

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER The Highlands at Owasso		STREET ADDRESS, CITY, STATE, ZIP CODE 10098 N 123 E Ave Owasso, OK 74055	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>30267</p> <p>Based on record review and interview, the facility failed to accurately transcribe admission orders as written and failed to acquire medications within four hours for one (#2) of five sampled residents whose clinical records were reviewed for pharmacy services.</p> <p>The DON identified 99 residents who resided in the facility.</p> <p>Findings:</p> <p>Resident #2 had diagnoses which included chronic obstructive pulmonary disease, depressive episodes, and dementia with mood disturbance.</p> <p>A hospital history and physical, dated 10/11/24, read in parts, Assessment/Plan .Depression/anxiety - PRN Xanax [alprazolam] [benzodiazepine medication]. The history and physical documented the resident was to continue taking alprazolam 1mg by mouth every six hours if needed.</p> <p>The facility admission orders, dated 10/11/24, documented Xanax 1mg every 6 hours to be given routinely, and Nuvigil 150mg to be given daily.</p> <p>The controlled drug receipt record/disposition forms for Nuvigil (CNS stimulant) 150mg tablets and Xanax 1mg tablets documented the medications were first delivered on 10/14/24.</p> <p>The medication administration record documented the resident received their first dose of Xanax 1mg on 10/15/24 at 12:00 a.m., then again at 6:00 a.m., 12:00 p.m., and 6:00 p.m.</p> <p>The medication administration record documented the resident received their first dose of Nuvigil 150mg on 10/15/24 at 12:00 p.m.</p> <p>On 12/12/24 at 5:10 p.m., CMA #1 stated they re-ordered medications early enough for the resident not to have an interruption in their medication treatment. The CMA stated they would order a medication only to find out the pharmacy did not send the medication. The CMA stated they would call the pharmacy and find out the medication required a written script. The CMA stated they would inform the nurse that an ordered medication required a script from the physician.</p> <p>(continued on next page)</p>

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
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/12/24 at 5:20 p.m., LPN #1 stated the floor nurses received a copy of the new residents hospital discharge instructions, transcribed, and confirmed the orders with the physician before sending the orders to the pharmacy to fill. The LPN stated they usually received the admitted residents medications within four hours. The LPN stated they would not know a medication was not delivered until they compared what they received to the orders and contacted the pharmacy. The LPN stated if a medication required a written script from the physician, they would not know the pharmacy had not received the script until the medication did not arrive as expected.</p> <p>On 12/12/24 at 5:30 p.m., CMA #2 stated they had to contact the pharmacy if an ordered medication was not received to find out why the medication was not sent. The CMA stated the pharmacy did not send medications for a variety of reasons. The CMA stated the pharmacy did not contact the facility staff to inform them of the issue, but waited for the facility staff to contact them regarding the omission. The CMA stated that sometimes caused residents not to receive their medications as ordered.</p> <p>On 12/12/24 at 5:50 p.m., the DON reviewed the hospital discharge instructions for Resident #2, dated 10/11/24, and stated the order for Xanax appeared to have been transcribed in error as 1mg every six hours routine instead of as needed as the discharge instructions read.</p> <p>On 12/13/24 at 12:50 p.m., LPN #2 stated the floor nurses were responsible for admitting new residents. The LPN stated they received a text from the facility's admission coordinator stating the nurse would receive an admission. The LPN stated they would then review the hospital discharge instructions for medications, treatments, and other instructions, and transcribe the instructions into the admitting residents electronic medical record. The LPN stated that after they transcribed the orders, they would contact the facility's admitting physician, tell them the resident was in the facility, and the orders were entered from the resident's discharge records. The LPN stated they usually then received an OK from the physician. The LPN stated they did not read off the transcribed orders to the physician, and waited for pharmacy to notify them of any issues with the ordered medications. They stated if the pharmacist had concerns, the nurse would contact the physician with any needed changes to the order and usually received a simple verbal confirmation from the physician. The nurse stated the written script for Xanax and Nuvigil was sent on 10/14/24.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>30267</p> <p>Based on observation and interview, the facility failed to serve hot foods at an appealing temperature.</p> <p>The DON identified 99 residents who ate meals prepared in the kitchen.</p> <p>Findings:</p> <p>On 12/11/24 at 12:45 p.m., Resident #4 stated they ate their meals in their room and the food was never hot and rarely warm. The resident stated some of the meals were not thoroughly cooked or were over-cooked/burnt, but were still served.</p> <p>On 12/11/24 at 1:00 p.m., Resident #6 stated the meals tasted bad and at times they felt the kitchen staff purposely sent food out they knew was not edible.</p> <p>On 12/11/24 at 4:50 p.m., the dietary manager stated the kitchen staff checked food temperatures before serving and checked the temperature of the meal cart once it was delivered to the residents' hall.</p> <p>On 12/11/24 at 5:40 p.m., the temperature gauge on the meal cart was observed to read 100 degrees Fahrenheit with the heating dial set to 145 degrees Fahrenheit.</p> <p>On 12/11/24 at 5:55 p.m., a test tray stored on the observed meal cart was received and food temperatures were taken with the dietary manager present. With multiple popcorn shrimp scored on the temperature probe, the temperature of the shrimp was 92 degrees Fahrenheit. The shrimp felt cold with a chewy texture, and covered in a damp/wet breading. The breading tasted bland and the shrimp had no flavor.</p> <p>On 12/11/24 at 5:55 p.m., the dietary manager stated that was not good, but they knew the food was hot when it left the kitchen.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30267</p> <p>Based on observation and interview, the facility failed to maintain an effective pest control program.</p> <p>The DON identified 99 residents in the facility.</p> <p>Findings:</p> <p>On 12/12/24 at 3:50 p.m., an environmental tour was conducted on the 400 hall. Evidence of roaches (droppings and dead roaches) was present along baseboards, near and under the refrigerator, on glue traps located in the corners of the room, storage drawers, and closets. Live roaches were observed in the corners nearest the bathroom door and near the heat/air unit in room [ROOM NUMBER] and 412.</p> <p>On 12/13/24 at 5:25 p.m., the corporate administrator stated the exterminator visited the facility monthly. The corporate administrator stated because of how the invoices were delivered, they were not sure if the administrator reviewed the recommendations the exterminator left on their invoices, but the exterminator responded quickly to any concerns the facility had related to vermin. The corporate administrator stated they would address the pest control issue immediately.</p>		