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**Delivery via email to: [westplainsed@isllc.com](mailto:westplainsed@isllc.com); [highlandsed@isllc.com](mailto:highlandsed@isllc.com)**

February 8, 2024

License Number: AL090201

Ms. Laura Benson, Interim Administrator  
Sand Sage Of The Highlands  
1017 West Highway 152  
Mustang, OK 73064

**Survey Event ID: V5WS11**

Dear Ms. Benson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **February 1, 2024**. 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,

A handwritten signature in black ink that reads "Lisa Calvin".

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

Enclosure

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## INVESTIGATIVE REPORT

**Facility:** **Sand Sage of the Highlands**  
**Address:** **1017 West Highway 152**  
**City, State, Zip:** **Mustang, OK, 73064**  
**Provider #:** **AL090201**  
**Complaint #:** **OK00060975**  
**Investigation Date(s):** **February 1<sup>st</sup>, 2024**

### ALLEGATION(S)

1. The facility failed to ensure residents were not involuntarily secluded.
2. The facility failed to ensure care was provided according to residents' preferences.

An unannounced on-site investigation was initiated 02/01/2024 at 8:40 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 throughout the survey. Staff were observed providing assistance with care, assessing residents, administering medications, and interacting with residents during activities. Residents were observed for activities and different locations throughout their day.

Residents were interviewed related to staff treatment, assistance, and their preferences.

Resident records were reviewed including assessments, care plans, physician orders, physician progress notes, and nursing notes. Facility policy and procedures were reviewed. State reported incidents and grievances were reviewed.

Staff members were interviewed regarding the facility policies related to assistance provided per residents' preferences.

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: 02/01/2024

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL090201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 02/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAND SAGE OF THE HIGHLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1017 WEST HIGHWAY 152 MUSTANG, OK 73064</b>		
(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
C 000	INITIAL COMMENTS  A complaint investigation (#OK00060975) was conducted on 02/01/24. No deficiencies were cited.  Facility Census: 53	C 000		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE