1. Resident #2's comprehensive annual assessment, dated 04/30/25, showed they were admitted on 07/10/23 with diagnoses which included type 2 diabetes and osteopenia. The assessment showed the resident was alert and oriented to person and place and their memory was intact. A final incident report form 283, dated 05/22/25, read in part, "med aide came into Res room to give medication at approx. [approximately] [4:45 p.m.] and found Res. sitting on the bed with no clothes on and a [gender withheld] resident standing in front of [them] near bed naked from the waist down and attempting to put on [their] clothes."..."I asked [Resident #2] what happened and [they] described unwanted and uninvited touches and advances." Resident #2's nurses note, dated 05/22/25, showed a med aide went into Resident #2's room at 4:40 p.m. to administer medication and observed Resdient #2 on the bed with no clothes on and Resident #3 standing at Resident #2's bed side partially dressed. The note showed Resident #2 nodded their head at the aide and voiced,"I don't want [them] in here." The note showed Resident #3 voiced to the aide to not say anything and this would be their secret. The note showed the medication aide instructed Resident #3 to leave Resident #2's apartment. The not showed Resident #2 reported Resident #3 forced themselves on them. The note showed the executive director, families of both residents, and the police were notified. Resident #2's nurses note, dated 05/30/25, read	C1512		

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C1512	Continued From page 6	C1512		

in part, "On 05/25/25 at 12:30 staff reported the res was sitting at the dining table and just finished lunch and [they] looked at the CMA and kept saying '[they] raped me. I'm scared.' CMA walked [them] to [their] bedroom, they stopped and pointed at [Resident #3's] door and repeated '[they] raped me, I'm scared." The CMA locked the door behind [them] when they were inside the room, walked [them] to [their] bed and [they] freaked out. CMA said, 'sit on the bed. You are safe. [They] are not going to hurt you again.'..."[Resident #2] is very sad and solemn."

2. Resident #3's comprehensive bi-annual assessment, dated 03/25/25, showed Resident #3 had diagnoses which included dementia without behaviors and hyperlipidemia. The assessment showed Resident #3 was alert and oriented to person, place and time, their memory appears intact, they had no history of behavioral concerns.

Resident #3's nurses notes, dated 05/22/25, showed a med aide went into Resident #2's room at 4:40 p.m. to administer medication and observed Resident #2 on the bed with no clothes on and Resident #3 standing at Resident #2's bed side partially dressed. The note showed Resident #2 nodded their head at the aide and voiced ,"I don't want [them] in here." The note showed Resident #3 voiced to the aide to not say anything and this would be their secret. The note showed the medication aide instructed Resident #3 to leave Resident #2's apartment. The note showed Resident #2 reported Resident #3 forced themselves on them.

On 05/30/25 at 12:37 p.m., the wellness director stated the abuse allegation was made after the med aide reported Resident #2 was in their room

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C1512	Continued From page 7 in bed with no clothes and Resident #3 was standing bed side with pants around their knees. The wellness director stated they were unable to determine if sexual intercourse happened based upon the investigation. The wellness director stated Resident #2 was sent to the emergency room at the request of family for a sexual assault nurse examination. The wellness director stated they were unable to get a copy of the sexual assault nurse examination. The wellness director stated staff reported Resident #2 was shaken up when they returned from the emergency room. On 05/30/25 at 1:25 p.m., a family representative for Resident #2 stated they were notified on 05/22/25 of an alleged sexual assault on their family at the center. They stated Resident #2 used the word "rape" when they accounted the incident to them. The family representative stated Resident #2 had been crying a lot since the incident on 05/22/25. On 05/30/25 at 2:00 p.m., a police agency detective stated they were notified of sexual assault allegations on 05/22/25 at 4:54 p.m. and they were presenting to the district attorney a case of sexual assault. On 05/30/25 at 2:05 p.m., Resident #2 was asked about any concerns at the facility. They stated "A [gender withheld] came into my room and raped me. It was a tough thing to go through. Every so often, I think about it and want to lock my door, but [they] are gone now." On 05/30/25 at 2:40 p.m., CNA/MAT #2 stated Resident #2's door was propped open on 05/22/25 at around 4:30 p.m., so they went across the hall to the medication room to prepare Resident #2's medication. CNA/MAT #2 stated	C1512		

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C1512	Continued From page 8 they returned around three minutes later and Resident #2's door was closed. CNA/MAT #2 stated they knocked and did not hear anything so they went in and announced their presence. CNA/MAT #2 stated they observed Resident #2 laying in their bed on their back completely unclothed. CNA/MAT #2 stated Resident #3 was standing at the bedside with their pants around their ankles and wearing a brief, and buttoning their shirt. CNA/MAT #2 stated Resident #2 mouthed, "I don't want [them] in here" to CNA #2. CNA/MAT #2 stated Resident #3 told them "this is our secret, don't tell anyone" and left the room.	C1512		

OKLAHOMA State Department of Health

Oklahoma State Department of Health
Long Term Care
123 Robert S Kerr Ave, Suite 1702
Oklahoma City, OK 73012-6406
p. (405) 426-8200
f. (405) 900-7594

Assisted Living Informal Dispute Resolution Request Form

In Accordance with the Continuum of Care and Assisted Living Act

To access this form and the IDR process online at the Health Department web site click here.

Assisted Living Centers must complete this form to dispute cited deficiencies. If you have any questions, contact the IDR Coordinator by telephone at (405) 426-8200 or via e-mail at IDRCoordinator@health.ok.gov.

Submission

Complete this form, attach all documentary evidence relevant to each disputed deficiency and submit within **ten (10) calendar days** of receiving the official Statement of Deficiencies. Submit this form to Oklahoma State Department of Health, Long Term Care, Attention: IDR Coordinator, 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102-6406. **An IDR will not be granted when a request form is incomplete or inaccurate. Documentary evidence submitted past the required timeframe will not be considered.**

IDR Type: (Check One) Face-to-Face Meeting ☐ Record Review ☒ Telephone/Virtual Conference ☒

Facility Name: Legacy Village of Stillwater AL6010

Facility Administrator: Cody R. Erikson, LNHA codye@wslm.biz

Mailing Address: 5601 N Washington Street Telephone Number: ( ) 405-246-0888

City: Stillwater Zip Code: 74075 Facsimile Number: ( ) 405-564-0239

Date Statement of Deficiencies Received: 06 / 10 / 2025 Survey Exit Date: 06 / 02 / 2025

Dispute Description

Tag Number **Explanation of Dispute** (Why is facility disputing the deficiency? List reason for each.)

A separate sheet may be attached, but must clearly identify the following: facility name, ID, survey exit date, tag number, and the explanation of the dispute. All documentary evidence submitted must also identify these items.

1. C1512 The community pulled the Sex Offender Registry for accused resident, he was not listed. There was no history of behaviors, sexual or otherwise. There was no indication of need for any additional screening or monitoring of the resident. We are unaware of how we could have prevented this instance from occurring.

2.

3.

4.

Submitted by: Cody R. Erikson, LNHA Date: 6 / 20 / 2025

OKLAHOMA
State Department
of Health

July 7, 2025

VIA EMAIL

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

Subject: State Survey Agency Informal Dispute Resolution Determination
Re: AL6010, Legacy Village Of Stillwater July 7, 2025 Informal Dispute Resolution

Dear Mr. Erikson:

The Department of Health has received the determination of the Informal Dispute Resolution (IDR) Decision Making Panel concerning the June 2, 2025 survey conducted at Legacy Village Of Stillwater. The findings of the IDR Decision Making Panel have been reviewed. It is the determination of the State Survey Agency to uphold the Decision Making Panel's determination. The Statement of Deficiencies will not be amended.

Sincerely,

Digitally signed by
Philip Miller
Date: 2025.07.09
'15:16:43 -05'00

Philip Miller
Director, Long Term Care Services
Protective Health Services

cn

c: William Whited, Ombudsman
Lindsey Jeffries, Nurse Aide Registry
IDR Decision Making Panel
LeKenya Antwine
Edward Roth
Survey Team
Facility File

OKLAHOMA
State Department of Health

July 7, 2025

VIA EMAIL

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

Re: Legacy Village Of Stillwater – Informal Dispute Resolution Determination Report
License Number: AL6010

Dear Mr. Erikson:

Thank you for participating in the Informal Dispute Resolution (IDR) panel process of the Oklahoma State Department of Health concerning the survey conducted at your facility on June 2, 2025. The facility, the IDR Panel and all relevant persons were present at the meeting. The disputed deficiencies are discussed in the attached determination report.

A copy of this determination has been forwarded to the State Survey Agency for review.

Sincerely,

K Hamilton

Kourtney Hamilton
Chairperson
IDR Decision Making Panel
Protective Health Services

cn

Enclosure

c: Philip Miller
IDR Panel
Survey Team
Facility File

IDR
Informal Dispute Resolution
Impartial Decision Making Panel
Determination Report
Today's Date: 07-07-2025

Facility Name:
Legacy Village of Stillwater

Facility ID:
AL6010

Survey Date:
06-02-2025

IDR Date:
07-07-2025

Tags Disputed:
1. C1512 s/s=G

Status Change *
No change

Panel Members:
Kourtney Hamilton, Chairperson
Connie Beeler
Christine Maxwell
Sheila McLeod, OSDH

Determination Report:

The citation stands due to the facility's failure to comply with 63 O.S. §1-1918(B)(12), which states in part that all residents shall be free from abuse.

Signature KHamilton
Chairperson, Impartial Decision Making Panel

IDR Meeting Attendees Sign-In Sheet
07-07-2025
Microsoft Teams Meeting

Legacy Village of Stillwater

Survey Date: 06-02-2025

Name	Organization	Title
Kourtney Hamilton	IDR Panel – Chairperson	Administrator
Connie Beeler	IDR Panel	Executive Director
Christine Maxwell	IDR Panel	Administrator
Sheila McLeod	IDR Panel – OSDH	CHF Surveyor
Ed Roth	OSDH	Preventative Med Consultant
Rick Atkinson	OSDH	CHF Surveyor
Cody Erikson	Facility	Executive Director
Nicole Burke	Facility	Memory Care Director

OKLAHOMA
State Department of Health

FINAL DETERMINATION NOTICE
USPS Tracking #7021 2720 0002 0354 1846

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

July 23, 2025

License Number: AL6010

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

Survey Event ID: 0WSU12

Dear Mr. Erikson:

A revisit conducted **July 15, 2025**, revealed that your facility corrected deficiencies effective **July 15, 2025**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to OSDH.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

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 07/15/2025

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{C 000}	INITIAL COMMENTS A revisit was conducted on 07/15/25. All deficiencies from the 06/02/25 survey were cleared.	{C 000}		

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