



Oklahoma State Department of Health
Creating a State of Health

November 27, 2019

License Number: AL7261

Ms. Juile Dyson, Administrator
Legend At Mingo Road
7902 South Mingo Road East
Tulsa, OK 74133

RE: Survey Event ID: 0XNR11

Dear Ms. Dyson:

On **October 24, 2019**, agents from our office concluded a State Licensure survey 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 October 24, 2019.

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;

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Jenny Alexopoulos, DO
Terry R Gerard II, DO
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- (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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,



fp Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7261	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGEND AT MINGO ROAD

**7902 SOUTH MINGO ROAD EAST
TULSA, OK 74133**

(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 re-licensure survey was conducted on 10/23/19 and 10/24/19. The census was 62. The following deficient practice was cited.	C 000		
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. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 3 (#3, #7, and #8) of 10 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #3 Resident #3 moved into the center on 09/16/19 with diagnoses that included hypertension, Diabetes 2, and COPD. Her most current 14 comprehensive assessment, dated 09/16/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment.	C 543		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7261	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2019
NAME OF PROVIDER OR SUPPLIER LEGEND AT MINGO ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 7902 SOUTH MINGO ROAD EAST TULSA, OK 74133		
(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 543	Continued From page 1 RESIDENT #7 Resident #7 moved into the center on 08/30/19 with diagnoses that included hypertension, Alzheimer's Disease, and Esophageal stricture. Her most current 14 day comprehensive assessment, dated 08/30/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. RESIDENT #8 Resident #3 moved into the center on 07/24/19 with diagnoses that included Alzheimer's Disease, A-Fib, and Depression. Her most current 14 day comprehensive assessment, dated 07/24/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment. On 10/24/19 at 11:30 a.m., the registered nurse (RN) was asked about the missing signatures. The RN said no signatures were on the assessments for residents (#3, #7, and #8).	C 543		



Oklahoma State Department of Health
Creating a State of Health

December 5, 2019

License Number: AL7261

Ms. Juile Dyson, Administrator
Legend At Mingo Road
7902 South Mingo Road East
Tulsa, OK 74133

RE: Survey Event 0XNR11

Dear Ms. Dyson:

On October 24, 2019, a Licensure inspection 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 **December 16, 2019**.

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) 271-6868.

Sincerely,


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

LC/ks

Board of Health

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Commissioner of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7261	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2019
NAME OF PROVIDER OR SUPPLIER LEGEND AT MINGO ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 7902 SOUTH MINGO ROAD EAST TULSA, OK 74133		
(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
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Oklahoma State Department of Health

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

TITLE

(X8) DATE

STATE FORM

6869

0XNR11

If continuation sheet 1 of 2

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7261	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2019
NAME OF PROVIDER OR SUPPLIER LEGEND AT MINGO ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 7902 SOUTH MINGO ROAD EAST TULSA, OK 74133		
(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
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Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2019

Facility Name: Legend at Mingo Road

License Number: AL-7261

Survey Event ID: OXNR11

Date Survey Completed: 10/24/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543

Based on: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 3 (#3, #7 and #8) of 10 sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: We respectfully request a desk review, as this is a paperwork tag.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

An audit of resident charts (#3, #7, #8) will be completed and any signatures lacking will be obtained, as soon as plausible, once it is determined interviews were completed and will be completed for any lacking and any found lacking will be put through the QA/QMPI process and continue for 90 days.

OSDH Response: Element accepted Yes ☐ No ☒

2. How will other residents having the potential to be affected by the same deficient practice be identified?

An audit of resident assessments will be conducted and any lacking signatures will be obtained, as soon as plausible, once it is determined interviews were completed and will be completed for any lacking and any found lacking will be put through the QA/QMPI process and continue for 90 days.

OSDH Response: Element accepted Yes ☐ No ☒

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

A tracking tool will be implemented to check off when the parts of the assessments are completed with interview signature in place. This will continue and be put through the QA/QMPI process for 90 days.

OSDH Response: Element accepted Yes ☐ No ☒

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

Audit tracking tool will remain in place for 90 days or until consistent progress/completion is noted and spot check audits will continue.

Spot check audits will continue and corrections made immediately for any lacking items and will be put through QA/QMPI process as often as needed moving forward.

QA/QMPI tool and monthly QA/QMPI meeting will continue to ensure continued compliance.

Monthly chart audits will continue to ensure appropriate compliance.

OSDH Response: Element accepted Yes ☐ No ☒

5. On what date will corrective action be completed?		12/16/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>[Signature]</i> OAC 310:663-25-4(F)		Date 12/3/2019	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



Oklahoma State Department of Health
Creating a State of Health

January 9, 2020

License Number: AL7261

Ms. Juile Dyson, Administrator
Legend At Mingo Road
7902 South Mingo Road East
Tulsa, OK 74133

RE: Survey Event 0XNR12

Dear Ms. Dyson:

On **December 27, 2019**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 24, 2019**, have now been corrected effective **December 16, 2019**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Katie Stagner
for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ks

Board of Health

Gary Cox, JD
Commissioner of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGEND AT MINGO ROAD

**7902 SOUTH MINGO ROAD EAST
TULSA, OK 74133**

(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 follow-up survey was conducted on 12/27/19. The census was 64. All deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT
 Provider/Supplier Number
 AL7261

 Provider/Supplier Name
 LEGEND AT MINGO ROAD

Type of Survey (select all that apply)

2	D			
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

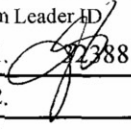
Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1.  27388	12/27/2019	12/27/2019	0.25	0.00	1.00	0.00	1.25	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours.....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No