

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 02/02/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to safely transfer a resident using a mechanical lift for 1 (#2) of 4 sampled residents reviewed for the safe use of a mechanical lift for transfers. The ADON identified 14 residents utilized a mechanical lift for transfers. Findings: On 01/07/26 at 2:21 p.m., Resident #2 was observed in their room, sitting in their recliner. Resident #2 was dressed and their call light was in reach. An undated facility policy titled Safe Lifting and Movement of Residents, read in part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Staff responsible for direct resident care will be trained in the use of manual (gait, transfer belts, lateral boards) and mechanical lifting devices. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving resident when necessary, only staff will documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. Enough slings, in the sizes required by residents in need, will be available at all times. As an alternative, residents with lifting and movement needs will be provided with single-resident use disposable slings. A quarterly assessment for Resident #2, dated 10/02/25, showed Resident #2 was severely impaired in cognition with a BIMS score of 5 and was dependent on others for most activities of daily living (including positioning and transfers). A care plan for Resident #2, revised 11/24/25, showed Resident #2 required the assistance of two or more staff members and a mechanical lift for transfers. A nurse's progress note for Resident #2, dated 12/06/25, showed Resident #2 slipped from the sling and fell during a mechanical lift transfer from the bed to the chair. The progress note showed the resident was transferred to the hospital for further evaluation due to routinely receiving blood thinners and Resident #2 complaining of head pain. The progress note showed there were two CNAs present who witnessed the fall and stated the resident hit their head on the floor. A state reportable incident report, dated 12/06/25, showed Resident #2 slipped and fell from the lift during a mechanical lift transfer. The incident report, read in part, Upon investigation, the nurse aids were attempting to ambulate [transfer] the resident in the lift and failed secure [their] back far enough on the lift [sling] per the guidance of our policies and procedures. This resulted in [Resident #2] falling from the top right of the sling and hitting [their] head onto the ground. The facility believes the CNAs neglected to secure the resident properly on the sling which led to the fall. A nurse's progress note for Resident #2, dated 12/06/25, showed Resident #2 had a small subdural hematoma requiring hospitalization. An in-service sign in sheet, dated 12/06/25, showed 102 staff members from the nursing department received an in-service on the lift machine and use of the lift machine for positioning and transfers. A QAPI meeting sign in sheet, dated 12/06/25, showed the QAPI team met to review lift use related to Resident #2. A PIP, dated 12/06/25 and revised 12/08/25, showed the facility goal was to ensure all lifts and slings were in working condition, all nursing staff providing direct care were educated and properly</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 375558	Facility ID: 375558 If continuation sheet Page 1 of 5

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 02/02/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>trained to use the lift and properly position and use the sling. The PIP showed the following steps completed:a. audited all residents using a mechanical lift to ensure proper care planning and overall appropriateness for mechanical devices;b. ordered new slings to make sure all residents had their own sling;c. in-serviced all nursing staff on appropriate use of mechanical lifts/slings;d. required all nursing staff to demonstrate competency on using the lift by demonstrating it on administrative staff;e. performed staff questionnaire on proper use of the lift; andf. created a log to routinely audit staff to visually check to see if staff were appropriately using the mechanical lifts. A nurse's progress note for Resident #2, dated 12/09/25, showed Resident #2 returned to the facility. An audit tool, dated 12/10/25 through 01/28/26, showed 17 staff members were monitored during a resident transfer to ensure they used the lift properly. On 01/15/26 at 2:30 p.m., the ADON stated Resident #2 fell during a lift transfer from the bed to the chair. The ADON stated CNA #4 and CNA #5 performed the lift transfer and one was on new hire orientation, but was not a new CNA. The ADON stated to determine what happened, the two CNAs reenact the transfer with the ADON posing as the resident. The ADON stated it was immediately obvious the CNAs had not properly positioned the sling which left the resident without trunk support. The ADON stated since the resident was without trunk support and could not hold themselves up while in the sling, the resident fell from the sling. The ADON stated they in-serviced staff on fitting/positioning a sling for a resident and use of a mechanical lift. The ADON stated the in-service included each staff member performing a return demonstration of a mechanical lift transfer on a member of the administration. The ADON stated all residents using a mechanical lift for transfers were checked to ensure they had the proper sling, slings were repaired/replaced if needed, and care plans accurately reflected the resident's needs. The ADON stated the quality assurance team performed random audits of mechanical lift transfers which they planned to continue. The ADON stated prior to the incident, their staff received instruction on mechanical lift transfers on hire, were in-serviced at least annually on mechanical lift transfers and reviewed/evaluated on mechanical lift transfers during their competency reviews.</p>		

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 02/02/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on record review and interview, the facility failed to ensure that medications were given as ordered for 1 (#16) of 7 sampled residents reviewed for physician's orders. The administrator identified 83 residents resided in the facility. Findings: A hospital discharge medication list for Resident #16, dated 01/09/26, showed Resident #16 was to continue taking furosemide (a diuretic medication) 60 mg by mouth every day. A physician's order for Resident #16, dated 01/09/26, showed that Resident #16 was to take furosemide 40 mg by mouth every day. An admission assessment for Resident #16, dated 01/16/26, showed Resident #16 had a BIMS score (a test for cognition) of 12, which indicated moderate cognitive impairment, and received a diuretic medication. On 01/22/26 at 10:00 a.m., Resident #16 stated at the hospital they were taking 60mg of furosemide every day and since they had been admitted to the facility, they were only receiving 40 mg a day. On 01/22/26 at 12:20 p.m., the ADON stated Resident #16's discharge order from the hospital indicated they were to receive 60 mg of furosemide daily, but the nurse had mistakenly entered 40 mg daily.</p>

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 02/02/2026
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on record review and interview, it was determined the facility failed to secure medications for 1 (#13) of 5 sampled residents reviewed for medication storage. The administrator identified 83 residents received medications in the facility. Findings: A physician's order for Resident #13, dated 11/06/25, showed Resident #13 received zinc oxide 20% external paste topically to the sacrum and buttocks every shift for skin integrity. A nurse's progress note for Resident #13, dated 11/06/25, showed Resident #13 had a stage II pressure ulcer to their coccyx with redness to the surrounding tissue. The progress note showed the nurse cleaned the wound, dried the wound, and applied a zinc cream and a padded dressing to the wound. A nurse's progress note for Resident #13, dated 11/09/25 at 9: 00 a.m., showed when the nurse entered Resident #13's room, they observed the resident mixing zinc oxide paste in with their oatmeal. The progress note showed Resident #13 responded yes when asked if they ate some of the oatmeal mixture. A comprehensive assessment for Resident #13, dated 11/13/25, showed Resident #13 had a BIMS of 15, which indicated the resident was cognitively intact. The assessment showed Resident #13 had no skin issues and had ointment or medication applied to areas of their body other than their feet. On 01/22/26 at 10:55 a.m., the MDS coordinator stated it was reported Resident #13 ate zinc oxide paste that was left at their bedside. The MDS coordinator stated the facility was unable to determine who left the zinc oxide paste at bedside. The MDS coordinator stated it was inappropriate to leave medications unattended at bedside for Resident #13. On 01/22/26 at 11:20 a.m., the ADON stated they were notified Resident #13 possibly ate zinc oxide cream that was left at the bedside. The ADON stated they were unable to determine who left the cream at bedside but immediately sent out an in-service via phone and as part of their monthly in-service.</p>		

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 02/02/2026
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on observation, record review, and interview, the facility failed to provide medically appropriate dental services for 1 (#1) of 3 sampled residents reviewed for dental services. The administrator identified 83 residents resided in the facility. Findings: On 01/07/26 at 2:21 p.m., Resident #1 was observed in bed with a denture cup at bedside. A social service progress note for Resident #1, dated 10/23/24 at 2:09 p.m., showed the guardian for Resident #1 provided contact information and wanted the resident to receive dental services. The progress note showed the guardian wanted Resident #1 to be assessed and fitted for dentures. Review of the clinical record did not show Resident #1 had been assessed and fitted for dentures. An e-mail provided by the social service director, dated 11/04/25, showed Resident #1 had impressions made for upper and lower dentures. An e-mail provided by the social service director, dated 11/18/25, showed Resident #1 received upper and lower dentures. The e-mail showed Resident #1's denture fitting needed no adjustment. An e-mail provided by the social service director, dated 01/15/26, showed Resident #1 had their dentures adjusted for comfort and given instructions on care of their dentures. On 01/07/26 at 2:21 p.m., Resident #1 stated their dentures were in their denture cup. On 02/02/26 at 1:30 p.m., the social service director stated they started working at the facility in June of 2025 and was not aware the resident requested dentures. The social service director stated there was no documentation in the clinical record regarding dental services for Resident #1, but they were able to find where the dental provider communicated with the facility regarding dental services for Resident #1. The social service director stated they did not know why the information was not part of the resident's clinical record. The social service director stated they did not know why it was more than a year before the resident received their dentures.</p>		