STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375233	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarcrest Care Center	1306 East College Broken Arrow, OK 74012

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46703 Based on record review and interview, the facility failed to thoroughly investigate an injury of unknown origin for 1 (#4) of 4 sampled residents reviewed for abuse. The assistant director of nursing reported 63 residents resided in the facility. Findings: An undated Abuse Prevention Policy and Procedure policy, read in part, an immediate investigation will be initiated into any allegation of abuse, neglect or misappropriation of resident property .1. The Director of Nursing/Wellness Director or designee will complete the investigation process and document the steps taken and the information obtained. Resident #4 had diagnoses which included Alzheimer's disease, dementia, anxiety, and delusional disorders. A quarterly minimum data set assessment, dated 12/22/24, showed the resident's brief interview for mental status score was 99, which indicated the resident could not participate in the interview. On 03/03/25 at 10:43 a.m., LPN #1 stated in October the nurse aides found Resident #4 with their top lip discolored and with bite marks underneath. LPN #1 stated, We don't know how it happened, it was not there the day before. We padded the wall in case they bumped their face on it, but it was not determined how it happened. LPN #1 stated family member #1 was notified and a report to OSDH [Oklahoma State Department of Health] was made. On 03/03/25 at 10:45 a.m., the DON stated the resident was found on the morning of 10/08/25 with a swollen and discolored top lip right at shift change. The DON stated, No body is taking ownership of it. If it was done by a mechanical lift it had to have been night shift because they get the resident up. I spoke with day shift, but did not document it and with the [name withheld], but I did not speak with night shift staff. I do not know what in services were done. There was not a skin assessment done during the investigation. On 03/03/25 at 12:30 p.m., the resident care coordinator stated it was not determined how the resident's lip was injured. They stated the DON was the abuse coordinator and was responsible for the investigations.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE