OKLAHOMA
State Department
of Health

Delivery via email to: Rachel@featherstoneretirement.com

October 11, 2023

License Number: AL0703

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

RE: Survey Event ID: N7RH11

Dear Ms. McKinney:

On **October 3, 2023**, agents from our office concluded a State Licensure survey with complaint investigations 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 October 3, 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Featherstone Assisted Living Community of Durant**
Address: **1919 University Blvd**
City, State, Zip: **Durant, OK 74701**
Provider #: **AL0703**
Complaint #: **OK00060772**
Investigation Date(s): **10/02/23 through 10/03/23**

ALLEGATION(S)

The facility failed to ensure a safe, sanitary, and comfortable environment.
The facility failed to ensure food was prepared and served under sanitary conditions according to professional standards.

An unannounced on-site investigation was initiated 10/02/2023 at 9:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

An environmental tour was conducted upon entrance and intermittently throughout the survey. Water and air temperatures were taken. Residents, staff, and family members were interviewed. Facility policies, maintenance logs, and maintenance bills and receipts were reviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Featherstone Assisted Living Community of Durant**
Address: **1919 University Blvd**
City, State, Zip: **Durant, OK 74701**
Provider #: **AL0703**
Complaint #: **OK00061156**
Investigation Date(s): **10/02/23 through 10/03/23**

ALLEGATION(S)

The center failed to ensure staff were qualified for their positions.
The center failed to ensure the documentation on the residents' records was accurate.

An unannounced on-site investigation was initiated 10/02/2023 at 9:00 a.m.

A sample of nine residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Staff were observed caring for residents. Medication pass and dining were observed, along with other activities. Resident and staff interviews were conducted. Residents, staff, and families were interviewed. Resident records, physician orders, care plans, contracts, incident reports, and policies were reviewed. Employee records, certifications, licenses, and training records were reviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Featherstone Assisted Living Community of Durant**
Address: **1919 University Blvd**
City, State, Zip: **Durant, OK 74701**
Provider #: **AL0703**
Complaint #: **OK00061378**
Investigation Date(s): **10/02/23 through 10/03/23**

ALLEGATION(S)

The center failed to ensure residents were not subject to financial exploitation by staff members.

An unannounced on-site investigation was initiated 10/02/2023 at 9:00 a.m.

A sample of nine 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 statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

During the survey, residents were observed and interviewed. Staff members and family members were interviewed. Resident records, incident reports, bank records, contracts, and policies were reviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/06/2023

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 10/03/2023

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 10/02/23 through 10/03/23. Complaint investigations (#OK00060772, OK00061156, and OK00061378) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide F - Fahrenheit HTN - hypertension Res - resident RN - registered nurse	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food was stored, prepared, and served in accordance with Chapter 257. The administrator identified 30 residents who resided in the center. Findings: On 10/02/23 at 9:34 am, Cook #1 was observed in the kitchen preparing food. They were not wearing a hair net. The cook stated they were unable to find the hair nets.	C 391		

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C 391	Continued From page 1 On 10/02/23 at 11:00 am, a tour of the kitchen was conducted and the following observations were made. a. Cook #1 and Cook #2 were not wearing hair nets. b. In the stainless steel refrigerator, clear plastic containers of preaches, macaroni, and turkey pot pie were not labeled or dated. c. A plastic grocery bag of okra which had slime and dark spots was in the stainless steel refrigerator. d. In the stainless steel refrigerator, one plastic storage bag with biscuits and one plastic bag with lunch meat was not labeled. The lunch meat had dark spots. e. The dish machine hot water registered at 105 F. The machine's label documented a temperature of 120 was required. The chemicals were adequate. f. A large opened trash can in the dish washer room was up against and touching clean dishes on a shelving unit. g. The metal shelving units and steam table holding clean dishes were greasy and held dust and debris. h. The white refrigerator had a build up of brown residue on the outside where it had been handed while being opened. i. The pantry had multiple cardboard boxes on the floor under the shelving. Unable to inspect boxes because of recently delivered items taking	C 391		

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C 391	Continued From page 2 up floor space in pantry. During the tour, Cook #2 stated they did not wear hair nets. Cook #2 stated the dish machine company was just there a few days ago and checked the dish machine. Cook #1 stated the hot water tank had recently been replaced. Cook #1 stated the food should be dated and out dated food removed. Cook #1 stated they did not have a cleaning schedule, they just cleaned every day. On 10/03/23 at 4:00 p.m., the administrator was made aware of the issues and they stated some of the same issues were identified by the dietician the week before. They stated they were planning on removing all furnishings in the kitchen and clean the flooring and shelving.	C 391		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed once every twelve months for one (#5) of eight residents whose assessments were reviewed.	C 522		

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C 522	Continued From page 3 The administrator identified 30 residents who resided at the facility. Findings: Res #5's annual assessment, dated 06/07/22, documented the resident had chronic pain, depression, and hypothyroidism. The assessment documented the resident had good judgment; good mobility, strength, and gait; and walked with a walker. The resident's medical record did not contain an annual or significant change assessment since 06/07/22. On 10/03/23 at 4:00 p.m., the administrator stated the assessment was missed.	C 522		
C 541 SS=D	310:663-5-4(a) CONDUCT OF ASSESSMENT (a) The assessments shall be completed by appropriate participation of health professionals trained in the assessment process. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure assessments were completed by the appropriate health care professionals trained in the assessment process for two (#3 and #9) of eight sampled residents whose assessments were reviewed. The administrator identified 30 residents who resided in the facility.	C 541		

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C 541	Continued From page 4 Findings: 1. Res #3 was admitted to the facility on 07/03/23 with diagnoses which included cerebrovascular accident and congested heart failure. The resident's admission assessment, dated 07/19/23, documented the resident was alert. The rest of the mental/cognitive function status was not filled out. The medications were not listed or attached to the assessment. The signature of the resident or the representative was not documented if an interview was conducted. The assessment was conducted and signed by a ACMA. On 10/02/23 at 9:55, Res #3 was observed in bed. The resident stated they were attending a wedding the next day. The resident was observed being fed her medications in applesauce by MAT #1. 2. Res #9 was admitted to the facility on 08/22/23 and had diagnoses which included HTN and low back pain. The resident's admission assessment, dated 08/22/23, documented the resident was alert, confused at times, and had fair judgement. The medications were not listed or attached to the assessment. The signature of the resident or the representative was not documented if an interview was conducted. The assessment was conducted and signed by a ACMA. On 10/02/23 at 3:50 p.m., the resident walked into the room and said they were looking for their sister.	C 541		

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C 541	Continued From page 5 On 10/03/23 at 11:51 a.m., the administrator stated they thought if an RN or physician signed behind the aide it would be ok for them to conduct the assessment. The administrator stated the RN had been out during the time the assessments were completed.	C 541		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure all services that are specified in the resident's service contract were provided related to the resident being free from financial exploitation. The administrator identified 30 residents who resided in the center. Findings:	C1304		

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C1304	Continued From page 6 The center's policy, "Gratuities", read in part, "To ensure that no staff member takes advantage of a resident or favors one resident over another in any specific way. To ensure that no opportunities exist for false accusation of theft. Staff members are not permitted to accept tips. Monetary gifts are expressly forbidden..." The center's, "Policy Regarding Abuse and Neglect", read in part, "...Exploitation: The illegal or improper use of an incapacitated, vulnerable, or elderly adult, or their resources for another's financial profit or advantage..." Res #1's "Service Agreement", signed 05/23/22, documented in part, "...Our residents have the right to...have their records containing personal and financial information kept confidential...Live free from involuntary confinement and financial exploitation..." Res #1's bank account, "Deposit Account Signature Card", for account opened on 01/17/23, read in part, "...Payable-On-Death Beneficiary Information...Name: [Staff #1 name withheld] Relationship: Friend, Date of Birth: [Staff #1 birthday withheld]..." Res #1's bank account, "Deposit Account Signature Card", for account opened on 01/27/23, read in part, "...Payable-On-Death Beneficiary Information...Name: [Staff #1 name withheld] Relationship: Friend, Date of Birth: [Staff #1 birthday withheld]..." Res #1's annual assessment, dated 05/02/23, documented the resident was confused at times and had good judgement. The assessment documented the resident had good mobility, good strength, and poor gait. The assessment	C1304		

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C1304	Continued From page 7	C1304		

documented the resident used a wheelchair, was independent, and needed help with bathing. The assessment was conducted by a ACMA.

The resident's record documented the resident had expired on 09/13/23.

On 10/03/23 at 10:27, the resident's representative stated Staff #1 took Res #1 to the bank in January 2023. They stated Res #1 closed their checking account with the representative and the resident then opened two new accounts. The representative stated Res #1 opened a money market account and a checking account. The representative stated Res #1 had Staff #1 as the beneficiary on both of the accounts and the staff member would have been paid the amounts upon the death of the resident. The representative stated both accounts had large amounts of money involved. The representative stated the resident was confused at times and had lung cancer and dementia. The representative stated they were able to obtain guardianship right before the resident's death and had the staff member's name taken off the accounts. The representative stated she had told the administrator about the staff member's name being listed as beneficiary on the accounts. The representative stated Staff #1 did not tell her about being on Res #1's accounts until the day of the resident's death. The representative stated Staff #1 on the day of the resident's death told the representative that they had been listed as beneficiary and would go to the bank and get a certified check for the money in the accounts and give it to the representative.

On 10/03/23 at 11:11 a.m., the administrator stated she had no knowledge of Staff #1 taking the resident to the bank or of Staff #1 being on

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C1304	Continued From page 8	C1304		

the resident's accounts as beneficiary. The administrator stated the staff member should not have been listed on the accounts. The administrator stated the staff member should have contacted them about the situation.

On 10/03/23 at 12:32 p.m., Staff #1 stated Res #1 was "confused with everything" and "not in her right mind." Staff #1 stated the resident would read their bank statements and say their representative was taking their money. Staff #1 stated the representative was paying the resident's bills. Staff #1 stated the resident did not want their representative on their account anymore. The staff member stated they took the resident to the bank in January 2023 and the resident closed the account they had with the representative and opened another checking account and a money market account. Staff #1 stated the banker told the resident that they needed a beneficiary for the accounts. The staff member stated the resident told the banker they did not have anyone to be the beneficiary. Staff #1 stated the resident asked them to be the beneficiary and they agreed to make the resident happy. The staff member stated they did not tell the representative until the day of the resident's death. The staff member stated they told the representative that they would go to the bank and get them a certified check for the money in the accounts. The staff member stated the representative told them that they recently obtained guardianship and had taken the staff member's name off the accounts. Staff #1 stated she did not tell the administrator about the resident's new accounts and using the staff member as the beneficiary. She stated she did tell the assistant administrator about taking the resident to the bank and the resident changing their accounts.

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C1304	Continued From page 9 On 10/03/23 at 3:35 p.m., the assistant administrator stated Staff #1 did tell her about taking the resident to the bank and the resident taking her representative off their account. The assistant administrator stated she did not know Staff #1 was added as the beneficiary. The assistant administrator stated she had not said any thing to the administrator about it.	C1304		

OKLAHOMA
State Department
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Delivery via email to: Rachel@featherstoneretirement.com

November 15, 2023

License Number: AL0703

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

Survey Event ID: N7RH11

Dear Ms. McKinney:

On **October 3, 2023,** a Relicensure survey and a Complaint investigation were 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 17, 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

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: 11/9/2023** **Facility Name:** Featherstone Assisted Living Durant **License Number:** AL0703 **Survey Event ID:** N7RH11 **Date Survey Completed: 10/3/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements as evidenced by: C 391Based on observation and interview, the center failed to ensure food was stored, prepared, and served in accordance with Chapter 257.

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 will conduct in-service training with dietary staff and implement a cleaning schedule to ensure all areas of concern are addressed. The administrator/assistant will audit the kitchen for compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Administrator will conduct weekly audits to ensure compliance is met and report in QA to evaluate effectiveness of 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?	Adminstrator will conduct weekly audits to ensure compliance is met and report in QA to evaluate effectiveness of compliance.
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.	Administrator/Assistant will conduct routine audits of the cleaning schedule and monitor for compliance and will review in QA to evaluate the effectiveness. The administrator/assistant will follow up on any non-compliance noted. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/9/2023**

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			
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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: 11/9/2023** **Facility Name:** Featherstone Assisted Living Durant **License Number:** AL0703 **Survey Event ID:** N7RH11 **Date Survey Completed: 10/3/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522	Based on: This REQUIREMENT is not met as evidenced by: C 522Based on record review and interview, the center failed to ensure comprehensive assessments were completed once every twelve months for one (#5) of eight residents whose assessments were reviewed

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 will conduct a complete audit of all assessments and will implement Assessment Tracking Tool to ensure timely/current assessment of residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit Tracking Tool in place to ensure timely/current assessment of residents.
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?	Adminstator will conduct monthly audits to ensure compliance is met and report in QA.
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.	Routine audits will be conducted of cleaning schedule and compliance of proper kitchen etiqute and will be reviewed in QA to evaluate the effectiveness of compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/9/2023**

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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: 11/9/2023** **Facility Name:** Featherstone Assisted Living Durant **License Number:** AL0703 **Survey Event ID:** N7RH11 **Date Survey Completed: 10/3/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C541	Based on: This Rule is not met as evidenced by:C 541Based on observation, record review, and interview, the center failed to ensure assessments were completed by the appropriate health care professionals trained in the assessment process for two (#3 and #9) of eight sampled residents whose assessments were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 will conduct a complete audit of all assessments and will implement an Assessment Tracking Tool to ensure appropriate staff members involvement of current assessment of residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit Tracking Tool in place to ensure appropriate staff member assessment credential involvement of residents.
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?	Adminstator will conduct monthly audits to ensure compliance is met and report in QA.
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 for our end and /or physician signature and review in quarterly QA to evaluated the effective and compliance. The Adminstrator will followup on any non-compliance noted. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/9/2023**

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SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: This REQUIREMENT is not met as evidenced by: C1304 Based on record review and interview, the center failed to ensure all services that are specified in the resident's service contract were provided related to the resident being free from financial exploitation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 will ensure that all staff members will be in serviced according to Policies & Procedures of the community. Noted staff member received disciplinary action and individualized training regarding the appropriateness of actions. An audit conducted of all resident files to ensure resident and/or family members have appropriate documentation of Resident Rights.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit conducted of all resident files to ensure resident and/or family members have appropriate documentation of Resident Rights. New residents will be provided appropriate education of Resident Rights.
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 staff will be inserviced on Policies and Procedures and educated on Residents Rights according to Gratuties and Exploitation. Administrator will continue to do Resident File audits and in-service training will be ongoing.
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.	The administrator will conduct audits to ensure that resident and/or family members have appropriate documentation of Resident Rights. Monthly audit for compliance and reported in QA. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date 11/9/2023**
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OKLAHOMA
State Department
of Health

Delivery via email to: Rachel@featherstoneretirement.com

November 17, 2023

License Number: AL0703
Survey Event ID: **N7RH11**

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

Dear Ms. McKinney:

On **October 3, 2023**, a Licensure survey and a complaint investigation were conducted at your Adult Day Care facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 will be corrected on **November 17, 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

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/9/2023** **Facility Name:** Featherstone Assisted Living Durant **License Number:** AL0703 **Survey Event ID:** N7RH11 **Date Survey Completed: 10/3/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C541	Based on: This Rule is not met as evidenced by:C 541Based on observation, record review, and interview, the center failed to ensure assessments were completed by the appropriate health care professionals trained in the assessment process for two (#3 and #9) of eight sampled residents whose assessments were reviewed.

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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 will conduct a complete audit of all assessments and will implement an Assessment Tracking Tool to ensure appropriate staff members' involvement of current assessment of residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit Tracking Tool in place to ensure appropriate staff member assessment credential involvement of residents.
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?	Adminstrator will conduct monthly audits to ensure compliance is met and report in QA.
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 for our end and /or physician's signature and review in quarterly QA to evaluate the effectiveness and compliance. The Adminstrator will followup on any non-compliance noted. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/10/2023**

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SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304	Based on: This REQUIREMENT is not met as evidenced by: C1304 Based on record review and interview, the center failed to ensure all services that are specified in the resident's service contract were provided related to the resident being free from financial exploitation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 will ensure that all staff members will be in-serviced according to the Policies & Procedures of the community. Noted staff member received disciplinary action and individualized training regarding the appropriateness of actions. An audit conducted of all resident files to ensure resident and/or family members have appropriate documentation of Resident Rights.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit conducted of all resident files to ensure resident and/or family members have appropriate documentation of Resident Rights. New residents will be provided with appropriate documentation of Resident Rights in accordance with Policies & Procedures of the community.
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 staff will be in-serviced on Policies and Procedures and educated on Residents Rights specific to Gratuities and Exploitation.
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.	The administrator will conduct audits to ensure that resident and/or family members have appropriate documentation of Resident Rights. Monthly audit will be conducted for compliance and reported in QA. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/13/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date 11/10/2023**
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SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: This REQUIREMENT is not met as evidenced by: C 522 Based on record review and interview, the center failed to ensure comprehensive assessments were completed once every twelve months for one (#5) of eight residents whose assessments were reviewed

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 will conduct a complete audit of all assessments and will implement Assessment Tracking Tool to ensure timely/current assessment of residents and appropriate staff credentials.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit Tracking Tool in place to ensure timely/current assessment of residents and appropriate staff credentials.
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?	Adminstator will conduct monthly audits to ensure compliance is met and report in QA.
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.	Routine audits wil be conducted of assessments and will implement an audit tracking tool to ensure compliance is met timely and reviewed/signed by appropriate staff. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/13/2023
OSDH Response: Element accepted Yes ☐ No ☐	

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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: 11/9/2023
Facility Name: Featherstone Assisted Living Durant
License Number: AL0703
Survey Event ID: N7RH11
Date Survey Completed: 10/3/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements as evidenced by: C 391Based on observation and interview. the center failed to ensure food was stored, prepared, and served in accordance with Chapter 257.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 will conduct in-service training with dietary staff and implement a cleaning schedule to ensure all areas of concern are addressed. Administrator/assistant will audit the kitchen for compliance
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Adminstator/assistant will conduct weekly audits to ensure compliance is met.
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?	Adminstator will conduct weekly audits to ensure compliance is met. And report in QA
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.	Routine audits wil be conducted of cleaning schedule and compliance of proper kitchen procedures. This will be reviewed in QA to evaluate the effectiveness of compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/13/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. **Date 11/10/2023**
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OKLAHOMA
State Department
of Health

Delivery via email to: Rachel@featherstoneretirement.com

December 11, 2023

License Number: AL0703

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

RE: Survey Event N7RH12

Dear Ms. McKinney:

On **December 7, 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 **October 3, 2023,** have now been corrected effective **November 17, 2023.**

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

Respectfully,

Lisa Calvin

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

Enclosure

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-C 12/07/2023

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 12/07/23. 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