OKLAHOMA
State Department
of Health

Delivery via email to: dweaver@tealcreekok.com

June 30, 2021

License Number: AL5541

Ms. Debra Weaver, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

Survey Event ID: Z5XX11

Dear Ms. Weaver:

On **June 1, 2021**, 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.

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 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 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 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:

OKLAHOMA
State Department
of Health

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 Digitally signed by Katie Stagner
Date: 2021.06.30 14:00:11 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Teal Creek Assisted Living and Memory Care**
Address: **13501 N. Bryant Ave.**
City, State, Zip: **Edmond Ok 73013**
Provider #: **AL5541**
Complaint #: **OK00055146**
Investigation Date(s): **05/26/21, 05/27/21 and 06/01/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement their abuse policy.	S

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

An unannounced on-site investigation was initiated on Wednesday, May 26, 2021 at 9:35 a.m.

A sample of three 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 and C1512 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman By Pamela Carlson RN

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/02/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Teal Creek Assisted Living and Memory Care**
Address: **13501 N. Bryant Ave.**
City, State, Zip: **Edmond OK, 73013**
Provider #: **AL5541**
Complaint #: **OK00055892**
Investigation Date(s): **05/26/21, 05/27/21 and 06/01/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide residents access to common areas.	**US**

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

An unannounced on-site investigation was initiated on Wednesday, May 26, 2021 at 9:35 a.m.

A sample of three 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 specific to resident access to common areas in the building was conducted.

The center had two elevators both working at the time of the survey. The residents on the second floor had an elevator on the assisted living side of the center and an elevator on the locked memory care unit. Residents were observed using both elevators, and were observed in the common areas downstairs throughout the survey.

The administrator was asked about the elevators. She stated one of the elevators was not working for a period of time. She stated it took longer to get parts due to COVID-19. She was asked if the residents had an

alternative method to get downstairs. She stated the residents were escorted either down the stairs or to the memory care elevators by the staff. She stated the residents who were able to have a code were given the code to get into the memory care to access the elevator that was working. She also stated the mail and meals were delivered to the residents' apartments due to COVID-19 restrictions.

Residents were asked about the elevators. They stated one of the elevators was broken for a while but they had access to the other elevator and the stairs. Residents on the second floor also stated they had been given the code to access the memory care unit elevator.

The incident reports, fire inspection, elevator inspection and work orders were reviewed. The incident reports did not reveal any residents had fallen on the stairs or had any adverse outcomes due to the elevator not working. The elevator was inspected and repairs were requested immediately upon discovering the elevator was not working properly.

No deficient practice was identified at the time of the survey.

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 By Pamela Anderson RN

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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 05/26/21, 05/27/21 and 06/01/21 to investigate complaint #OK00055146 and #OK00055892. Total residents: 47	C 000		
C1505 SS=G	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 of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ~ inform the resident's power of attorney prior to the resident being weighed by an outside hospice company; ~ensure the resident and the resident's POA were given the right to refuse to be weighed by the hospice company and; ~ensure the hospice company was aware of resident's physical capabilities prior to attempting to weigh the residents for one (#6) of one sampled resident who was not able to bear weight. This resulted in actual harm. The resident had a fall while the hospice company attempted to weigh her and she sustained a displaced fracture of proximal end of the left humerus (The arm bone between your shoulder and elbow.), closed non displaced fracture of metatarsal bone of the right foot (Long bone located between the toes and the mid foot.), AC separation (The collar bone separates from the shoulder blade.) and closed non displaced fracture of the left clavicle (The collar bone.) The center identified all residents had been weighed by a hospice company who performed a weight clinic at the center on 02/20/20.	C1505		

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C1505	Continued From page 2 Findings The center's policy, titled, 'Teal Creek Lift, Transfer & Repositioning Policy, documented, "...All residents will be assessed by the facility Care Plan team with regard to the need for assistance with transfer activities, mobility or repositioning. Manual lifting of all residents who are unable to bear weight will be minimized..." Resident #6 was admitted to the center with diagnoses which included dementia and weakness. A physician's progress, dated 12/11/19, documented, "...Functional Status: She is only mobile with a wheelchair and is now primarily bedbound..." The note was signed by the resident's physician. An annual assessment, dated 01/09/20, documented the resident was alert, oriented to self, confused and had poor judgment. The assessment documented the resident had poor mobility, strength, and gait, was bedfast and chairfast. The assessment documented the resident required two person assistance for transfers was non-ambulatory and could bear weight at times. The assessment was signed by the resident's daughter as the representative. A registered nurse skilled nursing note from the resident's hospice company, dated 02/11/20, documented, "...[Resident #6] has been bedbound for so long, that she is now unable to walk or stand at all...Pain daily...Pain site: joints..." An Oklahoma State Department of Health	C1505		

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C1505	Continued From page 3 incident report, dated 02/20/20, documented a hospice company was conducting a weight clinic at the center. The registered nurse and hospice aide and two of the center's staff entered resident #6's apartment to attempt to weigh her. The report documented the resident complained of pain when the hospice staff assisted her up to a sitting position and her legs gave way when she was stood up by the bed. The hospice staff put the resident back to bed and did not report the incident. The report documented a video camera was in the resident's apartment at the time of the incident. The report documented the hospital x-rays revealed a displaced fracture of the proximal end of the left humerus, fracture of metatarsal bone of the right foot, AC separation, non displaced fracture of the left clavicle. The report documented the resident had become bedfast/chair fast and received hospice services. On 05/26/21 at 3:30 p.m., certified nurse aide (CNA) #3 was asked if the resident was bedbound. She stated yes, the resident had not been out of bed. She was asked why the hospice staff had attempted to weigh resident #6. She stated the resident had never been weighed. The CNA was asked if she consulted with the center's nurse before they attempted to weigh the resident. She stated no. At 1:25 p.m., the daughter of resident #6 stated she was not informed about the weight clinic. She stated she did not know they had planned to weigh the resident and had not given the hospice company permission to weigh her. She was asked if the resident was bedbound. She stated yes, she had not been out of the bed in a year. The resident's daughter stated the resident was in pain when she was moved. The daughter stated the center had a video of the incident. She	C1505		

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C1505	Continued From page 4	C1505		

then stated on the video you could hear the resident saying no and "Protesting against getting up."

On 05/27/21 at 10:06 a.m., the administrator was asked what the hospice company was doing at the center. She stated the hospice company wanted to come in and market their company. She then stated she had arranged for the hospice to come and weigh the residents. She also stated the residents could choose if they wanted to let the hospice staff weigh them. The administrator was asked why the hospice company weighed resident #6 when the resident was on service with another hospice company. She stated she did not know.

At 11:07 a.m., the administrator was asked if the resident had given permission to be weighed. She stated according to the video, the hospice nurse did not give the resident time to refuse. The administrator was asked if the resident had a power of attorney (POA). She stated yes. The administrator was asked if the POA was contacted before they attempted to weigh the resident. She stated no. She was asked if the resident had the right to refuse treatment. She stated yes.

At 11:36 a.m., the director of nursing (DON) was asked if resident #6 had fallen. She stated what she remembered from the video the hospice staff was trying to get the resident up and it was like she went down. She stated, "To me it was not a fall." She stated the resident could not bear weight. She stated the hospice staff did not know the resident could not bear weight.

On 06/01/21 at 9:10 a.m., a former employee stated she witnessed the incident on 02/20/20.

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C1505	Continued From page 5 She stated the resident stated, "No, Stop and Ow" and stated she was in pain while the hospice company attempted to get the resident out of bed. She stated certified nurse aide (CNA) #3 stated it was okay for the hospice nurse and aide to weigh the resident. The former employee was asked if the resident had fallen. She stated yes, "They dropped her." She was asked if the resident's body hit the ground. She stated yes. She was asked if the resident was assessed for injuries after the fall. She stated no, the hospice nurse and aide put the resident back in bed and left the room. The former employee stated the resident's personal companion came back to the room and noticed the resident was in pain. The former employee stated she told the companion what had happened. On 06/01/21 at 9:35 a.m., the DON was asked if she had given the hospice company report on the residents' ability to ambulate or bear weight on the day of the weight clinic. She stated she did not recall giving them a report on the residents. The DON was asked if any other nurses were working on 02/20/20. She stated licensed practical nurse (LPN) #2 was working. The DON was asked who was responsible for the hospice company while they were in the building. She stated she was along with the other nurses who worked for the center. The DON stated she knew the hospice company was in the building doing a weight clinic but the hospice company employees did not report to her. The DON stated she was not informed by the hospice nurse resident #6 had fallen. On 06/01/21 at 10:08 a.m., the RN was asked for the fall assessment for resident #6. She stated she did not know where it would be. The fall risk assessment was not found in the residents	C1505		

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C1505	Continued From page 6 clinical record. She stated she had not done a fall risk assessment since she had been at the center. At 11:35 a.m., LPN #2 stated she did not give the hospice nurse report on the residents on the day of the weight clinic and was not told by the hospice nurse resident #6 had fallen.	C1505		
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions	C1512		

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C1512	Continued From page 7 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure ~ the staff reported a resident's fall immediately and; ~ the resident was assessed for injuries after a fall for one (#6) of three sampled residents who had falls. This had the potential to affect all 47 residents who resided in the center.	C1512		

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C1512	Continued From page 8 Findings The center's abuse policy, titled, 'Abuse Policy, documented."...Neglect may be defined as conduct resulting in the deprivation of care necessary to maintain an individual's minimum physical and mental health. Examples may include: lack of medical care or personal care...Any employee who witnesses or becomes aware of alleged...neglect...should report such incident to the administrator or supervisor on duty immediately..." Resident #6 was admitted to the center with diagnoses which included dementia and weakness. An annual assessment, dated 01/09/2020, documented the resident was alert, oriented to self, confused and had poor judgment. The assessment documented the resident had poor mobility, strength, and gait, was bedfast and chairfast. The assessment documented the resident required two person assistance for transfers was non-ambulatory and could bear weight at times. The assessment was signed by the resident's daughter as the representative. A registered nurse skilled nursing note from the resident's hospice company, dated 02/11/20, documented, "...[Resident #6] has been bedbound for so long, that she is now unable to walk or stand at all...Pain daily...Pain site: joints..." An Oklahoma State Department of Health incident report, dated 02/20/20, documented the hospice registered nurse and hospice aide and two of the center's staff attempted to weigh resident #6 during a weight clinic. The report	C1512		

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	AL5541	A. BUILDING: _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1512	Continued From page 9	C1512		

documented the resident complained of pain when the hospice staff assisted her up to a sitting position and her legs gave way when she was stood up by the bed. The hospice staff put the resident back to bed and did not report the incident. The report documented a video camera was in the resident's apartment at the time of the incident. The report documented the hospital x-rays revealed a displaced fracture of the proximal end of the left humerus, fracture of metatarsal bone of the right foot, AC separation, non displaced fracture of the left clavicle. The report documented the registered nurse (RN) and owner from the hospice company, administrator, director of nursing (DON) had a conference call. On the call the RN stated she notified the DON of resident #6's fall. The report documented the RN stated "that's my bad", after the DON and another licensed practical nurse (LPN) stated she did not report the fall when she turned in the weights.

A nurse's note, dated 02/21/20, documented report was received via phone call last night (02/20/20) that while a home care company was here doing weights yesterday they dropped the resident in the process. The note was signed by the DON.

A nurse's note, dated 02/28/20 at 3:15 p.m., documented the resident's daughter was in the building to meet with the hospice company who performed the weight clinic. The hospice company apologized for what occurred during the weight clinic. The note was signed by the DON.

A statement by the center's RN, dated 02/28/20, documented, "...I observed the video that was supplied by the family that displayed [Resident #6] being assisted to the floor and then lifted back into her bed by [name-deleted hospice] RN and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1512	Continued From page 10	C1512		

CNA. Teal Creek administrator then informed me that the resident had sustained a fracture from this occurrence and it had not been reported by [name-deleted Hospice]...Hospice administrator took accountability and stated she didn't understand why her RN had not reported it. I then informed the CNA to always report any incident and she stated she had thought the RN did. I then again stated to always write your own statement and report an incident. I let the administrator from [name-deleted hospice] know that this is a reportable incident and she should notify the Board of Nursing that the RN did not report the incident..."

On 05/26/21 at 3:30 p.m., certified nurse aide (CNA) #5 was asked if she reported resident #6's fall. She stated no, she thought the hospice nurse was going to report the fall.

At 1:25 p.m., the daughter of resident #6 was asked if the resident had fallen. She stated yes, The resident's daughter stated the video camera showed the hospice staff dropping the resident while they tried to get her up to be weighed and then they put her back to bed.

On 05/27/21 at 10:06 a.m., the administrator stated the weight clinic was set up by her to have the hospice company weigh the residents. She was asked who reported the fall resident #6 had on 02/20/20. She stated the resident's private sitter. She stated the resident's daughter stated she watched the video and the resident had been dropped. The administrator stated she also viewed the video. The administrator was asked about the center's policy and procedure after a resident had a fall. She stated after a resident had a fall, it would be reported immediately to the nurse. If the nurse was in the building, she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1512	Continued From page 11	C1512		

assess the resident immediately. The administrator was asked if the hospice RN assessed the resident after the fall. She stated based on the video, the hospice RN did not assess the resident after the fall.

At 11:36 a.m., the DON was asked about resident #6's fall. She stated she watched part of the video. She stated she remembered the hospice staff trying to get the resident up and it was like she went down. She stated to her it was not a fall. She stated the resident could not bear weight. She stated the hospice staff did not know the resident could not bear weight.

On 06/01/21 at 9:10 a.m., a former employee stated she witnessed the incident on 02/20/20. She stated the resident stated, "No, Stop and Ow" and stated she was in pain while the hospice company attempted to get the resident out of bed. She stated certified nurse aide (CNA) #5 stated it was okay for the hospice nurse and aide to weigh the resident. The former employee was asked if the resident had fallen. She stated yes, "They dropped her." She was asked if the resident's body hit the ground. She stated yes. She was asked if the resident was assessed for injuries after the fall. She stated no, the hospice nurse and aide put the resident back in bed and left the room. The former employee stated the resident's personal companion came back to the room and noticed the resident was in pain. The former employee stated she told the companion what had happened. She stated she did not report the fall because she thought the hospice nurse was going to report the fall.

On 06/01/21 at 9:35 a.m., the director of nursing (DON) was asked if resident #6's fall was reported to her. She stated no. She was asked if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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
C1512	Continued From page 12 she assessed the resident after the fall on 02/20/20. She stated no, because she did not know resident #6 had fallen. At 11:35 a.m., LPN #2 stated she did not give the hospice nurse report on the residents on the day of the weight clinic and was not told by the hospice nurse resident #6 had fallen. She also stated she did not assess the resident.	C1512		

OKLAHOMA
State Department
of Health

Delivery via email to: dweaver@tealcreekok.com

July 19, 2021

License Number: AL5541

Ms. Debra Weaver, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

Survey Event ID: Z5XX11

Dear Ms. Weaver:

On **June 1, 2021,** 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 **September 13, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.07.19 14:18:18 -05'00'

Tempal Killman, Administrative Assistant
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: 7/13/2021** **Facility Name:** Teal Creek Assisted Living & Memory Care **License Number:** AL5541 **Survey Event ID:** Z5XX11 **Date Survey Completed: 6/1/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: interview and record review, it was determined the center failed to inform the resident's power of attorney prior to the resident being weighed by an outside hospice company; ensure the resident and the resident's POA were given the right to refuse to be weighed by the hospice company and; ensure the hospice company was aware of resident's physical capabilities prior to attempting to weigh the residents for one (#6) of one sampled resident who was not able to bear weight.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather, it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific action in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors.

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?	As of 2/21/2020, there have been no weight clinics conducted by hospice companies or other outside vendors in this facility. The practice of allowing other healthcare companies to weigh our residents has been permanently discontinued. Care coordination with third party vendors will be performed quarterly to promote complete understanding by all parties of the resident's condition, capabilities and needs. The next third party care coordination meeting will be held on or before 8/13/2021. If a new third party vendor begins to care for residents in our facility, a third party care coordination meeting will be scheduled as soon as possible between the facility DON, facility administrator, a care staff member and the third party vendor. Education and training regarding resident rights, abuse and neglect, care planning, and incident reporting will be provided to all care staff by the DON or her designee, on or before 9/01/2021.This education will ensure resident's rights are understood and honored, that residents are free from abuse and neglect, that care planning is accurate and revisions are made as needed, and that all incidents involving injuries receive proper intervention and a timely response.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	As stated above, there have been no weight clinics conducted by hospice or other outside vendors since 2/21/2020. The practice of allowing other healthcare providers to weigh our residents has been permanently discontinued. To identify residents having the potential to be affected by the same deficient practice, all residents

	receiving home health or hospice services will be discussed at the third party care coordination meeting scheduled for 8/13/21. Because all residents are deemed to be at some risk for abuse or neglect due to frailty, dependence, and/or cognitive impairment, they will be observed by care staff to ensure that safety and quality care is provided at all times. Any concerns will be brought to the DON and Administrator to be addressed immediately and the safety committee/safety coordinator will be notified. Education and training on 9/1/2021 and on-going training regarding resident rights, abuse and neglect, care planning, and incident reporting will give the care staff a more thorough understanding of these issues and how they might intervene to protect the residents in their charge.
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?	As stated above, there have been no weight clinics conducted by hospice or other outside vendors since 2/21/2020 and these clinics have been permanently discontinued. Therefore, the potential to be affected by this practice no longer exists. To ensure that all residents receive the best care possible, training regarding resident's rights, abuse and neglect, care planning, and incident reporting will be completed on or before 9/01/2021. 3rd party care coordination meetings will take place quarterly. The next care coordination meeting is scheduled for 8/13/2021. A safety committee has been newly formed to address the safety needs of all residents. The first meeting of the safety committee will be held on 7/27/2021. Monthly safety meeting minutes will be reviewed at the quarterly performance improvement meetings as a measure to further enhance communication and identify resident needs or concerns. Daily stand-up meetings for the nursing staff/care team will begin on 7/19/2021. The goal of these meetings is to enhance communication regarding resident changes, concerns, or needs. The DON will record changes and notify appropriate parties if deemed necessary. POA's will be notified of any concerns or changes by the DON, her desigated representative, or the Administrator. Care plan changes will be made as necessary and appropriate with consideration given to any physical, emotional, and/or cognitive challenges that arise. POA's of residents requiring care plan changes will be notified of proposed changes and asked for input in the care plan. The resident council meets the first Monday of every month to address the needs and concerns of all residents and to make sure resident rights are honored. The facility representative present at these council meetings will notify management staff of any environmental safety concerns, perceived violations of

	resident rights, or instances of abuse or neglect so these concerns may be immediately addressed.
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.	Audits will be conducted by the Administrator or designee to ensure all new and existing facility staff have received education on resident rights, abuse and neglect, proper use of the care plan, and incident reporting. These audits will be carried out on a weekly basis for 2 months, then monthly for 6 months. The correction will be considered effective as evidenced by completed education and training by all staff, absence of any abuse or neglect, care plan changes/updates are pertinent and made appropriately, and incidents/accidents are reported immediately with timely and proper intervention. Resident rights will be honored by all staff members, as reported by the resident council. The correction will be incorporated into our quality assurance system by reviewing education and training records, safety meeting minutes, incident reports, third party coordination of care meeting notes, care plans that may require changes, and incident reports during quarterly QA meetings. Safety meeting minutes, QA meeting minutes, incident reports, third party coordination of care meeting notes, care plans, and education and training records will be kept in the DON's office. These documents will be reviewed during quarterly QA meetings, monthly safety meetings, and more often if needed. These records are evidence of the measures put in place to ensure no recurrence of the deficient practice.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/13/2021
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. Debra Weaver, Administrator OAC 310:663-25-4(F)	**Date 7/13/2021**
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: 7/13/2021** **Facility Name:** Teal Creek Assisted Living & Memory Care **License Number:** AL5541 **Survey Event ID:** Z5XX11 **Date Survey Completed: 6/1/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: interview and record review, it was determined the center failed to ensure the staff reported a resident's fall immediately and; the resident was assessed for injuries after a fall for one (#6) of three sampled residents who had falls. This had the potential to affect all 47 residents who resided in the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather, it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific action in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors.

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 fall risk assessment and Berg balance Scale will be completed upon admission with every resident and upon any change in condition. Current residents known to be at an enhanced risk for falls will be identified by the care team and referred to nursing for a fall risk assessment, and to the safety coordinator for monitoring. As an additional fall prevention measure, the Berg Balance Scale will be utilized with each fall risk assessment. Care coordination with third party vendors will be performed quarterly to promote complete understanding by all parties of the resident's condition, capabilities and needs. The next third party care coordination meeting will be held on or before 8/13/2021. If a new vendor begins to care for a resident in our facility, a third party care coordination meeting will be scheduled as soon as possible between the facility DON, facility administrator, a care staff member and the third party vendor. Education and training regarding resident rights, abuse and neglect, care planning, fall prevention, and incident reporting will be provided to all care staff by the DON or her designee, on or before 9/01/2021.This education will ensure resident's rights are understood and honored, that residents are kept free from abuse and neglect, that care planning is accurate and revisions are made as needed, that residents are protected from preventable falls, and that all incidents involving injuries receive proper intervention and a timely response.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	To identify residents having the potential to be affected by the same deficient practice, all residents with a history of falls or those who use assistive devices will receive a new fall risk assessment and Berg Balance Scale on or before

	9/12/2021. New residents will receive a fall risk assessment and a Berg Balance Scale upon admission. Current residents identified by the care staff to be at an enhanced risk for falls will be referred to nursing for a fall risk assessment, Berg Balance Scale, and to the safety coordinator/DON for monitoring.
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?	To ensure that the deficient practice will not recur, the following measures have been and/or are being taken: Training regarding resident's rights, abuse and neglect, care planning, fall prevention, and incident reporting will be provided to all care staff by the DON or her designee, on or before 9/1/2021. A safety committee has been newly formed to address the safety needs of all residents. The first meeting of the safety committee will be held on 7/27/2021. Monthly safety meeting minutes will be reviewed at the quarterly QA meetings as a measure to further enhance communication and identify resident needs or concerns. Daily stand-up meetings for the nursing staff/care staff will begin on 7/19/2021. The goal of these meetings is to improve communication regarding resident changes, concerns, or needs. The DON will document any needs or concerns and notify the appropriate parties if deemed necessary. POA's will be notified of any concerns or changes by the DON, her designated representative, or the Administrator. Care plan changes will be made as necessary and appropriate with consideration given to the desires of the resident and any physical, emotional, and/or cognitive challenges that arise. POA's of residents and residents requiring a change in condition assessment and updated care plan, will be notified of proposed changes and asked for input in the care plan. The resident council meets the first Monday of every month to address the needs and concerns of all residents.The facility representative present at these council meetings will notify management staff of any environmental safety concerns, Covid-19 infection control concerns, perceived violations of resident rights, or instances of abuse or neglect so these concerns may be immediately addressed.
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.	Audits will be conducted by the Administrator, DON or designee to ensure all new and existing facility staff have received education on resident rights, abuse and neglect, proper use of the care plan, fall prevention, and incident reporting. These audits will be carried out on a weekly basis for 2 months, then monthly for 6 months. The correction will be considered effective as evidenced by completed education and training by all staff, absence of any abuse or neglect, care plan changes/updates are

	pertinent and made appropriately, and falls/ incidents/accidents are reported immediately with timely and proper intervention. Resident rights will be honored by all staff members, as reported by the resident council. Any violations of rights or safety will be immediately reported to the Administrator/DON/safety coordinator for resolution. The corrections will be incorporated into our quality assurance system during quarterly meetings by reviewing education and training records, safety meeting minutes, incident reports, third party coordination of care meeting notes, and care plans that may require changes during quarterly QA meetings. Safety meeting minutes, QA meeting minutes, incident reports, third party coordination of care meeting notes, care plans, and education and training records will be kept in the DON's office. These documents will be reviewed during quarterly QA meetings, monthly safety meetings, and more often if needed. These records are evidence of the measures put in place to ensure no recurrence of the deficient practice.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/13/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Debra Weaver, Administrator OAC 310:663-25-4(F)		**Date 7/13/2021**
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: sslemp@omegasrliving.com

April 18, 2022

License Number: AL5541

Mr. Scott Slemp, Administrator
Teal Creek Assisted Living & Memory Care
13501 N Bryant Ave
Edmond, OK 73013

Survey Event ID: Z5XX12

Dear Mr. Slemp:

A revisit conducted **April 6, 2022**, revealed that your facility corrected deficiencies effective **September 13, 2021**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Sincerely,

Katie Stagner
Digitally signed by Katie Stagner
Date: 2022.04.18 08:52:00 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5541	A. BUILDING: _____ B. WING _____	R 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAL CREEK ASSISTED LIVING & MEMORY CARE	13501 N BRYANT AVE 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 02/22/22 and 04/04/22 through 04/06/22. All deficiencies from the 06/01/21 survey were cleared.	{C 000}		

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