OKLAHOMA
State Department
of Health

Delivery via email to: klazear@cedarridgesl.com

August 14, 2026

License Number: AL7256

Ms. Kari Lazear, Executive Director
Cedar Ridge Senior Living
0107 South Garnett Road
Broken Arrow, OK 74011

RE: Survey Event ID: MUX311

Dear Ms. Lazear:

On **August 6, 2026**, agents from our office concluded a State Licensure survey 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 **August 6, 2026**.

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:

(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 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: IDRCoordinator@health.ok.gov

or mail 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,

Tempal Killman

Tempal Killman, 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 _____	08/06/2026

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 08/03/26 through 08/06/26. Deficiencies were cited. Facility Census: 63	C 000		
C 397 SS=E	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 undercooked eggs. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure unpasteurized eggs were served in a manner to prevent foodborne illness for 1 of 2 meal service observations. The administrator identified 63 residents received nutrition from the kitchen. Findings: On 08/03/26 at 10:38 a.m., unpasteurized whole shell eggs were observed in the kitchen refrigerator. On 08/05/26 at 8:55 a.m., a resident was observed eating a soft cooked egg with a runny yolk. On 08/05/26 at 9:04 a.m., the administrator	C 397		

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 _____	08/06/2026

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CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

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C 397	Continued From page 1 stated they followed the state regulations regarding pasteurized eggs. The administrator stated unpasteurized eggs should have been fully cooked. On 08/05/26 at 9:10 a.m., the dietary manager stated they failed to communicate to the cook that unpasteurized eggs must be fully cooked. On 08/05/26 at 12:35 p.m., the dietitian stated they thought the center had liquid eggs and pasteurized eggs only.	C 397		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual fire inspection was completed. The administrator identified 63 residents resided in the center. Findings: A fire inspection report, dated 07/02/25, showed the fire department conducted a fire inspection on 07/02/25. On 08/05/26 at 2:00 p.m., the administrator stated the center did not have a policy regarding annual fire inspections to be completed. The administrator stated the current fire marshal	C 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE SENIOR LIVING	10107 SOUTH GARNETT ROAD BROKEN ARROW, OK 74011

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C 711	Continued From page 2 inspection was out of compliance.	C 711		

OKLAHOMA
State Department
of Health

Delivery via email to: klazear@cedarridgesl.com

August 26, 2026

License Number: AL7256

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

RE: Survey Event MUX311

Dear Ms. Lazear:

On **August 6, 2026**, a Licensure inspection 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 in a timely manner. **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 **August 25, 2026.**

We will conduct a revisit 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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/19/2026** **Facility Name:** Cedar Ridge Senior Living **License Number:** AL7256-7256 **Survey Event ID:** MUX311 **Date Survey Completed: 8/6/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 711	Based on: Record review and interview, the center failed to ensure an annual fire inspection was completed.

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?	The Executive Director and Maintainence Director reviews the facility's current fire and life-safety documentation to determine whether any other required inspections, certifications, or testing were expired or approaching expiration. Any deficiencies will be immediately addressed and documented.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The maintenance director will implement and review a tracking system monthly to ensure all required inspections remain current.
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?	The executive director and maintenance director will audit the fire and life-safety compliance binder monthly for 3 months to verify that required inspections and certifications are current. After 3 months of successful monitoring, the facility will continue to review fire and life-safety inspections expirations as part of its routine regulatory compliance process.
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.	The executive director and maintenance director will audit the fire and life-safety compliance binder monthly for 3 months to verify that required inspections and certifications are current. After 3 months of successful monitoring, the facility will continue to review fire and life-safety inspections expirations as part of its routine regulatory compliance process. The facility will incorporate fire and life-safety inspection compliance into its Quality Assurance/Performance improvement (QAPI) monitoring process. A community calendar will be maintained in the Life-Safety binder marking 60 days prior to expiration of each required inspection or certification so that adequate time is available to schedule inspection.

	Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/25/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. **Date 8/19/2026**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/19/2026** **Facility Name:** Cedar Ridge Senior Living **License Number:** AL7256-7256 **Survey Event ID:** MUX311 **Date Survey Completed: 8/6/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 397	Based on: Observation and interview, the center failed to ensure unpasteurized eggs were served in a manner to prevent food borne illness for 1 of 2 meal services observed.

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?	The dietary manager and Executive Director reviewed current food production practices to determine whether any other residents may have been affected by the identified practice. Any questionable egg products were removed from use.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The facility will continue to monitor residents for any signs or symptoms of foodborne illness and will follow established procedures for reporting and responding to suspected foodborne illness.
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?	All dietary employees involved in food preparation will be inserviced on the prohibition against using unapproved/unpasteurized egg products. Education will be completed by 8/19/26.
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.	Upon delivery, staff will inspect egg products for proper pasteurized labeling. Dietary manager will conduct a weekly audit of egg products for 4 consecutive weeks to verify compliance. After 4 weeks of successful compliance, monitoring will continue monthly for 3 months. The results of the monistoring will be reviewd by the Executive Director and the quality assurance committee The community will maintain documentation of staff education, audits, corrective actions and monitoring results.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/21/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date 8/19/2026**

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.			