OKLAHOMA
State Department
of Health

Delivery via email to: Gwyn@featherstoneretirement.com

May 30, 2023

License Number: AL1409

Ms. Gwyn Gilkeson, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

RE: Survey Event ID: BRO811

Dear Ms. Gilkeson:

On **May 18, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for 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 May 18, 2023.

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

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

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

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1409	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF	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	INITIAL COMMENTS A relicensure survey was conducted from 05/17/23 through 05/18/23. Listed below are abbreviations that will be used throughout the document. ACMA - advanced certified medication aide CNA - certified nursing assistant CPR - cardiopulmonary resuscitation MAR - medication administration record MAT - medication administration technician mcg - microgram 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 facility failed to ensure the ice machine was kept clean. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: On 05/17/23 at 8:56 a.m., a tour of the kitchen was conducted. There was an accumulation of white and brown residue inside the ice machine. On 05/18/23 at 11:20 a.m., during an interview with the administrator, they was made aware of the dirty ice machine. They reported it should	C 391		

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C 391	Continued From page 1 never be dirty.	C 391		
C 397 SS=E	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure whole eggs with their shell intact were pasteurized for eggs served not thoroughly cooked. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: On 05/17/23 at 8:56 a.m., a tour of the kitchen was conducted. There was a carton of a dozen non-pasteurized eggs with their shells intact in the cooler. The dining director was asked if the eggs were used for over easy or over medium. The dining director reported they have about five residents who request over easy eggs in the mornings. The dining director was made aware eggs that are cooked over easy or over medium	C 397		

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C 397	Continued From page 2 have to be pasteurized. They reported they will order them today.	C 397		
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 for three (#1, 6, and #8) of eight sampled residents. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: 1. Resident #6 was admitted to the center on 04/27/18 with diagnoses which included hypertension, atrial fibrillation, and diabetes. There was no documentation a comprehensive assessment was completed in 2022. 2. Resident #8 was admitted to the facility on 06/12/20 with diagnoses of chronic obstructive	C 522		

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C 522	Continued From page 3 pulmonary disease, hypertension, and myocardial infarction. There was no documentation a comprehensive assessment was completed in 2022. On 05/18/23 at 11:20 a.m., the administrator reported the assessments should have been completed. 3. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. An "Admission Resident Assessment" form, dated 05/02/23, was partially completed by the administrator of the facility. On 05/17/23 at 11:15 a.m., the administrator stated having documented most of the information on the assessment due to a lack of RN availability. They stated they do not possess a nursing or physician's license and should not have attempted to complete the admission assessment for this resident.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were coordinated by an RN or physician for two (#1 and #5) of eight residents whose comprehensive assessments were reviewed.	C 542		

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C 542	Continued From page 4 The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: 1. Resident #5's comprehensive assessment, dated 02/25/23, was not signed by the resident's representative and the RN or the resident's personal physician. 2. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. An "Admission Resident Assessment" form, dated 05/02/23, was not signed by the RN or physician. On 05/17/23 at 11:15 a.m., the administrator was asked if the assessment had been signed by an RN or physician. They stated the RN had been out on sick leave for a few weeks and no one had been available to complete the assessments. They stated an RN or physician should have signed the assessments by now, but it hadn't happened yet.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

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C 543	Continued From page 5	C 543		

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to ensure a comprehensive assessment included a personal interview between the resident or resident's representative and the person completing the form for six (#1, 2, 3, 4, 5, and #7) of eight sampled residents reviewed for comprehensive assessments.

The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility.

Findings:

1. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome.

An "Admission Resident Assessment" form, dated 05/02/23, was not signed by the resident or resident's representative.

On 05/17/23 at 11:15 a.m., the administrator was asked if the resident or the resident's representative had been interviewed regarding the assessment. The administrator stated the RN had been out on sick leave for a few weeks and no one had been available to review the assessment with the resident. They stated the resident or resident's representative should have been interviewed and signed the assessment, but this did not happen.

2. Resident #2 had diagnoses which included vascular dementia, emphysema, and atrial fibrillation.

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C 543	Continued From page 6 A "14-Day Resident Assessment" form, dated 07/22/22, was not signed by the resident or the resident's representative. On 05/18/23 at 1:42 p.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or physician but should have been. 3. Resident #3 had diagnoses which included multiple sclerosis, cerebral infarction, and dementia. An "Annual Resident Assessment" form, dated 05/27/22, was not signed by the resident or the resident's representative. On 05/18/23 at 1:44 p.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or physician but should have been. 4. Resident #4 had diagnoses which included hypertension, cerebral infarction, and seizures. An "Annual Resident Assessment" form, dated 05/16/22, was not signed by the resident or the resident's representative. On 05/18/23 at 1:46 p.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or physician but should have been. 5. Resident #5's comprehensive assessment, dated 02/25/23, was not signed by the resident's representative and the RN or resident's personal	C 543		

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C 543	Continued From page 7 physician. 6. Resident #7's comprehensive assessment, dated 05/05/22, was not signed by the resident or the resident's representative. On 05/18/23 at 11:20 a.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or resident's personal physician.	C 543		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a care plan was completed for two (#1 and #5) of eight sampled residents reviewed for care plan. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: 1. Resident #5 admitted to the center on 02/25/23, and had diagnoses which included	C 552		

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C 552	Continued From page 8 dementia, diabetes, and hypertension. The clinical record did not contain a plan of care. On 05/18/23 at 11:20 a.m., the administrator reported the plan of care should have been completed. 2. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. The clinical record did not contain a plan of care. On 05/17/23 at 11:20 a.m., the administrator stated a plan of care had not been completed due to not having an RN available for the last few weeks.	C 552		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions;	C 911		

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C 911	Continued From page 9	C 911		

This Rule is not met as evidenced by:
Based on record review and interview, the center's registered nurse failed to ensure a pulse was taken daily for one (#2) of one sampled resident with an order for Digoxin medication.

The administrator stated only one resident received Digoxin medication at the center.

Findings:

1. Resident #2 had diagnoses which included vascular dementia, emphysema, and atrial fibrillation.

A physician order, dated 08/19/22, documented Digoxin 125 mcg daily, take pulse before and hold if 60 or lower.

A "March 2023 MAR," had a daily pulse documented on one of 31 opportunities.

An "April 2023 MAR," had a daily pulse documented on one of 30 opportunities.

A "May 2023 MAR," had no daily pulse documented from 05/01/23 through 05/18/23.

On 05/18/23 at 1:00 p.m., MAT #1 stated the resident's pulse had not been checked and documented daily. They stated staff have only obtained the pulse and documented in the medical record once monthly.

On 05/18/23 at 1:40 p.m., the administrator stated they were not aware the pulse was not being checked and documented daily. They stated the problem would be addressed

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C 911	Continued From page 10 immediately with staff. On 05/18/23 at 2:02 p.m., MAT #2 stated having administered Digoxin to the resident daily over the last several months. They denied having checked or documented a pulse prior to administration. They stated they were not aware of the physician order, but would ensure the resident's pulse was checked prior to Digoxin administration from now on.	C 911		
C 921 SS=E	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 LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure monthly medication reviews were condcuted by the RN or pharmacy consultant monthly for seven (#2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for medication consults. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings:	C 921		

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C 921	Continued From page 11 The documentation for April 2023 medication reviews for residents were not conducted. 1. Res #2's physician medication orders, dated 04/23, were not signed by an RN or pharmacy consultant. 2. Res #3's physician medication orders, dated 04/23, were not signed by an RN or pharmacy consultant. 3. Res #4's physician medication orders, dated 04/23, were not signed by an RN or pharmacy consultant. On 05/18/23 at 11:20 a.m., the administrator stated there was no monthly medication reviews conducted for April 2023.	C 921		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure a licensed dietician or qualified nutritionist developed the assisted living center's diet plan. This filed practice resulted in the widespread potential for more than minimal harm for all 30 residents who received their meals at the center.	C 940		

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C 940	Continued From page 12 Findings: On 05/18/23 at 1:23 p.m., the dining director was asked for the menus, they provided menus written on notebook paper. The dietary manager was asked if the menus were approved by a registered dietician. They stated "Are they supposed to be? You'll have to ask Gwyn." On 05/18/23 at 1:30 p.m., the administrator was asked if the menus are approved by the registered dietician. The administrator reported that she shows her the menus when she is in the building for consultations. The administrator was asked how often the registered dietician is here. The administrator reported every three months.	C 940		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and first aid training for four (ACMA#1, MAT #3, CNA #1, and CNA #2) of 21 direct care staff employees reviewed. Findings:	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1409	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF	301 NORTH EASTERN AVENUE MOORE, OK 73160

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C 954	Continued From page 13 On 05/17/23 at 11:35 a.m., during record review, four direct care staff employees had no documentation of CPR and first aid training. The administrator reported that if the paperwork is not there then they do not have it.	C 954		

OKLAHOMA
State Department
of Health

Delivery via email to: gwyn@featherstoneretirement.com

June 16, 2023

License Number: 1409
Survey Event ID: BRO811

Ms. Gwyn Gilkeson, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

Dear Ms. Gilkeson:

On **May 18, 2023**, agents from our office concluded a relicensure inspection at your facility. You were advised of the findings of that inspection in our notice of **May 30,2023**.

The original STATE FORM/statement of deficiencies report has been revised during administrative review of this case on **June 16, 2023.** Upon administrative review, tag C397 was removed from the deficiencies. A copy of the corrected statement of deficiencies (STATE FORM) report is included. The corrected STATE FORM report is being provided for your records. Deficiencies identified during the were affected by these corrections and a plan of correction in response to this Amended STATE FORM is required.

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FEATHERSTONE ASSISTED LIVING COMMUNITY OF	301 NORTH EASTERN AVENUE MOORE, OK 73160

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C 000	INITIAL COMMENTS On 06/16/23, after administrative review the 2567 was amended. A relicensure survey was conducted from 05/17/23 through 05/18/23. Listed below are abbreviations that will be used throughout the document. ACMA - advanced certified medication aide CNA - certified nursing assistant CPR - cardiopulmonary resuscitation MAR - medication administration record MAT - medication administration technician mcg - microgram 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 facility failed to ensure the ice machine was kept clean. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: On 05/17/23 at 8:56 a.m., a tour of the kitchen was conducted. There was an accumulation of white and brown residue inside the ice machine.	C 391		

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FEATHERSTONE ASSISTED LIVING COMMUNITY OF	301 NORTH EASTERN AVENUE MOORE, OK 73160

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C 391	Continued From page 1 On 05/18/23 at 11:20 a.m., the administrator was made aware of the dirty ice machine. They stated it should never be dirty and cleaned at least once a week.	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 for three (#1, 6, and #8) of eight sampled residents. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: 1. Resident #6 was admitted to the center on 04/27/18 with diagnoses which included hypertension, atrial fibrillation, and diabetes. There was no documentation a comprehensive assessment was completed in 2022.	C 522		

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	AL1409	A. BUILDING: _____ B. WING _____	05/18/2023

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FEATHERSTONE ASSISTED LIVING COMMUNITY OF	301 NORTH EASTERN AVENUE MOORE, OK 73160

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C 522	Continued From page 2 2. Resident #8 was admitted to the facility on 06/12/20 with diagnoses of chronic obstructive pulmonary disease, hypertension, and myocardial infarction. There was no documentation a comprehensive assessment was completed in 2022. On 05/18/23 at 11:20 a.m., the administrator reported the assessments should have been completed. 3. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. An "Admission Resident Assessment" form, dated 05/02/23, was partially completed by the administrator of the facility. On 05/17/23 at 11:15 a.m., the administrator stated having documented most of the information on the assessment due to a lack of RN availability. They stated they do not possess a nursing or physician's license and should not have attempted to complete the admission assessment for this resident.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were coordinated	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1409	A. BUILDING: _____ B. WING _____	05/18/2023

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FEATHERSTONE ASSISTED LIVING COMMUNITY OF	301 NORTH EASTERN AVENUE MOORE, OK 73160

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C 542	Continued From page 3 by an RN or physician for two (#1 and #5) of eight residents whose comprehensive assessments were reviewed. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: 1. Resident #5 had diagnoses which included dementia, diabetes, and hypertension. Resident #5's comprehensive assessment, dated 02/25/23, was not signed by the resident's representative and the RN or the resident's personal physician. 2. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. An "Admission Resident Assessment" form, dated 05/02/23, was not signed by the RN or physician. On 05/17/23 at 11:15 a.m., the administrator was asked if the assessment had been signed by an RN or physician. They stated the RN had been out on sick leave for a few weeks and no one had been available to complete the assessments. They stated an RN or physician should have signed the assessments by now, but it hadn't happened yet.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the	C 543		

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	AL1409	A. BUILDING: _____ B. WING _____	05/18/2023

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C 543	Continued From page 4 person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a comprehensive assessment included a personal interview between the resident or resident's representative and the person completing the form for six (#1, 2, 3, 4, 5, and #7) of eight sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: 1. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. An "Admission Resident Assessment" form, dated 05/02/23, was not signed by the resident or resident's representative. On 05/17/23 at 11:15 a.m., the administrator was asked if the resident or the resident's representative had been interviewed regarding the assessment. The administrator stated the RN had been out on sick leave for a few weeks and no one had been available to review the assessment with the resident. They stated the resident or resident's representative should have been interviewed and signed the assessment, but	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 543	Continued From page 5 this did not happen. 2. Resident #2 had diagnoses which included vascular dementia, emphysema, and atrial fibrillation. A "14-Day Resident Assessment" form, dated 07/22/22, was not signed by the resident or the resident's representative. On 05/18/23 at 1:42 p.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or physician but should have been. 3. Resident #3 had diagnoses which included multiple sclerosis, cerebral infarction, and dementia. An "Annual Resident Assessment" form, dated 05/27/22, was not signed by the resident or the resident's representative. On 05/18/23 at 1:44 p.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or physician but should have been. 4. Resident #4 had diagnoses which included hypertension, cerebral infarction, and seizures. An "Annual Resident Assessment" form, dated 05/16/22, was not signed by the resident or the resident's representative. On 05/18/23 at 1:46 p.m., the administrator stated the assessments had not been signed to include a personal interview between the resident	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 543	Continued From page 6 or the resident's representative and the RN or physician but should have been. 5. Resident #5's comprehensive assessment, dated 02/25/23, was not signed by the resident's representative and the RN or resident's personal physician. 6. Resident #7's comprehensive assessment, dated 05/05/22, was not signed by the resident or the resident's representative. On 05/18/23 at 11:20 a.m., the administrator stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or resident's personal physician.	C 543		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a care plan was completed for two (#1 and #5) of eight sampled residents reviewed for care plan. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23,	C 552		

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C 552	Continued From page 7 documented 30 residents resided in the facility. Findings: 1. Resident #5 admitted to the center on 02/25/23, and had diagnoses which included dementia, diabetes, and hypertension. The clinical record did not contain a plan of care. On 05/18/23 at 11:20 a.m., the administrator reported the plan of care should have been completed. 2. Resident #1 had diagnoses which included Parkinson's, cataracts, and post-polio syndrome. The clinical record did not contain a plan of care. On 05/17/23 at 11:20 a.m., the administrator stated a plan of care had not been completed due to not having an RN available for the last few weeks.	C 552		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions;	C 911		

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C 911	Continued From page 8	C 911		

This Rule is not met as evidenced by:
Based on record review and interview, the center's registered nurse failed to ensure a pulse was taken daily for one (#2) of one sampled resident with an order for Digoxin medication.

The administrator stated only one resident received Digoxin medication at the center.

Findings:

1. Resident #2 had diagnoses which included vascular dementia, emphysema, and atrial fibrillation.

A physician order, dated 08/19/22, documented Digoxin 125 mcg daily, take pulse before and hold if 60 or lower.

A "March 2023 MAR," had a daily pulse documented on one of 31 opportunities.

An "April 2023 MAR," had a daily pulse documented on one of 30 opportunities.

A "May 2023 MAR," had no daily pulse documented from 05/01/23 through 05/18/23.

On 05/18/23 at 1:00 p.m., MAT #1 stated the resident's pulse had not been checked and documented daily. They stated staff have only obtained the pulse and documented in the

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C 911	Continued From page 9 medical record once monthly. On 05/18/23 at 1:40 p.m., the administrator stated they were not aware the pulse was not being checked and documented daily. They stated the problem would be addressed immediately with staff. On 05/18/23 at 2:02 p.m., MAT #2 stated having administered Digoxin to the resident daily over the last several months. They denied having checked or documented a pulse prior to administration. They stated they were not aware of the physician order, but would ensure the resident's pulse was checked prior to Digoxin administration from now on.	C 911		
C 921 SS=E	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 LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure monthly medication reviews were condcuted by the RN or pharmacy consultant monthly for seven (#2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for medication consults.	C 921		

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C 921	Continued From page 10 The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 30 residents resided in the facility. Findings: The documentation for April 2023 medication reviews for residents were not conducted. 1. Res #2's physician medication orders, dated 04/23, were not signed by an RN or pharmacy consultant. 2. Res #3's physician medication orders, dated 04/23, were not signed by an RN or pharmacy consultant. 3. Res #4's physician medication orders, dated 04/23, were not signed by an RN or pharmacy consultant. On 05/18/23 at 11:20 a.m., the administrator stated there was no monthly medication reviews conducted for April 2023.	C 921		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure a licensed	C 940		

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C 940	Continued From page 11 dietician or qualified nutritionist developed the assisted living center's diet plan. Findings: On 05/18/23 at 1:23 p.m., the dining director was asked for the menus, they provided menus written on notebook paper. The dietary manager was asked if the menus were approved by a registered dietitian. They stated "Are they supposed to be? You'll have to ask the administrator." On 05/18/23 at 1:30 p.m., the administrator was asked if the menus are approved by the registered dietitian. The administrator reported that she shows her the menus when she is in the building for consultations. The administrator was asked how often the registered dietitian is here. The administrator reported every three months.	C 940		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and first aid training for four (ACMA#1, MAT #3, CNA #1, and	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 954	Continued From page 12 CNA #2) of 21 direct care staff sampled for reviewed. Findings: On 05/17/23 at 11:35 a.m., during record review, four direct care staff employees had no documentation of CPR and first aid training. On 05/17/23 at 11:35 a.m., the administrator reported that if the paperwork is not there then they do not have it.	C 954		

OKLAHOMA
State Department
of Health

Delivery via email to: gwyn@featherstoneretirement.com

June 30, 2023

License Number: AL1409

Ms. Gwyn Gilkeson, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

RE: Survey Event BRO811

Dear Ms. Gilkeson:

On **May 18, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 25, 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: 6/28/2023** **Facility Name:** Featherstone Assisted Living **License Number:** AL 1409 **Survey Event ID:** BRO811 **Date Survey Completed: 5/18/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C-391	Based on: Based on observation and interview, the facility failed to ensure the ice machine was kept clean.

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?	Dietary staff were in-serviced on 6/1/23 regarding the cleaning of the ice machine. The Dietary staff will check ice machine daily to ensure cleanliness and clean immediately if dirty. Maintenance performed a deep clean. Maintenance will perform deep clean quarterly and as needed and will document on the "ice machine audit/schedule log".
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The audit tools and cleaning schedule will be monitored by the Administrator. Audits will be conducted on a monthly basis and randomly to assure ice machine is clean at all times.
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?	There is a cleaning schedule for the ice machine. The staff have been inserviced in how to clean and sanitize the ice machine. Dietary lead will check weekly to assure cleanliness. Maintenance Dir will check monthly to assure cleanliness. The Administrator will check monthly to assure cleanliness.
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.	Audits and Cleaning schedule will be checked monthly by Administrator. Random checks of the ice machine by Administrator, dietary staff and Maintenance will be recorded on audit/cleaning schedule. Any new dietary staff will be in-serviced how to clean and where to report if ice machine is dirty. This will be an on-going audit to ensure the ice machine stays clean daily. Evidence of these audits will be reviewed in QA.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/25/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Jimmy A Gibson MHA	**Date** 6/28/2023	6/28/2023
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.
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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: 6/28/2023
	Facility Name: Featherstone AL of Moore
	License Number: AL-1409
	Survey Event ID: BRO811
	Date Survey Completed: 5/18/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Based on record review and interview, the center failed to ensure comprehensive assessments were completed for three of eight sampled residents.

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?	An audit of all charts was completed. Of those residents who had a comprehensive assessment due, The RN is completing those assessments to get them in compliance. We have hired a new RN and the RN is interviewing the resident/responsible party in order to complete these assessments as per regulation. The audit tool will be assessed monthly to ensure no resident is without the admission assessment, the 14 day assessment and the annual assessment, or if needed, a significant change assessment.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Training was provided to the new RN and Lead ACMA(s) on when assessments are due along with who is to be involved in the assessment, i.e. the resident and whomever the resident approves to be there.
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 Administrator will audit assessments monthly to assure all assessments are in the residents chart and signed by the RN, resident/responsible party. The ACMA's will alert the RN for any significant changes in residents condition.
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 RN will audit charts monthly to assure all assessments are completed in a timely manner with resident input. Administrator will audit charts monthly to assure the resident was assessed in a timely manner. ACMA's will alert RN to any significant changes in residents condition. Significant Change assessments will be done immediately.

	This will be an on-going audit to ensure all assessments are done in a timely manner and include the resident. Evidence of these audits will be reviewed in QA.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/25/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Quinn C Gilleson LNHA	**Date** Enter a date of signature. 6/28/23

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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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: 6/28/2023** **Facility Name:** Featherstone AL of Moore **License Number:** AL-1409 **Survey Event ID:** BRO811 **Date Survey Completed: 5/18/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: c542	Based on: Based on record review and interview, the center failed to ensure assessments were coordinated by an RN or physician for two of eight residents whose comprehensive assessments were reviewed.

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?	An audit of all charts was completed. Of those residents who had a comprehensive assessment due, The RN is completing those assessments to get them in compliance. The RN is interviewing the resident/responsible party in order to complete these assessments as per regulation. The audit tool will be assessed monthly to ensure no resident is without the admission assessment, the 14 day assessment and the annual assessment, or if needed, a significant change assessment. The RN will sign every assessment when completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Training was provided to the RN and Lead ACMA(s) on who should be involved in the assessments i.e. resident and or responsible party if needed.
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?	Administrator will interview residents/responsible parties prn to assure they were involved in their assessment.
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 RN will interview residents to gather information for the assessment. The Administrator will conduct random audit to ensure residents/responsible party involved in assessments. The Audit tool will be updated as needed. This will be an ongoing audit to ensure all assessments are done in a timely manner and include the RN or physicians signature. Evidence of audit will be reviewed in QA.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/25/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	Quinn A Gilkeson MHA	**Date** Enter a date of signature.	6/28/23
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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: 6/28/2023** **Facility Name:** Featherstone AL of Moore **License Number:** AL-1409 **Survey Event ID:** BRO811 **Date Survey Completed: 5/18/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: c543	Based on: Based on record review and interview, the center failed to ensure assessments were coordinated by an RN or physician for two of eight residents whose comprehensive assessments were reviewed.

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?	An audit of all charts was completed. Of those residents who had a comprehensive assessment due, The RN is completing those assessments to get them in compliance. The RN is interviewing the resident/responsible party in order to complete these assessments as per regulation. The audit tool will be assessed monthly to ensure no resident is without the admission assessment, the 14 day assessment and the annuall assessment, or if needed, a significant change assessment. The RN will sign every assessment when completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Training was provided to the RN and Lead ACMA(s) on who should be involved in the assessments i.e. Resident and or responsible party if needed.
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?	Administrator will conduct random audit to ensure residents/responsible parties were involved in their assessment.
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 RN will interview residents to gather information for the assessment. The Administrator will interview residents and responsible parties prn to assure they were involved in their assessment. The Audit tool will be updated as needed. This will be an ongoing audit to ensure all assessments are done in a timely manner and include the RN or physicians signature. Evidence of audit will be reviewed in QA.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		8/25/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Quinn A Gilkeson MHA	**Date** Enter a date of signature.	6/28/23
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