OKLAHOMA
State Department
of Health

Delivery via email to: grace@tealridge.com; Shekita@tealridge.com

December 28, 2023

License Number: AL5535

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

Survey Event ID: LKX711

Dear Ms. Grajeda:

On **December 4, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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:

(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 will be completed for each violation; and
(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 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 a 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 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: **Tealridge Assisted Living**
Address: **2200 N E 140th**
City, State, Zip: **Edmond, OK, 73013**
Provider #: **AL5535**
Complaint #: **OK00061323**
Investigation Date(s): **12/01/23 and 12/04/23**

ALLEGATION(S)

The center failed to provide adequate staff to ensure residents received care according to standards of practice and failed to prevent new or worsening pressure wounds.
The center failed to ensure proper lift education and equipment were provided for resident safety.
The facility failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 12/01/2023 at 5:20 a.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 other various times throughout the survey. Resident halls were observed for odors and potential urine saturation of residents. Staff were observed for assisting residents with activities of daily living, transfer assistance, and toileting needs, including providing incontinent care.

Resident records were reviewed including assessments, care plans, physician orders, nursing notes, treatment records from outside agency, activities of daily living records, hospital records, diagnostic reports, incident reports, and State reportable incidents. Facility policy and procedures were reviewed. Grievance records were reviewed. Staffing records were reviewed.

Residents were interviewed related to the provision of activities of daily living assistance, transfers, incontinent care, and wound care. They were asked if there were adequate staff to assist them in a timely manner.

Staff members were interviewed regarding the facility policy on incontinent care, assistance with activities of daily living, and transfers. An outside agency performs wound care for the residents.

The attached Statement of Deficiencies, Form 2567 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: 12/07/2023

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 12/04/2023

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 complaint investigation (#OK00061323) was conducted on 12/01/23 and 12/04/23. Facility Census: 68 The following abbreviations will be used throughout this document: ADLs- activities of daily living CNA- certified nurse aide DON- director of nursing OSDH- Oklahoma State Department of Health	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences	C1505		

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C1505	Continued From page 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the center failed to provide care in a manner which prevented cross-contamination for five (#1, 5, 6, 10, and #11) of six sampled residents observed receiving care. The facility room roster, undated, documented 68 residents resided in the facilty. Findings: The facility "Hand Washing Policy", undated, read in part, "...Proper hand washing is important in controlling the spread of infections..." On 12/01/23 at 5:37 a.m., CNA #1 unfastened Resident #6's brief, used several disposable wipes to provide incontinent care to the resident, removed the soiled brief, threw it in the trash, and placed a new disposable brief on the resident. The same gloves were used throughout the incontinent care. CNA #1 removed their gloves after the care was complete, threw them into the trash can, and removed the trash bag. CNA #1	C1505		

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C1505	Continued From page 2	C1505		

exited Resident #6's room without washing or sanitizing their hands.

On 12/01/23 at 5:50 a.m., CNA #1 entered the laundry room and placed the trash bag in a grey barrel. CNA #1 closed the laundry room door with their hands, then knocked on the bathroom door across from the conference room, entered the room, and washed their hands with soap and water.

On 12/01/23 at 5:54 a.m., CNA #1 stated staff were to wash their hands after changing residents or dealing with blood. They stated staff should also wash their hands after taking stuff out.

On 12/01/23 at 6:01 a.m., CNA #1 was asked if there was a reason they did not use the sink in the resident's room to wash their hands. They stated they felt it was an invasion of the resident's privacy. They stated, "I probably should have."

On 12/01/23 at 6:52 a.m., CNA #3 assisted Resident #5 to a seated position on their bed while wearing gloves, assisted the resident with getting dressed, donning shoes, and ambulating via walker to the bathroom.

On 12/01/23 at 6:58 a.m., Resident #5 voided on the toilet. CNA #3 provided peri care to the resident with the same gloves on, and removed their gloves and threw them away. CNA #3 did not wash or sanitize their hands after performing peri care. CNA #3 pulled the resident's pants up and assisted the resident to their wheelchair. CNA #3 handed Resident #5 their glasses, phone, Kleenex, and a soda they obtained from the resident's refrigerator. CNA #3 opened the resident's door, and turned off the light in the room.

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C1505	Continued From page 3 On 12/01/23 at 7:08 a.m., CNA #3 wheeled Resident #5 to the dining room, removed Resident #5's feet from the foot pedals of the wheelchair, and locked the resident's wheelchair in place. CNA #3 took out their keys, walked outside of the building, got into their car, obtained their work badge then reentered the building. CNA #3 still had not washed/sanitized their hands after performing peri care. On 12/01/23 at 7:11 a.m., CNA #3 walked back into the dining room to Resident #10 touched the alarm button located around the resident's neck, and used the magnet on CNA #3's badge to turn the alarm off. CNA #3 still had not washed or sanitized their hands from the peri care provided to Resident #5. On 12/01/23 at 7:15 a.m., CNA #3 obtained a pair of gloves from the nurses' station but did not put them on. CNA #3 walked to Resident #11's room, picked up a basket of clothes on from the floor outside the door, walked into the resident's room, and placed the basket in the resident's room. CNA #3 who still had not washed or sanitized their hands placed their hand on Resident #11's walker, the resident used the walker to stand, and CNA #3 assisted Resident #11 to the medication room for pain medication. CNA #3 used the magnet on their badge to turn off the alarm button around Resident #11's neck and left the room. On 12/01/23 at 7:19 a.m., CNA #3 walked to Resident #11's door and closed it. The CNA still did not wash or sanitize their hands. On 12/01/23 at 7:20 a.m., CNA #3 knocked on Resident #1's door, walked over to the resident and touched their electric wheelchair. CNA #3	C1505		

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C1505	Continued From page 4 picked up a plate and cup in the resident's room and threw it away, removed a phone from their pocket, and stated, "Call lights were sent through text messages too." On 12/01/23 at 7:21 a.m., CNA #3 stated there was hand sanitizer located on the hall which they used occasionally when they walked down the hall. They stated they would wash their hands after they gave showers. They stated they had not washed/sanitized their hands after assisting Resident #5 in the bathroom. On 12/04/23 at 10:45 a.m., the DON stated staff should wash their hands every third room or sanitize. They stated staff should be wearing gloves and sanitizer was located on the hall. The Resident Care Coordinator stated staff should wash/sanitize their hands immediately after resident care.	C1505		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes;	C1912		

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C1912	Continued From page 5 (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure an allegation of neglect was reported to OSDH for one (#2) of three sampled residents reviewed for assistance with ADLs. The facility room roster, undated, documented 68 residents resided in the facilty. Findings: The facility "Abuse/Neglect" policy, undated, read	C1912		

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C1912	Continued From page 6	C1912		

in part, "...Residents shall be free from mental and physical abuse...Identification: Staff to report suspicious occurrences, bruising of unknown origin, pattern and trending..."

Resident #2 had diagnoses which included hereditary motor and sensory neuropathy and functional urinary incontinence.

An "Annual Resident Assessment Form", dated 07/10/23, documented Resident #2 was not weight bearing, and was incontinent of bowel and bladder.

A "Nursing Note", dated 08/31/23, documented the morning CNA on the B Hall informed the lead medication aide Resident #2 had been up all night, their clothes were not changed, and the resident was not laid down all night. It documented Resident #2 was up in their power chair with the lights on in the room. It documented videos were reviewed, and CNA #4 was observed leaving the residents room at 10:40 [does not specify a.m. or p.m.] and left the lights on. It documented throughout the night, no one entered Resident #2's room.

An "Incident Report", dated 08/31/23 on the 6:00 p.m. to 6:00 a.m. shift, documented Resident #2 was found in their room at 7:00 a.m. with the same clothes on from the day before. It documented Resident #2 was placed in their bed and cleaned up because they were saturated with urine and had feces running down their leg. It documented security footage was observed to see who was involved in the neglectful practice. It documented CNA #4 entered the resident's room from 8:38 to 8:40 (it did not specify a.m. or p.m.) and left the light on. It documented no one re-entered the resident's room until the morning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1912	Continued From page 7 It documented the Agency was contacted and a link to report the incident to their abuse and ethics board was sent. It documented CNA #4 was not to return to the facility. There was no documentation the OSDH was notified of this allegation of neglect. On 12/01/23 at 10:45 a.m., the DON reviewed the 08/31/23 note and stated CNA #4 was an agency staff member. The DON stated they along with the administrator spoke with the agency about the incident and informed them CNA #4 was not to return to their facility. The DON stated the agency staff sent them a link to fill out a report for the neglect. The DON stated they completed an incident report and called the residents family. The DON stated if neglect involved an agency staff member, they would submit the allegation to the agency not the State department. The DON stated since CNA #4 was agency, they filled out the report for them and the agency handled it internally.	C1912		

OKLAHOMA
State Department
of Health

Delivery via email to: Shekita@tealridge.com

January 12, 2024

License Number: AL5535

Ms. Shekita Anderson, Administrator
Tealridge Assisted Living
2200 N E 140th
Edmond, OK 73013

Survey Event ID: LKX711

Dear Ms. Anderson:

On **December 4, 2023,** a complaint investigation was 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 **February 5, 2024**.

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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/5/2024

Facility Name: Tealridge Assisted Living And Memory Care

License Number: AL-5535-5535

Survey Event ID: LKX711

Date Survey Completed: 12/4/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on observation, record review and Interview, the center failed to provide care in a manner which prevented cross-contamination for five(#1,5, 6, 10, and # 11) of six sampled residents observed receiving care.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	All staff staff will be trained on CDC Hand Hygiene guidelines.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to 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?	Staff will be monitor for proper hand hygiene during scheduled shift by Executive Director and/or Director of Nursing for compliance. Findings of the reviews will be placed in writing 1 x per week.
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.	Results of the reviews will be reviewed in the QA meeting. QA team will recommend and put in place additional interventions if needed. Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/5/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Shekita Anderson Ed OAC 310:663-25-4(F)	**Date 1/5/2024**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/5/2024** **Facility Name:** Tealridge Assisted Living And Memory Care **License Number:** AL-5535-5535 **Survey Event ID:** LKX711 **Date Survey Completed: 12/4/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1912	Based on: Based on observation, record review and Interview, the center failed to ensure an allegation of neglect was repored to OSDH for one (#2) of three sampled residents reviewed for assistance with ADL's.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	A report will be sent to OKDHS with the findings of the investigation including agency staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to 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?	All incident reports will be reviewed by the Executive Director and/or Director of Nursing for reporting requirements. Findings of the reviews will be placed in writing 1 x per week.
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.	Results of the reviews will be reviewed in the QA meeting. QA team will recommend and put in place additional interventions if needed. Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/5/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Shekita Anderson Ed** OAC 310:663-25-4(F)	**Date 1/5/2024**

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

Delivery via email to: Shekita@tealridge.com; executivedirector@tealridge.com

February 20, 2024

License Number: AL5535

Ms. Shekita Anderson, Administrator
Tealridge Assisted Living
2200 N E 140th
Edmond, OK 73013

Survey Event ID: LKX712

Dear Ms. Anderson:

On **February 15, 2024,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 4, 2023,** have now been corrected effective **February 15, 2024.**

If you have any questions concerning the information in this letter, please contact 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

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 02/15/2024

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 revisit was conducted from 02/15/24 through 02/15/24. All deficiencies from the 12/04/23 survey were cleared. Facility Census: 69	{C 000}		

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