



Oklahoma State Department of Health
Creating a State of Health

October 4, 2019

License Number: AL0703

Ms. Rachel McKinney, Administrator
Featherstone Assisted Living Community Of Durant
1919 University Blvd
Durant, OK 74701

Survey Event ID: LT7K11

Dear Ms. McKinney:

On **September 18, 2019**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;

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- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action will be completed for each violation; and
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

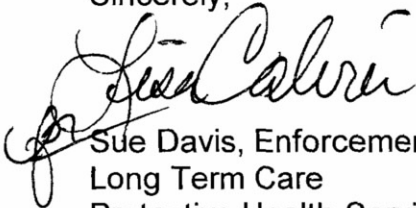
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

A handwritten signature in black ink, appearing to read "Sue Davis", is written over the typed name and title.

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

INVESTIGATIVE REPORT

Facility: Featherstone Assisted Living Community of Durant
Address: 1919 University Blvd
City, State, Zip: Durant, OK
Provider #: AL0703
Complaint #: OK00054339
Investigation Date(s): 09/17/19 through 09/18/19

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure residents' medications were administered according to physicians' orders.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 09/17/19 at 2:07 p.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 Description of Significant Findings Related to Each Allegation is Provided Below:

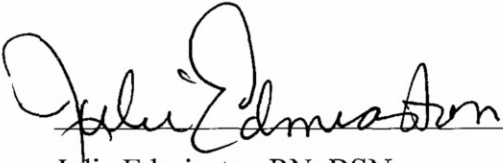
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 5010 and 1951 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

 9/19/19

Julie Edmiaston RN, BSN

Date report completed: 09/19/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2019
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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI	STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701
---	---

(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 On 09/17/19 through 09/18/19 a complaint investigation was conducted to investigate complaint #OK00054339. Census was 38. The following deficient practice was cited:	C 000		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to maintain an organized, accurate, clinical record for one (#3) of one sampled resident who received Coumadin (Blood thinner medication) therapy. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: On 09/17/19 at 4:15 p.m., requested resident #3's orders to reflect her Coumadin therapy by facsimile from home health. An order sent for September 4, 2019 to hold Coumadin times 1 (day) and recheck (PT/INR) on Thursday September 5, 2019 was faxed over to the center. On 09/18/19 at 9:56 a.m., the administrator was asked about the Coumadin not being held on September 4, 2019. She stated she had notified the home health agency on September 4, 2019, but she did not document it. The administrator	C1951		

Oklahoma State Department of Health	TITLE	(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0703	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/18/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701		
(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
C1951	Continued From page 1 was asked about the policy for third party provider visitor sheets. She stated the third party provider sheets have always been in place and home health should have been doing them. The administrator was asked why the center did not ensure the third party provider's sheets were being completed. She stated there was no excuse but she was out of town assisting another community. The new order for resident #3's Coumadin received on September 6, 2019, documented Coumadin (Warfarin) 4 mg (milligrams) to be administered daily. The pharmacy bubble pack card had nine (9) doses of Coumadin missing from the card. There was ten (10) days between September 7, 2019 and September 16, 2019. There was one dose held by the certified medication aide (CMA) #2 and she failed to indicate she had held resident #3's Coumadin. On 09/18/19 at 10:09 a m., CMA #2 via telephone with the administrator stated she held a dose of Coumadin 4 mg on September 7th and that was why the card did not have 10 (ten) doses missing like it should have. She documented on a provider sheet the Coumadin was not given, but did not document on resident #3's medication administration record. She wanted to clarify she was giving the correct dosage of Coumadin and contacted resident #3's home health agency for clarification because it was a new dose to her and she did not hear back from them	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent,	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0703	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/18/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI	STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701
---	---

(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
C5010	Continued From page 2 periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

STATE WORKLOAD REPORT

Provider/Supplier Number AL0703	Provider/Supplier Name FEATHERSTONE ASSISTED LIVING COMMUNITY OF DURANT
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Type of Survey (select all that apply)

3				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	09/17/2019	09/18/2019	1.50	0.00	6.50	0.00	4.00	2.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

OCT 07 2019 *jm*



Oklahoma State Department of Health
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November 4, 2019

License Number: AL0703

Ms. Rachel McKinney, Administrator
Featherstone Assisted Living Community Of Durant
1919 University Blvd
Durant, OK 74701

Survey Event ID: LT7K11

Dear Ms. McKinney:

On September 18, 2019, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 22, 2019**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

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Commissioner of Health

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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/17/2013

Facility Name: Featherstone Assisted Living Community of Durant

License Number: AL0703

Survey Event ID: LT7K11

Date Survey Completed: 9/18/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951

Based on: interview and record review it was determined the center failed to maintain an organized, accurate, clinical record for one (#3) of one sampled resident who received coumadin therapy.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is prepared and submitted as required by law and should not be construed as an admission of or agreement with the findings and conclusion in the statement of deficiencies or any related sanction or fine. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Medication orders have been clarified for resident number #3, clinical communication plans will be established with the outside agency and care plan has been updated.

2. How will other residents having the potential to be affected by the same deficient practice be identified?

All residents that have orders for Coumadin (Blood Thinner Medication) Therapy will be identified, care plans will include specifics policies for monitoring.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

A Coumadin (Blood Thinner Medication) policy will be put in place. Provider communication sheets will be updated to enhance clinical communication with outside agencies. Letters will be sent to all third party providers to increase compliance with communication. Audits of the Medication Record will be conducted on all residents that are prescribed Coumadin

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

Care plans of residents requiring Coumadin will be amended to include policy protocols. All Medication Administration Staff members will be provided additional training on Coumadin Management to include documentation, testing, monitoring and special precautions. Documentation of training will be maintained in the in-service manual.

All evidence of QA monitoring will be available for review with the Executive Director.

QA Meetings are held quarterly

Compliance with third party communication forms will be monitored and reported in QA Meetings. Audits of

		Medication Administration Records that include coumadin will be conducted and reported to QA.	
5. On what date will corrective action be completed?		11/22/2019	
Administrator's Signature OAC 310:663-25-4(F) <i>Rachel Melnyk</i>		Date Enter a date of signature. 11/11/2019	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/17/2013

Facility Name: Featherstone Assisted Living Community of Durant

License Number: AL0703

Survey Event ID: LT7K11

Date Survey Completed: 9/18/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010

Based on: interview and record review it was determined that the center failed to coordinate services with home health agency to allow time to adjust the coumadin dosage.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is prepared and submitted as required by law and should not be construed as an admission of or agreement with the findings and conclusion in the statement of deficiencies or any related sanction or fine. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Medication orders have been adjusted for resident #3 to allow for time to receive dosage changes ordered by the PCP. Develop a new provider communication sheet to enhance coordination of care.

2. How will other residents having the potential to be affected by the same deficient practice be identified?

A new blood thinner (Coumadin) policy will be developed and all residents on Coumadin will be monitored per protocol. Care will be coordinated with third party providers through an enhanced communication system.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

Letters will be sent out to all third party providers regarding compliance with regulations and communication systems. Any residents with new Coumadin Therapy orders will have updated care plans.

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

Audits will be conducted regularly on compliance with the provider communication form. Staff will be trained on Coumadin Therapy protocol and documentation will be maintained.

Results of provider communication audits will be maintained by the Executive Director to ensure coordination of care is improved. Results of Audits will be communicated in QA meetings.

5. On what date will corrective action be completed?

11/22/2019

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Shane McCreary

Date Enter a date of signature.

10/17/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

Facility in Compliance by: Click here to enter a date.



Oklahoma State Department of Health
Creating a State of Health

December 23, 2019

License Number: AL0703

Ms. Rachel McKinney, Administrator
Featherstone Assisted Living Community Of Durant
1919 University Blvd
Durant, OK 74701

Survey Event ID: LT7K12

Dear Ms. McKinney:

On **December 5, 2019**, a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 18, 2019**, have now been corrected effective **November 22, 2019**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lcd

Enclosure

Board of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/05/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI			STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701		
(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 On 12/03/19 through 12/05/19 a follow-up survey was conducted. Census was 36. All deficient practice was cleared.	{C 000}			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT
 Provider/Supplier Number
 AL0703

 Provider/Supplier Name
 FEATHERSTONE ASSISTED LIVING COMMUNITY OF DURANT

Type of Survey (select all that apply)

3	D			
---	---	--	--	--

 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

Extent of Survey (select all that apply)

--	--	--	--	--

 A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey
SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	12/03/2019	12/05/2019	0.25	0.00	1.00	0.00	0.50	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No