OKLAHOMA
State Department
of Health

Delivery via email to: crb-ed@12oaks.net

November 1, 2023

License Number: AL7256

Ms. Kari Lazear, Administrator
Cedar Ridge Senior Living
10107 South Garnett Road
Broken Arrow, OK 74011

RE: Survey Event ID: 6XLG11

Dear Ms. Lazear:

On **October 17, 2023**, agents from our office concluded a State Licensure survey with complaint investigations 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 **October 17, 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.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Cedar Ridge Senior Living**
Address: **10107 South Garnett Road**
City, State, Zip: **Broken Arrow, OK 74011**
Provider #: **AL7256**
Complaint #: **OK00059636**
Investigation Dates: **10/16/23 and 10/17/23**

ALLEGATIONS

The facility failed to provide timely incontinent care for dependent residents.
The facility failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 10/16/2023 at 2:45 p.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, the presence of odors, access to fluids, and call lights. Activities were observed. Meals were observed at various times throughout the survey.

Grievance reports, incident reports, menus, policies and procedures were reviewed. Resident records including contracts, assessments, care plans, physician orders, nursing notes, and medication records were reviewed.

A visual count of direct care nursing staff on duty was taken and compared to the State mandated staffing requirement. Past facility staffing schedules were reviewed for staffing patterns and compared to the State mandated staffing requirements. Staff training records and licenses related to job requirements were reviewed

Family members, staff and residents were interviewed regarding care needs, medications, and treatment of residents. Staff members were interviewed regarding the facility's policies.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/18/2023

INVESTIGATIVE REPORT

Facility: **Cedar Ridge Senior Living**
Address: **10107 South Garnett Road**
City, State, Zip: **Broken Arrow, OK 74011**
Provider #: **AL7256**
Complaint #: **OK00061616**
Investigation Dates: **10/16/23 and 10/17/23**

ALLEGATIONS

The center failed to ensure residents received medications as ordered by the physician.
The center failed to have and/or implement an effective system for receiving and documenting new medications/orders.

An unannounced on-site investigation was initiated 10/16/2023 at 2:45 p.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs, the presence of odors, access to fluids, and call lights. Activities were observed. Meals were observed at various times throughout the survey.

Grievance reports, incident reports, menus, policies and procedures were reviewed. Resident records including contracts, assessments, care plans, physician orders, nursing notes, and medication records were reviewed.

A visual count of direct care nursing staff on duty was taken and compared to the State mandated staffing requirement. Staff training records and licenses related to job requirements were reviewed

Family members, staff and residents were interviewed regarding care needs, medications, and treatment of residents. Staff members were interviewed regarding the facility's policies.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7256	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

(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 10/16/23 through 10/17/23. Complaint investigations (#OK00059636 and #OK00061616) were conducted in conjunction with the survey. Listed below are abbreviation that will be used throughout this document. CMA - certified medication aide DRC - director of resident care ER - emergency room MAR - medication administration record mg - milligram	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7256	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

(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
C1505	Continued From page 1 medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: a. ensure medications were provided as ordered by the physician for two (#2 and #11) of eleven sampled residents whose records were reviewed for medications provided per physician orders; and b. ensure medications were available for administration for one (#12) of five residents observed during the medication administration observation. The "Entrance Conference Checklist" identified 53 residents who resided in the facility. Findings: The facility's "Reordering Medications" policy, dated 08/01/2018, documented the community staff should review medications daily and reorder	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7256	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

(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
C1505	Continued From page 2	C1505		

medications when a five day supply of the medication was remaining.

1. Resident #2 had diagnoses which included dementia and other major depressive disorders.

An "ER Visit Summary", dated 09/20/23, documented the resident was taking Risperidone 0.5 mg once a day.

The "Medication Administration Record" documented the medication was not administered until 09/28/23.

On 10/17/23 at 3:06 p.m., the DRC stated a family member delivered the Risperidone prescription to a medication aide. The medication aide did not log the medication onto a medication ledger or inform the charge nurse. The DRC stated on 08/28/23 the family inquired about the medication. That was when they realized the medication was not being administered as prescribed by the physician.

2. Resident #11 had diagnoses which included primary hypertension.

The "Individual Care Plan", dated 08/20/23, documented the staff were responsible to administer medications to the resident.

The "Physician Order Review", dated 10/17/23, documented the resident was ordered Verapamil HCL 240 mg one time every day at 8:00 a.m.

On 10/17/23 at 8:48 a.m., CNA # 2 was observed to administer medications to Resident #11. The CNA did not administer the Verapamil.

On 10/17/23 at 2:12 p.m., CMA #2 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7256	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

(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
C1505	Continued From page 3	C1505		

Verapamil was not given because the directions on the physician order documented the medication was to be given in the morning but the prescription label on the medication bottle instructed the medication was to be administered in the evening. CNA #2 stated they had never given the resident the Verapamil.

On 10/17/23 at 2:26 p.m., the DRC reviewed the MAR for Verapamil and stated the last time the medication was administered was on 10/15/23. The DRC stated they would have to find out why the medication was not administered per physician orders.

3. Resident #12 had diagnoses which included hypothyroidism, chronic pain, and cough variant asthma.

The "Individual Care Plan", dated 06/23/23, documented the staff were responsible to administer medications to the resident.

The "Physician Order Review", dated 10/17/23, documented the resident was ordered Levothyroxine 75mcg at 8:00 a.m., Lidocaine 5% patch at 8:00 a.m., and Trilegy Ellipta 100-62.5-25 mcg inhaler one puff at 8:00 a.m.

On 10/17/23 at 8:15 a.m., CMA #1 was observed to administer medications to Resident #12. CMA #1 did not administer Levothyroxine, the Lidocaine patch, or the Trilegy inhaler. CMA #1 stated they would need to reorder the medications from the pharmacy because they were not available.

On 10/17/23 at 2:26 p.m., the DRC stated the CMAs should have reordered the medications for Resident #12 to ensure they were available for administration as ordered by the physician. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7256	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

(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
C1505	Continued From page 4 Director of Resident Care stated they needed to train the staff on the medication reordering protocol.	C1505		

OKLAHOMA
State Department of Health

Delivery via email to: crb-ed@12oaks.net

November 13, 2023

License Number: AL7256

Ms. Kari Lazear, Administrator
Cedar Ridge Senior Living
10107 South Garnett Road
Broken Arrow, OK 74011

Survey Event ID: 6XLG11

Dear Ms. Lazear:

On **October 17, 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 have been corrected and you were in substantial compliance by **November 7, 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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/7/2023** **Facility Name:** Cedar Ridge Senior Living **License Number:** AL7256 **Survey Event ID:** 6XLG11 **Date Survey Completed: 10/17/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C-1505	Based on: Based on observation, record review, and interview the facility failed to A:Ensure medications were provided as ordered, B:Ensure medications were available for administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	DRC in-serviced CMA's on medication administration polices and procedures on 10/17/2023. DRC completed med cart audit 10/17/23. DRC ordered medication STAT, was delivered 10/17/23 Pharmacist in-service scheduled on 11/7/2023 on cart audits and medication administration. All new physicians orders will be reviewed and verified by DRC. Executive Director to monitor for accuracy and completion through 1:1 meeting with DRC monthly for 6 months.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Cart audits are conducted monthly and verified by DRC. Medications will be re-ordered when resident reaches a 7 day supply. DRC to be notified when a new medication is delivered to community.
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?	In-service with Pharmacist on 11/7/2023. Resident Care Coordinator to complete monthly cart audit and DRC will verify. Communication log implemented and monitored by DRC and reviewed weekly by Executive Director.
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.	DRC will review and verify all Physicians orders. Cart audits will be conducted monthly. Accomplish quality assurance objectives by monitoring, reviewing, and enforcing policies and procedures. Maintain complaint and nonconformance processing through records and tracking. Monitor risk-management procedures. Medication received binder put into place. Medication administration report to be conducted weekly. DRC will review and verify. Executive Director will monitor for completion
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed? OSDH Response: Element accepted Yes ☐ No ☐		11/7/2023	
Administrator's Signature **Kari Lazear** OAC 310:663-25-4(F)			**Date 11/7/2023**
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.			

Title: Optimizing Medication Ordering and Medication Management

Cedar Ridge Assisted Living

By Gary McKinney DPH

November 7, 2023

I. Introduction
   a. Importance of Medication Ordering and Management
   b. Goals of the Talk
   c. Overview of Key Topics

II. Medication Ordering Process
   a. Importance of Accurate Prescriptions
   b. Electronic Prescribing Systems
   c. Nursing Staff's Responsibilities
   d. Medication Aide Responsibilities

III. Medication Availability
   a. Following up on orders
   b. Inventory Management
   c. Communication between facility and Pharmacy

IV. Minimizing Medication Errors
   a. Notifying the Nurse New Medications
   b. Giving Medication "as Directed"
   c. Documentation and Reporting

V. Conclusion
   a. Recap of Key Points
   b. Q&A

OKLAHOMA
State Department
of Health

Delivery via email to: crb-ed@12oaks.net

December 22, 2023

License Number: AL7256

Ms. Kari Lazear, Administrator
Cedar Ridge Senior Living
10107 South Garnett Road
Broken Arrow, OK 74011

RE: Survey Event 6XLG12

Dear Ms. Lazear:

On **December 20, 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 **October 17, 2023,** have now been corrected effective **November 7, 2023.**

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
	AL7256	A. BUILDING: _____ B. WING _____	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

(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 12/20/23. 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