OKLAHOMA
State Department
of Health

Delivery via email to: Katie@legacyseniorhomes.com

August 25, 2026

License Number: AL5576

Katie Dickey, Administrator
Legacy Senior Living At Preston Hills East
6900 Nw 129 Street
Oklahoma City, OK 73142

RE: Survey Event ID: D6UR11

Dear Ms. Dickey:

On **August 11, 2026**, agents from our office concluded a State Licensure re-licensure survey with complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **August 11, 2026**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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:

- Address how corrective action will be accomplished for affected residents;
- Address how other residents with the potential to be affected will be identified;
- Address measures or systemic changes to ensure the deficiency will not recur;
- Indicate how the center plans to monitor performance to ensure corrections are sustained;
- Include dates when corrective action and monitoring will be completed for each violation;
- 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 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 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 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 Senior Living East
Address:6900 NW 129th St.
City, State, Zip: Oklahoma City, OK 73142
Provider #: Al5576
Complaint #: OK00083770
Investigation Date(s): 08/11/26 to 8/12/26

ALLEGATION(S)
The facility failed to administer medication per physician orders

An unannounced on-site investigation was initiated 08/11/2026 at 10:00a.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: Observations of medication administration by facility staff and staff to resident interactions were made. Records of incident reports, resident health charts, service plans, assessments, physician orders and center policies were reviewed. Interviews with residents, the ombudsman, staff, and family members regarding medication administration were conducted.

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: 08/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5576	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY SENIOR LIVING AT PRESTON HILLS EAST	6900 NW 129 STREET OKLAHOMA CITY, OK 73142

(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 survey with complaint (#OK0008370) was conducted from 08/11/26 through 08/12/26. Deficiencies were cited Facility census: 7	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure bread products were free of mold during 1 of 1 kitchen observation. The administrator identified 7 residents received nutrition from the kitchen. Findings: On 08/10/26 at 10:30 a.m., an initial tour of the kitchen was conducted. The following observations were made: a. an unopened 12 count package of rolls was observed to have a blue green substance; and b. an opened package of bagels was observed to have a blue green substance. A policy titled "Food Services," issued 2022, read in part,"The following guidelines are to be used for the length of storage in refrigerators once food has been prepared for serving. 1 to 5 Days Storage, Breads- Rolls, Buns, Sweet Rolls,	C 391		

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C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff were trained in first aide and cardiopulmonary resuscitation for 1 (LPN #1) of 5 sampled direct care employees reviewed for staffing requirements. The administrator identified 12 direct care staff members worked in the center. Findings: A policy titled "Employment Criteria," dated 2022, read in part, "Each employee will have a personnel file that should include the following: Copy of license or certificates, if applicable." On 08/10/26 at 11:20 a.m., LPN #1's employee	C 954		

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C 954	Continued From page 2 file was reviewed. Documentation showed LPN #1's first aide and cardiopulmonary resuscitation certifications expired on 10/23/25. There was no documentation to show the certifications had been renewed. On 08/10/26 at 1:45 p.m., the administrator stated there were no records to show LPN #1's current first aide and cardiopulmonary resuscitation certification had been completed.	C 954		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to implement written procedures to ensure safe administration of medication for 1 of 1 medication room observation. The administrator identified seven residents received medication administration from the center. Findings: On 08/10/26 at 11:09 a.m., the medication room was observed with CMA #1. The following observation were made: a. a cabinet containing medications was observed unlocked and open;	C1920		

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C1920	Continued From page 3 b. the keys to the lock narcotic box were observed in the lock. The narcotic box was observed open and the cabinet which contained the narcotic box was observed unlocked; and c. the medication refrigerator located in a lower kitchen cabinet was observed unlocked. A policy titled "Assistance with Medications," dated 2022, read in part, "medications will be stored under lock and key in the [name of facility withheld] medication cabinet." On 08/10/26 at 10:15 a.m., CMA #1 stated the medication cabinets should have been locked at all times. CMA #1 stated they should have locked all the medications cabinets before administering medications. On 08/10/26 at 2:45 p.m., the administrator stated all medications should have been under lock and key.	C1920		

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Delivery via email to: Katie@legacyseniorhomes.com

September 4, 2026

License Number: AL5576

Katie Dickey, Administrator
Legacy Senior Living At Preston Hills East
6900 Nw 129 Street
Oklahoma City, OK 73142

RE: Survey Event D6UR11

Dear Ms. Dickey:

On **August 11, 2026,** agents from our office completed an Assisted Living Center survey with complaints at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C391, C954, & C1920:** The plan of correction was missing the QAPI component.

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

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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C 391	Continued From page 1 Coffee Cakes, Muffins, Corn Bread." On 08/10/26 at 10:35 a.m., Cook #1 stated they used first in first out procedures to ensure freshness of food preparation. Cook #1 stated the unopened package of rolls had blue green mold and they should have been discarded. Cook #1 stated the opened package of bagels had blue green mold and should have been thrown away. On 08/11/26 at 10:15 a.m., the administrator stated any food that had mold should have been discarded immediately.	C 391	The Administrator/designee will review completed food audits weekly for four weeks and monthly for two months thereafter to verify continued compliance. Any deficient practice identified will be corrected immediately and additional staff education will be provided as indicated.	
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff were trained in first aide and cardiopulmonary resuscitation for 1 (LPN #1) of 5 sampled direct care employees reviewed for staffing requirements. The administrator identified 12 direct care staff members worked in the center. Findings: A policy titled "Employment Criteria," dated 2022, read in part, "Each employee will have a personnel file that should include the following: Copy of license or certificates, if applicable." On 08/10/26 at 11:20 a.m., LPN #1's employee	C 954	LPN #1's CPR and first-aid certifications were renewed on Aug. 19, 2026, and current documentation was placed in the employee's personnel file. No specific resident injury or adverse event was identified as resulting from the expired certification. Because LPN #1 provided direct care, all residents receiving care from LPN #1 had the potential to be affected by the deficient practice. To identify any other residents who could potentially be affected, the Administrator reviewed the CPR and first-aid certification status of all direct-care employees. Any employee identified without current required training/certification will have the deficiency corrected before continuing to work in a capacity requiring that training. To prevent recurrence, the facility established a credential-tracking process identifying CPR and first-aid expiration dates for direct-care employees. Certifications will be reviewed in advance of expiration so renewal can occur timely.	

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C 954	Continued From page 2 file was reviewed. Documentation showed LPN #1's first aide and cardiopulmonary resuscitation certifications expired on 10/23/25. There was no documentation to show the certifications had been renewed. On 08/10/26 at 1:45 p.m., the administrator stated there were no records to show LPN #1's current first aide and cardiopulmonary resuscitation certification had been completed.	C 954	The Administrator/designee will review the direct-care certification tracker monthly for three months and quarterly thereafter to verify that required CPR and first-aid training remains current. Any expired or missing certification identified will be corrected immediately.	8/19/26
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to implement written procedures to ensure safe administration of medication for 1 of 1 medication room observation. The administrator identified seven residents received medication administration from the center. Findings: On 08/10/26 at 11:09 a.m., the medication room was observed with CMA #1. The following observation were made: a. a cabinet containing medications was observed unlocked and open;	C1920	The Administrator/designee reviewed medication incident/error reports and narcotic count/discrepancy records to determine whether any resident experienced a medication error, unauthorized access to medication, medication discrepancy, or adverse outcome associated with the identified condition. No such occurrence was identified. The Administrator/designee inspected all medication storage areas to identify any other locations where medications could be accessed without proper security. All medication storage areas were verified to be secured.	

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September 21, 2026

License Number: AL5576

Katie Dickey, Administrator
Legacy Senior Living At Preston Hills East
6900 Nw 129 Street
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RE: Survey Event D6UR11

Dear Ms. Dickey:

On **August 11, 2026**, 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 Amended 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 **August 31, 2026**.

We will conduct a revisit 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY SENIOR LIVING AT PRESTON HILLS EAST	6900 NW 129 STREET OKLAHOMA CITY, OK 73142

(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 391	Continued From page 1 Coffee Cakes, Muffins, Corn Bread." On 08/10/26 at 10:35 a.m., Cook #1 stated they used first in first out procedures to ensure freshness of food preparation. Cook #1 stated the unopened package of rolls had blue green mold and they should have been discarded. Cook #1 stated the opened package of bagels had blue green mold and should have been thrown away. On 08/11/26 at 10:15 a.m., the administrator stated any food that had mold should have been discarded immediately.	C 391	Results of the food storage audits will be reviewed through the facilities QAPI process. The administrator or designee will track audit findings and compliance trends. Any identified noncompliance will result in immediate corrective action and staff re-education as indicated. Findings will be reviewed monthly for 3 months to determine whether the corrective measures have been identified. LPN #1's CPR and first-aid certifications were renewed on Aug.19, 2026, and current documentation was placed in the employee personnel file. No specific resident injury or adverse event was identified as resulting from the expired certification. Because LPN #1 provided direct care, all residents receiving care from LPN had the potential to be affected by the deficient practice. To identify any other residents who could potentially be affected, the Administrator reviewed the CPR and first-aid certification status of all direct-care employees. Any employee identified without current required training/certification will have the deficiency corrected before continuing to work in a capacity requiring that training. To prevent recurrence, the facility established a credential-tracking identifying CPR and first-aid expiration dates for direct-care employees. Certifications Will be reviewed in advance of expiration so renewd can occur timely	
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff were trained in first aide and cardiopulmonary resuscitation for 1 (LPN #1) of 5 sampled direct care employees reviewed for staffing requirements. The administrator identified 12 direct care staff members worked in the center. Findings: A policy titled "Employment Criteria," dated 2022, read in part, "Each employee will have a personnel file that should include the following: Copy of license or certificates, if applicable." On 08/10/26 at 11:20 a.m., LPN #1's employee	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5576	A. BUILDING: _____ B. WING _____	C 08/11/2026

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C 954	Continued From page 2 file was reviewed. Documentation showed LPN #1's first aide and cardiopulmonary resuscitation certifications expired on 10/23/25. There was no documentation to show the certifications had been renewed. On 08/10/26 at 1:45 p.m., the administrator stated there were no records to show LPN #1's current first aide and cardiopulmonary resuscitation certification had been completed.	C 954	Staff credential and qualification compliance will be incorporated into the facility's QAPI process. The Administrator or designee will review the credential tracker and audit results monthly for 3 months and quarterly thereafter. Any expired, missing or deficient credential will be addressed immediately, and trends or recurring deficiencies will result in additional corrective action, education, or process changes as appropriate.	08/19/2026
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to implement written procedures to ensure safe administration of medication for 1 of 1 medication room observation. The administrator identified seven residents received medication administration from the center. Findings: On 08/10/26 at 11:09 a.m., the medication room was observed with CMA #1. The following observation were made: a. a cabinet containing medications was observed unlocked and open;	C1920	The Administrator/designee reviewed medication incident/error reports and narcotic count/dscrepancy records to determine whether any resident experienced a medication error, unauthorized access to medication, medication discrepancy, or adverse outcome associated with the identified condition. No such occurrence was identified. The Administrator/designee inspected all medication storage areas to identify any other locations where rnedications could be accessed without proper security. All medication storage were verified to be secured.	

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C1920	Continued From page 3 b. the keys to the lock narcotic box were observed in the lock. The narcotic box was observed open and the cabinet which contained the narcotic box was observed unlocked; and c. the medication refrigerator located in a lower kitchen cabinet was observed unlocked. A policy titled "Assistance with Medications," dated 2022, read in part, "medications will be stored under lock and key in the [name of facility withheld] medication cabinet." On 08/10/26 at 10:15 a.m., CMA #1 stated the medication cabinets should have been locked at all times. CMA #1 stated they should have locked all the medications cabinets before administering medications. On 08/10/26 at 2:45 p.m., the administrator stated all medications should have been under lock and key.	C1920	Medication staff were in-serviced on the facility's medication-administration policy, with specific ernphasis on keeping medication cabinets, storage, and medication refrigerators locked when not actively in use; maintaining control of medication keys; and the importance of secured medication storage to prevent unauthorized access, medication error, accidental ingestion, or diversion. To prevent recurrence, medication staff are required to verify that all medication storage areas are secured after medication administration and anytime the medication-storage area is not under their immediate control. Medication storage and security compliance will be incorporated into the facility's QAPI process. The Administrator or designee will review medication storage audit findings and identified trends. Random audits will be conducted twice weekly for four weeks and monthly for two months thereafter. Any noncompliance will be corrected immediately and will result in staff re-education and/or additional corrective action as indicated. QAPI review will be used to determine whether the corrective measures have been effective and sustained.	8/26/26 8/31/26

OKLAHOMA
State Department
of Health

Delivery via email to: Katie@legacyseniorhomes.com

October 8, 2026

License Number: AL5576

Katie Dickey, Administrator
Legacy Senior Living At Preston Hills East
6900 Nw 129 Street
Oklahoma City, OK 73142

RE: Survey Event D6UR12

Dear Ms. Dickey:

On **October 8, 2026,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaints on **August 11, 2026,** have now been corrected effective **August 31, 2026.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 10/08/26. All deficiencies from the 08/11/26 survey were cleared.	{C 000}		

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