OKLAHOMA
State Department of Health

Delivery via email to: highcedarresidentialcare@gmail.com

August 21, 2026

License Number: RC1404
Survey Event ID: **QO0611**

Mr. Dalton Brandon, Administrator
High Cedar Residential Care
10151 Maguire Road
Noble, OK 73068

Dear Mr. Brandon:

Enclosed is a report of the complaint investigation conducted at your Residential Care facility on **August 19, 2026**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **High Cedar Residential Care**
Address: **18601 Cedar Lane**
City, State, Zip: **Noble, OK, 73068**
Provider #: **RC1404**
Complaint #: **OK00073797**
Investigation Date(s): **08/19/26**

ALLEGATION(S)

1. The facility failed to maintain financial solvency to ensure day to day operations.

An unannounced on-site investigation was initiated 08/19/2026 at 3:00 p.m.

A sample of 4 residents, including 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 various times throughout the survey.

Observations were made of the phone services and telephone for residents. Observations were made of water temperatures in resident accessible areas. Residents were asked questions regarding water temperature and the availability of phone services. Staff were interviewed regarding interruptions in phone services and water temperatures for resident accessible areas.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/20/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **High Cedar Residential Care**
Address: **18601 Cedar Lane**
City, State, Zip: **Noble, OK, 73068**
Provider #: **RC1404**
Complaint #: **OK00082761**
Investigation Date(s): **08/19/26**

ALLEGATION(S)

1. enter textThe home failed to ensure working telephone service was available in the building.
2. The home failed to ensure water temperatures were being maintained.

An unannounced on-site investigation was initiated 08/19/2026 at 3:00 p.m.

A sample of 4 residents, including 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 various times throughout the survey.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/20/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC1404	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH CEDAR RESIDENTIAL CARE	18601 CEDAR LANE NOBLE, OK 73068

(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
R 000	INITIAL COMMENTS Complaint investigations (#OK00073797 and #OK00082761) were conducted on 08/19/26. No deficiencies were cited. Facility Census: 18	R 000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE