OKLAHOMA
State Department
of Health

Delivery via email to: gwyn@featherstoneretirement.com

January 5, 2024

License Number: AL1409

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

Survey Event ID: XS2L11

Dear Ms. Gilkeson:

On **December 28, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 Services**, then **click on Long Term Care**. 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 will be completed for each violation; and
(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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual 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.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Featherstone Assisted Living Community of Moore**
Address: **301 North Eastern Avenue**
City, State, Zip: **Moore, OK, 73160**
Provider #: **AL1409**
Complaint #: **OK00060677**
Investigation Date(s): **12/27/23 through 12/28/23**

ALLEGATION(S)

The center failed to ensure qualified staff to administer medications.

An unannounced on-site investigation was initiated 12/27/2023 at 8:45 a.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

Tours of the facility were conducted upon entry and throughout the survey. Resident hallways were observed for staff assistance with resident care needs and the administration of medications. Staff were observed answering call lights in a timely manner and assisting residents. Staff were observed administering medications.

Resident medical records were reviewed including physician orders, medication administration records, progress notes, care plans, assessments, and physician progress notes. Policy and procedures were reviewed including staff qualifications and medication administration. Employee files were reviewed including training and certifications. Incident reports, including state reportable incidents were reviewed.

Residents were interviewed related to their safety and the medications they received. The residents who were interviewed reported the staff administered their medications in a timely manner according to the physicians' orders. The residents stated no adverse outcomes related to the medications they received. Staff were interviewed related to training, certifications, and medication administration policies and procedures.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/02/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Featherstone Assisted Living Community of Moore**
Address: **301 North Eastern Avenue**
City, State, Zip: **Moore, OK, 73160**
Provider #: **AL1409**
Complaint #: **OK00060968**
Investigation Date(s): **12/27/23 through 12/28/23**

ALLEGATION(S)

The facility failed to ensure residents were not physically, sexually or psychosocially abused.
The facility failed to ensure an allegation of abuse was reported to the Oklahoma State Department of Health.

An unannounced on-site investigation was initiated 12/27/2023 at 8:45 a.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

Tours of the facility were conducted upon entry and throughout the survey. Resident hallways were observed for staff assistance with resident care needs. Staff were observed answering call lights in a timely manner and assisting residents. Resident were observed participating in activities in the commons area.

Resident medical records were reviewed including physician orders, medication administration records, progress notes, care plans, assessments, and physician progress notes. Policy and procedures regarding abuse and incident reporting were reviewed. Incident reports, including state reportable incidents were reviewed.

Residents were interviewed related to their safety and the nursing care they received. The residents who were interviewed reported they felt safe from abuse in the facility. The residents stated they had not been abused by staff or other residents. Staff were interviewed related to abuse prevention, abuse detection, and incident reporting procedures.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/02/2024

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 _____	C 12/28/2023

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 Complaint investigations (#OK00060677 and #OK00060968) were conducted on 12/27/23 and 12/28/23. Facility Census: 30 Listed below are abbreviations that will be used throughout the document. ACMA - advanced certified medication aide CNA - certified nursing assistant CPR - cardiopulmonary resuscitation DON - director of nursing LTCA - long term care aide ODH - Oklahoma Department of Health OSDH - Oklahoma State Department of Health Res - resident	C 000		
C 922 SS=F	310:663-9-2(b) MEDICATION STAFFING (b) Unlicensed personnel administering medications shall have completed a training program that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure unlicensed personnel completed a training program approved by the Department for administration of medications for three (LTCA #1, 2, and #3) of 24 employees hired to assist residents with the administration of their medications.	C 922		

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C 922	Continued From page 1 The DON identified 30 residents resided in the facility. Findings: A review of the personnel files for LTCA #1, 2, and #3 revealed there was no documentation of completion of a training program approved by the Department for administration of medications. On 12/28/23 at 10:48 a.m., the administrator stated LTCA #1, 2, and #3 had not completed a training program approved by the Department for administration of medications and should not have been administering medications to residents. The administrator stated LTCA #1 had administered medications to residents during the employment dates of 03/20/22 through 12/29/22. The administrator stated LTCA #2 had administered medications to residents during the employment dates of 12/21/22 through 03/29/23. The administrator stated LTCA #3 had administered medications to residents during the employment dates of 03/13/23 through 09/06/23. .	C 922		
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.	C 954		

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

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C 954	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff received CPR and first aid training for two (ACMA #1 and ACMA #2) of five sampled staff reviewed for CPR and first aid training. The DON identified 30 residents resided in the facility. Findings: A review of the personnel files for ACMA #1 and ACMA #2 revealed no documentation of CPR or first aid training. On 12/28/23 at 9:00 a.m., the administrator was asked to provide documentation of CPR and first aid training for ACMA #1 and ACMA #2. On 12/28/23 at 9:30 a.m., the administrator stated ACMA #1 and ACMA #2 had not received CPR and first aid training yet. The administrator stated ACMA #1 and ACMA #2 should have received the training within their first week of employment.	C 954		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property;	C1912		

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C1912	Continued From page 3 (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to prepare a written incident report for an allegation of abuse one (#3)	C1912		

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C1912	Continued From page 4 of three sampled residents reviewed for abuse. The DON identified 30 residents resided in the facility. Findings: The facility "Abuse/Neglect" policy, dated 06/24/23, read in part, "...The administrator and/or designee (i.e. Nurse) will conduct the investigation through interviews of possible witnesses (staff or residents), reconstruction of staffing schedules, talking with resident who reported to have been abused, talking to the residents' attending physician (if medical treatment was required) and reviewing any pictures/video available in addition to any other relevant information. The information obtained throughout the investigation will be documented..." Resident #3 had diagnoses which included hypertension and dementia. An "Annual Resident Assessment Form", dated 08/22/23, documented Res #3 was alert, oriented to self, and confused at times. A nurse note, dated 12/25/23 at 8:01 p.m., read in part, "...This nurse was notified by CNA of resident crying. This nurse went to assess the resident. Resident and staff sitting in back area near room crying. This nurse asked questions on resident's well-being. Resident states, "He comes in my room and says he dicked me. I don't want to but he won't stop. I'm gonna kick his ass." This nurse educated staff to monitor her and ordered resident. Administrator notified. Will continue to monitor each shift..."	C1912		

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C1912	Continued From page 5 No additional documentation of the incident was found for Res #3. On 12/27/23 at 10:05 a.m., Res #3 was observed sitting on their bed. The resident stated they felt safe in the facility and had never been harmed by anyone in the facility. On 12/28/23 at 11:25 a.m., the DON stated they had written the nurse note regarding Res #3 on 12/25/23. The DON stated they had not documented an incident report and did not know if the administrator had completed one either. On 12/28/23 at 11:50 a.m., the administrator stated they had interviewed the resident, notified the family, and reviewed video surveillance after the statements made by the Res #3 on 12/25/23. The administrator stated they had not documented an incident report.	C1912		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure an allegation	C1914		

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C1914	Continued From page 6	C1914		

of abuse was reported to OSDH for one (#3) of three sampled residents reviewed for abuse.

The DON identified 30 residents resided in the facility.

Findings:

The facility "Abuse/Neglect" policy, dated 06/24/23, read in parts, "...The Administrator will make the following persons and agencies aware of the allegation: (A) The Family, (B) Oklahoma State Department of Health, (C) Chief Executive Officer, (D) Facility Nurse...A state approved incident report form (ODH form 283) will be completed as per regulations ..."

Resident #3 had diagnoses which included hypertension and dementia.

An "Annual Resident Assessment Form", dated 08/22/23, documented Res #3 was alert, oriented to self, and confused at times.

A nurse note, dated 12/25/23 at 8:01 p.m., read in part, " ...This nurse was notified by CNA of resident crying. This nurse went to assess the resident. Resident and staff sitting in back area near room crying. This nurse asked questions on resident's well-being. Resident states, "He comes in my room and says he dicked me. I don't want to but he won't stop. I'm gonna kick his ass." This nurse educated staff to monitor her and order resident. Administrator notified. Will continue to monitor each shift..."

There were no reports to OSDH for the incident documented by the facility.

On 12/27/23 at 10:05 a.m., Res #3 was observed

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C1914	Continued From page 7 sitting on their bed. The resident stated they felt safe in the facility and had never been harmed by anyone in the facility. On 12/28/23 at 11:25 a.m., the DON stated they had written the nurse note regarding Res #3 on 12/25/23. The DON stated the administrator had been notified but did not know if a report to OSDH had been submitted. On 12/28/23 at 11:50 a.m., the administrator stated they had interviewed the resident, notified the family, and reviewed video surveillance after the statements made by the Res #3 on 12/25/23. The administrator stated they did not report the incident to OSDH but should have.	C1914		
C1971 SS=D	310:663-19-4(b) POLICIES (b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the administrator or designee thoroughly investigated allegations of abuse and immediately act to rectify the problem, and make a report of the incident and its correction to the Department for one (#3) of three residents sampled for abuse.	C1971		

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C1971	Continued From page 8 The DON identified 30 residents resided in the facility. Findings: The facility "Abuse/Neglect" policy, dated 06/24/23, read in part, "...The administrator and/or designee (i.e. Nurse) will conduct the investigation through interviews of possible witnesses (staff or residents), reconstruction of staffing schedules, talking with resident who reported to have been abused, talking to the residents' attending physician (if medical treatment was required) and reviewing any pictures/video available in addition to any other relevant information. The information obtained throughout the investigation will be documented..." Resident #3 had diagnoses which included hypertension and dementia. An "Annual Resident Assessment Form", dated 08/22/23, documented Res #3 was alert, oriented to self, and confused at times. A nurse note, dated 12/25/23 at 8:01 p.m., read in part, " ...This nurse was notified by CNA of resident crying. This nurse went to assess the resident. Resident and staff sitting in back area near room crying. This nurse asked questions on resident's well-being. Resident states, "He comes in my room and says he dicked me. I don't want to but he won't stop. I'm gonna kick his ass." This nurse educated staff to monitor her and order resident. Administrator notified. Will continue to monitor each shift ..." No additional documentation of the incident was found for Res #3.	C1971		

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C1971	Continued From page 9 On 12/27/23 at 10:05 a.m., Res #3 was observed sitting on their bed. The resident stated they felt safe in the facility and had never been harmed by anyone in the facility. On 12/28/23 at 11:25 a.m., the DON stated they had written the nurse note regarding Res #3 on 12/25/23. The DON stated they had educated staff to monitor Res #3 more often. The DON stated the administrator was notified but did not know if the administrator documented an investigation of the incident. On 12/28/23 at 11:50 a.m., the administrator stated they had interviewed the resident, notified the family, and reviewed video surveillance after the statements made by the Res #3 on 12/25/23 and found no evidence of abuse. The administrator was asked to provide documentation of the investigation. The administrator stated they had not documented the investigation or corrective measures but should have.	C1971		

OKLAHOMA
State Department
of Health

Delivery via email to: skye@featherstoneretirement.com

February 23, 2024

License Number: AL1409

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

Survey Event ID: XS2L11

Dear Ms. Statum:

On **December 28, 2023,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 29, 2024**.

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, Enforcement Analyst
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: 2/15/2024** **Facility Name:** Featherstone Assisted Living Community of Moore **License Number:** AL1409 **Survey Event ID:** XS2L11 **Date Survey Completed: 12/28/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: record review, and interview, the facility failed to prepare a written incident report for an allegation of abuse 1 of 3 sampled residents that resided in the facility.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is a Plan of Correction for Featherstone Assisted Living regarding the statement of deficiencies by OSDH on the date of 12/28/2023. The Plan of Correction is not to be construed as an admission of or agreement with findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements in this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Administrator will train LPN on why and how to complete an incident report and how to conduct an investigation. Administrator will train LPN on why and how to submit a report to OSDH and APS. LPN will then complete an incident report and Aministrator will report to OSDH on resident #3. Administrator and LPN will conduct an investigation on the incident concerning resident #3. The investigation will be documented. Administrator will review incident report, the report made to OSDH, and the final investigation. F/U after reporting will include training staff on reporting Abuse, Neglect, and Mistreatment and completing Inicident reports. Training will be added to the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community were potentially affected. Administrator will complete and audit on all incident reports from 1/1/2024 to 2/15/24. And report and investigate accordingly. This audit will be added to the QA minutes. Staff and residents will be trained on Resident Rights and Abuse, Neglect, and mistreatment and who to report any allegations to. The training will be completed by the Administrator. This training will be added to the QA minutes.
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?	Staff will be trained on how and when to complete an incident report. Staff will be trained to call LPN on all incident reports. All reportable incident reports, LPN will notify the Administrator. Administrator will report to OSDH according to the required timeline and document an

	investigation. All Incident reports will be reviewed M-F by Administrator and or LPN.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	All Reportable Incidents will be tracked on a spreadsheet by the Administrator. The spreadsheet will include the date of the incident and the date it was reported to OSDH and investigation date. Administrator and LPN will review the spredahseet at the QA meetings to ensure the timeline per OSDH has been followed. These records will be kept in the front of the Incident Tracking Binder kept in the Administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/29/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye C. Statum** OAC 310:663-25-4(F)	**Date 2/15/2024**

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

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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: 2/15/2024** **Facility Name:** Featherstone Assisted Living Community of Moore **License Number:** AL1409 **Survey Event ID:** XS2L11 **Date Survey Completed: 12/28/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1914	Based on: record review, and interview, the facility failed to ensure an allegation of abuse was reported to OSDH for one of three sampled residents reviewed for abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Administrator will train LPN on why and how to complete an incident report and how to conduct an investigation. Administrator will train LPN on why and how to submit a report to OSDH and APS. LPN will then complete an incident report and Administrator will report to OSDH on resident #3. Administrator and LPN will conduct an investigation on the incident concerning resident #3. Administrator will review incident report, the report made to OSDH, and the final investigation. F/U after reporting will include training staff on reporting Abuse, Neglect, and Mistreatment and completing Inicident reports. Training will be added to the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community were potentially affected. Administrator will complete and audit on all incident reports from 1/1/2024 to 2/15/24. And report and investigate accordingly. This audit will be added to the QA minutes. Staff and residents will be trained on Resident Rights and Abuse, Neglect, and mistreatment and who to report any allegations to. The training will be completed by the Administrator. This training will be added to the QA minutes.
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?	Staff will be trained on how and when to complete an incident report. Staff will be trained to call LPN on all incident reports. All reportable incident reports, LPN will notify the Administrator. Administrator will report to OSDH according to the required timeline and document

	the investigation. All Incident reports will be reviewed M-F by Administrator and or LPN.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	All Reportable Incidents will be tracked on a spreadsheet by the Administrator. The spreadsheet will include the date of the incident and the date it was reported to OSDH and investigation date. Administrator and LPN will review the spredahseet at the QA meetings to ensure the timeline per OSDH has been followed. These records will be kept in the front of the Incident Tracking Binder kept in the Administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/29/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye C. Statum** OAC 310:663-25-4(F)	**Date 2/15/2024**

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SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1971	Based on: record review, and interview, the facility failed to ensure an allegation of abuse was reported to OSDH for one of three sampled residents reviewed for abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Administrator will train LPN on why and how to complete an incident report and how to conduct an investigation. Administrator will train LPN on why and how to submit a report to OSDH and APS. LPN will then complete an incident report and report to OSDH on resident #3. LPN will conduct an investigation on the incident concerning resident #3. Administrator will review incident report, the report made to OSDH, and the final investigation. F/U after reporting will include training staff on reporting Abuse, Neglect, and Mistreatment and completing Inicident reports. Training will be added to the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community were potentially affected. Administrator will complete and audit on all incident reports from 1/1/2024 to 2/15/24. And report and investigate accordingly. This audit will be added to the QA minutes. Staff and residents will be trained on Resident Rights and Abuse, Neglect, and mistreatment and who to report any allegations to. The training will be completed by the Administrator. This training will be added to the QA minutes.
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?	Staff will be trained on how and when to complete an incident report. Staff will be trained to call LPN on all incident reports. All reportable incident reports, LPN will notify the Administrator. Administrator and or LPN will report to OSDH according to the required timeline. All Incident reports will be reviewed M-F by Administrator and or LPN.

OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	All Reportable Incidents will be tracked on a spreadsheet by the Administrator. The spreadsheet will include the date of the incident and the date it was reported to OSDH and investigation date. Administrator and LPN will review the spredahseet at the QA meetings to ensure the timeline per OSDH has been followed. These records will be kept in the front of the Incident Tracking Binder kept in the Administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/29/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye C. Statum** OAC 310:663-25-4(F)	**Date 2/15/2024**

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SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C922	Based on: record review, and interview, the facility failed to ensure unlicensed personnel completed a training program approved by the Department for administration of medications for three of the 24 employees hired to assist residents with the administration of their medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Administrator will complete an audit on all employees that administer medication. Any employees that have not completed current, up to date, training approved by OSDH will be removed off medication cart. The Audit will be reviewed by the Health & Wellness Director and be placed with the monthly QA minutes. The administrator will check the credentials/training of all new hires prior to starting work. This documentation of current credentials will be added to the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any Residents that receive medications by facility staff residing in community were potentially affected. A print out of all residents that receive medications by facility staff will be printed out and reviewed by LPN and Administrator. This documentation will be added to the QA minutes.
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 check the credentials/training of all new hires prior to starting work. This documentation of current credentials will be signed off by LPN and Administrator and added to the QA minutes.
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;	The facility administrator will create and maintain a employee spreadsheet with credetnials and dates of expirations. This spreadsheet will be reviewed and signed off on by Administrator and LPN at each QA minutes. Employees will be giving a 30 day notice of expiration date

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.	of training and if training is not kept current the employee will be removed off medication cart. The effectiveness of the monitoring the spreadsheet and giving the employee a 30 day notice of expiration date will be evaluated during the QA minutes and documented. The documents will be kept current. The documents will be kept in a Credential binder in the Administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/29/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye C. Statum** OAC 310:663-25-4(F)	**Date 2/15/2024**

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SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C954	Based on: record review, and interview, the facility failed to ensure direct care staff received CPR and first aid training for two ACMA staff out of five sampled staff.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is a Plan of Correction for Featherstone Assisted Living regarding the statement of deficiencies by OSDH on the date of 12/28/2023. The Plan of Correction is not to be construed as an admission of or agreement with findings and conclusions in the statement of deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements in this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Administrator will complete an audit on all direct care staff CPR/ first aide training. Any employees that have not completed current, up to date, training will be removed from the schedule until training is completed. The Audit will be reviewed by the Health & Wellness Director and be placed with the monthly QA minutes. The administrator will check the credentials/training of all new hires prior to starting work. The facility will offer CPR/First Aide training to all new staff prior to being placed on the schedule. This documentation of current credentials will be added to the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community were potentially affected. A resident rooster will be kept current and remain in the State Binder kept in the administrators office. Another copy of the resident rooster will be added to the QA minutes.
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 check the credentials/training of all new hires prior to starting work. Any new direct care staff hired without CPR/First aide training will be offered training by facility prior to being placed on schedule. This documentation of current credentials/training will be added to a staff spreadsheet that will include expiration date of training. Employees will be offered CPR/First Aide training prior to the expiration date and or yearly. The spreasheet will be reviewed by the Administrator and LPN and added to the QA meeting.

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 facility administrator will create and maintain a employee spreadsheet with CPR/First aide training and dates of expirations. This spreadsheet will be reviewed and signed off on by Administrator and LPN during the QA meetings. Employees will be giving a 30 day notice of expiration date of training and if training is not kept current the employee will be removed off schedule. Facility will offer CPR/First Aide training for new hires and yearly. The effectiveness of the monitoring the spreadsheet and giving the employee a 30 day notice of expiration date will be evaluated during the QA minutes and documented. The documents will be kept current. The documents will be kept in a Credential binder in the Administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/29/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Skye C. Statum OAC 310:663-25-4(F)	**Date 2/15/2024**

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