



Oklahoma State Department of Health
Creating a State of Health

October 24, 2019

License Number: AL1409

Mr. Michael Brown II, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

RE: Survey Event ID: 268V11

Dear Mr. Brown II:

On **September 12, 2019**, agents from our office concluded a State Licensure survey along with a complaint investigation 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 September 12, 2019.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

Board of Health

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

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

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

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

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

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

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

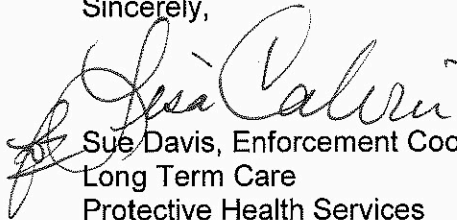
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

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

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Davis".

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

INVESTIGATIVE REPORT

Facility: Featherstone Assisted Living Community of Moore
Address: 301 North Eastern Avenue
City, State, Zip: Moore, OK
Provider #: AL1409
Complaint #: #OK00054297
Investigation Date(s): 09/10/19 through 09/12/19

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

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

An unannounced on-site investigation was initiated on 09/10/19 at 2:00 p.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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

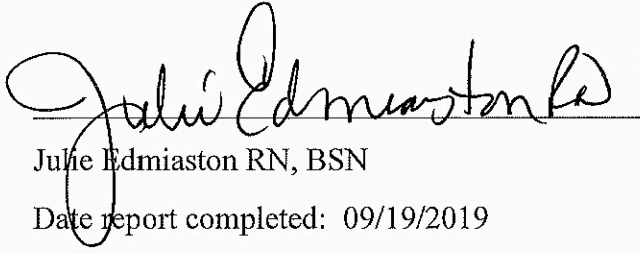
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, and Tag C-1505 for details.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

 9/19/19
Julie Edmiaston RN, BSN
Date report completed: 09/19/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/12/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(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
N 000	Initial Comments A re-licensure survey was conducted from 09/10/19 to 09/12/19. Complaint #OK 00054297 was investigated in conjunction with the survey. Resident census was 41. Deficient practice was cited as follows.	N 000		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center's nurse failed to validate skills for 5 (#1, 2, 10, 12, and #14) of 7 certified medication aides (CMA's) before the CMA's performed medication administration. This deficient practice had no actual harm with potential for more than minimal harm widespread. Findings: On 09/11/19 at 1:00 p.m., record review of personnel files with licensed practical nurse (LPN) #1 did not contain evidence of validation of skills for the following personnel: Certified Medication Aide (CMA) #1 and #10; and Advanced Certified Medication Aide (ACMA) #2, #12, and #14.	N1442		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N1442	Continued From page 1 At 2:15 p.m., LPN #1 stated there was no record of skills validation for the employees listed above.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted from 09/10/19 to 09/12/19. Complaint #OK 00054297 was investigated in conjunction with the survey. Resident census was 41. Deficient practice was cited as follows.	C 000		
C 522 SS=E	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 interview and record review it was determined the center failed to complete a comprehensive assessment for 4 (#1, 5, 7, and #8) of 8 sampled residents that had lived in the center for greater than one year. This deficient practice resulted in more than minimal harm at a pattern. Findings: Resident #1 On 09/11/19 at 3:02 p.m., licensed practical nurse (LPN) #1 was asked about the date of resident #1's current annual assessment. She stated, "04/08/18." She was asked if this was the most	C 522		

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C 522	Continued From page 2 current assessment. She stated she thought that it was the most current one. On 09/12/19 at 8:57 a.m., LPN #1 was asked if she had located resident #1's current annual assessment. She stated no. Resident #5 On 09/11/19 at 3:15 p.m., LPN #1 was asked about the date of resident #5's annual assessment. She stated, "04/27/18." On 09/12/19 at 9:20 a.m., the LPN #1 was asked if she located resident #5's assessment. She stated no, not hers. Resident #7 On 09/11/19 at 2:30 p.m., LPN #1 was asked about the date of resident #7's comprehensive assessment. She stated, "07/03/18." On 09/12/19 at 9:15 a.m., LPN #1 was asked if she located a current comprehensive assessment for resident #7. She stated no ma'am. Resident #8 On 09/11/19 at 2:45 p.m., the residents record was reviewed with the LPN #1. No annual assessment in the chart for resident #8 was found when reviewing the record. On 09/12/19 at 10:25 a.m., LPN #1 was asked if there was an annual assessment completed for resident #8. LPN #1 said she was missing the assessment for this year. Policy	C 522			

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C 522	Continued From page 3 The center's policy titled, OSDH (Oklahoma State Department of Health) Approved Assessment, dated December 2018, documented, an assessment will be completed prior to or upon admission, within the first 14 days, annually and with a significant change of condition.	C 522			
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the center's registered nurse failed to ensure a pulse was taken for 1 (#2) of 1 sampled resident with an order for Digoxin medication. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: A physician's order for resident #2, dated March 13, 2019, documented, recommend a daily pulse with Digoxin therapy. Please notify if you wish for her dose to be held if her pulse is below 60 and notify physician if held three consecutive days. This order was signed by the physician. On 09/12/19 at 9:06 a.m., licensed practical nurse (LPN) #1 was asked if resident #2 had a	C 911			

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C 911	Continued From page 4 physician's order for Digoxin. She stated yes. She was asked if there was a physician's order to record a pulse when the medication was administered. She stated yes, the doctor agreed to the parameter. She was asked about the pulse being taken for resident #2. She stated it looks like they did not do any for July (2019) or September (2019). She was asked when the physician ordered the pulse to be taken. She stated, "03/13/19." There were thirteen (13) pulses not recorded in August 2019.	C 911			
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review it was determined the center had no verification of medications being reviewed monthly by the registered nurse (RN). This resulted in the widespread potential for minimal harm at a pattern. Findings: On 09/12/19 at 9:21 a.m., licensed practical nurse (LPN) #1 was asked to submit the registered nurse's (RN's) monthly medication reviews. She was asked if the RN performed monthly medication reviews for each resident. She stated she should. She was asked if the RN	C 921			

If continuation sheet 6 of 11

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C 954	Continued From page 6 ACMA #10, #13 and #14 MAT #7. On 09/11/19 at 1:00 p.m., LPN #1 stated there was no documentation of first aid or CPR training for the above employees.	C 954		
C1505 SS=F	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure	C1505		

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C1505	Continued From page 7 medications were administered as directed by the physician for 3 (#1, 2, and #6) of 8 sampled residents whose medications were administered by the staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 A physician's order dated for August and September 2019, for resident #1, documented Hydrocodone/Acetaminophen 7.5 mg (milligrams) /325 mg one tablet by mouth four times daily. Resident #1's medication administration record (MAR) documented four (4) missed doses in August 31, 2019 of Hydrocodone and the reason documented why she did not receive it was "awaiting pharmacy." Resident #1's MAR documented eight (8) missed doses in September 2019 and the reason documented why resident #1 did not receive it was "awaiting pharmacy." On 09/12/19 at 8:55 a.m., licensed practical nurse (LPN) #1 was how many doses of Hydrocodone resident #1 had missed in August and September 2019. She stated she missed twelve doses. She was asked if she knew why resident #1 did not receive her Hydrocodone. She stated the prior nurse had a sufficient amount of time, but did not follow up on the order. She was asked about the center's policy for ordering narcotics. She stated typically to order seven (7) days before they run out. Resident #2 A physician's order dated on 07/22/19, for	C1505			

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C1505	Continued From page 8 resident #2, documented Align (probiotic) capsule 4 mg (milligrams) daily. Resident #2 missed thirty (30) doses of Align probiotic 4 mg daily in the month of August 2019. On 09/12/19 at 9:00 a.m., licensed practical nurse (LPN) #1 was asked if resident #2 had received a dose of Align in the month of August 2019. She stated it does not appear that she got any. She was asked how many doses were missed on resident #2's MAR in August 2019. She stated she missed 30 doses. She was asked if the staff were responsible for ordering resident #2's medication. She stated the nurse should be responsible. Resident #6 Resident #6 had an order for refresh tears 0.5% one drop in each eye three times daily. The medication administration record (MAR) documented 23/93 doses were missed for the month of August, and 12/30 for 9 days in September. On 09/11/19 at 10:43 a.m., resident #6 reported she was not getting her eye drops routinely. At 1:40 p.m., during an interview with the licensed practical nurse (LPN) #1 she stated the blanks on the medication administration record for resident #6 looked like the medications were not given or signed for. Policy The center's policy titled, 'Administration and Record Keeping' not dated, documented the MAR is initialed when the medication is prepared.	C1505			

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C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to document vital signs/ weights as physician ordered for 1 (#4) of one sampled resident with physician ordered vital signs. Additionally, the center failed to document document medication administered for one (#9) of one sampled resident who had received Lidocaine to her fistula site one hour prior to dialysis twice a week. These failed practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #4 Vital signs twice daily on 7-3 shift and 3-11 shift with weekly weights. Resident #4's medication record was missing 31 vital signs for the month of August. Additionally, his weight was only recorded one time for the month. Another center's administrator was asked about the blanks on resident #4's record. She stated yes the staff had missed recording his weight and blood pressures.	C1951			

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C1951	Continued From page 10 Resident #9 Lidocaine/Prilocaine 2.5%-2.5% apply to fistual site one hour prior to dialysis on Monday and Friday. The medication record had not been initialed to indicate the medication was administered for the month of September 2019. Resident #9 stated she would not leave the center for dialysis without getting her Lidocaine.	C1951			

STATE WORKLOAD REPORT

Provider/Supplier Number AL1409	Provider/Supplier Name FEATHERSTONE ASSISTED LIVING COMMUNITY OF MOORE
------------------------------------	---

Type of Survey (select all that apply)

2	3			
---	---	--	--	--

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

Extent of Survey (select all that apply)

A	B			
---	---	--	--	--

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	09/10/2019	09/12/2019	0.50	0.00	14.50	0.00	4.50	4.50
2. 41872	09/10/2019	09/12/2019	0.75	0.00	13.50	0.00	6.50	5.25
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

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

0.00

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

OCT 29 2019





Oklahoma State Department of Health
Creating a State of Health

November 20, 2019

License Number: AL1409

Mr. Michael Brown li, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

RE: Survey Event 268V11

Dear Mr. Brown li:

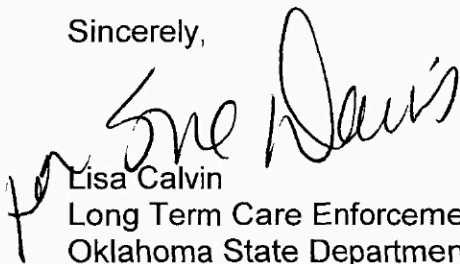
On September 12, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 30, 2019**.

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

Sincerely,


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

LC/ks

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
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Jenny Alexopoulos, DO
Terry R Gerard II, DO
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R Murali Krishna, MD
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Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/30/2019

Facility Name: Featherstone Assisted Living-Moore

License Number: AL 1409

Survey Event ID: 268V11

Date Survey Completed: 9/12/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on interview and record review it was determined the center failed to complete a comprehensive assessment for 4 (#1, 5, 7, and #8) of 8 sampled residents that had lived in the center for greater than one year. This deficient practice resulted in more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

ASSISTED LIVING CENTER'S PLAN ELEMENTS

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

RN assessments have been completed using the OSDH Recommended Assisted Living Resident Assessment Form for annual assessments on residents #1, 5, 7, and #8.

OSDH Response: Element accepted Yes ☐ No ☐

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

Center has hired a new Health and Wellness Director (HWD) who has reviewed all resident's assessments to ensure RN completes all annual, 14 day and significant change assessments within 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?

HWD will meet with Administrator the first week of each month to review previous month's annual (et.al) assessments to ensure completion as well as schedule assessments for current month. Any assessments not completed within the previous month will result in disciplinary action.

OSDH Response: Element accepted Yes ☐ No ☐

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

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

Monthly assessment meeting notes will be recorded for Administrator's meetings with HWD and be presented and discussed during quarterly QA meetings. Additionally, more comprehensive discussion and recording will occur in quarterly QA meetings to present a clearer picture as to the status/progress of resident's assessments.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

11/8/2019

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Administrator's signature required

Date Enter a date of signature

OAC 310:663-25-4(F)

Michael Brown

11/06/2019

process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Davis".

 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/11/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI			STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(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
{N 000}	Initial Comments A follow up survey was completed on 12/10/19 and 12/11/19. Census was 39.	{N 000}			
{C 000}	INITIAL COMMENTS A follow up survey was completed on 12/10/19 and 12/11/19. Census was 39. Deficient practice was recited as follows.	{C 000}			
{C 911} SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to provide registered nurse supervision and follow up of physician orders for 3 (#1, #3 and #4) of 3 sampled residents with hypertension and diabetes. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 On 12/10/19 at 1:30 p.m., the blood pressure log documented no blood pressure results were taken for 5 of 10 days for the month of December	{C 911}			

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A BUILDING. _____ B WING. _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(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 911}	Continued From page 1 2019. On 12/11/19 at 10:40 a.m. the LPN/DON stated she did not know why there was no documentation the blood pressures were not taken for those days. Resident #3 December 2019 physician orders documented resident #3 was to perform his own FSBS (fingerstick blood sugar) before breakfast and after dinner. The nurse was to monitor FSBS and self performance and documentation weekly. On 12/10/19 at 2:10 p.m., the LPN/DON (licensed practical nurse/director of nursing) stated she had been monitoring the residents FSBS results weekly. The LPN/DON was asked where it was documented the FSBS results were being monitored weekly. The LPN/DON stated she looked at the results, but did not document that she monitored the resident's FSBS results. On 12/11/19 at 10:30 a.m., resident #3 stated he performed his own FSBS and recorded it two times per day. Resident #3 said the nurses check the results occasionally. On 02/13/19, resident #3's Hemoglobin A1c (the percentage of glycated hemoglobin in the blood) was 5.8%. On 12/05/19, hemoglobin A1c lab result was 8.2 %. Resident #4 December 2019 physician orders were to obtain FSBS daily at bedtime, resident to perform and staff to monitor weekly. Levemir insulin, inject 11 units daily in the evening, resident to perform,	{C 911}		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 12/11/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI			STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(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 911}	Continued From page 2 staff to monitor weekly. On 12/10/19 at 1:08 p.m., resident #4 was asked if she performed her own FSBS, and self administered her insulin. Resident #4 stated no, she was not taking her insulin, she had not taken it in about 6 months. She was taking her FSBS but not documenting them. No log was available in the room. At 1:15 p.m., the LPN/DON stated medications and orders are reviewed monthly by herself and the registered nurse. At 2:45 p.m., the LPN/DON and employee #17 (residential care coordinator) were not aware resident #4 was not taking her insulin. The LPN/DON, employee #17, and this surveyor went into resident #4's room. Resident #4 was asked if she was taking her insulin, and where her FSBS log was kept in the room. Resident #4 said she had not been taking her insulin and she did not know where the log was in her room. On 12/11/19 at 10:40 a.m., the LPN/DON stated the resident's FSBS log had not been located and the center had not provided another one so she could record her FSBS results.	{C 911}			
{C1951} SS=E	310.663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice.	{C1951}			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C1951}	Continued From page 3 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to document blood pressure results for 1 (#1) of one sampled resident with physician ordered daily blood pressures. Additionally, the center failed to ensure correct documentation for medication administration for 1 (#4) of one sampled resident who had received Lidocaine to her fistula site one hour prior to dialysis twice a week. These failed practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #1 On 12/10/19 at 1:30 p.m., the blood pressure log documented no blood pressure results were taken for 5 of 10 days for the month of December 2019. On 12/11/19 at 10:40 a.m. the LPN/DON stated she did not know why there was no documentation the blood pressures were taken for those days. Resident #4 On 12/10/19 at 1:15 p.m., the medication administration record (MAR) was reviewed with the LPN/DON. The order was written for Lidocaine/Prilocaine 2.5-2.5% apply to fistula site one hour prior to dialysis on Monday and Friday. The MAR documented that the Lidocaine was administered by the staff every day of the month for December 2019. The LPN/DON stated the resident was not getting the lidocaine	{C1951}		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL1409	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C1951}	Continued From page 4 administered everyday.	{C1951}		

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.
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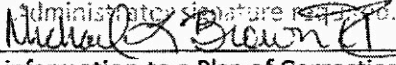
Items Below Are For OSDH Use Only

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: 11/5/2019	
	Facility Name: Featherstone Assisted Living-Moore	
	License Number: AL 1409	
	Survey Event ID: 268V11	
Date Survey Completed: 9/12/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on interview and record review it was determined the center failed to ensure medications were administered as directed by the physician for 3 (#1, 2, and #6) of 8 sampled residents whose medications were administered by the staff. This failed practice had the potential for more than minimal harm at a pattern.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: "This Plan of Correction is prepared and submitted as required by law and should not be construed as an admission of or agreement with the findings and conclusion in the statement of deficiencies or any related sanction or fine. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Medications for residents identified on the survey have had medications ordered and are being administered in accordance with Doctor's orders.	
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 residents have the potential to be affected by the same deficient practice.	
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?	The Health and Wellness Director has identified a more accurate and efficient method for tracking and ordering medications by identifying 2 shifts per week to inventory and order all medications for residents. Additionally, medication aides will be in-serviced on Friday, November 8 th , 2019 to educate on the correct administration of all medications as ordered. Lastly, the community's purchase of the Electronic Medication Administration Record system will prevent medication aides from missing resident's medications and will stop additional medication administration until all resident medication requirements have been met. HWD will review medication administration compliance reports on a bi-weekly basis to review all residents received all required medications per orders. This bi-weekly report will be reviewed in weekly meeting with Administrator and HWD.	
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	Weekly meeting with Administrator and HWD will be documented in meeting notes. These weekly meeting notes will serve as evidence of compliance will be presented for review in Quality Assurance meeting and recorded in QA meeting notes.	

c. How monitoring records will be kept to evidence the correction.		
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		11/30/2019
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature DAC 310:663-25-4(F)	Administrator's signature required. 	Date Enter a date of signature. 11/06/2019
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	Enter a date of addendum.	Submitted by Enter name of person submitting addendum.
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/12/2019
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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF	STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160
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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
N 000	Initial Comments A re-licensure survey was conducted from 09/10/19 to 09/12/19. Complaint #OK 00054297 was investigated in conjunction with the survey. Resident census was 41. Deficient practice was cited as follows.	N 000		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center's nurse failed to validate skills for 5 (#1, 2, 10, 12, and #14) of 7 certified medication aides (CMA's) before the CMA's performed medication administration. This deficient practice the widespread potential for more than minimal harm. Findings: On 09/11/19 at 1:00 p.m., the personnel files were reviewed with licensed practical nurse (LPN) #1. The files did not contain evidence of validation of skills for the Certified Medication Aide (CMA) #1, 2, 10, 12, and #14. At 2:15 p.m., LPN #1 stated there was no record of skills validation for the employees listed above.	N1442	POC submitted via template	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Michael K. Brown

TITLE

Executive Director

(X6) DATE

11/6/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/12/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF :		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(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	Continued From page 1	C 000		
C 000	INITIAL COMMENTS A re-licensure survey was conducted from 09/10/19 to 09/12/19. Complaint #OK 00054297 was investigated in conjunction with the survey. Resident census was 41. Deficient practice was cited as follows.	C 000		
C 522 SS=E	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 interview and record review it was determined the center failed to complete a comprehensive assessment for 4 (#1, 5, 7, and #8) of 8 sampled residents that had lived in the center for greater than one year. This deficient practice resulted in more than minimal harm at a pattern. Findings: Resident #1 On 09/11/19 at 3:02 p.m., licensed practical nurse (LPN) #1 was asked about the date of resident #1's current annual assessment. She stated, "04/08/18." She was asked if this was the most current assessment. She stated she thought that it was the most current one.	C 522	POC submitted via template	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/12/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNITY OF I

**301 NORTH EASTERN AVENUE
MOORE, OK 73160**

(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 522	Continued From page 2 On 09/12/19 at 8:57 a.m., LPN #1 was asked if she had located resident #1's current annual assessment. She stated no. Resident #5 On 09/11/19 at 3:15 p.m., LPN #1 was asked about the date of resident #5's annual assessment. She stated, "04/27/18." On 09/12/19 at 9:20 a.m., the LPN #1 was asked if she located resident #5's assessment. She stated no, not hers. Resident #7 On 09/11/19 at 2:30 p.m., LPN #1 was asked about the date of resident #7's comprehensive assessment. She stated, "07/03/18." On 09/12/19 at 9:15 a.m., LPN #1 was asked if she located a current comprehensive assessment for resident #7. She stated no ma'am. Resident #8 On 09/11/19 at 2:45 p.m., the residents record was reviewed with the LPN #1. No annual assessment in the chart for resident #8 was found when reviewing the record. On 09/12/19 at 10:25 a.m., LPN #1 was asked if there was an annual assessment completed for resident #8. LPN #1 said she was missing the assessment for this year. Policy The center's policy titled, OSDH (Oklahoma State Department of Health) Approved Assessment, dated December 2018, documented, an	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/12/2019
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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF I	STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160
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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 522	Continued From page 3 assessment will be completed prior to or upon admission, within the first 14 days, annually and with a significant change of condition.	C 522		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the center's registered nurse failed to ensure a pulse was taken for 1 (#2) of 1 sampled resident with an order for Digoxin medication. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: A physician's order for resident #2, dated March 13, 2019, documented, recommend a daily pulse with Digoxin therapy. Please notify if you wish for her dose to be held if her pulse is below 60 and notify physician if held three consecutive days. This order was signed by the physician. On 09/12/19 at 9:06 a.m., licensed practical nurse (LPN) #1 was asked if resident #2 had a physician's order for Digoxin. She stated yes. She was asked if there was a physician's order to record a pulse when the medication was	C 911	Pc submitted via template	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/12/2019
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF I			STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
(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 911	Continued From page 4 administered. She stated yes, the doctor agreed to the parameter. She was asked about the pulse being taken for resident #2. She stated it looks like they did not do any for July (2019) or September (2019). She was asked when the physician ordered the pulse to be taken. She stated, "03/13/19." There were thirteen (13) pulses not recorded in August 2019.	C 911			
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review it was determined the center had no verification of medications being reviewed monthly by the registered nurse (RN). This resulted in the widespread potential for minimal harm at a pattern. Findings: On 09/12/19 at 9:21 a.m., licensed practical nurse (LPN) #1 was asked to submit the registered nurse's (RN's) monthly medication reviews. She was asked if the RN performed monthly medication reviews for each resident. She stated she should. She was asked if the RN documented monthly medication reviews. She stated she had not seen anything.	C 921	P.C submitted via template		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary	C 954	P.C Submitted via template		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF	STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160
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C 954	Continued From page 5 resuscitation. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure 9 (#6, 7, 8, 9, 10, 11, 12, 13, and #14) of 19 direct care staff had evidence of training in first aid, and failed to ensure 8 (#6, 7, 8, 9, 10, 11, 13, and #14) of 19 direct care staff had evidence of Cardiopulmonary Resuscitation (CPR) training. This deficient practice had the potential for widespread harm. Findings: On 09/11/19 at 1:00 p.m., the employee files were reviewed with Licensed Practical Nurse (LPN) #1. The records did not contain evidence of first aid training for: Certified nurse Aide (CNA) #6, #8, #9, and #11 Advanced certified medication aide (ACMA) #10, #12, #13 and #14 Medication Administration Technician (MAT) #7 On 09/11/19 at 1:00 p.m., the employee files were reviewed with LPN #1. the files did not contain evidence of CPR for: CNA #6, #8, #9 and #11 ACMA #10, #13 and #14 MAT #7. On 09/11/19 at 1:00 p.m., LPN #1 stated there was no documentation of first aid or CPR training for the above employees.	C 954		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF I	STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160
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C1505	Continued From page 6	C1505		
C1505 SS=F	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure medications were administered as directed by the physician for 3 (#1, 2, and #6) of 8 sampled residents whose medications were administered by the staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1	C1505 C1505	PAC submitted via template	

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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF I		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
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C1505	Continued From page 7 A physician's order dated for August and September 2019, for resident #1, documented Hydrocodone/Acetaminophen 7.5 mg (milligrams) /325 mg one tablet by mouth four times daily. Resident #1's medication administration record (MAR) documented four (4) missed doses in August 31, 2019 of Hydrocodone and the reason documented why she did not receive it was "awaiting pharmacy." Resident #1's MAR documented eight (8) missed doses in September 2019 and the reason documented why resident #1 did not receive it was "awaiting pharmacy." On 09/12/19 at 8:55 a.m., licensed practical nurse (LPN) #1 was how many doses of Hydrocodone resident #1 had missed in August and September 2019. She stated she missed twelve doses. She was asked if she knew why resident #1 did not receive her Hydrocodone. She stated the prior nurse had a sufficient amount of time, but did not follow up on the order. She was asked about the center's policy for ordering narcotics. She stated typically to order seven (7) days before they run out. Resident #2 A physician's order dated on 07/22/19, for resident #2, documented Align (probiotic) capsule 4 mg (milligrams) daily. Resident #2 missed thirty (30) doses of Align probiotic 4 mg daily in the month of August 2019. On 09/12/19 at 9:00 a.m., licensed practical nurse (LPN) #1 was asked if resident #2 had received a	C1505		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNITY OF I

**301 NORTH EASTERN AVENUE
MOORE, OK 73160**

(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
C1505	Continued From page 8 dose of Align in the month of August 2019. She stated it does not appear that she got any. She was asked how many doses were missed on resident #2's MAR in August 2019. She stated she missed 30 doses. She was asked if the staff were responsible for ordering resident #2's medication. She stated the nurse should be responsible. Resident #6 Resident #6 had an order for refresh tears 0.5% one drop in each eye three times daily. The medication administration record (MAR) documented 23/93 doses were missed for the month of August, and 12/30 for 9 days in September. On 09/11/19 at 10:43 a.m., resident #6 reported she was not getting her eye drops routinely. At 1:40 p.m., during an interview with the licensed practical nurse (LPN) #1 she stated the blanks on the medication administration record for resident #6 looked like the medications were not given or signed for. Policy The center's policy titled, 'Administration and Record Keeping' not dated, documented the MAR is initiated when the medication is prepared.	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document	C1951	RC submitted via template	

Oklahoma State Department of Health

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C1951	Continued From page 9 all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to document vital signs/ weights as physician ordered for 1 (#4) of one sampled resident with physician ordered vital signs. Additionally, the center failed to document document medication administered for one (#9) of one sampled resident who had received Lidocaine to her fistula site one hour prior to dialysis twice a week. These failed practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #4 Vital signs twice daily on 7-3 shift and 3-11 shift with weekly weights. Resident #4's medication record was missing 31 vital signs for the month of August. Additionally, his weight was only recorded one time for the month. Another center's administrator was asked about the blanks on resident #4's record. She stated yes the staff had missed recording his weight and blood pressures. Resident #9 Lidocaine/Prilocaine 2.5%-2.5% apply to fistula site one hour prior to dialysis on Monday and Friday. The medication record had not been	C1951		

Oklahoma State Department of Health

STATE FORM

5993

268V11

If continuation sheet 10 of 11

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C1951	Continued From page 10 initialed to indicate the medication was administered for the month of September 2019. Resident #9 stated she would not leave the center for dialysis without getting her Lidocaine.	C1951			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/30/2019

Facility Name: Featherstone Assisted Living-Moore

License Number: AL 1409

Survey Event ID: 268V11

Date Survey Completed: 9/12/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1442

Based on interview and record review, it was determined the center's nurse failed to validate skills for 5 (#1, 2, 10, 12 and #14) of 7 certified medication aides (CMA's) before the CMA's performed medication administration. This deficient practice has the widespread potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

Certified 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?

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Medication Aides #1, 2, 10, 12 and #14 have had skills validation completed by the nurse in the form of a Certified Medication Aide Skills Performance Checklist.

All Medication Aides on staff as well as all future Medication Aides will have skills validation completed by the nurse in the form of a Certified Medication Aide Skills Performance Checklist prior to administering medications to residents.

Administrator will utilize a Facility Staffing Certificate & Credentials Checklist to record dates of skills validations and will review monthly to ensure the skills checklists are current for each medication aide. This Credentials Checklist will be kept in the binder that holds all staff certificates and skills checklists which is in the Administrator's office. Additionally, Administrator will develop a new hire checklist which will include the Certified Medication Aide Skills Performance Checklist to ensure that is completed for each new medication aide that is hired in the future.

QA will be amended to require the presentation and review of the Facility Staffing Certificate & Credentials Checklist to ensure compliance. Any deficiencies will be recorded in the QA Meeting notes along with an immediate plan of action for resolution.