Oklahoma State Department of Health
Creating a State of Health

August 29, 2019

License Number: AL5535

Ms. Cheryl Bales, Administrator
Tealridge Assisted Living
2200 N E 140th
Edmond, OK 73013

Survey Event ID: YGKF11

Dear Ms. Bales:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **August 22, 2019**. 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) 271-6868.

Sincerely,

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

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INVESTIGATIVE REPORT
LICENSURE

Facility: **Tealridge Assisted Living**
Address: **2200 NE 140th**
City, State, Zip: **Edmond, Ok 73013**
Provider #: **AL5535**
Complaint #: **OK00054123**
Investigation Date(s): **08/21/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have adequate staff to ensure a safe environment.	US

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, August 22, 2019 at 4:30 a.m.

A sample of 3 residents including any identified residents was selected for the investigation based on the concerns relevant to the allegation.

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation related to staffing to meet the needs of the resident, staffing for supervision to prevent falls, family notification of falls and misappropriation of controlled medications.

Upon entrance to the center no staff members were outside smoking, two staff members were working in the memory care unit and two staff members were working in assisted living. No puddles were observed in the hallways, dining room or common areas. No residents had odors of urine or feces and were not saturated with urine or feces. No residents were found on the floor. A random narcotic count was conducted and all counts were correct.

The staff stated there were two staff members who worked in the memory care unit on the night shift and did not have any residents who required more than two person assistance. The staff stated if there was a spill they would clean it up as soon as they could or would put a wet floor sign out and were not aware of any residents slipping or falling in puddles of water. The staff stated they called the family before transferring a resident to the hospital. The staff stated they were not aware of any discrepancies in the narcotic medications. A resident family member (from memory care) stated she was notified when her family member had a fall and or before she was transported to the hospital. She stated she was not aware of a discrepancy in the resident's medications. The family member stated she felt like there was enough staff to care for the residents. A resident in the assisted living area stated the staff was very good and the center was very clean and was not aware of any residents falling due to water puddles. Interviews were attempted with the resident's on the memory care unit. Two residents refused to be interviewed.

Incident reports were reviewed and documented the family had been notified prior to the residents going to the hospital. No residents were documented to have fallen due to water puddles or to have had multiple visits to the emergency room due to falls. The punch logs were reviewed and documented at least two staff members were on duty in the memory care and two staff members in the assisted living on the night shift.

At the time of the investigation, the center was adequately staffed; was free from water puddles, and no narcotics were missing.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Billie Seeman

Billie Seeman, RN, Clinical Health Facility Surveyor

Date report completed: 08/26/2019

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
	AL5535	A. BUILDING: _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEALRIDGE ASSISTED LIVING	2200 N E 140TH EDMOND, OK 73013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted on 08/22/19 to investigate complaint #OK00054123. Current census was 64. No deficient practice was cited.	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	Provider/Supplier Name
AL5535	TEALRIDGE ASSISTED LIVING

Type of Survey (select all that apply)

3				

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

Extent of Survey (select all that apply)

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. BS 36191	08/22/2019	08/22/2019	1.00	3.50	3.75	0.00	2.00	3.00
2.								
3.								
4.								
5.								
6.								
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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**

AUG 30 2019