OKLAHOMA
State Department
of Health

Delivery via email to: grace@tealridge.com

May 17, 2023

License Number: AL5535

Ms. Grace Grajeda, Administrator
Tealridge Assisted Living
2200 N E 140th
Edmond, OK 73013

RE: Survey Event ID: TQRW11

Dear Ms. Grajeda:

On **April 27, 2023**, 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 April 27, 2023.

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;
(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 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
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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Tealridge Assisted Living**
Address: **2200 NE 140th**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5535**
Complaint #: **OK00059767**
Investigation Date(s): **04/25/23-04/27/23**

ALLEGATION(S)

1. The facility failed to follow infection control policies and procedures.
2. The facility failed to provide and environment free of offensive odors.

An unannounced on-site investigation was initiated 04/25/2023 at 1:35 p.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:

A tour of the center was conducted.

There were no offensive odors throughout the center.

No uninhabited rooms contained biohazard containers.

No black trash bags containing bags of biohazardous materials were observed in the kitchen.

No resident complained about odors, at the time of the survey.

No staff complained about odors, black trash bags, or biohazard materials, at the time of the survey.

Deficient practice was not cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Melissa Swaim RN

Date report completed: 04/27/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility:	**Tealridge Assisted Living**
Address:	**2200 NE 140th**
City, State, Zip:	**Edmond, OK 73013**
Provider #:	**AL5535**
Complaint #:	**OK00060116**
Investigation Date(s):	**04/25/23-04/27/23**

ALLEGATION(S)

1. The center failed to have and/or implement an effective pest control program.

An unannounced on-site investigation was initiated 04/25/2023 at 1:35 p.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:

A tour of the center was conducted.

Monthly pest control records were reviewed.

Resident's room, bedding and mattress were observed with no bed bugs.

No resident complained about bed bugs, at the time of the survey.

Staff stated they had not seen any bed bugs, but would report it if they did.

Deficient practice was not cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

M Sweem RN

Melissa Swaim RN

Date report completed: 04/27/2023

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 _____	C 04/27/2023

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 A relicensure survey was conducted 04/25/23 through 04/27/23. Complaint investigations (#OK00059767 and #OK00060116) were conducted in conjunction with the survey. Listed below are abbreviations used throughout this document. DON - Director of Nursing RN - registered nurse	C 000		
C 391 SS=D	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 record review, observation, and interview, the center failed to ensure food items were properly labeled, stored and dated according to "Chapter 257" and Company policy. Findings: The DON reported 63 residents at the center. Policies for labeling food, storing food, and dating food was requested. The facility didn't have a policy. 0n 04/25/23 at 3:23 p.m., during the kitchen observation with the executive chef, multiple food items were found undated and unlabeled in the refrigerator which included turkey meat, mustard, tomato and chicken soup.	C 391		

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 _____	C 04/27/2023

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 391	Continued From page 1 On 04/25/23 at 3:24 p.m., the Executive chef stated, "The food that's in those containers is turkey meat, tomato soup, chicken soup and mustard."	C 391		
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 record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for eight (#1, 2, 3, 6, 7, 8, 9, and #10) of ten residents whose comprehensive assessments were reviewed. Findings: On 04/27/23 at 10:51 a.m., during record review with the RN, Resident #1's comprehensive assessment dated 12/02/22 was not signed by the resident's representative. Resident #2's comprehensive assessment dated	C 543		

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 _____	C 04/27/2023

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 543	Continued From page 2 07/27/22 was not signed by the resident's representative. Resident #3's comprehensive assessment dated 04/03/23 was not signed by the resident's representative. Resident #6's comprehensive assessment dated 03/03/23 was not signed by the resident or the resident's representative. Resident #7's comprehensive assessment dated 11/03/22 was not signed by the resident's representative. Resident #8's comprehensive assessment dated 03/08/23 was not signed by the resident's representative. Resident #9's comprehensive assessment dated 01/11/23 was not signed by the resident's representative. Resident #10's comprehensive assessment dated 08/23/22 was not signed by the resident or their representative. On 04/27/23 at 10:53 a.m., the RN stated the comprehensive assessments reviewed had not been signed to include a personal interview between the resident or the resident's representative and the RN or physician.	C 543		

OKLAHOMA
State Department
of Health

Delivery via email to: grace@tealridge.com

June 2, 2023

License Number: AL5535

Ms. Grace Grajeda, Administrator
Tealridge Assisted Living
2200 N E 140th
Edmond, OK 73013

Survey Event ID: TQRW11

Dear Ms. Grajeda:

On **April 27, 2023,** a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. 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 **June 26, 2023**.

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,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/26/2023** **Facility Name:** Tealridge Assisted Livine and Memory Care **License Number:** AL5535 **Survey Event ID:** TQRW11 **Date Survey Completed: 4/27/2023**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391 SS=D	Based on: record review, observation, and interview, the center failed to ensure food items were properly labeled, stored and dated according to "Chapter 257" and Company policy.
ASSISTED LIVING CENTER'S PLAN OF CORRECTION	
Assisted Living Center's Comments: The Dietary Manager and Executive Director will monitor this POC to ensure this deficiency is addressed.	
REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	This deficiency could have effected all residents and this was discussed in an inservice for all dietary staff (cooks & aides) on May 24, 2023. The importance and the effects this deficiency could have caused was discussed. The inservice covered the importance of labeling and dating food items as well as the proper storage procedure that is to be followed. Reviewed the "FIFO", first in first out, storage prodedure that is to be followed. State regulation for 310-663-3-8(a) Food Storage, Preparation and Service, Chapter 257, as it pertains to labeling, dating and storage of food items as well as policy were discussed. By following the proper procedures residents will not be effected by this deficiency.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residence could have been affected, thus maintaining proper labeling, dating and storing procedures, other residents should not be affected.
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?	Dietary manager will create a form for the the cooks to sign off that food items are labeled and dated. Checks shall occur twice a week. See attached form.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: a. Dietary Manager and Executive Dir. will randomly check the form as well as food items to ensure that proper procedures are being followed and comply with state regs. b. Quaterly QA meetings will review, and Dietary Manager will report that forms are being completed and proper procedure of labeling, dating,and storage are being performed.

	c. The form that is created will be monitored by the Dietary Manager and Executive Director and kept in a binder.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	6/26/2023		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Dana S Brazda		**Date 5/26/2023**	
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.			

LABEL & DATE VERIFICATION FORM

Week of Monday _____ _____ Through Sunday Month _____ ___

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM Cook/ employee putting truck away - Make sure ALL fridge items are labeled and Dated every Saturday and Monday							
PM Cook/employee putting truck away - Make sure all freezer items are labeled and Dated every Sunday & Thursday							
PM Cook/ employee putting truck away - Make sure all dry storage items are labeled and Dated Every Tuesday and Friday							
AM Cook Verification truck is complety put away every Tuesday and Friday							

THIS IS MANDATORY AND MUST BE SIGNED ACCORDING TO THE SCHEDULED DATES ABOVE

All items must be fully put away. No items can be left on the floor. This is everyones responsibility by 2PM

ED Profit Dept C391

ID Prefix C391

AL Meeting Agenda 5-24-2023

- Label and Date verification form
- State Inspection
- Policy and procedure book
- Resident Directory Book
- Clocking in/out for break
- FIFO + Putting away a truck

EMPLOYEE SIGN IN SHEET

5-24-2023

AM Meeting	
Name	
1	Theresa Lacy
2	
3	
4	Grace Lilley
5	
6	
7	
8	
9	
10	

PM Meeting	
Name	
1	
2	
3	Tracia Williams
4	
5	
6	
7	
8	
9	
10	

5-24-23 ID Prefix Jacy C391

2nd sheet that was also signed

EMPLOYEE SIGN IN SHEET

	AM Meeting	PM Meeting
	Name	Name
1	Teresa Gay	1
2	Stacia Williams	2
3	Pam Pope	3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
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30		30

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/26/2023** **Facility Name:** Tealridge Assisted Livine and Memory Care **License Number:** AL5535 **Survey Event ID:** TQRW11 **Date Survey Completed: 4/27/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543 SS=E	Based on: record review and interview, the center failed to ensure each comprehensive assessment included a personel interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for eight (#1,2,3,6,7,8,9, and 10) of ten residents whose comprehensive assessments were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Director of Nursing and the Executive Director will monitor this POC to ensure this deficiency is addressed.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Residents assessments of those affected (#1,2,3,6,7,8,9) will be reviewed and a new assessment will be obtained that will include the resident/representative signature for the personal interview. Going forward from April 27, 2023 (date of survey exit), residents assessments will include a signature from the personal interview.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents assessments will be audited. This will be conducted by the RN, DON. The ED and DON will audit weekly to verify that a signature is on the personal interview.
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 tickler file will be created with a section for each month of the year. Each resident will have a card with admission date and ongoing assessments documented. The LPN will be trained to assist in the gathering of information/data for an assessment and the importance of obtaining the signature once the personal interview is completed. Each month the file will be checked to determine any upcoming assessments that need to be performed. A list will be created and assigned to the LPN to collect data and obtain a signature from the personal interview.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and	a)All residents assessments will be audited. This will be conducted by the RN, DON. The DON and ED will audit weekly (from the tickler created), to verify that a signature is on the personal interview. Enter methods to evaluate for effectiveness:

c. How monitoring records will be kept to evidence the correction.	b)At the quarterly QA the DON will present verification that all assessments have been audited for a personal interview and signature. c)A list will be kept in the QA binder (in the DON office). This list will consist of verification that the DON and ED have checked that all sassessments are signed on the personal interview.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Laura S Diagada	**Date** Enter a date of signature. 5-26-23

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.

Name _____ Admission date _____

14 Day Assessment _____

Annual Assessment dates

_____ _____ _____

_____ _____ _____

_____ _____ _____

Significant Change _____ _____

_____ _____

ID Prefix Dog C 543

Long Term Care

Oklahoma State
Department of Health

Assisted Living Optional Plan of Correction Form

Customer Feedback

Did you find the assisted living optional plan of correction form and instructions helpful?

Yes ☑

No ☐

Did not use ☐

What about the form or instructions did you find or not find helpful? Yes

Please let us know if there is anything you would like to see changed or improved on the form or instructions.

Please return with your plan of correction or fax to 405.271.2206 or email to LTC@health.ok.gov. Thank you for your feedback.

OKLAHOMA
State Department of Health

Delivery via email to: grace@tealridge.com

August 18, 2023

License Number: AL5535

Ms. Grace Grajeda, Administrator
Tealridge Assisted Living
2200 N E 140th
Edmond, OK 73013

RE: Survey Event TQRW12

Dear Ms. Grajeda:

On **August 14, 2023,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 27, 2023,** have now been corrected effective **June 26, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 _____	R-C 08/14/2023

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 offsite/paper revisit was conducted on 08/14/23. The facility was in substantial compliance.	{C 000}		

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