

Delivery via email to: executivedirector@tealridge.com

March 3, 2025

License Number: AL5535

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

RE: Survey Event ID: 47JW11

Dear Ms. Anderson:

On **February 21, 2025**, 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 **February 21, 2025**.

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:

- (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 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 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, 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: AL5535	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER TEALRIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 from 02/20/25 through 02/21/25. Facility Census: 62 Listed below are abbreviations that will be used throughout the document. RN- registered nurse	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure annual comprehensive assessments were signed/coordinated by a RN or physician for 1 (#9) of 10 residents reviewed for assessments coordinated by a RN or physician. The executive director identified 62 residents resided in the center. Findings: Resident #9 was admitted on 01/08/24 with diagnoses which included essential primary hypertension, vitamin B12 deficiency anemia, hypothyroidism, enlarged prostate, pure hypercholesterolemia, restless leg syndrome, unspecified glaucoma, polyneuropathy, thrombocytopenia, vitamin D deficiency.	C 542		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5535	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER TEALRIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 542	Continued From page 1 Resident #9's comprehensive annual assessment, dated 01/08/25, did not show it was signed/coordinated by a RN or physician. On 02/21/25 at 12:30 p.m., licensed practical nurse #1 who was responsible for conducting assessments stated the above assessment was not signed by a RN or physician.	C 542		



Delivery via email to: executivedirector@tealridge.com

March 17, 2025

License Number: AL5535

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

RE: Survey Event 47JW11

Dear Ms. Anderson:

On **February 21, 2025**, a Re-Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and in a timely manner. **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 **April 30, 2025**.

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,

Tempal Killman

Tempal Killman, 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: 3/13/2025		
	Facility Name: Tealridge Assisted Living and Memory Care		
	License Number: AL5535		
	Survey Event ID: 47JW11		
Date Survey Completed: 2/21/2025			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 542		Based on: Record review the center failed to insure annueal comprehensive assessments were signed/coordinated by RN or Physician.	
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?		Executive Director will In-service RN and LPN on Policy and Procedures for having Assessments signed by all required parties within the required time frame.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Other residents having the potential to be affected will be identified by weekly monitoring by Executive Director.	
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?		Measures inluced: Weekly monitoring of assessments for signatures on Comprehensive 14 day assessment, Annual, Change in Condition, or New Admission by ED and RN. Documentation will be in Executive Director's office.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Results of documentation will be reviewed in the weekly manager meeting and monthy QA meeting. Nesassary chages will be made to ensure compliance.	
a. How the correction will be evaluated for effectiveness;		QA team will identify and put in place additional interventions as needed.	
b. How the correction will be incorporated into the center's quality assurance system; and		Enter methods to incorporate into QA system:	
c. How monitoring records will be kept to evidence the correction.		Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		4/30/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Shekita Anderson</i> OAC 310:663-25-4(F)		Date 3/14/2025	
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	Shekita Anderson Executive Director
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.			



Delivery via email to: Shekita Anderson <executivedirector@tealridge.com>

May 6, 2025

License Number: AL5535

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

RE: Survey Event 47JW12

Dear Ms. Anderson:

On **May 5, 2025**, an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 21, 2025**, have now been corrected effective **April 30, 2025**.

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

Respectfully,

A handwritten signature in black ink that reads "Lisa Calvin". The signature is written in a cursive, flowing style.

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: AL5535	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/05/2025
NAME OF PROVIDER OR SUPPLIER TEALRIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 05/05/25. 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