OKLAHOMA
State Department
of Health

Delivery via email to: Scott Slemp <sslemp@omegasrliving.com>;
lmehmood@omegasrliving.com

July 22, 2024

License Number: AL5541

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

Survey Event ID: 32CQ11

Dear Mr. Slemp:

On **June 21, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Teal Creek AL & MC**
Address: **13501 N Bryant Ave**
City, State, Zip: **Edmond, OK 73013**
Provider #: **AL5541**
Complaint #: **OK00065351**
Investigation Date(s):06/18/24 – 06/21/24

ALLEGATION(S)

The center failed to protect residents from physical abuse.

An unannounced on-site investigation was initiated 06/18/2024 at 9:05 a.m.

A sample of 3 residents, including any identified residents, 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 Summary of Complaint Investigation:

An investigation related to physical abuse, resident records, assessments, care plans, hospital records, personnel records, training, staffing, incident reports, nurses notes, physician notes, policies, and contracts were conducted.

At the time of the survey, no resident had any complaint about staff or their care.

At the time of the survey, staff had an understanding of the center's abuse policy.

At the time of the survey, there was no deficient practice cited in relation to physical abuse.

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: 06/24/2024

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 06/21/2024

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 complaint investigation (#OK00065351) was conducted 06/18/24 and 06/21/24. Facility Census: 91 The following abbreviations will be used throughout this document: DON - director of nursing ED - emergency department EMSA - emergency medical services authority ER - emergency room	C 000		
C1912 SS=E	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital;	C1912		

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 06/21/2024

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
C1912	Continued From page 1 (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to OSDH for 2 (#4 and #5) residents which required reporting. The DON identified 91 residents resided in the facility. Findings: 1. Resident #5 had diagnosis to include disorder of the brain, CKD-stage 3, and heart disease. A "nurses note," dated 04/21/24, read in part, "...resident in hallway on the floor...complained of left shoulder...large hematoma to right head...sent to ER..." A "hospital record," dated 04/21/24, read in part, "...fracture of the right distal clavicle...given 2 units of platelets...subarachnoid bleed..."	C1912		

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 06/21/2024

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
C1912	Continued From page 2 An "internal/accident report," dated 05/10/24, read in part, "...resident got up from chair and fell striking her right shoulder (previously injured)...awake, screaming in pain...EMSA...hospital..." A "hospital record," dated 05/10/24, read in part, "...known right clavicle fracture from a fall 2 weeks ago...increased pain to area since fall...medications administered during the ED stay...acetaminophen (Tylenol) tablet 1000 mg..." 2. Resident #4 had diagnosis to include Alzheimer's dementia, anxiety, and diabetes mellitus, type II. An "internal/accident report," dated 05/20/24, read in part, "...on the floor...bathroom...hit his head...EMSA...hospital..." A "hospital record," dated 05/20/24, read in part, "...Closed head injury..." An "internal/accident report," dated 05/31/24, read in part, "...a witness fall...trying to pull chair back to sit down and lost his balance tripped over his feet and fell face forward...hospital..." A "hospital record," dated 05/31/24, read in part, "...Closed head injury..." On 06/20/24 at 2:21 p.m., the DON stated they were closed head injuries, if they weren't a state report would have been completed. The DON was not aware a physician's diagnosis of closed head injury was reportable to the Department. On 06/21/24 at 3:11 p.m., the DON stated the fracture and treatment at the hospital had not	C1912		

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 06/21/2024

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
C1912	Continued From page 3 been reported to the Department.	C1912		
C1951 SS=E	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 observation, record review, and interview, the center failed to ensure an organized, accurate clinical record to include: a) physician notification of incidents for 2 (#4 and #5), b) internal incident/accident reports were completed for 1 (#4), c) interventions for falls documented for 1 (#4); and d) missing hospital documentation for 2 (#4 and #5) of 3 residents whose records were reviewed. The DON identified 91 residents at the center. Findings: a) Resident #4 had internal documentation of falls 04/23/24, 05/20/24 and 05/31/24, but there was no documentation the physician had been notified. Resident #5 had a fall 04/27/24 and 05/10/24, but there was no documentation the physician had been notified.	C1951		

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 06/21/2024

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
C1951	Continued From page 4 On 06/21/24 at 3:06 p.m., the DON stated physician notification of incidents were not being notated. b) On 04/21/24, Resident #5 had a nurses note about a fall, but no internal incident/accident report completed. On 06/21/24 at 3:11 p.m., the DON stated she didn't know why there were missing internal incident/accident reports. c) Resident #5 had a fall 04/21/24, 04/27/24, 05/10/24, but there was no documentation interventions had been implemented. On 06/21/24 at 3:00 p.m., the DON stated it would be important for interventions to be documented to safeguard the resident who had multiple falls. d) Resident #4 and Resident #5 had missing hospital documentation. On 06/21/24 at 2:55 p.m., the DON stated it would be important to know what the resident was seen for at the hospital so they would know if the resident received treatment and to know what interventions to put into place.	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: Scott Slemp <sslemp@omegasrliving.com>

August 6, 2024

License Number: AL5541

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

Survey Event ID: 32CQ11

Dear Mr. Slemp:

On **June 21, 2024**, 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:

- **C1912 & C1951:** These dates do not allow the State agency to complete a follow-up and identify compliance in the required timeframes. In accordance with 310:663-25-4(b)(E), "Include dates when corrective action will be completed for each violation. The corrective action completion dates shall not exceed sixty (60) calendar days from receipt of notice of violation."
  1. The survey exit date was **June 21, 2024**.
  2. This POC documents audits for compliance did not start until **July 1, 2024**
  3. The identified date of compliance in the plan is **October 4, 2024**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/5/2024** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 32CQ11 **Date Survey Completed: 6/21/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1912	Based on: Based on record review and interview, the center failed to submit an incident report to OSDH for 2 (#4 and #5) residents which required reporting.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not constitue an admission or agreement with these findings. The community denies any defeciencies.

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?	Health and Wellness Director or designee will audit affected residents incident reports starting July 1 onward.
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 audit incident reports from July 1 onward to identify any affected 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?	Executive Director will inservice Health and Wellness Director and Staff Nurses on OSDH Reporting.
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.	Health and Wellness Director or designee will audit all Incident Reports from July 1 to August 1 to ensure effectiveness. Health and Wellness Director or designee will do random weekly audits for 3 montths to ensure compliance. Health and Wellness Director will report findings of audits to QA Committee monthly for possible recommendations. Audits & recommendation will be kept in QA Committee Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/4/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 8/5/24

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: 8/5/2024** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 32CQ11 **Date Survey Completed: 6/21/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Based on observation, record review, and interview, the center failed to ensure an organized, accurate clinical record to include:a) physician notification of incidents for 2 (#4 and #5),b) internal incident/accident reports were completed for 1 (#4),c) interventions for falls documented for 1 (#4);

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not constitute and admission or agreement with these findings. The community denies any defeciencies.

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?	Health and Wellness Director or designee will audit affected residents incident reports starting July 1 onward.
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 audit incident reports from July 1 on to identify any affected 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?	Executive Director will inservice healthcare staff on correct incident reporting policy.
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.	Health and Wellness Director or designee will audit all Incident Reports from July 1 to August 1 to enure compliance. Health and Wellness Director or designee will do random weekly audits for 3 months to ensure compliance. Health and Wellness Director will report findings of audits to QA Committee monthly for possible recommendations. Audits and recommendations will be kept in QA Committee Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/4/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature ~~Administrator signature required.~~ [signature] **Date** ~~Date/ administrator signature.~~ 8/5/24
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	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

August 14, 2024

License Number: AL5541

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

Survey Event ID: 32CQ11

Dear Mr. Slemp:

On **June 21, 2024,** 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 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 **September 21, 2024**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/5/2024** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 32CQ11 **Date Survey Completed: 6/21/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Based on observation, record review, and interview, the center failed to ensure an organized, accurate clinical record to include:a) physician notification of incidents for 2 (#4 and #5),b) internal incident/accident reports were completed for 1 (#4),c) interventions for falls documented for 1 (#4);

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not constitute and admission or agreement with these findings. The community denies any defeciencies.

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?	Health and Wellness Director or designee will audit affected residents incident reports from June 1 to July 1.
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 audit incident reports from June 1 to August 1.
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?	Executive Director will inservice healthcare staff on correct incident reporting policy.
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.	Health and Wellness Director or designee will do random weekly audits for 3 moths to ensure compliance. Enter methods to evaluate for effectiveness: Health and Wellness Director will report findings of audits to QA Committee monthly for possible recommendations. Audits and recommendations will be kept in QA Committee Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/21/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date** Enter a date of signature.	8/5/24

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 date of addendum. 8/6/24	**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: 8/5/2024** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 32CQ11 **Date Survey Completed: 6/21/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: Based on record review and interview, the center failed to submit an incident report to OSDH for 2 (#4 and #5) residents which required reporting.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not constitue an admission or agreement with these findings. The community denies any defeciencies.

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?	Health and Wellness Director or designee will audit affected residents incident reports from June 1 to August 1.
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 audit incident reports from June 1 to August 1 to identify any affected 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?	Executive Director will inservice Health and Wellness Director and Staff Nurses on OSDH Reporting.
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.	Health and Wellness Director or designee will perform random weekly audits for 3 months to enure compliance. Enter methods to evaluate for effectiveness: Health and Wellness Director will report findings of audits to QA Committee monthly for possible recommendations. Audits & recommendation will be kept in QA Committee Binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/21/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date** Enter a date of signature.	8/5/24

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. 8/6/24	**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: Scott Slemp <sslemp@omegasrliving.com>

October 24, 2024

License Number: AL5541

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

Survey Event ID: 32CQ12

Dear Mr. Slemp:

On **October 22, 2024,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 21, 2024,** have now been corrected effective **September 21, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5541	A. BUILDING: _____ B. WING _____	R-C 10/22/2024

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 offsite/paper revisit was conducted on 10/22/24. 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