



Oklahoma State Department of Health
Creating a State of Health

January 16, 2020

License Number: AL6202

Ms. Linda Coffelt, Administrator
Featherstone Assisted Living Community Of Ada
1501 North Monte Vista
Ada, OK 74820

RE: Survey Event ID: R2YJ11

Dear Ms. Coffelt:

On January 9, 2020, 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 January 9, 2020.

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;

Board of Health

Gary Cox, JD
Commissioner of Health

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(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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

The facility must submit the completed IDR Request Form and supporting documentation

under separate cover to:

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

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

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

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

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

Sincerely,



 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/09/2020
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNI		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 NORTH MONTE VISTA ADA, OK 74820		
(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 re-licensure survey was conducted on 01/06/20 through 01/09/20. Current census was 29. The following deficiencies were cited.	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, interview, and record review, it was determined the center failed to ensure compliance with chapter 257 Food Service Establishment Regulations in regards to: a. Person in charge; b. Thawing meat; and c. Warewashing chemical sanitation. 310:257-3 Person in charge The person in charge shall ensure that: (9) Employees are properly sanitizing cleaned multiuse equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, and chemical concentration, pH, temperature, and exposure time for chemical sanitizing; (12) Employee are properly trained in food safety.	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 1 310:257-5-56 Thawing Food shall be thawed (2) Completely submerged under running water: (A) At a water temperature of 21 degrees C (70 degrees F) or below, (B) With sufficient water velocity to agitate and float off water particles in an overflow. 310:257-7-75 Manual and mechanical warewashing equipment, chemical sanitization-temperature, pH, concentration, and hardness (A) Chemical sanitizer used in a sanitizing solution for a manual or mechanical operation shall be used in accordance with the manufacturers label. These failed practices had the potential for more than minimal harm for all 29 residents who received their nutrition from the kitchen. Findings: On 01/08/20 at 2:00 p.m., a tour of the kitchen was conducted and the following was found: PERSON IN CHARGE Cook #1 in charge of the kitchen at the time of the kitchen observation was not aware of proper thawing procedures or how to check the warewashing machine to ensure the dishes were being sanitized correctly. THAWING MEAT A partially frozen raw loaf of hamburger meat was thawing in the sink with drips of warm water running over the meat. The temperature of the	C 391		

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C 391	Continued From page 2 water dripping over the meat was 98.0 degrees Fahrenheit (F). At 2:29 p.m., cook #1 stated she was thawing the hamburger meat for chili for supper. The cook stated she had warm water dripping over the hamburger meat to thaw it for the evening meal. She stated she was unaware of the proper way to thaw the meat under running water. WAREWASHING SANITATION A dish machine had an data processing plate that indicated the dish machine used a chemical sanitizing agent to sanitize the dishes. The plate indicated the the water temperature should meet 125.0 degrees F minimum and chlorine residual 50 parts per million (ppm). The dish machine chemical concentration form, dated 01/01/20 through 01/08/20, documented 100-110 at various times throughout the day. Cook #1 stated the 100 and 110 documented on the form was the temperature of the water in the dish machine. At 2:05 p.m., cook #1 stated she did not know how to test the sanitation solution. She stated she ensured the soap and sanitizer solutions were filled. The dish machine was checked and the chemical concentration was 200 ppm. (Low temperature machines using chlorine as a chemical sanitizer should have a concentration between 50 ppm and 100 ppm.) Cook #1 stated the water temperature was a little over a 100 degrees. She stated the temperature was not hot enough and the chemical concentration was higher than 50 to 100 ppm. POLICY	C 391		

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C 391	Continued From page 3 A dietary policy, dated 03/2019, documented, "...Methods for Thawing Food...Submerging in running water...Food being thawed by running water must be completely submerged in running water...Water temperature used to thaw must be no greater than 70 degrees Fahrenheit.." A food safety policy, dated 03/2019, documented, "...All staff will be aware of proper handling of dirty and clean utensils...Temperatures and disinfection of utensils will be monitored..."	C 391		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally	C1505		

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C1505	Continued From page 4 incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to follow physician ordered wound care for 1 (#2) of 1 sampled resident with documented wounds. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 A physician's order for resident #2, dated 01/06/20, documented to apply Bacitracin (ointment used to prevent skin infections) to his left ear lobe and left wrist wounds twice a day until healed, cover the left wrist with a Band-Aid during day hours, and leave open to air at bedtime. On 01/06/19 at 2:00 p.m., licensed practical nurse (LPN) #1 stated resident #2 had scabbed areas from previous cancer/radiation sites which he picked on his ear lobe and wrist. She stated the resident had new orders for wound care to be done twice a day. On 01/08/20 at 11:55 a.m., resident #2's left ear lobe and wrist had black scabbed areas on them. LPN #1 cleansed the resident's left ear lobe and wrist with normal saline, applied Muprion (used to treat certain skin infections) 2% ointment and covered the wrist with a Band-Aid. She stated she knew she did not use the correct ointment ordered by the physician. LPN #1 also stated she used the Muprion ointment for the dressing change on 01/07/19 because she could not find the Bacitracin. LPN #1 did not use the correct	C1505		

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C1505	Continued From page 5 ointment for the dressing change on 01/07/20 or 01/08/20. POLICY A medication policy, dated 03/2019, documented, "...Only prescribed medications may be stored and administered to residents..."	C1505		
C1507 SS=E	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to provide an effective pest control service to prevent bed bugs for 1 (#1) of 1 sampled resident who had live bed bugs in her apartment. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1's apartment had been treated for bed bugs on 10/29/19, 11/22/19 and 12/30/19.	C1507		

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C1507	Continued From page 6 On 01/06/20 at 1:30 p.m., the administrator stated the center had recently sprayed resident #1's apartment for bed bugs. She stated she was unsure if the resident had any live bed bugs at this time. At 2:00 p.m., licensed practical nurse (LPN) #1 stated she had seen a live bed bug in resident #1's apartment over the past weekend. On 01/07/20 at 12:14 p.m., resident #1's apartment was observed for bed bugs with the administrator and housekeeper #1. When removing the pillow cases and bed spreads; three live bed bugs were found crawling on the bed. At 2:00 p.m., the administrator reviewed the pest control log and agreed the pest control was not effective if the apartment had been sprayed for bed bugs the past three months and the resident continued to have bed bugs. At 2:35 p.m., resident #1 stated she had seen bed bugs since the exterminator had sprayed her apartment. She stated she had one area on her neck that itched and she thought it was a bite. Upon observation, there was one raised pink area on resident #1's back left side of her neck. A pest policy, dated 03/2019, documented, "...If a bed bug is seen, alive or dead, the Executive Director must be notified immediately...The pest control company will be notified immediately..."	C1507		

STATE WORKLOAD REPORT

Provider/Supplier Number AL6202	Provider/Supplier Name FEATHERSTONE ASSISTED LIVING COMMUNITY OF ADA
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Type of Survey (select all that apply)

☒ 2 ☐ ☐ ☐ ☐

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

Extent of Survey (select all that apply)

☒ A ☐ ☐ ☐ ☐

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.  36191	01/06/2020	01/09/2020	1.00	0.00	20.75	0.00	11.50	6.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

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

0.00

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

JAN 21 2020





Oklahoma State Department of Health
Creating a State of Health

January 29, 2020

License Number: AL6202

Ms. Linda Coffelt, Administrator
Featherstone Assisted Living Community Of Ada
1501 North Monte Vista
Ada, OK 74820

RE: Survey Event R2YJ11

Dear Ms. Coffelt:

On January 9, 2020, 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 **February 26, 2020**.

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

Sincerely,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Board of Health

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Commissioner of Health

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Oklahoma State Department of Health

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

TITLE

(X6) DATE

"E FORM

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R2YJ11

If continuation sheet 1 of 7

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF .		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 NORTH MONTE VISTA ADA, OK 74820			
(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 2 water dripping over the meat was 98.0 degrees Fahrenheit (F). At 2:29 p.m., cook #1 stated she was thawing the hamburger meat for chili for supper. The cook stated she had warm water dripping over the hamburger meat to thaw it for the evening meal. She stated she was unaware of the proper way to thaw the meat under running water. WAREWASHING SANITATION A dish machine had an data processing plate that indicated the dish machine used a chemical sanitizing agent to sanitize the dishes. The plate indicated the the water temperature should meet 125.0 degrees F minimum and chlorine residual 50 parts per million (ppm). The dish machine chemical concentration form, dated 01/01/20 through 01/08/20, documented 100-110 at various times throughout the day. Cook #1 stated the 100 and 110 documented on the form was the temperature of the water in the dish machine. At 2:05 p.m., cook #1 stated she did not know how to test the sanitation solution. She stated she ensured the soap and sanitizer solutions were filled. The dish machine was checked and the chemical concentration was 200 ppm. (Low temperature machines using chlorine as a chemical sanitizer should have a concentration between 50 ppm and 100 ppm.) Cook #1 stated the water temperature was a little over a 100 degrees. She stated the temperature was not hot enough and the chemical concentration was higher than 50 to 100 ppm. POLICY	C 391			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/09/2020
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNITY OF , 1501 NORTH MONTE VISTA
ADA, OK 74820

(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 3 A dietary policy, dated 03/2019, documented, "...Methods for Thawing Food...Submerging in running water...Food being thawed by running water must be completely submerged in running water...Water temperature used to thaw must be no greater than 70 degrees Fahrenheit.. A food safety policy, dated 03/2019, documented, "...All staff will be aware of proper handling of dirty and clean utensils...Temperatures and disinfection of utensils will be monitored..."	C 391		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally	C1505	using optional template see attached	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/09/2020
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNITY OF .

1501 NORTH MONTE VISTA
ADA, OK 74820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 4 incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to follow physician ordered wound care for 1 (#2) of 1 sampled resident with documented wounds. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 A physician's order for resident #2, dated 01/06/20, documented to apply Bacitracin (ointment used to prevent skin infections) to his left ear lobe and left wrist wounds twice a day until healed, cover the left wrist with a Band-Aid during day hours, and leave open to air at bedtime. On 01/06/19 at 2:00 p.m., licensed practical nurse (LPN) #1 stated resident #2 had scabbed areas from previous cancer/radiation sites which he picked on his ear lobe and wrist. She stated the resident had new orders for wound care to be done twice a day. On 01/08/20 at 11:55 a.m., resident #2's left ear lobe and wrist had black scabbed areas on them. LPN #1 cleansed the resident's left ear lobe and wrist with normal saline, applied Muprion (used to treat certain skin infections) 2% ointment and covered the wrist with a Band-Aid. She stated she knew she did not use the correct ointment ordered by the physician. LPN #1 also stated she used the Muprion ointment for the dressing change on 01/07/19 because she could not find the Bacitracin. LPN #1 did not use the correct	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/09/2020
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF .		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 NORTH MONTE VISTA ADA, OK 74820			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C1505	Continued From page 5 ointment for the dressing change on 01/07/20 or 01/08/20. POLICY A medication policy, dated 03/2019, documented, "...Only prescribed medications may be stored and administered to residents..."	C1505			
C1507 SS=E	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to provide an effective pest control service to prevent bed bugs for 1 (#1) of 1 sampled resident who had live bed bugs in her apartment. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1's apartment had been treated for bed bugs on 10/29/19, 11/22/19 and 12/30/19.	C1507	Using optional template See Attached		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/09/2020
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF ,		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 NORTH MONTE VISTA ADA, OK 74820			
(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
C1507	Continued From page 6 On 01/06/20 at 1:30 p.m., the administrator stated the center had recently sprayed resident #1's apartment for bed bugs. She stated she was unsure if the resident had any live bed bugs at this time. At 2:00 p.m., licensed practical nurse (LPN) #1 stated she had seen a live bed bug in resident #1's apartment over the past weekend. On 01/07/20 at 12:14 p.m., resident #1's apartment was observed for bed bugs with the administrator and housekeeper #1. When removing the pillow cases and bed spreads, three live bed bugs were found crawling on the bed. At 2:00 p.m., the administrator reviewed the pest control log and agreed the pest control was not effective if the apartment had been sprayed for bed bugs the past three months and the resident continued to have bed bugs. At 2:35 p.m., resident #1 stated she had seen bed bugs since the exterminator had sprayed her apartment. She stated she had one area on her neck that itched and she thought it was a bite. Upon observation, there was one raised pink area on resident #1's back left side of her neck. A pest policy, dated 03/2019, documented, "...If a bed bug is seen, alive or dead, the Executive Director must be notified immediately...The pest control company will be notified immediately..."	C1507			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/22/2020

Facility Name: Featherstone Assisted Living Ada

License Number: AL6202

Survey Event ID: R2YJ11

Date Survey Completed: 1/9/2020

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391

Based on: observation, interview, and record review, it was determined that the center failed to ensure compliance with chapter 257

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All residents have the potential to be affected by this alleged deficient practice.

- A. An in-service was conducted on 1/17/20 regarding kitchen regulations and policies and procedure concerning knowledge of kitchen function and duties outlined on orientation check sheet.
- B. Staff were educated on 1/17/20 on proper methods to be used when thawing meat.
- C. Staff were educated on 1/13/20 by Autochlor service tech concerning proper sanitation of and checking the warewashing machine.

OSDH Response: Element accepted Yes ☐ No ☐

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

All residents have the potential to be affected by the alleged deficient practice

- A. Staff will be educated upon hire regarding kitchen regulations and policies and procedure concerning knowledge of kitchen function and duties outlined on the orientation check sheet.
- B. Food service safety class will be conducted upon hire, annually, and as needed.
- C. Staff will be in-serviced quarterly by AutoChlor service tech regarding warewashing equipment and sanitation.

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?

Measures or systemic changes

- A. Staff will be educated upon hire regarding kitchen regulations and policies and procedure concerning knowledge of kitchen function and duties outlined on the orientation sheet. Training for current staff

		will be completed on system monitoring on 1/22/20 Any non-compliance will result in employee disciplinary action. B. Food service safety class will be conducted upon hire, annually, and as needed. C. Staff will be in-serviced quarterly by AutoChlor service tech regarding warewashing equipment and sanitation. Use of warewashing log checking sanitation was implemented on 1/13/20
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.		Executive Director will ensure, through use of orientation checklist/evaluation, that all staff have the knowledge necessary for kitchen duties, food safety (ie: meat thawing) and sanitation. Executive director will monitor warewashing sanitation log weekly for 3 months to ensure compliance and will report findings to QA committee. QA committee will add the three areas identified to the quarterly QA form. Orientation checklists, annual food service training, and food safety classes will be monitored each quarter and reported to QA committee for review to ensure compliance regulations.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		2/1/2020
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 1-24-2020
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	Enter a date of addendum.	Submitted by Enter name of person submitting addendum.
Items Below Are For OSDH Use Only		
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor		
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.		
Facility in Compliance by: Click here to enter a date.		



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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/22/2020

Facility Name: Featherstone Assisted Living

License Number: AL6202

Survey Event ID: R2YJ11

Date Survey Completed: 1/9/2020

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505

Based on: observation, interview, and record review, it was determined that the center failed to follow physician ordered wound care for 1 (#2) of 1 sampled resident with wounds.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A medication error was written on 1/8/20 for resident #2. One on one education was conducted on 1/10/20 with LPN who failed to follow the physician order. All medication administration staff were in-serviced on 1/17/20 regarding physician orders.

All residents have the potential to be affected by the alleged deficient practice. Resident physician orders will be monitored weekly.

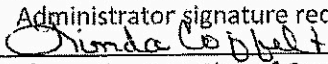
Measures or systemic changes
A new RN consultant began working in December with her focus being on measures and systemic changes to ensure physician orders are followed.
Education on the five rights of medication administration will be conducted by the RN with each medication administration staff person and is posted in the medication room.

Physician orders will be monitored by the RN Consultant to insure correct medications are administered as ordered.

RN consultant will track medication errors weekly and report findings to QA Committee

QA Committee will add the area identified to the QA form

Medication errors, physician orders, and tracking log will be monitored each quarter by the QA Committee to ensure regulations are followed

5. On what date will corrective action be completed?		2/20/2020	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Administrator signature required. 	Date Enter a date of signature. 1-24-20
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/22/2020

Facility Name: Featherstone Assisted Living Ada

License Number: AL6202

Survey Event ID: R2YJ11

Date Survey Completed: 1/9/2020

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1507

Based on: observation, interview, and record review, it was determined that the center failed to failed to provide an effective pest control service

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required.
OAC 310:663-25-4(F) *Junda C. Pelt*

Date Enter a date of signature.
1-24-2020

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

Facility in Compliance by: Click here to enter a date.



Oklahoma State Department of Health
Creating a State of Health

March 11, 2020

License Number: AL6202

Ms. Linda Coffelt, Administrator
Featherstone Assisted Living Community Of Ada
1501 North Monte Vista
Ada, OK 74820

RE: Survey Event R2YJ12

Dear Ms. Coffelt:

On **March 10, 2020**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 9, 2020**, have now been corrected effective **February 26, 2020**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/10/2020
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNI

**1501 NORTH MONTE VISTA
ADA, OK 74820**

(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 follow-up survey was conducted on 03/10/20. Current census was 28. All deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number AL6202	Provider/Supplier Name FEATHERSTONE ASSISTED LIVING COMMUNITY OF ADA
------------------------------------	---

Type of Survey (select all that apply)

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

Extent of Survey (select all that apply)

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. <i>JS</i> 36191	03/10/2020	03/10/2020	0.50	0.00	2.25	0.00	2.50	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours....

0.00

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