OKLAHOMA
State Department
of Health

Delivery via email to: Rachel@featherstoneretirement.com

March 21, 2023

License Number: AL0703

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

RE: Survey Event ID: OXTH11

Dear Ms. McKinney:

On **March 9, 2023**, 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 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 March 9, 2023.

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) 426-8200 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 _____	03/09/2023

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 relicensure survey was conducted from 03/07/23 through 03/09/23. The following abbreviations may be used throughout this document: # - Number CMA - Certified Medication Aide CNA - Certified Nurse Aide CT - Computed Topography H & P - History and Physical Res - Resident RN - Registered Nurse	C 000		
C 103 SS=E	310:663-1-3(c) SMOKING PROHIBITED (c) Smoking or possessing a lighted tobacco product is prohibited in a continuum of care or assisted living facility and within fifteen (15) feet of each entrance to a facility and of any air intakes; provided however, the facility may provide a smoking room not available to the public for use by residents. This Rule is not met as evidenced by: Based on record review, observation, and interview the center failed to follow their smoking policy for three (#6, 7, and #10) of three residents reviewed for smoking. The Administrator reported three residents in the center smoked. Findings: A "Smoking: Prohibited" policy, dated September 2020, read in parts, " ...smoking is prohibited in	C 103		

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 103	Continued From page 1 any area of the building, including dwelling units, because of the health and safety hazards ..." Page 11 of the "Service Contract", dated 2016, read in parts, " ...(name of center withheld) is a non-smoking residence. Smoking outside must be at least 15 feet away from the building ..." On 03/07/23 at 1:45 p.m., the hallway outside Res #7's room smelled of cigarette smoke. Upon entrance, Res #7's room smelled of cigarette smoke. Res #7 reported they smoked in their room. On 03/07/23 at 2:00 p.m., the hallway outside Res #6's room smelled of cigarette smoke. Upon entrance, Res #6's room smelled of cigarette smoke and Res #6 was observed to be smoking a cigarette. On 03/08/23 at 9:30 a.m., the hallway outside Res #10's room smelled of cigarette smoke. Upon entrance, Res #10's room smelled of cigarette smoke. Res. #10 reported they smoked in their room because they were having difficulty ambulating to a designated smoking area. On 03/08/23 at 10:45 a.m., the Administrator reported she was not aware that Res #6, 7, and #10 were smoking in their rooms. The Administrator stated "Smoking is not permitted in residents' rooms."	C 103		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.	C 542		

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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 542	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were signed by the RN or physician for five (#1, 3, 6, 9 and #10) of 11 residents whose resident assessments were reviewed. The "Resident Birthday List" documented 29 residents resided in the center. Findings: A resident assessment, dated 05/19/22, for Res #1 was not signed by the RN or physician. A resident assessment, dated 05/06/22, for Res #3 was not signed by the RN or physician. Resident assessments, dated 05/25/22, and 06/08/22, for Res #6 were not signed by the RN or physician. A resident assessment, dated 05/19/22, for Res #9 was not signed by the RN or physician. Resident assessments, dated 09/30/22, and 10/14/22 for Res #10 were not signed by the RN or physician. On 03/09/23 at 10:05 a.m., the Administrator reported the resident assessments should have been signed by either the RN or physician.	C 542		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the	C1914		

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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
C1914	Continued From page 3 Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the center failed to report to the Department, one incident for one (Res #11), of one resident who required medical treatment at a hospital. Findings: An "Occurance Report Form", dated 10/31/22, documented in parts, "...fell on door knob and busted head open...911 called..." A "Hospitalist H & P" report, dated 10/31/22, documented in parts, "...admission date 10/31/22...Chief Complaint: Ground-level fall... experienced...fall with head strike prompting...to seek medical care...CT head...subarachnoid hemorrhage...CT abdomen pelvis acute superior and inferior pubic rami fractures..." On 03/09/23 at 11:15 a.m., the Administrator reported they had not reported the incident for Res #11. The administrator reported they were not sure of the criteria for reporting incidents to the Department. The Administrator reported the incident for Res #11 should have been reported to the Department.	C1914		

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 _____	03/09/2023

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
C6000	Continued From page 4	C6000		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or	C6000		

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 _____	03/09/2023

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

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C6000	Continued From page 5 denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on record review and interview, the center failed to monitor and ensure fingerprint based criminal history background checks were completed for two (CMA #1 and CNA #1) of five	C6000		

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 _____	03/09/2023

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FEATHERSTONE ASSISTED LIVING COMMUNITY OF	1919 UNIVERSITY BLVD DURANT, OK 74701

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C6000	Continued From page 6 sampled employees who currently worked at the center. Findings: A review of CMA #1's personnel file showed a hire date of 05/07/22. A Criminal History Background Check was completed on 01/08/23. A review of CNA #1's personnel file showed a hire date of 07/06/22. A Criminal History Background Check was completed on 01/08/23. On 03/09/23 at 11:00 a.m., the Administrator reported they had not completed the background checks for CMA #1 and CNA #1 within the required 90 day time frame.	C6000		

OKLAHOMA
State Department
of Health

Delivery via email to: Rachel@featherstoneretirement.com

April 14, 2023

License Number: AL0703

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

RE: Survey Event OXTH11

Dear Ms. McKinney:

On **March 9, 2023**, 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 **April 10, 2023**.

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) 426-8200.

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.04.14 14:26:52 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/27/2023** **Facility Name:** Featherstone Assisted Living - Durant **License Number:** AL0703 **Survey Event ID:** OXTH11 **Date Survey Completed: 3/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 103	Based on: Record Review observation and interview, the center failed to follow their smoking policy for 3 residents reviewed for smoking.

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?	The administrator discussed the Smoking Policy with each resident who smokes. The resident who refused to cooperate will be given a move out notice according to the Oklahoma State Department of Health Regulations. Administration and Omsbudsman had care plan meeting with resident & family, she verbalized that she refuses to cooperate with policy and continues to smoke in her room.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident identified to use tobacco products will be evaluated for the ability to properly adhere to facility procedure and to safely execute safe smoking practices. The Administrator or designee will follow up on any non-compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	We will monitor the residents engaging in the smoking practice. The staff will be educated via Inservice to complete an internal incident report when resident is found in violation of policy. The Administrator will followup of all incident reports related to smoking policy violation.
OSDH Response: Element accepted Yes ☐ No ☐	
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.	All incident reports including those related to smoking violations will be reviewed in QA to evaluate the effectiveness of compliance. All incident reports will be reviewed in quarterly QA meetings. QA minutes will be kept as evidence of this review and actions taken. QA minutes will be kept as evidence of this review and actions taken.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	4/4/2023		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Rachel McKee	**Date 3/31/2023**	
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.
Items Below Are For OSDH Use Only			
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: 8/28/2013
Facility Name: Featherstone Assisted Living
License Number: AL0703
Survey Event ID: OXTH11
Date Survey Completed: 3/9/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542	Based on: record review and interview, the center failed to ensure the resident assessments were signed by the RN or Physician.

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?	A record review will be conducted on all assessments and corrective actions will be made to be compliant including RN and/or Physicians signature.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A schedule of asssessments and dates due will be implemented for RN and/or physician review for signatures.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A schedule of assessments and due dates will be implemented for RN and/or Physician to review for signatures.
OSDH Response: Element accepted Yes ☐ No ☐	
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.	We will monitor the Assessment schedule and due dates for RN and or physician signatures and review in quarterly QA to evaluate the effectiveness of compliance. The administrator will followup on any non-compliance. Random audits will be completed and presented in QA Quarterly meetings. Random audits will be completed and presented in QA Quarterly meetings. QA meeting minutes will be maintained as evidence of compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Paul Meling	**Date 3/31/2023**

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.

Items Below Are For OSDH Use Only
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: 8/29/2013** **Facility Name:** Featherstone Assisted Living **License Number:** AL0703 **Survey Event ID:** OXTH11 **Date Survey Completed: 3/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1914	Based on: record review and interview, the center failed to report to the Department, one incident of a resident who required medical treatment at a hospital.

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?	All incident reports will be reviewed and initialed by the administrator to ensure compliance with regulatory reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All incident reports will be reviewed by the administrator to ensure compliance and completion of 283 incident report form.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All incident reports will be reviewed by the administrator to ensure compliance with regulations. Any incidents found to be unreported will have a 283 completed.
OSDH Response: Element accepted Yes ☐ No ☐	
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.	All incident reports will be reviewed by the administrator to ensure compliance with regulatory reporting requirements to the Department and reviewed in the quarterly QA meeting to ensure effectiveness of compliance. All incidents will be reviewed in QA. Audit Summaries will be present in QA. QA Minutes will be kept as evidence of this review and actions taken.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date 3/31/2023**	

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.

Items Below Are For OSDH Use Only

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: 8/29/2013** **Facility Name:** Featherstone Assisted Living **License Number:** AL0703 **Survey Event ID:** OXTH11 **Date Survey Completed: 3/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 6000	Based on: record review and interview, the center failed to monitor and ensure fingerprint based criminal history background checks were completed.

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?	Administrator or designee will conduct an employee records review to ensure compliance with criminal background check and fingerprints.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All employee records will be reviewed to address any deficiencies by administrator or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A records review will be conducted by administration upon hire and again in the first 30 days of employment to ensure compliance and a follow up review at the 90 day employemt date.
OSDH Response: Element accepted Yes ☐ No ☐	
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.	Employee records will be reviewed in quarterly QA meetings to review the effectiveness of compliance. Audit Summaries will be presented in QA Quarterly meetings. Audit Summaries will be presented in QA Quarterly meetings. QA minutes will be kept on file to demonstrate evidence of compliance until cleared.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Rachel McKinney	**Date 3/31/2023**

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.

Items Below Are For OSDH Use Only

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

Delivery via email to: Rachel@featherstoneretirement.com

August 2, 2023

License Number: AL0703

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

RE: Survey Event OXTH12

Dear Ms. McKinney:

On **June 16, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 13, 2023,** have now been corrected effective **April 10 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 _____	R 06/16/2023

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 An offsite/paper revisit was conducted on 06/16/23. The facility was in substantial compliance.	{C 000}		

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