

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: JYO511

Dear Mr. Slemp:

On **April 6, 2022**, 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 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:

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: 2022.04.18 10:22:41 -05'00'

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

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Teal Creek AL & MC
Address: 13501 N Bryant Ave
City, State, Zip: Edmond, OK 73013
Provider #: AL5541
Complaint #: OK00058448
Investigation Date(s): 02/22/22 and 04/04/22 through 04/06/22.

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to provide a safe dignified environment.	US
2. The center failed to ensure medications were administered as ordered by the physician.	US
3. The center failed to provide care according to the contract.	US

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

An unannounced on-site investigation was initiated on 02/22/2022 at 2:37 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A 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 the environment was conducted. Residents were observed in a common area, dining room, and hallway spaced apart. There was space for residents to exit the common area. The stairwell doors were locked.

Residents were observed in geri-chairs, wheelchairs, couches, and chairs with no obstruction to the stairwells or elevator.

There was no documentation from the fire marshal or OSDH indicating too many residents to safely occupy the unit.

There were no agency staff working on the memory care unit at the time of the survey. Staff demonstrated the use of their keys to resident rooms and the code to the elevator.

The gospel channel was observed in the common area. The staff stored the remote on the medication cart or at the desk. No resident complained about the TV channel.

At the time of the survey, there was no deficient practice in relation to the environment.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to administration of medications was conducted.

Staff demonstrated their ability to access PCC to administer physician ordered medications.

The center provided documentation medication was administered as ordered by the physician.

There were no cups of cream observed left in resident rooms.

At the time of survey, there was no deficient in relation to administration of medications as ordered by the physician.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to services provided according to the resident's contract was conducted.

Residents were observed throughout the survey dressed in street clothes not pajamas. Meal service was observed and residents received their food trays. Staff were observed cueing and/or feeding residents. Incontinent care was observed. Linens were clean. There were no odors in the center. A test tray was sampled. The food temperatures were not too hot to touch. Staff were observed wearing name tags.

No resident complained about clothing, meal service, food trays, incontinent care, linens, odors, food temperatures, or staff name tags.

At the time of the survey, there was no deficient practice in relation to services provided according to the resident's contract.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, 2, and #3. 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.



Melissa Swaim RN

Date report completed: 04/07/2022

INVESTIGATIVE REPORT LICENSURE

Facility: Teal Creek AL & MC
Address: 13501 N Bryant Ave
City, State, Zip: Edmond, OK 73013
Provider #: AL5541
Complaint #: OK00058193
Investigation Date(s): 02/22/22 and 04/04/22 through 04/06/22.

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide adequate, safe medical care, according to the residents' contracts.	S
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☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/22/2022 at 2:37 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A 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 C-0522, C-1914 and C-1951 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.

A handwritten signature in cursive script, reading "Melissa Swaim RN", followed by a horizontal line.

Melissa Swaim RN

Date report completed: 04/07/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Teal Creek AL & MC
Address: 13501 N Bryant Ave
City, State, Zip: Edmond, OK 73013
Provider #: AL5541
Complaint #: OK00058010
Investigation Date(s): 02/22/22 and 04/04/22 through 04/06/22.

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to protect the resident from neglect.	US
☒ Violation (s) unrelated to this complaint were also cited during the investigation.	

An unannounced on-site investigation was initiated on 02/22/2022 at 2:37 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A 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 incontinent care and an allegation of abuse/mistreatment was conducted.

Incontinent care was observed. No wipe was left in the resident's brief or vagina. No resident complained of incontinent care or a wipe being left in their brief or vagina during the survey.

The center provided documentation of a thorough investigation.

Residents were asked about the staff. They liked the staff and had no complaints about staff abuse/mistreatment.

Staff were asked about incontinent care and an allegation of abuse/mistreatment, but no one had witnessed any abuse during incontinent care to report to their nurse.

The administrator was asked about abuse and provided documentation of in-service training with staff.

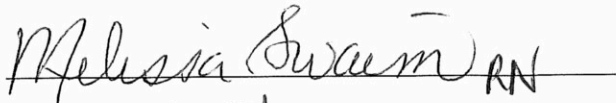
At the time of the investigation, there was no deficient practice related to abuse/mistreatment.

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.

A handwritten signature in black ink that reads "Melissa Swaim RN". The signature is written in a cursive style and is positioned above the printed name.

Melissa Swaim RN

Date report completed: 04/07/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint investigations (#OK00058010, OK00058193, and #OK00058448) were conducted on 02/22/22 and 04/04/22 through 04/06/22. Listed below are abbreviations used throughout this document. A&O-alert and oriented ADL-activities of daily living AL-assisted living AMS-altered mental status CHF-Chronic Heart Failure HENT-head, ears, nose, throat HTN-Hypertension LE-lower extremity MAR-medication administration record mg-milligram PCC-point click care (electronic record) RN-registered nurse OSDH-Oklahoma State Department of Health prn-as needed pt-patient UE-upper extremity	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition.	C 522		

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: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 522	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to perform a significant change assessment for one (#2) of three sampled residents who returned from the hospital with a significant change. The center identified 53 residents who resided at the center. Findings: 'Resident Bill of Rights', dated 12/03/20, read in part, "...Each resident or the resident's designated representative be given a copy...Residents have the right...to participate in their initial care/service plan and an revisions or updates at the time changes occur..." A comprehensive assessment, dated 12/01/20, documented the resident had diagnoses to include dementia, CHF, and HTN. The resident was alert and oriented (2-3) and forgetful with fair judgement with mild cognitive impairment. The resident had good mobility and strength, and fair gait/shuffle with full range of motion, ambulatory without assistance using a walker and staff to monitor and assist prn. The resident needed only set up for eating, a one person assist with bathing, dressing, transferring, toileting and stand by assist for ambulation. The resident was incontinent at times/leakage of urine and continent of bowel with assistance with adult briefs.	C 522		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 522	Continued From page 2 A physician's order, dated 01/06/21, read in part, "...(name-deleted) to eval (evaluate) for Hospice..." A progress note, dated 01/06/21, read in part, "...unable to take mediations..." A hospital record, dated 01/06/21, read in part, "...chief complaint of altered mental status...the pt presents to the ED today complaining of worsening AMS for the past few days, saying that she has been "deteriorating and hallucinating, speaking with people that aren't there...history of dementia...typically A&Ox 3 at baseline...Altered mental status...presenting symptoms: confusion...severity: moderate...duration: few days...progression: worsening...Mental status change..." "...physical exam...temp: 99.3 degrees Fahrenheit...HENT:ecchymosis to left upper forehead and scalp area...neurological:does not obey commands. Won't open eyes. Moves all 4 extremities. Screams out in pain with touch..." "...clinical impression...final diagnoses: encephalopathy..." "...admission diagnoses: abnormal behaviors...discharge diagnoses: progressive vascular dementia...failure to thrive...principal problem: acute encephalopathy...active problems: inadequate oral intake..." "...ended with redirection of care towards hospice, comfort. She was transitioned to a nursing center (AL), on 01/13/21, with hospice services to follow..." "...mental status exam...orientation:	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
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C 522	Continued From page 3 person...recent/remote memory: recent memory impaired...insight and judgment: poor...musculoskeletal...gait and station: bed bound..." "...ADL assessment...grooming: total assist supported sitting in bed due to decreased strength, decreased activity tolerance and impaired cognition...UE dressing: total assist due to decreased strength, decreased activity tolerance and impaired cognition...LE dressing: total assist due to decreased strength, decreased activity tolerance and impaired cognition..." A progress note, dated 01/13/21, read in part, "...resident returned to facility from (name-deleted) hospital admission on 01/06/21...in the hospital for acute encephalopathy (requiring short-term medical care of sudden onset, functional alteration of mental status)...discharged back...(name-deleted) hospice with comfort measures...has bruising to bilat (bilateral) lower arms, left knee, an area on her left forehead she has a fading yellowish bruise, there are three small purple to red areas on her upper chest...appears confused and is unable to walk...not using her left arm and hand she holds it immobile at her waist and along with the bruising the hand is noted to be edematous..." There was no significant change assessment with an updated care plan in the residents record. On 04/05/22 at 2:05 p.m., during Res #2 record review, the RN was asked about resident's who returned from a hospital stay. She stated she hoped a new (significant) change assessment would be completed. No significant change assessment or updated care plan could be found.	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
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C1914	Continued From page 4	C1914		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report for a resident with a change in mental status to the OSDH for one (#2) of one resident who was sent to the hospital for treatment. The center identified 53 residents who resided at the center. Findings: A hospital record, dated 01/06/21, read in part, "...chief complaint of altered mental status...the pt presents to the ED today complaining of worsening AMS for the past few days, saying that she has been "deteriorating and hallucinating, speaking with people that aren't there...history of dementia...typically A&Ox 3 at baseline...Altered mental status...presenting symptoms: confusion...severity: moderate...duration: few days...progression: worsening...Mental status change..."	C1914		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 13501 N BRYANT AVE EDMOND, OK 73013		
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C1914	Continued From page 5 "...physical exam...temp: 99.3 degrees Fahrenheit...HENT:ecchymosis to left upper forehead and scalp area...neurological:does not obey commands. Won't open eyes. Moves all 4 extremities. Screams out in pain with touch..." There was no documentation at the center about the resident's change in condition or what caused ecchymosis to the left upper forehead scalp area. On 04/05/22 at 1:44 p.m., during record review, RN#1 was asked if there were any incident report(s) for resident #2. RN#1 stated there were no incident reports for resident #2. She was asked about any progress notes in PCC. She stated there were no progress notes in relation to what the cause was for the resident to be sent to the hospital or why the resident was sent to the hospital.	C1914		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to: a) document a change in level of consciousness; and b) reassess a resident after returning from the	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1951	Continued From page 6 hospital for a significant change for one (#2) of three sampled residents reviewed. The center identified 53 residents who resided in the center. Findings: A comprehensive assessment, dated 12/01/20, documented the resident had diagnoses to include dementia, CHF, and HTN. The resident was alert and oriented (2-3) and forgetful with fair judgement with mild cognitive impairment. The resident had good mobility and strength, and fair gait/shuffle with full range of motion, ambulatory without assistance using a walker and staff to monitor and assist prn. The resident needed only set up for eating, a one person assist with bathing, dressing, transferring, toileting and stand by assist for ambulation. The resident was incontinent at times/leakage of urine and continent of bowel with assistance with adult briefs. A fall risk assessment, not dated, read in part, "...total score 10...total score above 10 represents high risk..." A MAR, dated 01/02/21, read in part, "...acetaminophen tablet 325 mg, give 2 table by mouth every 6 hours as needed for pain, mild/temperature...to = 650 mg...pain level 2...effective..." A physician's order, dated 01/06/21, read in part,	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1951	Continued From page 7 "...(name-deleted) to eval (evaluate) for Hospice..." A progress note, dated 01/06/21, read in part, "...unable to take mediations..." A hospital record, dated 01/06/21, read in part, "...chief complaint of altered mental status...the pt presents to the ED today complaining of worsening AMS for the past few days, saying that she has been "deteriorating and hallucinating, speaking with people that aren't there...history of dementia...typically A&Ox 3 at baseline...Altered mental status...presenting symptoms: confusion...severity: moderate...duration: few days...progression: worsening...Mental status change..." "...physical exam...temp: 99.3 degrees Fahrenheit...HENT:ecchymosis to left upper forehead and scalp area...neurological:does not obey commands. Won't open eyes. Moves all 4 extremities. Screams out in pain with touch..." "...Lumbar Puncture...emergent situation...critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: infection and altered mental status...intravenous fluids were administered for dehydration..." "...clinical impression...final diagnoses: encephalopathy..." "...admission diagnoses: abnormal behaviors...discharge diagnoses: progressive vascular dementia...failure to thrive...principal problem: acute encephalopathy...active problems: inadequate oral intake..."	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1951	Continued From page 8 "...ended with redirection of care towards hospice, comfort. She was transitioned to a nursing center (AL), on 01/13/21, with hospice services to follow..." "...mental status exam...orientation: person...recent/remote memory: recent memory impaired...insight and judgment: poor...musculoskeletal...gait and station: bed bound..." "...ADL assessment...grooming: total assist supported sitting in bed due to decreased strength, decreased activity tolerance and impaired cognition...UE dressing: total assist due to decreased strength, decreased activity tolerance and impaired cognition...LE dressing: total assist due to decreased strength, decreased activity tolerance and impaired cognition..." A progress note, dated 01/13/21, read in part, "...resident returned to facility from (name-deleted) hospital admission on 01/06/21...in the hospital for acute encephalopathy (requiring short-term medical care of sudden onset, functional alteration of mental status)...discharged back...(name-deleted) hospice with comfort measures...has bruising to bilat (bilateral) lower arms, left knee, an area on her left forehead she has a fading yellowish bruise, there are three small purple to red areas on her upper chest...appears confused and is unable to walk...not using her left arm and hand she holds it immobile at her waist and along with the bruising the hand is noted to be edematous..." On 04/05/22 at 1:54 p.m., the RN was asked about missing documentation. She stated she thought there would be a progress note when the resident was sent to the hospital with an	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5541	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER TEAL CREEK ASSISTED LIVING & MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1951	Continued From page 9 explanation. At 2:05 p.m., during Res #2 record review, the RN was asked about resident's who returned from a hospital stay. She stated she hoped a new (significant) change assessment would be completed. No significant change assessment or updated care plan could be found. There was missing documentation. There was no progress note or incident report in relation to the ecchymosis to left upper forehead and scalp area noted at the hospital 01/06/22 by a physician.	C1951		

Delivery via email to: sslemp@omegasrliving.com

May 2, 2022

License Number: AL5541

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

Survey Event ID: JYO511

Dear Mr. Slemp:

On **April 6, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

Tag C522

- There are no systemic changes such as in-services to ensure that the deficient practice will not recur.
- There are no indications on how often or how long the registered nurse will monitor and report to the QA committee changes to level of care and readmissions from hospitals.
- The completion date is greater than 60 days from survey exit date.

Tag C1914

- There are no systemic changes such as in-services to ensure that the deficient practice will not recur.
- There is no indication on how often the facility plans to monitor its performance to ensure solutions are sustained.
- The completion date is greater than 60 days from survey exit date.

Tag C1951

- There are no systemic changes such as in-services to ensure that the deficient practice will not recur.
- There are no indications on how often or how long the facility plans to monitor its performance to ensure solutions are sustained.

-Completion date is greater than 60 days from survey exit date.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Katie Stagner

Digitally signed by Katie
Stagner
Date: 2022.05.02 10:50:38
-05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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: Click here to enter a date.	
	Facility Name: Teal Creek Assisted Living and Memory Care	
	License Number: AL5541	
	Survey Event ID: JY0511	
Date Survey Completed: 4/6/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: the center failed to perform a significant change assessment for one (#2) of three sampled residents who returned from the hospital with a significant change	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: The center denies these deficiencies due to occurring prior to ownership change that occurred on January 28, 2022. The deficiency cited occurred December 2020 to January 2021. Current ownership cannot be responsible due to this occurred prior to sale of facility.		
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?		Resident no longer resides at facility.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		There is no way to identify other residents affected due to ownership and management company change that occurred on 1/28/22. This deficiency was from 15 months ago under the previous ownership entity, management entity and leadership team.
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?		Current leadership team will follow new ownership/management companies policy and procedures. HWD will update assessment for return from hospital admission and with change of condition.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		RN will report to QA Committee changes to level of cares and readmissions from hospital.
a. How the correction will be evaluated for effectiveness;		RN will report change in level of care to QA Committee.
b. How the correction will be incorporated into the center's quality assurance system; and		There is no correction to be made as this occurred prior to change of ownership and management company.
c. How monitoring records will be kept to evidence the correction.		QA committee will review changes in level of care.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		6/29/2022
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Scott Slemp OAC 310:663-25-4(F)		Date 4/29/2022
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.			

Delivery via email to: sslemp@omegasrliving.com

May 2, 2022

License Number: AL5541

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

Survey Event ID: JYO511

Dear Mr. Slemp:

This notice replaces the letter sent on May 2, 2022 at 10:55 a.m.

On **April 6, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

Tag C522

- There are no systemic changes such as in-services to ensure that the deficient practice will not recur.
- There are no indications on how often or how long the registered nurse will monitor and report to the QA committee changes to level of care and readmissions from hospitals.
- The completion date exceeds sixty (60) calendar days from receipt of notice of violation.

Tag C1914

- There are no systemic changes such as in-services to ensure that the deficient practice will not recur.
- There is no indication on how often the facility plans to monitor its performance to ensure solutions are sustained.
- The completion date exceeds sixty (60) calendar days from receipt of notice of violation.

Tag C1951

- There are no systemic changes such as in-services to ensure that the deficient practice will not recur.

-There are no indications on how often or how long the facility plans to monitor its performance to ensure solutions are sustained.

-The completion date exceeds sixty (60) calendar days from receipt of notice of violation.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Katie Stagner

Digitally signed by Katie
Stagner
Date: 2022.05.02 14:50:54
-05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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: Click here to enter a date.	
	Facility Name: Teal Creek Assisted Living and Memory Care	
	License Number: AL5541	
	Survey Event ID: JY0511	
Date Survey Completed: 4/6/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: the center failed to perform a significant change assessment for one (#2) of three sampled residents who returned from the hospital with a significant change	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: The center denies these deficiencies due to occurring prior to ownership change that occurred on January 28, 2022. The deficiency cited occurred December 2020 to January 2021. Current ownership cannot be responsible due to this occurred prior to sale of facility.		
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?		Resident no longer resides at facility.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		There is no way to identify other residents affected due to ownership and management company change that occurred on 1/28/22. This deficiency was from 15 months ago under the previous ownership entity, management entity and leadership team.
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?		Current leadership team will follow new ownership/management companies policy and procedures. HWD will update assessment for return from hospital admission and with change of condition.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		RN will report to QA Committee changes to level of cares and readmissions from hospital.
a. How the correction will be evaluated for effectiveness;		RN will report change in level of care to QA Committee.
b. How the correction will be incorporated into the center's quality assurance system; and		There is no correction to be made as this occurred prior to change of ownership and management company.
c. How monitoring records will be kept to evidence the correction.		QA committee will review changes in level of care.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		6/29/2022
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Scott Slemp OAC 310:663-25-4(F)		Date 4/29/2022
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.			

Delivery via email to: sslemp@omegasrliving.com

May 11, 2022

License Number: AL5541

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

Survey Event ID: JYO511

Dear Mr. Slempp:

On **April 6, 2022**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your 2nd amended plan of correction for these deficiencies. Your 2nd amended plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 17, 2022**.

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: 2022.05.11 14:46:55 -05'00'

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

enc

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 5/6/2022	
	Facility Name: Teal Creek Assisted Living and Memory Care	
	License Number: AL5541	
	Survey Event ID: JY0511	
Date Survey Completed: 4/6/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: the center failed to perform a significant change assessment for one (#2) of three sampled residents who returned from the hospital with a significant change	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: The center denies these deficiencies due to occurring prior to ownership change that occurred on January 28, 2022. The deficiency cited occurred December 2020 to January 2021. Current ownership cannot be responsible due to this occurred prior to sale of facility.		
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?		Resident no longer resides at facility.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		There is no way to identify other residents affected due to ownership and management company change that occurred on 1/28/22. This deficiency was from 15 months ago under the previous ownership entity, management entity and leadership team.
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?		Current leadership team will follow new ownership/management companies policy and procedures. HWD will update assessment for return from hospital admission and with change of condition. ED will do monthly audits of returning residents and report findings to QA. HWD will be inserviced on change of condition assessment.
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.		RN will report to QA Committee changes to level of cares and readmissions from hospital monthly for 3 months. ED will report audit for change in level of care to QA Committee. There is no correction to be made as this occurred prior to change of ownership and management company. QA committee will review audit for change in level of care.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		6/17/2022
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature Scott Slep OAC 310:663-25-4(F)		Date 5/6/2022	
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	5/9/2022	Submitted by	Scott Slep
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: 5/6/2022

Facility Name: Teal Creek Assisted Living and Memory Care

License Number: AL5541

Survey Event ID: JY0511

Date Survey Completed: 4/6/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1914

Based on: the center failed to submit an incident report for a resident with a change in mental status to the OSDH for one (#2) of one resident who was sent to the hospital for treatment.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center denies these deficiencies due to occurring prior to ownership change that occurred on January 28, 2022. The deficiency cited occurred December 2020 to January 2021.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

This occurred under a previous owner, management company and leadership team. Resident no longer resides at facility.

There is no way to identify other residents affected due to ownership and management company change that occurred on 1/28/22. This deficiency was from 15 months ago under the previous ownership entity, management entity and leadership team.

Current leadership team will follow new ownership/management companies policy and procedures. Staff will turn in incident reports to HWD. HWD and ED will review incident reports and they will be placed in a binder in HWD office. HWD will perform random monthly audits of incident reports and report findings to QA. HWD will be inserviced on state reportable incident reports.

RN will report incident reports audit to QA Committee monthly for 3 months.

Executive Director will review incident reports.

RN will present incident reports to QA Committee monthly.

QA committee will review audit reports to look for discrepancies.

6/17/2022

Administrator's Signature Scott Slemp

Date 5/6/2022

OAC 310:663-25-4(F)

10012013

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	5/9/2022	Submitted by	Scott Slemp
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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: 5/6/2022	
	Facility Name: Teal Creek Assisted Living and Memory Care	
	License Number: AL5541	
	Survey Event ID: JY0511	
Date Survey Completed: 4/6/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1951	Based on: the center failed to: a) document a change in level of consciousness; and b) reassess a resident after returning from the hospital for a significant change for one (#2) of three sampled residents reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: The center denies these deficiencies due to occurring prior to ownership change that occurred on January 28, 2022. The deficiency cited occurred December 2020 to January 2021. Current ownership cannot be responsible for medical records storage prior to change of ownership.		
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?		Resident no longer resides at facility.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Current ownership and management company have no way of identifying missing records from previous ownership and previous residents.
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?		Facility will follow policies and procedures regarding record maintenance. Currently using Vitalware and EMAR. HWD will be inserviced on significant change assessments. All residents residing at community prior to 1/28/22 will be reassessed.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Assisted Living will follow current policies and procedures regarding record maintenance.
a. How the correction will be evaluated for effectiveness;		Executive Director will report to QA Committee regarding policies and procedures regarding records maintenance monthly for 3 months.
b. How the correction will be incorporated into the center's quality assurance system; and		Executive Director will audit files to ensure records are being kept in appropriate place and report findings to QA Committee.
c. How monitoring records will be kept to evidence the correction.		QA committee will review audits to look for discrepancies.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		6/17/2022
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Scott Slemph		Date 5/6/2022
OAC 310:663-25-4(F)		

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	5/9/2022	Submitted by	Scott Slemp
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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.](#)



Assisted Living Informal Dispute Resolution Request Form **In Accordance with the Continuum of Care and Assisted Living Act**

To access this form and the IDR process online at the Health Department web site [click here](#).

Assisted Living Centers must complete this form to dispute cited deficiencies. If you have any questions, contact the IDR Coordinator by telephone at (405) 426-8200 or via e-mail at IDRCoordinator@health.ok.gov.

Submission

Complete this form, attach all documentary evidence relevant to each disputed deficiency and submit within **ten (10) calendar days** of receiving the official Statement of Deficiencies. Submit this form to Oklahoma State Department of Health, Long Term Care, Attention: IDR Coordinator, 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102-6406. **An IDR will not be granted when a request form is incomplete or inaccurate. Documentary evidence submitted past the required timeframe will not be considered.**

IDR Type: (Check One) Face-to-Face Meeting ☐ Record Review ☒ Telephone/Virtual Conference ☐

Facility Name: Teal Creek Assisted Living and Memory Care

AL5541

Facility Administrator: Scott Slempp

sslemp@omegasrliving.com

Mailing Address: 13501 N. Bryant Ave.

Telephone Number: () 4052460222

City: Edmond Zip Code: 73013

Facsimile Number: () 4055135921

Date Statement of Deficiencies Received: 04 / 18 / 2022

Survey Exit Date: 04 / 06 / 2022

Dispute Description

Tag Number **Explanation of Dispute** (Why is facility disputing the deficiency? List reason for each.)
A separate sheet may be attached, but must clearly identify the following: facility name, ID, survey exit date, tag number, and the explanation of the dispute. All documentary evidence submitted must also identify these items.

1. C1914 All deficiencies cited occurred well before ownership, management and leadership all changed.

Deficiencies occurred Dec. 2020/Jan. 2021. Ownership changed Jan 28, 2022. See attached email chain.

2. C1951 All deficiencies cited occurred well before ownership, management and leadership all changed.

Deficiencies occurred Dec. 2020/Jan. 2021. Ownership changed Jan 28, 2022. See attached email chain.

3. C522 All deficiencies cited occurred well before ownership, management and leadership all changed.

Deficiencies occurred Dec. 2020/Jan. 2021. Ownership changed Jan 28, 2022. See attached email chain.

4. _____

Submitted by: Scott Slempp

Date: 04 / 29 / 2022



OKLAHOMA
State Department
of Health

April 28, 2022

VIA EMAIL

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

Re: Informal Dispute Resolution Notification
License Number: AL5541

Dear Mr. Slemph:

We have received your request for an Informal Dispute Resolution (IDR) concerning the deficiencies cited at your facility during the complaint investigation of April 6, 2022. The meeting has been scheduled for **Monday, May 16, 2022 at 10:00am**. Since your facility requested a record review IDR, neither the facility nor the OSDH survey team will be in attendance.

The Informal Dispute Resolution meeting is informal. It is regulation that attorneys do not attend. Testimony is not presented under oath and documentary evidence is submitted without formality.

If you wish to withdraw your IDR request, we must receive written notification at least seventy-two (72) hours prior to the meeting date. If you have any questions or need additional information, please contact me at (405) 426-8200 or email idrcoordinator@health.ok.gov.

Sincerely,

Clorissa Nubine

Clorissa Nubine
IDR Coordinator
Long Term Care
Protective Health Services

c: William Whited, Ombudsman
Facility File
Janene Stewart
Shayla Spriggs
Zachary Collins
Survey Team

May 16, 2022

VIA EMAIL

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

Re: Teal Creek Assisted Living & Memory Care - Informal Dispute Resolution Determination Report
License Number: AL5541

Dear Mr. Slempp:

Thank you for participating in the Informal Dispute Resolution (IDR) panel process of the Oklahoma State Department of Health concerning the survey conducted at your facility on April 6, 2022. The facility, the IDR Panel and all relevant persons were present at the meeting. The disputed deficiencies are discussed in the attached determination report.

A copy of this determination has been forwarded to the State Survey Agency for review.

Sincerely,

K. Hamilton, RN

Kourtney Hamilton
Chairperson
IDR Decision Making Panel
Protective Health Services

cn

Enclosure

c: Janene Stewart
IDR Panel
Survey Team
Facility File

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IDR
Informal Dispute Resolution
Impartial Decision Making Panel
Determination Report
Today's Date: 05-16-2022

Facility Name:

Teal Creek Assisted Living & Memory Care

Facility ID:

AL5541

Survey Date:

04-06-2022

IDR Date:

05-16-2022

Tags Disputed:

1. C0522 s/s=D
2. C1914 s/s=D
3. C1951 s/s=D

Status Change *

Tag Removed
Tag Removed
Tag Removed

Panel Members:

Kourtney Hamilton, Chairperson
Anita Raley
Kimberly Crenshaw
Sheila McLeod, OSDH

Determination Report:

C0522 s/s=D Will be removed per title 63 Section 1-1905(D)(4) *"The transferor shall remain liable for all penalties assessed against the facility which are imposed for violations occurring prior to transfer of ownership."*

C1914 s/s=D Will be removed per title 63 Section 1-1905(D)(4) *"The transferor shall remain liable for all penalties assessed against the facility which are imposed for violations occurring prior to transfer of ownership."*

C1951 s/s=D Will be removed per title 63 Section 1-1905(D)(4) *"The transferor shall remain liable for all penalties assessed against the facility which are imposed for violations occurring prior to transfer of ownership."*

Signature K. Hamilton, RN
Chairperson, Impartial Decision Making Panel

May 24, 2022

VIA EMAIL

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

Subject: State Survey Agency Informal Dispute Resolution Determination
Re: AL5541, Teal Creek Assisted Living & Memory Care May 16, 2022 Informal Dispute Resolution

Dear Mr. Slemph:

The Department of Health has received the determination of the Informal Dispute Resolution (IDR) Decision Making Panel concerning the April 6, 2022 complaint investigation conducted at Teal Creek Assisted Living & Memory Care. The findings of the IDR Decision Making Panel have been reviewed. It is the determination of the State Survey Agency to uphold the Decision Making Panel's determination. The amended state Statement of Deficiencies (Form CMS-2567) is enclosed. If applicable, further instructions regarding the impact of these changes on any previous enforcement action will be forthcoming from the Long Term Care Enforcement office.

The facility is encouraged to submit an amended plan of correction on the enclosed Statement of Deficiencies. The amended Statement of Deficiencies must be signed, dated, and indicate the signee's title in the appropriate spaces on page one (1). Return the amended Statement of Deficiencies with your plan of correction to:

Ms. Tempal Killman, Administrative Assistant
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste 1702
Oklahoma City, OK 73102-6406

The amended copy of the Statement of Deficiencies (Form CMS-2567) will be the releasable copy *only* when a signed amended plan of correction is provided by the facility. The original Form CMS-2567 is disclosable if a signed amended plan of correction is not submitted by the facility. [Chapter 7, State Operations Manual §7212]