
Delivery via email to: erin@featherstoneretirement.com

December 11, 2025

License Number: AL1409

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

RE: Survey Event ID: IQG211

Dear Ms. Davis:

On **November 6, 2025**, 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 **November 6, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 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 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 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 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Featherstone Assisted Living Community
Address: 301 North Eastern Avenue
City, State, Zip: Moore, OK, 73160
Provider #: AL1409
Complaint #: OK00068275
Investigation Date(s): 11/03/25, 11/05/25 – 11/06/25

ALLEGATION(S)
The center failed to ensure adequate supervision was provided to prevent accidents.
The center failed to ensure the residents were provided a comfortable temperature.
The center failed to have an administrator on-site.
The center failed to ensure residents were given a choice of physician, hospice, or home health services.

An unannounced on-site investigation was initiated 11/03/2025 at 12:45 p.m.

A sample of 8 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:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Resident halls, rooms, and common areas were observed for defects and accident risk. Residents observed moving about the center. Room and common area temperatures were checked. Administrator on site at time of entrance.

Resident records were reviewed including assessments, care plans, physician orders, nurse notes, medication administration records were reviewed. Facility policy and procedures and grievances were reviewed. State reports and incidents were reviewed.

Residents were interviewed related to the provision of safety, facility temperature, access to the administrator, and choices.

Staff were interviewed regarding the provision of resident safety, room temperature regulations and facility temperature, and administration.

The attached State form, Statement of Deficiencies, 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: 11/13/2025

INVESTIGATIVE REPORT

Facility: Featherstone Assisted Living Community
Address: 301 North Eastern Avenue
City, State, Zip: Moore, OK, 73160
Provider #: AL1409
Complaint #: OK00081189
Investigation Date(s): 11/03/25, 11/05/25 – 11/06/25

ALLEGATION(S)
The center failed to provide a safe environment with equipment and structure in safe order.
The center failed to ensure medications were not administered with a physician's order.
The center failed to ensure residents were not involuntarily secluded by denying access from exit doors.
The center failed to ensure staff had access to administration.

An unannounced on-site investigation was initiated 11/03/2025 at 12:45 p.m.

A sample of 8 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:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Resident halls, rooms, and common areas were observed for defects. Residents observed moving about the center both going in and out. Medication administration was observed. Administrator on site at time of entrance.

Resident records were reviewed including assessments, care plans, physician orders, nurse notes, medication administration records were reviewed. Facility policy and procedures and grievances were reviewed. State reports and incidents were reviewed.

Residents were interviewed related to the provision of their medication, facility structure, administration availability, and leaving and entering the building.

Staff were interviewed related to the provision of maintenance, medications, exiting the facility and administration.

The attached State form, Statement of Deficiencies, 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: 11/13/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160		
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C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00068275 and #OK00081189) was conducted from 11/03/25, and 11/05/25 through 11/06/25. Deficiencies were cited as a result of this survey. Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide CNA - certified nursing assistant DON - director of nursing L/MIN - liters per minute NC - nasal cannula OSDH - Oklahoma State Department of Health PPM - parts per million SOB - shortness of breath SPO2- peripheral oxygen saturation	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, record review, and interview, the facility failed to ensure: a. hand hygiene was implemented while plating food during meal service, b. hair nets were worn while in the kitchen, c. food was labeled and dated in the refrigerator, and	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 d. daily verification of the dishwasher sanitization ppm was conducted. The administrator identified 30 residents ate from the kitchen. Findings: On 11/03/25 at 2:34 p.m., during the initial tour of the kitchen, the following items were found in the refrigerator: a. One Ziploc bag with three and a half blocks of orange cheese with no label or date, and b. One Ziploc bag of partially used smoked sausage with no date. On 11/03/25 at 2:40 p.m., the cook director was observed not wearing a hair net while cutting potatoes. On 11/05/25 at 11:40 a.m., an unlabeled form, dated "July 2025," at the top, had dates of the month on it. The form was located on the wall next to the dishwasher. The form showed ppm's on it for the month of July 2025. The form had not been completed after 07/20/25. A policy titled "Employee Hygiene in the Kitchen," dated 11/2022, read in part, "Employees must keep hair from contacting exposed food, clean equipment, utensils and linens." A policy titled "Food safety," dated 11/2022, read in part, "Food will be served in such a way as to prevent growth of bacteria."..."disinfection of utensils will be monitored." A policy titled "Storage of Refrigerated and Dry	C 391			

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C 391	Continued From page 2 Foods," dated 11/2022, read in part, "All containers must be labeled with the contents and date food item was placed in storage." On 11/03/25 at 2:43 p.m., the cook director stated the policy was to wear hair nets and they were caught On 11/03/25 at 2:44 p.m., the cook director stated the policy for food storage was to date from when it was made or opened. On 11/05/25 at 11:42 a.m., the cook director stated the form on the wall was for the dishwasher chemicals and they did not know how often the dishwasher ppm for sanitization should be performed. The cook director stated they were not taught. The cook director stated the dishwasher ppm monitoring was not current. On 11/05/25 at 11:49 a.m., meal service started with the cook wearing gloves. The cook was observed to perform the following. a. at 11:52 a.m., the cook went from the the steam table prepping the trays, b. to putting the rolls in the oven, touching surfaces of the pan, and refrigerator, c. wiped down the counter with a rag, adjusted their apron, opened the oven and touched the rolls, and d. returned to the service line and passed two trays. There was no observation of changing gloves or washing hands between surfaces or food. With the same gloves on, the cook left the service line again to get a glass of milk and plated three more plates and touched a cutting board and knife and checked the rolls in the oven. e. at 11:57 a.m., the cook then removed soup from the microwave and plated it and served it. They then checked the rolls in the oven with the	C 391		

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C 391	Continued From page 3 same gloved hands and removed them from the oven, applied butter to them and put them in a pan with the same gloved hands and placed on the steam table. f. at 11:58 a.m., the cook was observed to resume plating with the same gloves and used hands to lay the chicken on the plate, touched the rolls with gloved hand again. On 11/05/25 at 12:12 p.m. the cook stated the policy and procedure for hand hygiene was to change gloves when going to grab something else. They stated they did not change gloves after touching food and surfaces.	C 391		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history.	C 532		

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C 532	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident assessment accurately reflected the resident status for 1 (#1) of 8 sampled residents reviewed for assessment accuracy. The administrator identified 30 residents resided in the facility. Findings: On 11/05/25 at 10:28 a.m., Resident #1 was observed wearing oxygen via nasal cannula from a concentrator set a 3 liters. A policy titled "OSHD Approved Assessment," dated 11/2022, read in part, "1. This form will be used for nursing assessments of the Resident." A "Transfer/Discharge Report," dated 08/19/25, showed Resident #1 had diagnoses of congestive heart failure and shortness of breath. A physician order, dated 08/04/25, read in part, "Oxygen at 2-4 l/min NC continuously for SOB, May titrate as needed to keep SPO2 above 90% every shift for SOB." An "OSDH Recommended Assisted Living Resident Assessment Form," dated 08/19/25, did not show Resident #1 required the use of oxygen. On 11/05/25 at 11:11 a.m., the DON stated Resident #1 used oxygen as needed and did not wear the oxygen when came out of room at times per their discretions.	C 532		

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C 532	Continued From page 5 On 11/06/25 at 12:32 p.m., the DON stated they did an assessment on Resident #1 when they returned from the skilled facility on 08/19/25 to see how much help they would need. The DON stated they did not see the oxygen noted on the assessment.	C 532		
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 facility failed to ensure a resident's service plan was updated upon return from another facility to reflect their service level needs for 1 (#1) of 8 sampled residents whose service plans were reviewed. The administrator identified 30 residents resided at the facility. Findings: On 11/05/25 at 10:28 a.m., Resident #1 was observed wearing oxygen via nasal cannula from a concentrator set a 3 liters. A policy titled "Assistance/Service Plan," dated	C 552		

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C 552	Continued From page 6 11/2022, read in part, "1. An assistance/service plan will be completed." Resident #1's service plan, updated on 08/15/23, and did not show the use of oxygen. A physician order, dated 08/04/25, read in part, "Oxygen at 2-4 l/min NC continuously for SOB, May titrate as needed to keep SPO2 above 90% every shift for SOB." A "Transfer/Discharge Report," dated 08/19/25, showed Resident #1 had diagnoses of congestive heart failure and shortness of breath. On 11/06/25 at 12:27 p.m., the DON stated they had not done a service plan when Resident #1 returned to the facility.	C 552			
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.	C 711			

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C 711	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an annual fire marshal inspection was conducted for 2025. The administrator identified 30 residents resided in the facility. Findings: A document titled "Inspection Report," dated 09/04/24, showed a fire marshal inspection date of 09/04/24. There was no documentation a fire marshall inspection had been conducted in 2025. On 11/05/25 at 2:10 p.m., the maintenance director stated they had provided all they could find.	C 711		
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, the facility failed to have a licensed dietician or qualified nutritionist to address the needs of residents. The administrator identified 30 residents resided in the facility.	C 940		

Oklahoma State Department of Health

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C 940	Continued From page 8 Findings: Review of the menus showed dietician signature on them. There were no identified weight loss or gain concerns during survey. On 11/05/25 at 9:20 a.m., the administrator stated they did not know how long they had gone without a dietician and they had a signed contract with a dietician to start today. The administrator stated they had someone with corporate doing the menus but did not have anyone looking at the diets and weight loss.	C 940		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a physician order for oxygen usage from the transfer/discharge orders were transcribed upon readmission for 1 (#1) of 8 sampled residents reviewed for receiving medications as prescribed. The administrator identified 30 residents resided in the facility. Findings:	C1921		

Oklahoma State Department of Health

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C1921	Continued From page 9 On 11/05/25 at 10:28 a.m., Resident #1 was observed wearing oxygen via nasal cannula from a concentrator set a 3 liters. A "Transfer/Discharge Report," dated 08/19/25, showed Resident #1 had diagnoses of congestive heart failure and shortness of breath. A physician order dated 08/04/25, read in part, "Oxygen at 2-4 l/min NC continuously for SOB, May titrate as needed to keep SPO2 above 90% every shift for SOB." Review of Resident #1's active orders did not show the use of oxygen. On 11/06/25 at 12:32 p.m., the DON stated they did not see an order for oxygen at admission.	C1921			
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 2 (CNA #1 and ACMA #1) of 5 sampled employees whose records were	C1972			

Oklahoma State Department of Health

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C1972	Continued From page 10 reviewed for abuse training. The administrator identified 30 residents resided in the facility. Findings: The employee file for CNA #1 showed a hire date of 06/18/24. There was no documentation to show abuse training had been done within 90 days of hire. The employee file for ACMA #1 showed a hire date of 11/01/24. There was no documentation to show abuse training had been done within 90 days of hire. On 11/05/25 at 2:04 p.m., the administrator stated they were unable to locate the abuse training on hire from that far back for CNA #1 and ACMA #1.	C1972		

Delivery via email to: erin@featherstoneretirement.com

January 9, 2026

License Number: AL1409

Erin Davis, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

RE: Survey Event IQG211

Dear Ms. Davis:

On **November 6, 2025**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C0940:** The plan of correction does not address QA.

Please provide a new plan of correction as soon as possible.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00068275 and #OK00081189) was conducted from 11/03/25, and 11/05/25 through 11/06/25. Deficiencies were cited as a result of this survey. Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide CNA - certified nursing assistant DON - director of nursing L/MIN - liters per minute NC - nasal cannula OSDH - Oklahoma State Department of Health PPM - parts per million SOB - shortness of breath SP02- peripheral oxygen saturation	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, record review, and interview, the facility failed to ensure: a. hand hygiene was implemented while plating food during meal service, b. hair nets were worn while in the kitchen, c. food was labeled and dated in the refrigerator, and	C 391		

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 d. daily verification of the dishwasher sanitization ppm was conducted. The administrator identified 30 residents ate from the kitchen. Findings: On 11/03/25 at 2:34 p.m., during the initial tour of the kitchen, the following items were found in the refrigerator: a. One Ziploc bag with three and a half blocks of orange cheese with no label or date, and b. One Ziploc bag of partially used smoked sausage with no date. On 11/03/25 at 2:40 p.m., the cook director was observed not wearing a hair net while cutting potatoes. On 11/05/25 at 11:40 a.m., an unlabeled form, dated "July 2025," at the top, had dates of the month on it. The form was located on the wall next to the dishwasher. The form showed ppm's on it for the month of July 2025. The form had not been completed after 07/20/25. A policy titled "Employee Hygiene in the Kitchen," dated 11/2022, read in part, "Employees must keep hair from contacting exposed food, clean equipment, utensils and linens." A policy titled "Food safety," dated 11/2022, read in part, "Food will be served in such a way as to prevent growth of bacteria."..."disinfection of utensils will be monitored." A policy titled "Storage of Refrigerated and Dry	C 391			

Oklahoma State Department of Health

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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 2 Foods," dated 11/2022, read in part, "All containers must be labeled with the contents and date food item was placed in storage." On 11/03/25 at 2:43 p.m., the cook director stated the policy was to wear hair nets and they were caught On 11/03/25 at 2:44 p.m., the cook director stated the policy for food storage was to date from when it was made or opened. On 11/05/25 at 11:42 a.m., the cook director stated the form on the wall was for the dishwasher chemicals and they did not know how often the dishwasher ppm for sanitization should be performed. The cook director stated they were not taught. The cook director stated the dishwasher ppm monitoring was not current. On 11/05/25 at 11:49 a.m., meal service started with the cook wearing gloves. The cook was observed to perform the following. a. at 11:52 a.m., the cook went from the the steam table prepping the trays, b. to putting the rolls in the oven, touching surfaces of the pan, and refrigerator, c. wiped down the counter with a rag, adjusted their apron, opened the oven and touched the rolls, and d. returned to the service line and passed two trays. There was no observation of changing gloves or washing hands between surfaces or food. With the same gloves on, the cook left the service line again to get a glass of milk and plated three more plates and touched a cutting board and knife and checked the rolls in the oven. e. at 11:57 a.m., the cook then removed soup from the microwave and plated it and served it. They then checked the rolls in the oven with the	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 3 same gloved hands and removed them from the oven, applied butter to them and put them in a pan with the same gloved hands and placed on the steam table. f. at 11:58 a.m., the cook was observed to resume plating with the same gloves and used hands to lay the chicken on the plate, touched the rolls with gloved hand again. On 11/05/25 at 12:12 p.m. the cook stated the policy and procedure for hand hygiene was to change gloves when going to grab something else. They stated they did not change gloves after touching food and surfaces.	C 391			
✓ C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history.	C 532			

E. J. Davis

12.12.25

Oklahoma State Department of Health

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C 532	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident assessment accurately reflected the resident status for 1 (#1) of 8 sampled residents reviewed for assessment accuracy. The administrator identified 30 residents resided in the facility. Findings: On 11/05/25 at 10:28 a.m., Resident #1 was observed wearing oxygen via nasal cannula from a concentrator set a 3 liters. A policy titled "OSHD Approved Assessment," dated 11/2022, read in part, "1. This form will be used for nursing assessments of the Resident." A "Transfer/Discharge Report," dated 08/19/25, showed Resident #1 had diagnoses of congestive heart failure and shortness of breath. A physician order, dated 08/04/25, read in part, "Oxygen at 2-4 l/min NC continuously for SOB, May titrate as needed to keep SPO2 above 90% every shift for SOB." An "OSDH Recommended Assisted Living Resident Assessment Form," dated 08/19/25, did not show Resident #1 required the use of oxygen. On 11/05/25 at 11:11 a.m., the DON stated Resident #1 used oxygen as needed and did not wear the oxygen when came out of room at times per their discretions.	C 532		

Oklahoma State Department of Health

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C 532	Continued From page 5	C 532		
C 552 SS=D	On 11/06/25 at 12:32 p.m., the DON stated they did an assessment on Resident #1 when they returned from the skilled facility on 08/19/25 to see how much help they would need. The DON stated they did not see the oxygen noted on the assessment. 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 facility failed to ensure a resident's service plan was updated upon return from another facility to reflect their service level needs for 1 (#1) of 8 sampled residents whose service plans were reviewed. The administrator identified 30 residents resided at the facility. Findings: On 11/05/25 at 10:28 a.m., Resident #1 was observed wearing oxygen via nasal cannula from a concentrator set a 3 liters. A policy titled "Assistance/Service Plan," dated	C 552		

E. J. Davis

Oklahoma State Department of Health

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C 552	Continued From page 6 11/2022, read in part, "1. An assistance/service plan will be completed." Resident #1's service plan, updated on 08/15/23, and did not show the use of oxygen. A physician order, dated 08/04/25, read in part, "Oxygen at 2-4 l/min NC continuously for SOB, May titrate as needed to keep SPO2 above 90% every shift for SOB." A "Transfer/Discharge Report," dated 08/19/25, showed Resident #1 had diagnoses of congestive heart failure and shortness of breath. On 11/06/25 at 12:27 p.m., the DON stated they had not done a service plan when Resident #1 returned to the facility.	C 552		
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.	C 711		

E. Davis

Oklahoma State Department of Health

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C 711	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an annual fire marshal inspection was conducted for 2025. The administrator identified 30 residents resided in the facility. Findings: A document titled "Inspection Report," dated 09/04/24, showed a fire marshal inspection date of 09/04/24. There was no documentation a fire marshall inspection had been conducted in 2025. On 11/05/25 at 2:10 p.m., the maintenance director stated they had provided all they could find.	C 711			
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, the facility failed to have a licensed dietician or qualified nutritionist to address the needs of residents. The administrator identified 30 residents resided in the facility.	C 940			

Eri Davis

Oklahoma State Department of Health
STATE FORM C

6809

IQG211

12.12.25

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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C1921	Continued From page 9 On 11/05/25 at 10:28 a.m., Resident #1 was observed wearing oxygen via nasal cannula from a concentrator set a 3 liters. A "Transfer/Discharge Report," dated 08/19/25, showed Resident #1 had diagnoses of congestive heart failure and shortness of breath. A physician order dated 08/04/25, read in part, "Oxygen at 2-4 l/min NC continuously for SOB, May titrate as needed to keep SPO2 above 90% every shift for SOB." Review of Resident #1's active orders did not show the use of oxygen. On 11/06/25 at 12:32 p.m., the DON stated they did not see an order for oxygen at admission.	C1921		
G1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 2 (CNA #1 and ACMA #1) of 5 sampled employees whose records were	C1972		

E. J. Davis

Oklahoma State Department of Health

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C1972	Continued From page 10 reviewed for abuse training. The administrator identified 30 residents resided in the facility. Findings: The employee file for CNA #1 showed a hire date of 06/18/24. There was no documentation to show abuse training had been done within 90 days of hire. The employee file for ACMA #1 showed a hire date of 11/01/24. There was no documentation to show abuse training had been done within 90 days of hire. On 11/05/25 at 2:04 p.m., the administrator stated they were unable to locate the abuse training on hire from that far back for CNA #1 and ACMA #1.	C1972		

E. Davis

12.12.25

C940

The rule is not met as evidenced by:

Based on observation, record review and interview, the facility failed to have a licensed dietitian or qualified nutritionist to address the needs of residents.

All staff was in-serviced on 11-7-2025 on the importance of having a licensed dietitian available to address the needs of the residents.

The RDN, DON, and ED will meet monthly on residents for 3 months to ensure proper documentation is established. The facility will conduct audits for 6 months to ensure all residents are reviewed quarterly by the RDN.

An audit will be completed on all residents to ensure they have appropriate documentation from the RDN.

C711

The rule is not met as evidenced by:

Based on record review and interviews, the facility failed to ensure an annual fire marshall inspections was conducted for 2025.

An in-service was completed on 11.7.25 with all the maintenance staff to to educate on the importance of having the fire marshall out to complete annual inspections.

The fire marshall was contacted to complete the inspection.

The date of the inspection was _____.

An audit will be quarterly to ensure the facility remains consistent with the timeline of an annual fire marshall inspection.

The findings of the annual inspections will be discussed in QA meetings.

C1972

The rule is not met as evidenced by:

Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire.

All staff was educated with an in-service on 11/7/2025 regarding abuse training within the first 90 days of employment.

An all staff audit was conducted to ensure all staff had abuse training.

Abuse training was added to the new hire packet and will be completed upon new hire orientation.

An audit on abuse training will be completed weeklyx4, monthlyx3, and discussed in QA meetings for 6 months.

C391

The rule is not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure: proper hand hygiene was implemented while plating food, proper hair net(s) usage was implemented, food was appropriately labeled and dated when being stored in the refrigerator, and daily verification of the dishwasher sanitization ppm was conducted.

All dietary staff was in-serviced on 11-7-2025 on appropriate usage of hair net(s), proper hand hygiene, appropriate labeling and storage of refrigerated foods and daily verification of the dishwasher sanitization ppm.

Audits of appropriate hand hygiene, proper hair net(s) usage, labeling and storage of refrigerated food, and daily verification of the dishwasher sanitization ppm will be conducted weeklyx4, monthlyx3, and discussed in QA meetings for 6 months.

C532

The rule is not met as evidenced by:

Based on record review, and interview, the facility failed to ensure a resident assessment accurately reflects the resident status for 1 of 9 sampled residents reviewed for assessment accuracy.

An in-service was completed on 11.7.25 with all staff to educate on the importance of the comprehensive assessment, what should be included in it and the timeline to have it completed.

All current residents will have charts audited to ensure the comprehensive assessment is present and complete.

An audit will be completed weeklyx4, monthlyx3, and discussed in QA meetings for 6 months.

C552

The rule is not met as evidenced by:

Based on record review and interviews, the facility failed to ensure resident service plan was updated upon return from another facility to reflect their service level needs for 1 of 8 sampled residents whose service plans were reviewed.

An in-service was completed on 11.7.25 with all staff to educate on the need for physician orders and using your assessment findings to develop the plan of care.

All current residents will have charts audited to ensure the all doctor's orders, care plans, and assessments were completed and correct.

An audit will be completed weeklyx4, monthlyx3, and discussed in QA meetings for 6 months.

C1921

The rule is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to physician orders for oxygen usage from transfer/discharge orders were transcribed upon re-admissions for 1 of 8 sampled residents reviewed for receiving medications as prescribed.

An in-service was completed on 11.7.25 pertaining to medications and following physician orders.

All residents were assessed and medications were reviewed to ensure their safety.

An audit completed on all residents and their physician orders reviewed to ensure they are all complete and transcribed correctly.

An audit will be completed weeklyx4, monthlyx3, and discussed in QA meetings for 6 months.

Delivery via email to: erin@featherstoneretirement.com

January 13, 2026

License Number: AL1409

Erin Davis, Administrator
Featherstone Assisted Living Community Of Moore
301 North Eastern Avenue
Moore, OK 73160

RE: Survey Event IQG211

Dear Ms. Davis:

On **November 6, 2025**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. The amended plan of correction you submitted is not acceptable for the following reasons:

- **C0940:** The plan of correction does not address QA.

Please provide a new plan of correction and return as soon as possible.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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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, record review, and interview, the facility failed to ensure: a. hand hygiene was implemented while plating food during meal service, b. hair nets were worn while in the kitchen, c. food was labeled and dated in the refrigerator, and	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

IQG211

If continuation sheet 1 of 11

E. J. Davis

12.12.25

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1409	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/06/2025
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF		STREET ADDRESS, CITY, STATE, ZIP CODE 301 NORTH EASTERN AVENUE MOORE, OK 73160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 391	Continued From page 1 d. daily verification of the dishwasher sanitization ppm was conducted. The administrator identified 30 residents ate from the kitchen. Findings: On 11/03/25 at 2:34 p.m., during the initial tour of the kitchen, the following items were found in the refrigerator: a. One Ziploc bag with three and a half blocks of orange cheese with no label or date, and b. One Ziploc bag of partially used smoked sausage with no date. On 11/03/25 at 2:40 p.m., the cook director was observed not wearing a hair net while cutting potatoes. On 11/05/25 at 11:40 a.m., an unlabeled form, dated "July 2025," at the top, had dates of the month on it. The form was located on the wall next to the dishwasher. The form showed ppm's on it for the month of July 2025. The form had not been completed after 07/20/25. A policy titled "Employee Hygiene in the Kitchen," dated 11/2022, read in part, "Employees must keep hair from contacting exposed food, clean equipment, utensils and linens." A policy titled "Food safety," dated 11/2022, read in part, "Food will be served in such a way as to prevent growth of bacteria."..."disinfection of utensils will be monitored." A policy titled "Storage of Refrigerated and Dry	C 391			