OKLAHOMA
State Department
of Health

Delivery via email to: PQuartey@enlivant.com

June 16, 2023

License Number: AL5505

Ms. Patience Quartey, Administrator
Blue Ridge Place
615 West Blue Ridge Drive
Midwest City, OK 73110

RE: Survey Event ID: 9P0A11

Dear Ms. Quartey:

On **June 5, 2023**, agents from our office concluded a State Licensure survey with a 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 June 5, 2023.

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 (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 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 and monitoring will be completed for each violation;
(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Blue Ridge Place**
Address: **615 West Blue Ridge Drive**
City, State, Zip: **Midwest City, OK, 73110**
Provider #: **AL5505**
Complaint #: **OK00060516**
Investigation Date(s): **06/01/23 – 06/02/23, 06/05/23**

ALLEGATION(S)

1. The facility failed to assess, monitor and intervene for a change in condition.
2. The facility failed to ensure medications were administered according to physicians' orders.
3. The facility failed to provide a safe and comfortable environment.
4. The facility failed to ensure therapeutic diets were served according to physicians' orders.

An unannounced on-site investigation was initiated 06/01/2023 at 11:25 a.m.

A sample of eight 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:

A tour of the facility was conducted upon entrance and at other times throughout the survey. Resident halls and bedrooms were observed for provision of a safe and comfortable environment. The kitchen and dining room were observed for therapeutic diets served according to physicians' orders. Medication administration was observed for medications being given according to physicians' orders.

Residents were interviewed regarding staff response to a change in condition, getting meals and medications as ordered, and safety and comfort of their environment. Staff members were interviewed relating to facility policies on response to a change in condition, medication administration, food service, and safety and comfort of residents.

Residents' records reviewed included assessments, physician's orders, laboratory results, care plans, hospital records, and progress notes. Facility policies and procedures were reviewed.

Deficient practice was not cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Eyitayo Awopeju

Digitally signed by Eyitayo Awopeju
Date: 2023.06.07 21:27:54 -05'00'

Eyitayo Awopeju, CHFS

Date report completed: 06/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5505	A. BUILDING: _____ B. WING _____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE PLACE	615 WEST BLUE RIDGE DRIVE MIDWEST CITY, OK 73110

(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 was conducted from 06/01/23 through 06/02/23 and 06/05/2. Complaint investigations (#OK00060516) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: CPR- cardiopulmonary resuscitation CMA- certified medication aide CNA- certified nurse aide	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the 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 facility failed to complete an admission assessment for one (#3) of two sampled residents reviewed for admission assessments. The facility identified three residents who had been admitted to the facility in the last 60 days. Findings: Resident #3 was admitted to the facility on 03/17/23 with a diagnosis of diabetes.	C 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5505	A. BUILDING: _____ B. WING _____	C 06/05/2023

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C 521	Continued From page 1 A review of the clincal record contained no documentation the facility had completed an admission assessment on 03/17/23 and/or within 30 days of admission. On 06/02/23 the Care Service Manager was asked for Resident #3 admission assessment. The Care Service Manager stated they would look for it. 06/25/2023 at 10:55 a.m., the Care Service Manager stated the admission assessment had not been completed. They stated they had called the consulting Registered Nurse and the corporate office and no assessments were located for Resident #3.	C 521		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a comprehensive assessment within 14 days after admission for one (#3) of two sampled residents reviewed for a comprehensive assessment.	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5505	A. BUILDING: _____ B. WING _____	C 06/05/2023

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C 522	Continued From page 2 The facility identified three residents who had been admitted to the facility in the last 60 days. Findings: Resident #3 was admitted to the facility on 03/17/23 with a diagnosis of diabetes. A review of the clinical record contained no documentation the facility had completed a comprehensive assessment within 14 days after admission On 06/02/23 the Care Service Manager was asked for Resident #3 comprehensive assessment. The Care Service Manager stated they would look for it. 06/25/2023 at 10:55 a.m., the Care Service Manager stated the comprehensive asessments had not been completed for Resident #10.	C 522		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5505	A. BUILDING: _____ B. WING _____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE PLACE	615 WEST BLUE RIDGE DRIVE MIDWEST CITY, OK 73110

(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 954	Continued From page 3 failed to ensure employees received training on CPR for five (CNA #1, CNA #2, CMA #3, CMA #4, and CMA #5) of six employee files reviewed for CPR training. The Care Service Manager identified 23 active employees working at the facility. Findings: 1. A review of the employee file for CNA #1 documented they were hired at the facility on 01/06/23. There was no documentation the CNA had received CPR training . 2. A review of the employee file for CNA #2 documented they were hired at the facility on 01/11/23. There was no documentation the CNA had received CPR training . 3. A review of the employee file for CMA #3 documented they were hired at the facility on 04/19/23. There was no documentation the CMA had received CPR training. 4. A review of the employee file for CMA #4 documented they were hired at the facility on 03/30/23. There was no documentation the CMA had received CPR training . 5. A review of the employee file for CMA #5 documented they were hired at the facility on	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5505	A. BUILDING: _____ B. WING _____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE PLACE	615 WEST BLUE RIDGE DRIVE MIDWEST CITY, OK 73110

(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 954	Continued From page 4 03/21/23. There was no documentation the CMA had received CPR training . On 06/02/2023 at 11:15 a.m., the administrative assistant was asked for documentation CNA #1, CNA #2, CMA #3, CMA #4, and CNA #5 had received CPR training. They stated it had not been completed and the facility had not provided any CPR since October 2022.	C 954		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure new employees were trained on abuse within 90 days of hire for two (CNA #1 and CNA #2) of six employee files reviewed for abuse training on hire. The Care Service Manager identified 23 active employees working at the facility. Findings:	C1972		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5505	A. BUILDING: _____ B. WING _____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE PLACE	615 WEST BLUE RIDGE DRIVE MIDWEST CITY, OK 73110

(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
C1972	Continued From page 5 1. A review of the employee file for CNA #1 documented they were hired at the facility on 01/06/23. There was no documentation the CNA had abuse training within 90 days of being hired. 2. A review of the employee file for CNA #2 documented they were hired at the facility on 01/11/23. There was no documentation the CNA had abuse training within 90 days of being hired. 06/02/2023 at 11:15 a.m., the administrator assistant was asked for documentation CNA #1 and CNA #2 had been provided abuse training. They stated it had not been completed and the facility had not provided any abuse training since she started back at the facility in October 2022.	C1972		

OKLAHOMA
State Department
of Health

Delivery via email to: blueridgemail@enlivant.com

July 20, 2023

License Number: AL5505

Ms. Carrie Elmore, Administrator
Blue Ridge Place
615 West Blue Ridge Drive
Midwest City, OK 73110

Survey Event ID: 9P0A11

Dear Ms. Elmore:

On **June 5, 2023,** a Relicensure survey and a complaint investigation were 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 **August 4, 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** Blueridge Place **License Number:** AL5505 **Survey Event ID:** 9POA11 **Date Survey Completed: 6/5/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521	Based on: Based on record review and interview the facilityfailed to complete an admission assessment forone (#3) of two sampled residents reviewed foradmission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	On 6/27/23, Care Service Manager (CSM) completed Resident #3's state assessment, state assessment is current and active.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By 8/04/23, CSM and or designee will audit current resident charts to assess for completion of admission state assessment, CSM to address findings as necessary.
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?	On 6/28/23 Regional Director of Care Services (RDCS) provided education to Executive Director (ED) and CSM on requirement for completing an admission assessment within 30 days before or at the time of admission.
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.	Beginning 7/07/23, ED and/or designee will review new resident files to ensure the admission state assessment has been completed weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/4/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Michael Hunt ED	**Date** Enter a date of signature. 6-30-2023

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** Blueridge Place **License Number:** AL5505 **Survey Event ID:** 9POA11 **Date Survey Completed: 6/5/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Based on record review and interview, the facility failed to complete a comprehensive assessment within 14 days after admission for one (#3) of two sampled residents reviewed for a comprehensive assessment.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	On 6/27/23, CSM completed resident #3's comprehensive state assessment, state assessment is current and active.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By 8/04/23, CSM and or designee will audit current charts to assess for compliance with 14 day comprehensive state assessments, CSM to address findings as necessary.
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?	On 6/28/23, RDCS educated ED and CSM on requirement for comprehensive assessments to be completed within 14 days after admission.
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.	Beginning 7/07/23, ED and or designee will review current resident files to ensure the comprehensive state assessment has been completed according to required timelines weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/4/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required.	**Date** Enter a date of signature.
OAC 310:663-25-4(F) Mark Bond ED	6-30-2023

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTI/ON TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** Blueridge Place **License Number:** AL5505 **Survey Event ID:** 9POA11 **Date Survey Completed: 6/5/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C954	Based on: Based on record review and interview, the facility failed to ensure employees received training on CPR for five (CNA #1, CNA #2, CMA #3, CMA #4,and CMA #5) of six employee files reviewed for CPR training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	On 6/06/23 CSM and/or designee assigned CPR training to CNA #1, CNA#2, CMA #3, CMA #4, CMA #5. All have been completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 6/08/23 CSM and/or designee to complete CPR training with current staff. CSM and/or designee will train new hires within first 5 days of employment and annually thereafter in CPR.
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?	By 6/28/23 Regional Director of Care Services to provide education to ED and or designee on staff training guidelines for CPR. ED and/or designee to ensure annual CPR training is conducted with staff, tracking will be maintained via employee roster and stored within in-service binder.
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.	On 7/07/23 ED and/or designee to audit 5 personnel files to monitor progress of upon hire/annual CPR and first aid training via QA meetings weekly x 4 weeks biweekly for 1 month and monthly thereafter until compliance is met. Enter methods to evaluate for effectiveness: Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Enter methods to keep monitoring records: records of CPR training will be maintained in the employee file.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed? OSDH Response: Element accepted Yes ☐ No ☐		8/4/2023	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date** Enter a date of signature.
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 CORRECTI/ON TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** Blueridge Place **License Number:** AL5505 **Survey Event ID:** 9POA11 **Date Survey Completed: 6/5/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1972	Based on: Based on record review and interview, the facility failed to ensure new employees were trained on abuse within 90 days of hire for two (CNA #1 and CNA #2) of six employee files reviewed for abuse training on hire.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

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?	On 6/05/23 ED and or designee trained CNA #1 and CNA #2 on abuse and neglect policy.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 6/08/23 ED and/or designee to complete abuse and neglect training with current staff. ED and/or designee will train new hires within first 5 days of employment and annually thereafter in abuse and neglect.
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?	On 6/28/23 Regional Director of Care Services to provide education to ED and or designee on staff training guidelines for abuse and neglect. ED and/or designee to ensure annual abuse and neglect training is conducted with staff, tracking will be maintained via employee roster and stored within in-service binder.
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.	On 7/07/23 ED and/or designee to audit 5 personnel files to monitor progress of upon hire/annual abuse and neglect training via QA meetings weekly x 4 weeks biweekly for 1 month and monthly thereafter until compliance is met. Enter methods to evaluate for effectiveness: Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

		Enter methods to keep monitoring records: records of abuse and neglect training will be maintained in the employee file.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/4/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date** Enter a date of signature.
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: caelmore@moradamidwestcity.com; pquartey@moradamidwestcity.com

August 29, 2023

License Number: AL5505

Ms. Carrie Elmore, Administrator
Blue Ridge Place
615 West Blue Ridge Drive
Midwest City, OK 73110

RE: Survey Event 9P0A12

Dear Ms. Elmore:

On **August 29, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 5, 2023,** have now been corrected effective **August 4, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5505	A. BUILDING: _____ B. WING _____	R-C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE PLACE	615 WEST BLUE RIDGE DRIVE MIDWEST CITY, OK 73110

(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 08/21/23 and 08/28/23. 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