STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375558	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands at Owasso	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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A past noncompliance immediate Jeopardy situation was determined to exist effective [DATE] related to the facility's failure to ensure residents were free from significant medication errors. Based on record review and interview, the facility failed to ensure:a. the correct resident was identified before administering medications; andb. a resident was free from significant medication errors for 1 (#1) of 3 sampled residents reviewed for medication administration.The ADON identified 88 residents received medications from the facility. Findings:Resident #1's face sheet from their electronic health record showed they were admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease, hyperlipidemia, hypertension, and person history of a traumatic brain injury.A quarterly assessment for Resident #1, dated [DATE], showed the resident's cognition was significantly impaired with a brief score for mental illness score of 03. The assessment showed Resident #1 was taking and antidepressant, an opioid, an antiplatelet, and an anti-convulsant. The assessment did not show Resident #1 rejected care. Resident #1's vital signs taken from their electronic health record, dated [DATE] at 8:03 a.m., showed their blood pressure was 147/76 and their pulse was 83 beats per minute.A nurses note for Resident #1, dated [DATE], showed at 8:00 a.m. LPN #4 was notified by an unidentified CMA, Resident #1 was administered medications that were intended for Resident #2, their roommate. The note showed at 8:40 a.m. Resident #1 was diaphoretic, lethargic, pale, had cyanosis around the lips, labored breathing, and was unresponsive. The note showed EMS transferred Resident #1 to the hospital around 9:00 a.m.A final facility reported incident to the Oklahoma State Department of Health, dated [DATE], showed CMA #4 administered the wrong medication to Resident #1 due to CMA #4 asked Resident #1 if their name was Resident #2's name. Resident #1 replied yes and CMA #4 administered Resident #1 medications prescribed to Resident #2 in error. The report showed CMA #4 notified LPN #4 who assessed Resident #1, notified the medical director, and sent Resident #1 to the hospital for increased labored respirations.Hospital records for Resident #1, dated [DATE], showed the resident was treated at the hospital due to being administer the wrong medications. The note showed Resident #1 was diagnosed as hypotensive, bradycardia, and asystole (cardiac arrest). The hospital record showed Resident #1 was administered Narcan and epinephrine by EMS. The record showed Resident #1 was pronounced expired on [DATE] at 9:50 a.m.EMS records for Resident #1, dated [DATE], showed EMS arrived at the facility and was informed by the facility staff, Resident #1 was administered the wrong medications 40 minutes prior to EMS's arrival to the facility. The report showed the facility reported amlodipine, aldactone, aspirin, baclofen, cyanocobalamin, fluoxetine, glimepiride, labetalol, lamotrigine, lisinopril, metformin, and potassium chloride were administered to Resident #1 in error. The report showed Resident #1 was lethargic and showed signs of sinus bradycardia with arrythmia 40 - 70 beats bpm (beats per minute), had shallow respirations, and cardiac arrest protocol were initiated. The EMS report showed Resident #1 was administered Narcan and epinephrine by EMS.Physician active orders for Resident #1, dated [DATE], showed the resident had an order for amlodipine 5 mg for hypertension and to hold the medication if the systolic blood pressure was less than 115 or heart rates was less than 50. The orders did not show they were prescribed aldactone, baclofen, fluoxetine, glimepiride, labetalol, lamotrigine, lisinopril, and potassium (continued on next page)

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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	chloride.On [DATE] at 3:22 p.m., the medical director stated the medication labetalol 300 mg administered in error could have caused Resident #1 to expire. On [DATE] at 12:55 p.m., CMA # 4 stated on [DATE] around 8:00 a.m. they administered Resident #1 the medications prescribed to Resident #2 due to Resident #1 identifying themselves as being Resident #2. CMA #4 stated when they were administering Resident #2's medications, they became aware they administered Resident #1 the wrong medications. CMA #4 stated, they notified LPN #4 who notified the physician of the medication administration error. CMA #4 stated the wrong medications were administered because they were unfamiliar with the residents and Resident #1 misrepresented their identity during medication administration.On [DATE] at 1:12 p.m., LPN #4 stated CMA #4 notified them Resident #1 was administered Resident #2's medication in error due to Resident #1 identified themselves as being Resident #2. LPN #4 stated they notified the physician of the medication error. They stated around 8:40 a.m. Resident #1 became clammy, had low respirations, and no verbal response. They called 911 and Resident #1 was transported to the hospital. On [DATE] at 1:45 p.m., the ADON stated they were notified on [DATE] at 8:47 a.m. by LPN #4 Resident #1 was administered Resident #2's medications in error. They stated LPN #4 reported to them Resident #1's respirations were 6 respirations per minute and Resident #1 was unresponsive. The ADON stated the medication administration error occurred due to CMA #4 asking Resident #1 if they were Resident #2 who replied, yes. The ADON stated Resident #1 missed 11 medications that were prescribed to them and only received Resident #2's medications. They stated CMA #4 failed to identify the correct resident as they were trained. They stated three of the 11 significant medications Resident #1 received in error which were prescribed for Resident #2 were as follows:a. amlodipine 10 mg (a vasodilator which lowered blood pressure) one tablet by mouth one time a day, hold if SBP was less than 110 on [DATE],b. lisinopril 40 mg (an ace inhibitor used to lower blood pressure) one tablet by mouth one time a day, hold if SBP was less than 115 on [DATE], andc. labetalol 300 mg (beta blocker used to lower high blood pressure) one tablet by mouth one time a day, hold if SBP was less than 115 and heart rate is less than 50 on [DATE].On [DATE] at 2:00 p.m., the DON stated they were informed on [DATE] at 8:01 a.m., Resident #1 was administered Resident #2's medications in error. The DON stated at 8:47 a.m. Resident #1 was sent to the hospital because they were declining. They stated Resident #1's photo in the health record should have been used to identify Resident #1 during medication administration due to Resident #1's cognition and hearing impairment.On [DATE] at 2:35 p.m., the medical director stated they reviewed Resident #1's EMS and hospital records dated [DATE]. They stated Resident #1's blood pressure was 90/50 and EMS gave them Narcan and epinephrine. The medical director stated labetalol, amlodipine, and lisinopril all lowered the blood pressure. The medical director stated the epinephrine was administer by EMS with labetalol could have cause an acute cardiac event.On [DATE] at 2:45 p.m., resident representative #1 stated they were notified on [DATE] by LPN #4 Resident #1 was administered the wrong medications. They stated this should have never happened because Resident #1 had dementia. Resident representative #1 stated Resident #1 expired as a result of the medication administration error. On [DATE] at 3:39 p.m., the owner of the facility stated they felt the three doses of epinephrine given to Resident #1 resulted in the death of the resident.The immediacy was removed effective [DATE] after the facility's QAPI committee put measures in place to prevent recurrence. The following actions were taken:a. on [DATE], a QAPI meeting was conducted. The facility IDT (interdisciplinary team) team reviewed their medication administration policy and procedures to ensure the policies and procedures in place would keep residents safe,b. the QAPI committee put in place in-service education by the DON and ADON on [DATE] for all staff administering medications which covered the topic of medication administration policies and procedures which included identifying the correct resident when administering medications, andc. the QAPI committee put in place bi-weekly visual audits of staff administering medications to ensure they were following medication administration policies and procedures. The facility provided documentation showing:a. They observed medication aides and nursing staff to ensure they were (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	identifying the correct resident during medication pass,b. medication aide's certifications,c. medication aide skills check offs,d. nursing licenses were reviewed to ensure accurate training, ande. CMA # 4 was suspended immediately on [DATE] and self-terminated. Multiple CMA's and nursing staff from multiple shifts were observed and interviewed to ensure they had the proper skills and knowledge to ensure they were identifying the appropriate resident during medication pass and administering the appropriate medications as prescribed by a physician.