OKLAHOMA
State Department
of Health

Delivery via email to: Rachel@featherstoneretirement.com

November 12, 2021

License Number: AL0703

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

Survey Event ID: LYIK11

Dear Ms. McKinney:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **November 2, 2021**. 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.

Sincerely,

Lisa Calvin

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Featherstone Assisted Living Community of Durant**
Address: **1919 University Blvd**
City, State, Zip: **Durant ok, 74701, Bryan**
Provider #: **AL0701**
Complaint #: **OK00056181**
Investigation Date(s): **11/02/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to administer medications as ordered.	**US**

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

An unannounced on-site investigation was initiated on 11/02/2021 at 8:15 a.m.

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

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failed to administer medications as ordered was conducted.

Upon entry and throughout the investigation residents were observed being assisted by staff. Residents were observed to receive medications during routine medication administration times. Residents were observed up and interacting with staff. No residents were observed groggy or drooling while asleep.

Residents were interviewed and stated they received their medications as scheduled. Residents reported the staff informs them of medication changes. Residents reported staff had never given medications which did not belong to them.

Family members were interviewed and reported their loved ones received their prescribed medications. Family members reported staff had never, to their knowledge substituted medications or given a medication which was not prescribed to their loved one. Family members reported to have been happy with their loved ones care.

Staff were interviewed and reported the residents were given only the medications which was prescribed to them. Staff reported they had never been instructed to give medications by a non-medical person. Staff reported to have never given medications out of their pockets. Staff reported medications were not shared among residents.

The medication room and the narcotic storage units were observed, and under double lock and each medication was labeled with resident prescriptions. There was no ABH gel found in the medication room or the narcotic storage units. There was no ABH gel found in the center.

Physician orders, progress notes, medication administration records, grievances, resident council minutes, care plans, hospice notes, hospice orders, hospice medication records, and staffing schedule were reviewed.

Other: The identified complainant was contacted and stated there was no knowledge regarding the allegations and stated to have never initiated the complaint.

Determination Summary and Follow-Up Action:

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Sharon Griffith signed by Zach Collins, PMC.

Sharon Griffith, R.N.

Date report completed: 11/02/2021

Oklahoma State Department of Health

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 _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF	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 A complaint investigation (OK00056181) was conducted on 11/02/21. No deficiencies were cited.	C 000		

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