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

RE: Survey Event ID: K5DO11

Dear Ms. McKinney:

On **December 5, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on December 5, 2019.

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 (attached). 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;
(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 and monitoring will be completed for each violation;
(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,

for Susa Davis

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0703	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNI	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 re-licensure survey was conducted. Census was 36. The following deficient practice was cited.	C 000		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to update a plan of care related to frequent falls for 1 (#9) of 1 sampled resident with nine documented falls for the month of November 2019. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #9's significant change assessment, dated 10/18/19, documented resident #9 required x 1 assist with all activities of daily living except eating. Mental/Cognitive status: Often confused with fair judgment. Resident #9's physician's orders, dated 10/24/19, documented diagnoses to include Alzheimer's disease and age related Osteoporosis. Resident #9's plan of care was last reviewed by the registered nurse (RN) on 10/29/18 related to falls and no additional fall interventions were added to the plan of care at that time. On 12/05/19 at 1:00 p.m., licensed practical nurse (LPN) was asked if resident's #9's plan of care	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 552	Continued From page 1 had been updated for her recent falls. She stated no. She was asked if the center had a protocol for falls. She stated she was not aware of one and had not seen one.	C 552		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the registered nurse (RN) failed to implement a current plan of care for falls and delegate adequate supervision to prevent or decrease the risk of falls for 1 (#9) of 1 sampled resident with a history of a hip fracture from a previous fall. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #9 had a fall (unreportable event) on 09/10/19, resident #9 crawled from her room to the hall. On 09/12/19, resident #9 had a reportable fall in the living room and mobile x-ray revealed a fracture to her right hip. Resident #9 was sent to ER (emergency room) and will go to skilled nursing facility after surgery. Resident #9 had three additional falls (unreportable events) on	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FEATHERSTONE ASSISTED LIVING COMMUNI	1919 UNIVERSITY BLVD DURANT, OK 74701

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C 911	Continued From page 2 10/19/19, 10/21/19, and 10/28/19. Resident #9 had nine (9) more unreportable falls for the month of November 2019 with no update made to her plan of care for falls. Resident #9's negotiated risk agreement, dated on 10/23/19, documented issue(s) concern(s): frequent falls from unassisted transfers. Resident/family preference: Resident to remain in community on hospice care and to encourage to call for assist. Possible Consequences: fracture or injury, head trauma, and serious injury. Resident #9's plan of care was last reviewed by the registered nurse (RN) on 10/29/18 related to falls and no additional fall interventions were added to the plan of care at that time. The last fall interventions added to resident #9's plan of care was made in February 17, 2017. On 12/05/19 at 1:18 p.m., the executive director was asked about a procedure or protocol for fall prevention. She stated, "No, we just do the negotiated risk."	C 911		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 3 incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to ensure adequate supervision to prevent or decrease the risk of falls for 1 (#9) of 1 sampled resident with a history of a hip fracture from a previous fall. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #9's significant change assessment, dated 10/18/19, documented, resident #9 required x 1 assist with all activities of daily living except eating. Mental/Cognitive status: Often confused with fair judgment. Resident #9's negotiated risk agreement, dated on 10/23/19, documented issue(s) concern(s): frequent falls from unassisted transfers. Resident/family preference: Resident to remain in community on hospice care and to encourage to call for assist. Possible Consequences: fracture or injury, head trauma, and serious injury. Resident #9's physician's orders, dated 10/24/19,	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 4 documented, diagnosis to include Alzheimer's disease and age related Osteoporosis. Resident #9's plan of care was last reviewed by the registered nurse (RN) on 10/29/18 related to falls and no additional fall interventions were added to the plan of care at that time. The licensed practical nurse (LPN) updated resident #9's plan of care on 08/15/19 to include hospice to assist with bathing two times a week, and for hospice to provide resident #9's medications and the facility would administer the medications. Resident #9's plan of care was not updated for falls after she broke her hip in September 2019 and returned to the center and had nine more falls in the month of November 2019. Resident #9 had an unreportable fall on 09/10/19, resident #9 crawled from her room to the hall. On 09/12/19, resident #9 had a reportable fall in the living room and a mobile x-ray revealed a fractured right hip. Resident #9 was sent to ER (emergency room) and had a surgery consult and then referred to a skilled nursing facility. Resident #9 had three unreportable falls on 10/19/19, 10/21/19, and 10/28/19. In November 2019, resident #9 had nine (9) unreportable falls with no additional fall interventions added to her plan of care. On 12/03/19 at 2:50 p.m., a verbal report by the licensed practical nurse (LPN) indicated resident #9 had a recent hospitalization for a broken hip and utilized a manual wheel chair for ambulation. Resident #9's plan of care indicated she used a walker for ambulation. Resident #9 was observed sitting in a manual wheel chair at the dining room table eating lunch. On 12/05/19 at 12:05 p.m., LPN was asked if	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 5 resident #9 was ambulatory. She stated no not anymore.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL0703	FEATHERSTONE ASSISTED LIVING COMMUNITY OF DURANT

Type of Survey (select all that apply)

2				

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

Extent of Survey (select all that apply)

A				

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	0.50	0.00	16.00	0.00	5.00	5.00
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

DEC 23 2019

Oklahoma State Department of Health
Creating a State of Health

February 6, 2020

License Number: AL0703

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

RE: Survey Event K5DO11

Dear Ms. McKinney:

On December 5, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **February 14, 2020**.

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,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/cn

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/8/2020** **Facility Name:** Featherstone Assisted Living-Durant **License Number:** AL 0703 **Survey Event ID:** K5DO11 **Date Survey Completed: 12/5/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C552	Based on: interview an record review it was determined the center failed to update a Plan of Care related to the frequent falls for 1 (#9) of 1 sampled resident with nine documented falls for month of November 2019. This deficient practice resulted in the potential for minimal harm at a pattern.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #9's care plan has been reviewed and care plan changes made, dated and signed off on by an RN.
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care plans of residents at risk for falls will be reviewed and updated to reflect their current status and assessment data.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Facility nursing staff will receive inservice training to review and update the care plan with each assessment and any falls. The RN will review and sign off on care plans when reviewing assessments and following resident falls.
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Monthly the RN or LPN will audit all incident reports and provide a report quarterly to the QI committee regarding the number of falls, number of residents who have fallen, number per shift and location of falls. In addition, the report will include an audit of care plans to assure that they are up to date with the resident's current status. The Executive Director will conduct a random review of care plans of residents who have fallen to monitor for compliance with update of care plans and sign and date care plan after review. The facility RN or LPN will submit a report quarterly to the QI committee regarding the number of falls, number of residents who have fallen, number per shift and location of falls. The report will include an audit of care plans to assure that they are up to date with the resident's current status.

	Incident report report form will be kept with the quarterly QI reports		
5. On what date will corrective action be completed?	2/14/2020		
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.		**Date 1/7/2020**
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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/8/2020** **Facility Name:** Featherstone Assisted Living-Durant **License Number:** AL 0703 **Survey Event ID:** K5DO11 **Date Survey Completed: 12/5/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C911	Based on: interview and record review it was determined the RN failed to implement a current plan of care for falls and delegate adequate supervision to prevent or decrease the risk for falls for 1 (#9) of one sampled resident with a history of a hip fracture from a previous fall.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #9's care plan has been reviewed and care plan changes made, dated and signed off on by an RN.
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care plans of residents at risk for falls will be reviewed by the RN and updated to reflect their current status and assessment data.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Facility nursing staff will receive inservice training to review, update and date the care plan with each assessment and any falls. The RN will review and sign care plans when reviewing assessments and following resident falls.
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Monthly the RN or LPN will audit all incident reports and provide a report quarterly to the QI committee regarding the number of falls, number of residents who have fallen, number per shift and location of falls. In addition, the report will include an audit of care plans to assure that they are up to date with the resident's current status and signed by an RN. The Executive Director will conduct a random review of care plans of residents who have fallen to monitor for compliance with update of care plans and sign and date care plan after review. The facility RN or LPN will submit a report quarterly to the QI committee regarding the number of falls, number of residents who have fallen, number per shift and location of falls. The report will include an audit of care plans to

	assure that they are up to date with the resident's current status and signed by the RN. Incident report audit form will be kept with the quarterly QI reports
5. On what date will corrective action be completed?	2/14/2020

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 1/7/2020**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/8/2020** **Facility Name:** Featherstone Assisted Living-Durant **License Number:** AL 0703 **Survey Event ID:** K5DO11 **Date Survey Completed: 12/5/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, interview, and recordreview it was determined the center failed toensure adequate supervision to prevent ordecrease the risk of falls for 1 (#9) of 1 sampledresident with a history of a hip fracture from aprevious fall. This deficient practice resulted inthe potential for more than minimal harm at a pattern.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #9's care plan has been reviewed and care plan changes made, dated and signed off on by an RN.
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care plans of residents at risk for falls will be reviewed by the RN and updated to reflect their current status and assessment data.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Facility nursing staff will receive inservice training to review, update and date the care plan with each assessment and any falls. The RN will review and sign care plans when reviewing assessments, following resident falls, and as needed with quarterly reviews .
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Monthly the RN or LPN will audit all incident reports and provide a report quarterly to the QI committee regarding the number of falls, number of residents who have fallen, number per shift and location of falls. In addition, the report will include an audit of care plans to assure that they are up to date with the resident's current status and signed by an RN. The Executive Director will conduct a random review of care plans of residents who have fallen to monitor for compliance with update of care plans and sign and date when reviewed. The facility RN or LPN will submit a report quarterly to the QI committee regarding the number of falls, number of residents who have fallen, number per shift and location of falls. The report will include an audit of care plans to

	assure that they are up to date with the resident's current status and signed by the RN. Incident report audit form will be kept with the quarterly QI reports
5. On what date will corrective action be completed?	2/14/2020

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 1/7/2020**

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.

FEB 11 2020

Oklahoma State Department of Health
Creating a State of Health

March 9, 2020

License Number: AL0703

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

RE: Survey Event K5DO12

Dear Ms. McKinney:

On **February 25, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 5, 2019,** have now been corrected effective **February 14, 2020.**

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

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0703	A. BUILDING: _____ B. WING _____	R 02/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNI	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 02/25/2020 a follow-up survey was conducted. Census was 38. The following deficient practice was cleared.	{C 000}		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL0703	FEATHERSTONE ASSISTED LIVING COMMUNITY OF DURANT

Type of Survey (select all that apply)

2	D			

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

Extent of Survey (select all that apply)

A				

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	02/25/2020	02/25/2020	0.25	0.00	4.00	0.00	7.00	1.00
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