OKLAHOMA
State Department
of Health

Delivery via email to: sslemp@omegaseniorliving.com

December 11, 2025

License Number: AL5541

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

RE: Survey Event ID: 200Q11

Dear Mr. Slemp:

On **November 20, 2025**, agents from our office concluded a State Licensure survey with complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **November 20, 2025**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you have questions or need assistance, please feel free to send an email to OSDH.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

INTERNAL COPY ONLY – AL INVESTIGATIVE REPORT

Enforcement Instructions: The first page is for internal use only. Enforcement will remove the first page prior to sending to the complainant and facility

Survey Team Instructions: Complete the information below. If deficient practice was cited, list the tag number next to the allegation on the ***first page only***.

Facility: **Teal Creek Assisted Living and Memory Care**
Address: **13501 N Bryant**
City, State, Zip: **Edmond, Ok 73013**
Provider #: **AL5541**
Complaint #: **OK00080587**
Investigation Date: **11/19/25 through 11/20/25**

ALLEGATION(S)		
Allegations:	Deficient Practice Cited? (Y/N)	If Yes, List tag number
1.The center failed to ensure adequate care and treatment was provided according to the plan of care and/or the standard of care.	N	
2. The center failed to ensure adequate supervision to prevent accidents.	N	
3. The center failed to ensure assistance with incontinent care was provided according to the plan of care and the contract.	N	

Ombudsman Notification:

11/19/25 @ 8:40 – voicemail left for D Crum on area wide aging voicemail.

11/19/25 @ 8:40 – email sent to D Crum – no response

11/20/25 @ 9:06 am – Voicemail on areawide aging main number

Complainant Contact: Name: APS

Wilma Bouska, CHFS III
11/20/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Teal Creek Assisted Living and Memory Care**
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City, State, Zip: **Edmond, Ok 73013**
Provider #: **AL5541**
Complaint #: **OK00080587**
Investigation Date: **11/19/25 through 11/20/25**

ALLEGATION(S)
1.The center failed to ensure adequate care and treatment was provided according to the plan of care and/or the standard of care.
2. The center failed to ensure adequate supervision to prevent accidents.
3. The center failed to ensure assistance with incontinent care was provided according to the plan of care and the contract.

An unannounced on-site investigation was initiated 11/19/2025 at 8:30 a.m.

A sample of nine participants, including any identified participants, 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: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, and grievances.

The attached State form, Statement of Deficiencies, 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: 11/20/2025

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 _____	11/20/2025

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 relicensure survey with complaint (#OK00080587) was conducted from 11/19/25 through 11/20/25. Deficiencies were cited as a result of the survey. Facility Census: 87 Listed below are abbreviations that will be used throughout this document: CMA - certified medication aide	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure: a. a cleaning schedule for the kitchen was followed for 2 of 2 observations, b. foods were labeled, dated, and covered in 2 of 2 refrigerators, and c. expired food items were disposed of in accordance with food safety guidelines in 1 of 2 observations. The director of nurses identified 86 residents received nutrition from the kitchen. Findings: 1. On 11/19/25 at 8:50 a.m., the following	C 391		

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C 391	Continued From page 1 observations were made in the kitchen: a. the floors in the food preparation area had debris and a black substance around the equipment and in the walkways, b. the floors under the food preparation sink had debris, pooled brown liquids, and a black substance in multiple areas, and c. the floors in the dry storage had sticky surfaces, debris, and a black substance around shelving legs and near walls. 2. On 11/19/25 at 8:55 a.m., the following observations were made in the walk-in refrigerator: a. sliced ham, loosely wrapped with plastic wrap were not labeled or dated, b. sausage patties were wrapped with plastic wrap were not labeled or dated, c. a square shaped plastic container with prepared orange colored liquid, was not labeled or dated, d. prepared salad in large plastic container with lid was not labeled or dated, f. an opened one-gallon container of tarter sauce, was not labeled or dated, g. an opened 2.26 kg container of sour cream, was not labeled or dated, and h. an opened container of chicken salad, had a manufacturer expiration date of 11/15/25. 4. On 11/19/25 at 9:30 a.m., the following was observed in the beverage area refrigerator in the serving area: a. two opened 46-ounce containers of grape juice were not labeled or dated, and b. one opened 46-ounce container of thick and easy clear kiwi strawberry was not labeled or dated. On 11/19/25 at 10:00 a.m., cook #1 was asked	C 391		

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C 391	Continued From page 2 about the process for cleaning the kitchen floors. Cook #1 stated the kitchen staff was responsible for cleaning in the kitchen and they did it at the end of each shift. Cook #1 was shown the unlabeled, undated, and expired food in the refrigerators. Cook #1 was asked if there was a policy for labeling and dating food, and food that was out of date. Cook #1 stated, they were unsure of the policies, but knew the food items should have been labeled and dated when they were opened. Cook #1 stated they should check and discard expired items daily. On 11/19/25 at 2:20 p.m., the director of nurses was shown the floors in the kitchen and was asked about the kitchen cleaning schedule. The director of nurses stated, they did not know the process for cleaning the kitchen, and the dietary manager was on vacation. The director of nurses stated the kitchen floors needed to be cleaned. On 11/20/25 at 3:36 p.m., the director of nurses was asked about policies related to cleaning the kitchen, labeling and dating food items in the refrigerators, and disposal of expired food items. The director of nurses stated they did not have any policies regarding the kitchen and the center followed state regulations."	C 391		
C 397 SS=D	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or	C 397		

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C 397	Continued From page 3 undercooked eggs. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure unpasteurized whole eggs were cooked thoroughly to prevent food born illness during 1 of 3 observations made in the kitchen. The director of nurses identified 86 residents received nutrition from the kitchen. Findings: On 11/19/25 at 8:55 a.m., a tour of the kitchen was conducted with cook #1. There was one 15 dozen box that was half full of non-pasteurized whole eggs with shells intact observed in the walk-in refrigerator. On 11/19/25 at 8:56 a.m., cook #1 was asked how they served the unpasteurized eggs. Cook #1 stated they used the unpasteurized shell eggs to serve residents fried, boiled or scrambled eggs. Cook #1 was asked if they were aware if the eggs were pasteurized or not. Cook #1 stated they had no idea, they just used what was in the refrigerator. On 11/20/25 at 3:20 p.m., the director of nurses was asked to provide any policies related to unpasteurized eggs. The director of nurses stated the facility did not have any policies related to unpasteurized eggs or egg products, and they referred to the state regulations.	C 397		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the	C 521		

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C 521	Continued From page 4 admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an admission assessment was completed within 30 days prior to admission or on the day of admission for 3 (#1, 7, and #8) of 9 sampled residents reviewed for assessments. The director of nurses identified 86 residents resided in the center. Findings: 1. Resident #1's admission assessment, dated 11/26/24, showed Resident #1 was admitted to the center on 11/25/24. The assessment was not completed until 11/26/24. 2. Resident #7's admission assessment, dated 10/20/25, showed Resident #7 was admitted to the center on 10/17/25. The assessment was not completed until 10/20/25. 3. Resident #8's admission assessment, dated 11/07/25, showed Resident #8 was admitted to the center on 11/04/25. The assessment was not completed until 11/07/25. On 11/20/25 at 3:45 p.m., the director of nurses was asked about the above admission assessments. The director of nurses stated the admission assessments were completed late.	C 521		
C 940 SS=D	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed	C 940		

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C 940	Continued From page 5 dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure: a. the daily menu was followed for puree foods prepared for 3 of 3 meals observed, and b. puree food items nutritional content was maintained. The director of nurses identified four residents received puree diets in the center. Findings: On 11/19/25 at 11:30 a.m., cook #1 was observed during puree process for lunch. Cook #1 placed 4 slices of roast beef in a blender, added tap water to the blender, and blended until puree consistency. Cook #1 filled three one cup containers, and one large compartment of a three compartment plate with the pureed roast. Cook #1 discarded the remaining puree left in the blender. On 11/19/25 at 11:38 a.m., cook #1 was observed placing eight 2-ounce scoops of brussel sprouts in a clean blender and added tap water. Cook #1 blended the contents until puree consistency. Cook #1 filled three half cup containers and one small compartment of a three compartment plate with pureed brussel sprouts, and discarded the remaining puree left in the blender. On 11/20/25 at 8:43 a.m., cook #1 was observed placing two 8-ounce scoops of oatmeal in four large bowls for pureed diets, then placed the	C 940		

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C 940	Continued From page 6 bowls in a covered cart on trays. On 11/20/25 at 8:44 a.m., CMA #3 was observed requesting a plate for a resident with a puree diet order. Cook #1 was observed giving CMA #3 a bowl of oatmeal from the covered cart, 8-ounce glass of juice, and 8-ounce glass of milk. CMA#3 was observed delivering food to a resident. On 11/20/25 at 12:05 p.m., lunch meal service was observed. Residents with puree diet orders received noodles and parmesan chicken pureed, and pureed asparagus. The centers lunch menu, dated 11/19/25, showed roast beef, loaded mashed potatoes, brussel sprouts, dinner roll, and strawberry shortcake were to be served. The centers breakfast menu, dated 11/20/25, showed juice of choice, cereal of choice, fresh fruit, scrambled eggs, bacon, assorted muffins, margarine and jelly, milk, coffee or hot tea were to be served. The centers lunch menu, dated 11/20/25, showed chicken parmesan, butter penne pasta, asparagus tips, garlic bread and fruit crisp were to be served. On 11/20/25 at 8:45 a.m., CMA #3 was asked if the tray they were given was usual food items for resident with pureed diet orders. CMA #3 stated, "yes, pureed diets all get the same thing, oatmeal, juice and milk." CMA #3 was asked if optional diet choices were given to residents with pureed diet orders. CMA #3 stated residents with puree orders were not given choices and they were always served oatmeal.	C 940		

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C 940	Continued From page 7 On 11/20/25 at 8:50 a.m., cook #1 was asked if the breakfast trays were the usual servings for pureed diets. Cook #1 stated they served oatmeal, juice and milk for breakfast for residents with pureed diet orders. Cook #1 was asked if the residents had the option for other food items. Cook #1 stated if the residents requested something different, they could blend it. Cook #1 was asked if the residents could order something different. Cook #1 stated they only served different items if residents requested, but cook #1 had never received a request form from residents. On 11/20/25 at 12:08 p.m., Cook #1 was asked about other food items that were on the menu for lunch, specifically the garlic bread and apple crisp. Cook #1 stated they could give the residents ice cream or pudding cups if they requested a dessert, but they did not serve that to the residents on the plates. Cook #1 stated they did not puree garlic bread. Cook #1 was asked if residents could substitute something else for the bread. Cook #1 stated residents did not ask for a substitution. On 11/20/25 at 3:10 p.m., director of nurses was asked about the policies for pureed foods and menus. The director of nurses stated the center did not have any policies for pureed foods and the dietary manager told them they follow the state regulations. The director of nurses was asked about the dietary consultations and kitchen observations. The director of nurses stated the dietician comes quarterly and reviewed the menus, followed weight loss, gave recommendations, and inspected the kitchen. The director of nurses was asked if they were aware of the puree process. The director of nurses stated they should use milk or gravy to	C 940		

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C 940	Continued From page 8 thin items. The director of nurses stated the residents should have a variety of foods at meals to meet the nutritional requirements.	C 940		

OKLAHOMA
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Delivery via email to: sslemp@omegasrliving.com

December 22, 2025

License Number: AL5541

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

RE: Survey Event 200Q11

Dear Mr. Slemp:

On **November 20, 2025**, a Licensure inspection with complaints was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **February 9, 2025**.

We will conduct a revisit for 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: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation and interview, the centerfailed to ensure:a. a cleaning schedule for the kitchen wasfollowed for 2 of 2 observations,b. foods were labeled, dated, and covered in 2 of 2 refrigerators, andc. expired food items were disposed of inaccordance with food safety guidelines in 1 of 2 observations.

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?	DSM will audit all refrigerators and dry food storage for expired food items. ED will inservice all dietary staff members on food safety guidelines for expired foods.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DSM will audit all refrigerators and dry food storage for expired food items.
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?	ED will inservice all dietary staff members on food safety guidelines for expired foods. DSM will audit all refrigerators and dry food storage for expired food items weekly for 1 month and then monthly for 2 months.
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.	DSM will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** OAC 310:663-25-4(F)	**Date 12/22/2025**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	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: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C397	Based on: observation the facility failed to ensure unpasteurized whole eggs were cooked thoroughly during 1 of 3 observations.

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?	DSM will audit all refrigerators to ensure all whole eggs are pasteurized.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DSM will audit all refrigerators to ensure all whole eggs are pasteurized.
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?	ED will inservice all dietary staff on use of unpasteurized and pasteurized eggs. DSM or designee will audit all refrigerators to ensure compliance with using pasteurized weekly for 1 month then monthly for 2 months.
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.	DSM will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** OAC 310:663-25-4(F)	**Date 12/22/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 12/22/2025
	Facility Name: Teal Creek Assisted Living and Memory Care
	License Number: AL5541
	Survey Event ID: 200Q11
	Date Survey Completed: 11/20/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521	Based on: record review and interview, the centerfailed to ensure an admission assessment wascompleted within 30 days prior to admission or onthe day of admission for 3 (#1, 7, and #8) of 9sampled residents reviewed for assessments.

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?	ED will inservice HWD on admission assessments timeframes. HWD or designee will audit all charts for compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	HWD or designee will audit all charts for compliance.
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?	HWD or designee will audit all new move-ins for compliance weekly for 3 months.
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.	HWD will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** **Date 12/22/2025**

OAC 310:663-25-4(F)

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C940	Based on: the center failed to ensure:a. the daily menu was followed for puree foods prepared for 3 of 3 meals observed, and b. puree food items nutritional content was maintained.

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?	ED will inservice all dietary staff regarding pureed foods and menu.. Dietary Service Manager or designee will monitor pureed food orders for compliance with menu.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Dietary Service Manager or designee will monitor pureed food orders for compliance.
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?	ED will inservice all dietary staff regarding pureed foods and compliance with menu. Dietary Service Manager or designee will monitor all pureed food orders daily for 3 months and report findings to QA monthly.
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.	Dietary Service Manager will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2025
OSDH Response: Element accepted Yes ☐ No ☒	

Administrator's Signature **Scott Slemp** OAC 310:663-25-4(F)	**Date 12/22/2025**

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Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department of Health

Delivery via email to: sslemp@omegasrliving.com

CORRECTION NOTICE

December 23, 2025

License Number: AL5541

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

RE: Survey Event 200Q11

Dear Mr. Slemp:

On **November 20, 2025**, a Licensure inspection with complaints was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **February 9, 2026**.

We will conduct a revisit for 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: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C940	Based on: the center failed to ensure:a. the daily menu was followed for puree foods prepared for 3 of 3 meals observed, and b. puree food items nutritional content was maintained.

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?	ED will inservice all dietary staff regarding pureed foods and menu.. Dietary Service Manager or designee will monitor pureed food orders for compliance with menu.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Dietary Service Manager or designee will monitor pureed food orders for compliance.
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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.	Dietary Service Manager will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** OAC 310:663-25-4(F)	**Date 12/22/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521	Based on: record review and interview, the centerfailed to ensure an admission assessment wascompleted within 30 days prior to admission or onthe day of admission for 3 (#1, 7, and #8) of 9sampled residents reviewed for assessments.

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.

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2. How will other residents having the potential to be affected by the same deficient practice be identified?	HWD or designee will audit all charts for compliance.
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?	HWD or designee will audit all new move-ins for compliance weekly for 3 months.
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.	HWD will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** **Date 12/22/2025**
OAC 310:663-25-4(F)

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C397	Based on: observation the facility failed to ensure unpasteurized whole eggs were cooked thoroughly during 1 of 3 observations.

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?	DSM will audit all refrigerators to ensure all whole eggs are pasteurized.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DSM will audit all refrigerators to ensure all whole eggs are pasteurized.
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?	ED will inservice all dietary staff on use of unpasteurized and pasteurized eggs. DSM or designee will audit all refrigerators to ensure compliance with using pasteurized weekly for 1 month then monthly for 2 months.
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.	DSM will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** OAC 310:663-25-4(F)	**Date 12/22/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/22/2025** **Facility Name:** Teal Creek Assisted Living and Memory Care **License Number:** AL5541 **Survey Event ID:** 200Q11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation and interview, the centerfailed to ensure:a. a cleaning schedule for the kitchen wasfollowed for 2 of 2 observations,b. foods were labeled, dated, and covered in 2 of 2 refrigerators, andc. expired food items were disposed of inaccordance with food safety guidelines in 1 of 2 observations.

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?	DSM will audit all refrigerators and dry food storage for expired food items. ED will inservice all dietary staff members on food safety guidelines for expired foods.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DSM will audit all refrigerators and dry food storage for expired food items.
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?	ED will inservice all dietary staff members on food safety guidelines for expired foods. DSM will audit all refrigerators and dry food storage for expired food items weekly for 1 month and then monthly for 2 months.
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.	DSM will report findings to QA Committee monthly for 3 months QA Committee will review results monthly and make recommendations as needed. Enter methods to incorporate into QA system: Findings and recommendations will be kept in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/9/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Scott Slemp** OAC 310:663-25-4(F)	**Date 12/22/2025**

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OKLAHOMA
State Department
of Health

Delivery via email to: sslemp@omegasrliving.com

February 10, 2026

License Number: AL5541

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

RE: Survey Event 200Q12

Dear Mr. Slemp:

On **February 9, 2026,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaints on **November 20, 2025,** have now been corrected effective **February 9, 2026.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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 02/09/2026

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 02/09/26. 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