OKLAHOMA
State Department of Health

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

November 26, 2025

License Number: AL6010

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

Survey Event ID: 56J311

Dear Mr. Erikson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **November 25, 2025**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

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

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, Okla 74075**
Provider #: **AL6010**
Complaint #: **OK00087853**
Investigation Date: **11/24/25 through 11/25/25**

ALLEGATION(S)
1. The center failed to ensure residents were free from restraints.

An unannounced on-site investigation was initiated 11/24/2025 at 8:00 a.m.

A sample of five participants, including any identified participants, 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 upon entrance and at various times throughout the survey. Residents were observed for outward signs of abuse, neglect and sedation/restraints. Residents named in the complaint were observed for abusive behavior or signs of emotional distress.

Resident records were reviewed including admission records, progress notes, physician orders, assessments, care plans and medication administration records. Incident reports were reviewed. Staffing records were reviewed.

Residents were interviewed regarding the allegation of the complaint. They were asked if they felt safe at the facility. They were interviewed regarding staff availability and response to their needs and requests for assistance.

Resident representatives were interviewed regarding the allegations of the complaint. They were asked if their loved ones were safe living at the facility and if they felt they were over sedated or chemically restrained.

Staff were interviewed regarding allegations of the complaint. They were interviewed regarding abuse and neglect. They were interviewed regarding staffing and staff training. They were interviewed regarding chemical restraints.

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: 11/25/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6010	A. BUILDING: _____ B. WING _____	C 11/25/2025

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 complaint investigation (#OK00087853) was conducted from 11/24/25 through 11/25/25. No deficiencies were cited. Facility Census: 92	C 000		

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