OKLAHOMA
State Department
of Health

**Delivery via email to: sslemp@omegasrliving.com**

October 20, 2023

License Number: AL5541

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

**Survey Event ID: 3Y1Z11**

Dear Mr. Slemp:

On **October 10, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Teal Creek Assisted Living & Memory Care**
**Address:** **13501 N Bryant Ave**
**City, State, Zip:** **Edmond, OK, 73013**
**Provider #:** **AL5541**
**Complaint #:** **OK00061452**
**Investigation Date(s):** **10/09/23 through 10/10/23**

## ALLEGATION(S)

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

An unannounced on-site investigation was initiated 10/09/2023 at 10:37 a.m.

A sample of six 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 Summary of Complaint Investigation:**

A tour of the center was conducted on entrance and at other various times throughout the survey. Resident halls were observed for pests. Residents were observed for signs and symptoms of bug bites.

Resident records were reviewed including assessments, plan of care, physician orders, skin notes, and nursing notes. Pest control services were reviewed. Facility policy and procedure were reviewed.

Residents were asked if they had any concerns with pests in the facility.

Staff members were interviewed regarding the facility policy on pest control.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/10/2023

10/10/2023

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Teal Creek Assisted Living & Memory Care**
**Address:** **13501 N Bryant Ave**
**City, State, Zip:** **Edmond, OK, 73013**
**Provider #:** **AL5541**
**Complaint #:** **OK00061515**
**Investigation Date(s):** **10/09/23 through 10/10/23**

## ALLEGATION(S)

| |
|---|
| The center failed to provide adequate staff to transfer residents in a safe manner according to the standard of care, failed to provide equipment necessary for safe transfers, failed to find a higher level of care for a resident who required a 2-person assist and failed to provide adequate nutrition and hydration according to the contract and plan of care. |
| The center failed to ensure incontinent care was provided according to the contract and/or in a timely manner. |
| The center failed to provide the necessary equipment to provide a safe 2-person transfer. |
| The center failed to provide adequate staff to meet the needs of the residents. |
| The center failed to report a fall with major injury to the Oklahoma State Department of Health. |

An unannounced on-site investigation was initiated 10/09/2023 at 10:37 a.m.

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

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

**A Summary of Complaint Investigation:**

A tour of the center was conducted on entrance and at other various times throughout the survey. Resident halls were observed for odors, staff presence, call lights, and transfer equipment. Residents were observed for incontinent care, transfers, and staff assisting with personal needs. Meal service was observed.

Resident records were reviewed including assessments, plan of care, physician orders, skin notes, incident reports, and nursing notes. State Reportable incidents were reviewed. Facility policy and procedure were reviewed.

Residents were interviewed related to the provision of incontinent care, transfers, meal service, call lights, and staffing.

Staff members were interviewed regarding the facility policy on incontinent care, transfers, staffing, meal service, and level of care required for the residents. They were asked when they would report an incident to the Oklahoma State Department of Health.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/10/2023

| 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 10/10/2023 |

| 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<br><br>Complaint investigations (#OK00061452 and #OK00061515) were conducted on 10/09/23 through 10/10/23.<br><br>The following abbreviations will be used throughout this document:<br><br>CNA- certified nurse aide<br>DON- director of nursing | C 000 | | |
| C 327 SS=D | 310:663-3-3(a)(7) DESCRIPTION OF SERVICES<br><br>(a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services:<br><br>(7) assistance with transfer or ambulation;<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to safely transfer a resident using proper technique for one (#4) of three sampled residents observed for transfers.<br><br>The Executive Director identified 79 residents resided in the facility.<br><br>Findings:<br><br>A "Completing a Two-Person Transfer" policy, undated, read in part, "...Transfer a resident safely with transfer belt and two people...Leader | C 327 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | AL5541 | A. BUILDING: _____ B. WING _____ | C 10/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TEAL CREEK ASSISTED LIVING & MEMORY CARE | 13501 N BRYANT AVE EDMOND, OK 73013 |

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|---|---|---|---|---|
| C 327 | Continued From page 1 | C 327 | | |

grasps belt on both sides from underneath...With a gentle rocking back and forth, pull the resident to stand on the count of three...Bending at the knees lower yourself with the resident to a sitting position..."

Resident #4 had diagnoses which included multiple sclerosis.

Resident #4's "Assessment and Service Plan", dated 07/31/23, documented the resident was dependent for all transfers and required maximum plus assistance of two staff members.

Resident #4's "Annual Resident Assessment" form, dated 08/08/23, documented the resident was weight bearing with maximum assistance.

On 10/09/23 at 11:37 a.m., Resident #4 stated they required one to two staff member to assist with transfers. They stated they had a lift available if staff wanted to use it. They stated they could bear very little weight.

On 10/10/23 at 8:50 a.m., CNA #1 and CNA #2 assisted Resident #4 to a seated position on their bed.

On 10/10/23 at 8:57 a.m., CNA #1 placed their arm under the resident's left arm while CNA #2 placed their arm under the resident's right arm. Both CNA's held onto the back of Resident #4's pants, and hoisted the resident up from their bed and onto their electric wheelchair. There was no gait belt used during the transfer of the resident.

On 10/10/23 at 9:05 a.m., CNA #1 stated when two staff members transferred a resident, they would use "arm and arm and hold the back of the pants." They stated they would use a gait belt

| 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 10/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TEAL CREEK ASSISTED LIVING & MEMORY CARE | 13501 N BRYANT AVE EDMOND, OK 73013 |

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|---|---|---|---|---|
| C 327 | Continued From page 2<br>when they were transferring by themselves and knew they could not lift the resident.<br><br>On 10/10/23 at 9:12 a.m., the DON stated for a two person transfer assist, staff would stand on either side of the resident and instruct the resident to stand and pivot. They stated if the resident was unable to do so, staff would do the transfer for them.<br><br>On 10/10/23 at 9:14 a.m., the DON stated some residents had their own gait belt, and the facility had some gait belts which were assigned to the residents. They stated if a gait belt was not used, two staff should place one arm under each the resident's arms, and place their other hand under the resident's bottom to get the resident to a standing position. The DON stated Resident #4 could not stand and bear weight. They stated the resident was a two person transfer. | C 327 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** sslemp@omegasrliving.com

November 1, 2023

License Number: AL5541

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

**Survey Event ID: 3Y1Z11**

Dear Mr. Slemp:

On **October 10, 2023,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 19, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date:** Click here to enter a date.<br>**Facility Name:** Teal Creek Assisted Living and Memory Care<br>**License Number:** AL5541<br>**Survey Event ID:** 3Y1Z11<br>**Date Survey Completed: 10/10/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C327 | Based on: Based on observation, record review andinterview, the facility failed to safely transfer aresident using proper technique for one (#4) ofthree sampled residents observed for transfers. |

**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 or conclusion of the statement of deficiency. The Plan of Correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.

| **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? | Gait Belts will be bought and placed in each affected residents room.<br>Staff will be inserviced regarding proper transfers. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Health and Wellness Director or designee will perform an audit and every resident needing assistance with transfers will be identified and will have a gait belt placed in their room for use. |
| 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? | Health and Wellness Director or designee will perform random audits monthly for 3 months and will do perform random observations of staff transferring residents. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Audits and Observations will be submitted to QA Committee for evaluation.<br>QA Committee will review results monthly.<br>QA Committee will give recommendations as needed.<br>Audits and Observations will be kept in a binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 12/19/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** **Scott Slemp** OAC 310:663-25-4(F) | **Date 10/27/2023** |
|---|---|

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |
|---|---|---|---|

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

**Delivery via email to:** sslemp@omegasrliving.com

December 27, 2023

License Number: AL5541

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

**Survey Event ID: 3Y1Z12**

Dear Mr. Slemp:

On **December 21, 2023,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 10, 2023,** have now been corrected effective **December 19, 2023.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5541 | A. BUILDING: _____ B. WING _____ | R-C 12/21/2023 |

| 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<br><br>An offsite/paper revisit was conducted on 12/21/23. The facility was in substantial compliance. | {C 000} | | |

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