OKLAHOMA
State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

May 2, 2023

License Number: AL6202

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

RE: Survey Event ID: 90J811

Dear Ms. Whitecloud:

On **April 14, 2023**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on April 14, 2023.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

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

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action

against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Featherstone Assisted Living Community of Ada**
Address: **1501 North Monte Vista**
City, State, Zip: **Ada, OK 74820**
Provider #: **AL6202**
Complaint #: **#OK00058702**
Investigation Date(s): **04/12/23, 04/13/23, and 04/14/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents received adequate and appropriate medical care, to include physician ordered renal diet.	**US**

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

An unannounced on-site investigation was initiated on 04/12/2023 at 10:00 a.m.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to physician ordered diets was conducted.

A record review was conducted related to resident agreements, menus and special diets. The center offers a wide array of special diets to include pureed, chopped, renal, and diabetic. The center's kitchen supervisor provided documentation to include a list of food choices related to a renal diet. The kitchen staff had received food service training.

The meals observed during survey included a pureed, chopped, and renal diet. The staff were attentive with meal service and delivered meals to resident rooms upon request. Staff provided eating assistance as required.

Residents also had mini refrigerators in their apartments with their own selection of foods. The meals were observed to be cooked properly. A family member reported the staff in the kitchen were excellent and even on the weekends they usually provided hot cooked meals.

Residents interviewed reported eating foods stored in their own refrigerators in their apartments. One resident provided a list of recommended foods they were allowed to eat and a list of foods they were to avoid eating. Some residents requested a change in the alternate food menu items from time to time. The dietary supervisor reported she had been provided with items to include in a renal diet from the registered dietitian; however, they also accommodate residents with their food preferences as well.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Julie Edmiaston Digitally signed by Julie Edmiaston
Date: 2023.04.19 18:56:22 -05'00'

Julie Edmiaston, RN, BSN

Date report completed: 04/17/2023

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	AL6202	A. BUILDING: _____ B. WING _____	C 04/14/2023

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

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 04/12/23 through 04/14/23. A complaint (#OK00058702) was conducted in conjunction with survey. Listed below are abbreviations that will be used throughout this document: BSC- bedside commode ACMA- Advanced Certified Medication Aide cm- centimeters CNA- Certified Nurse Aide COPD- Chronic Obstructive Pulmonary Disease CVA- Cerebrovascular Accident DM- Diabetes Mellitus HCL- Hydrochloride HRS- hours GM- gram LPN- Licensed Practical Nurse mcg- micrograms mg- milligrams NC- nasal cannula neb- nebulizer PO- by mouth POA- Power of Attorney PRN- as needed Q- every RN- Registered Nurse SOB- shortness of breath tab- tablet x's- times	C 000		
C 372 SS=D	310:663-3-6(b) MANAGEMENT OF RISK (b) The assisted living center shall specify the cause for concern, discuss the concern with the resident and representative, if any, and attempt to negotiate a written agreement that	C 372		

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minimizes risk and adverse consequences and offers alternatives while respecting resident preferences.

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the center failed to ensure the negotiated risk agreement was followed to minimize the risk and adverse consequences while respecting the resident preferences for one (#7) of one sampled resident who entered into a negotiated risk agreement with the center.

The "Resident Roster," dated 04/12/23, identified one resident with a negotiated risk agreement to wander around outside on the center's premises.

Findings:

A "Negotiated Risk Agreements" policy, dated November 2022, read in parts, "...It is the goal of assisted living to allow the resident choice in reasonable risk taking...The residence will identify in the agreement what they are responsible for and will only accept liability if that is not carried out...If the residence does not fulfill their portion of the Negotiated Risk Agreement, the residence may need to begin to help the individual find housing which is suitable for said risk..."

A "Negotiated Risk Agreement," dated 09/12/22, read in parts, "...Issue(s)/Concern(s)... [Resident #7] enjoys going for walks outside of the community and specifically behind the community in the field and wooded area. Resident also gathers discarded furniture and items out of or around the dumpster and carries into the woods

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behind the property. The concern is that the resident could fall, get hurt, have a medical problem such as low blood sugar or get attacked by an animal/insect. Also [Resident #7] has not been signing the resident out log whenever he goes on his walks outside...

Resident /Family Preference: signs out whenever leaving building also getting a noise maker in case of incidents...

Possible consequence: Resident could fall, get injured, attacked or have a health problem while unattended and whereabouts unknown. Resident may not be able to leave the property alone...

Alternative approaches to minimize risk: Resident sign out so that staff knows locations and times. Resident will not remove furniture and items out of the dumpster...

Agreed course of action: [Resident #7] will sign out anytime he is going for a walk or off his patio and will wear sound device to activate if he falls or has an incident...

Either party may terminate this Agreement by giving the other party written notice..." Signed by resident #7's representative and the facility representative. The resident had not signed out when they went out for walks around the assisted living center and they did not have a noise maker as outlined in the risk agreement.

A "Resident Assessment Form," dated 03/17/23, for Resident #7, read in parts, "...Aphasia [language disorder], CVA... Alert [times] 2, confused at times, Judgment: Good..."

An "Individualized Plan of Service," dated

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C 372	Continued From page 3 03/23/22, for Resident #7, read in parts "...telephone use; doesn't use phone..." The resident reported they did not have a cell phone and the plan of care indicated the resident did not use a phone in the event the resident had an emergency while out for a walk. On 04/13/23 at 10:00 a.m., LPN/Nurse Manager entered Resident #7's apartment with the surveyor. Resident #7 was asked if they had a noise maker. Resident shook head back and forth to indicate they did not. They were asked if they had a cell phone. They shook their head back and forth to indicate they did not have a cell phone. Surveyor attempted to call resident #7's POA and there was no answer and no voice mail was available. On 04/13/23 at 11:00 a.m., Resident #7 was observed outside behind the assisted living center walking around with a cane. On 04/14/23 at 8:15 a.m., the Administrator was asked to review the sign-out book related to resident #7. The Administrator was asked if Resident #7 had routinely signed out. They stated, "I am not seeing it." They stated the only time the resident signed out was with their son on 10/31/22, 02/18/23, and 04/09/23. They were asked if resident #7 had signed out on 04/13/23. They stated, "No, Ma'am"	C 372		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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C1304	Continued From page 4	C1304		

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interview, the center failed to assess and evaluate two (#4 and #7) of two sampled residents with contracted services who smoked cigarettes at the center.

The "Resident Roster," dated 04/12/23, identified two residents who smoked cigarettes at the center.

Findings:

A "Smoking: Prohibited" policy, dated November 2022, read in parts, "...To promote health and to assure safety for all residents...Smoking is prohibited in any area of the building, including dwelling units, because of the health and safety hazards..."

1) Resident #7's "Service Agreement" dated 03/05/21, read in parts, "...Included in this document are the following...A list of General Policies...Featherstone is a non-smoking residence. Smoking outside must be at least 15 feet away from the building..."

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C1304	Continued From page 5 On 04/13/23 at 09:00 a.m., resident #7 was observed sitting on the patio connected to the resident's apartment smoking a cigarette. A pack of cigarettes and lighter was observed on the dresser in their apartment. On 04/13/23 at 10:04 a.m., the LPN/Nurse Manager was asked to submit the center's smoking policy. They were asked if resident #7 should be smoking on the patio. They reported no, not according to the center's policy. They submitted the smoking evaluation tool and stated they would be implementing that tool for all smokers. They were asked if resident #7 was identified as a smoker at entrance conference. The LPN stated "no," but they would get that updated. 2) Resident #4's "Service Agreement," dated 04/01/23, read in parts, "...Included in this document are the following...A list of General Policies...Featherstone is a non-smoking residence. Smoking outside must be at least 15 feet away from the building..." On 04/13/23 at 10:20 a.m., LPN/Nurse Manager was asked about a smoking assessment for Resident #4. They reported the resident had not been evaluated for smoking and they would get it done today. The LPN/Nurse Manager reported the resident smoked outside in the enclosed courtyard and had an ashtray to extinguish the cigarettes. On 04/13/23 at 3:40 p.m., Resident #4 was asked about smoking. They reported they smoked whenever they wanted to and they kept the supplies in their apartment.	C1304		

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C1505	Continued From page 6	C1505		
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 incapacitated.	C1505		

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C1505	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to: a. Administer the correct dose of B-12 for one (#5) of 10 sampled residents reviewed for medications; b. Administer the correct dose of oxygen and failed to obtain physician orders to self-administer and monitor the usage of a rescue inhaler for one (#6) of one sampled resident who received oxygen therapy and kept a rescue inhaler at the bedside; c. Prevent or reduce the potential to develop a pressure ulcer on the left heel for one (#8) of two sampled residents with known pressure ulcers; and, d. Obtain signed physician orders for seven (#2, 5, 6, 9, 10, 11, and #12) of 10 sampled residents reviewed for medications. The "Resident Roster," dated 04/12/23, documented 31 residents resided in the center with medication assistance. Findings: A "Medication Administration and General Guidelines" policy, dated 2020 Edition, read in parts, "...Medications are administered in accordance with written orders of the attending physician..." A "Medication Policy," dated November 2022, read in parts, "...All medications will be administered by Featherstone staff unless the	C1505		

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C1505	Continued From page 8 Executive Director, Community RN, and the resident's physician approve self-administration of medications..." 1) A "Physician's Order," dated 03/31/23, for resident #5, read in parts "...B-12 tabs 500 mcg 1 tab PO Q Day..." On 04/12/23 at 10:55 a.m., a medication pass was initiated with ACMA #1 and Resident #5. ACMA #1 administered a 1000 mcg tablet of B-12 to Resident #5. On 04/12/23 at 2:58 p.m., LPN/Nurse Manager was asked to remove resident #5's B-12 bottle from the medication cart. They were asked about the difference in the dosage of the B-12 documented on the physician's order and the bottle of B-12 located on the medication cart. They stated, "the family must have got the wrong one." They stated the family brings the medication in and it must be a new bottle. 2) Resident #6's "Physician's Order" dated 12/14/21, read in parts, "...Albuterol Sulfate... (90 Base) ...2 puffs Q 6 HRS as needed...COPD..." Resident #6's "Physician's Order" dated 06/10/22, read in parts, "...Oxygen 3 liters NC inhalation continuously SOB..." On 04/12/23 at 12:10 p.m., a medication pass was observed with ACMA #1 and a rescue inhaler was observed on the bedside table next to Resident #6's bed. ACMA #1 was asked how many liters of oxygen was set on resident #6 's oxygen concentrator. They stated it was set on four liters of oxygen. The surveyor observed Resident #6 to be on four liters of oxygen via nasal cannula.	C1505		

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C1505	Continued From page 9 On 04/13/23 at 2:47 p.m., LPN/Nurse Manager was asked to obtain the rescue inhaler from resident #6's apartment. They were asked about the date on the box. They stated 09/29/22 and stated the resident needed a new one. They were asked how many doses remained. They stated 180 doses. They were asked about the expiration date of the inhaler. They stated 9/29/24. On 04/13/23 at 3:47 p.m., LPN/Nurse Manager was asked if the center had a system in place to monitor the remaining doses to ensure the resident did not run out. They stated, "no, but we will now." They were asked if they had an order to keep the rescue inhaler at the bedside. They stated they obtained the physician's order to self-administer the medication today (on the day of survey). They were asked about the physician's order for oxygen. They stated they found the physician's order, but it was not signed. 3) Resident #8's "Plan of Accommodation" dated 12/13/22, read in parts, "...Person or persons responsible for performing, monitoring, and assuring compliance with the plan: Primary care giving staff..." A "Resident Assessment Form," dated 03/10/23, read in parts, "...Annual assessment, significant change...Diagnoses: Parkinson, DM...alert x1, confused at times, forgetful, judgment poor...special treatments and procedures: hospice to perform wound care, turn q 2 [hours]...Wounds...R buttock... L buttock..." Resident #8's "Skin Check" dated 03/10/23, documented, "...Change of Condition...15=Right ischial tuberosity...16=Left ischial	C1505		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 10	C1505		

tuberosity...Pressure Ulcer #15...2 cm x 1 cm x 0.1 cm. #16...1.5 cm x 2 cm x 0.1 cm..." Resident #8 returned to the center after a hospital stay with pressure ulcers on 03/10/23. Resident #8 did not return to the center with a pressure ulcer on the left heel.

On 04/13/23 at 1:33 p.m., the hospice nurse was in Resident #8's apartment. Resident #8 complained about the left heel hurting. The nurse measured the red, soft, spot on the left heel area to be 2 cm x 1 cm. Resident #8 reported she usually had to ask the staff to change her.

On 04/14/23 at 8:55 a.m., the LPN/Nurse Manager was asked when Resident #8 returned to the center from a hospital stay with pressure ulcers. They stated it was on 03/10/23. They were asked if they performed a skin evaluation. They stated they had completed a skin assessment. They were asked if Resident #8 had a pressure sore on the left heel at that time. They stated, "No, Ma'am." The LPN/Nurse Manager was asked when they become aware of the pressure ulcer on the resident's left heel. They stated on 04/09/23, a CNA had called and they instructed her to start floating the resident's heels and to wear heel protectors and the CNA reported the resident would kick them off. They were asked if the resident had heel protectors. They stated the resident did at one point and they thought the daughter took them home. They were asked if the resident returned from the hospital with the heel protectors and they stated no they had them before that. They were asked if the resident developed the left heel pressure ulcer after she had returned from the hospital to the center. They replied, yes.

On 04/13/13 at 2:05 p.m., CNA #1 was asked if

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	AL6202	A. BUILDING: _____ B. WING _____	C 04/14/2023

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

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C1505	Continued From page 11 she turned Resident #8 every 2 hrs. They stated they tried to scoot her and turn her a little bit. 4) The current medication orders for resident #2, 5, 6, 9, 10, 11, and #12, dated 03/31/23, were not signed by the attending physician. They also did not have signed physician orders for the previous months and did not provide signed physician orders for the following sampled residents. a) Resident #2's "Physician's Orders" dated 03/31/23, read in parts, "...Furosemide tabs 40 mg-Give one tab PO Q Day @ noon except when out to dialysis...Velphoro tabs 500 mg give 1 tab PO TID controls serum phosphorous..." The orders had not been signed by the attending physician. On 04/12/23 at 12:08 p.m., ACMA #1 administered one 40 mg tablet of Furosemide and one 500 mg tablet of Velphoro to Resident #2. On 04/12/23 at 12:30 p.m., LPN/Nurse Manager was asked about Resident #2's physician's orders. They stated they were not signed by the physician. b) Resident #5's "Physician's Orders" dated 03/31/23, read in parts "...B-12 tabs 500 mcg 1 tab PO Q Day...Dicyclomine Hydrochloride Cap(s) 10 MG take one (1) capsule by mouth before each meal and at bedtime...Hydrocodone/Acetaminophen 7.5 mg-325 MG- Give 1/2 Tab PO 4 x's Daily..." The orders had not been signed by the attending physician. On 04/12/23 at 10:55 a.m., a medication pass was initiated with ACMA #1 and Resident #5.	C1505		

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C1505	Continued From page 12 ACMA #1 administered a 1000 mcg tablet of B-12, one 10 mg tablet of dicyclomine hydrochloride and 1/2 tablet of hydrocodone/acetaminophen 7.5 mg/325 mg to resident #5. On 04/12/23 at 2:58 p.m., LPN/Nurse Manager was asked if the physician's orders were signed. They stated they were not signed by the physician. c) Resident #6's "Physician's Orders," dated 03/21/23, read in parts, "...Ipratropium Bromide/Albuterol Sulfate 0.5 ml-2.5 (3) mg/3 ml give one vial for inhalation/neb Q day @ 12 noon..." The orders had not been signed by the attending physician. On 04/12/23 at 12:10 p.m., a medication pass was observed and ACMA #1 administered ipratropium bromide/albuterol sulfate breathing treatment to Resident #6. On 04/12/23 at 4:40 p.m., the LPN/Nurse Manager was asked if Resident #6's monthly physician orders were signed by the physician. They stated, "I just started and I have a plan to get them signed." d) Resident #9's "Physician's Orders," dated 03/31/23, read in parts, "...Losartan Potassium/Hydrochlorothiazide tab 50 mg-12.5 mg give 1 tab PO 2 X's daily..." The orders had not been signed by the attending physician. On 04/12/23 at 3:32 p.m., ACMA #2 administered one tablet of losartan potassium/hydrochlorothiazide 50 mg/12.5 mg to resident #9.	C1505		

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C1505	Continued From page 13 On 04/12/23 at 4:45 p.m., the LPN/Nurse Manager was asked about signed physician orders. They reported the doctor was good about signing orders and they would fax it and get a signature. e) Resident #10's "Physician's Orders," dated 03/31/23, read in parts, "...Sucralfate tab 1 GM-Give 1 tab PO before meals...Tylenol extra strength 500 mg- Give 1 tab PO Q 6 hours PRN pain..." The orders had not been signed by the attending physician. On 04/12/23 at 3:35 p.m., ACMA #2 administered sucralfate 1 gram tablet and one tablet of Tylenol Extra Strength 500 mg to Resident #10. On 04/12/23 at 4:45 p.m., the LPN/Nurse Manager was asked if she was waiting on Resident #10's physician to sign the orders. They stated, "Yes, I will take care of it this week." f) Resident #11's "Physician's Orders," dated 03/31/23, read in parts, "...Omeprazole caps 20 mg-1 cap PO Q Day breakfast and supper..." The orders had not been signed by the attending physician. On 04/12/23 at 3:27 p.m., ACMA #2 administered one 20 mg tablet of omeprazole capsule to resident #11. On 04/12/23 at 4:45 p.m., the LPN/Nurse Manager was asked about signed physician orders for Resident #11. They stated, "No, it's not signed." g) Resident #12's "Physician's Orders," dated 03/31/23, read in parts, "...Risperidone tabs 0.25 mg-Give 1 tab by mouth in the	C1505		

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C1505	Continued From page 14 afternoon...Pravastatin Sodium tab 10 mg give 1 tab PO daily with supper..." The orders had not been signed by the attending physician. On 04/12/23 at 3:42 p.m., ACMA #2 administered one risperidone 0.25 mg tablet and one tablet of pravastatin 10 mg to resident #12. On 04/12/23 at 4:45 p.m., the LPN/Nurse Manager was asked about signed physician orders for Resident #12. They stated, "No, it's on my to do list."	C1505		
C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and	C5015		

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C5015	Continued From page 15 the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to obtain the required signatures to implement a written plan of accommodation for one (#3) of four sampled residents with a plan of accommodation in place. The LPN/Nurse Manager reported four residents at the center with a plan of accommodation in place. Findings: Resident #3's "Plan of Accommodation" dated 04/10/23, read in parts, "...Plan of Accommodation [Name -Deleted-Hospice], BSC, raised toilet seat..." The physician's signature was blank, and the resident's representative was blank.	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5015	Continued From page 16 Resident #3's "Hospice Plan of Care" dated 04/10/23-06/08/23, read in parts, "... [Name Deleted-Hospice] ...bedside commode, wound supplies, blue pads, wipes..." On 04/13/23 at 10:30 a.m., the LPN/Nurse Manager was asked if she obtained the physician's signature on the plan of accommodation. They stated they were going to have to get the physician to sign it. They were asked if they had sent the plan of accommodation to the physician for signature. They stated, "Not yet." They were asked if the resident and/or representative signed the plan of accommodation. They stated the daughter had been out of town and when they come in, they would get them to sign it. On 04/13/23 at 2:15 p.m., the hospice nurse was observed in the apartment to provide wound care treatment for resident #3. A shower chair and raised toilet seat was observed in the apartment.	C5015		

OKLAHOMA
State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

May 11, 2023

License Number: AL6202

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

Survey Event ID: 90J811

Dear Ms. WhiteCloud:

On **April 14, 2023,** a Relicensure survey and a complaint investigation were 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 **June 7, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman Digitally signed by Tempal Killman
Date: 2023.05.11 16:08:53 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/11/2023** **Facility Name:** Featherstone of Ada **License Number:** AL6202 **Survey Event ID:** 90J811 **Date Survey Completed: 4/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 372	Based on: record review,observation, and interview, the center failed to ensure the negotiated risk agreement was followed one of the residents sampled.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Administrator will develop attainable negotiated risks. Resident number 7 will carry a whistle and he has agreed to carry whistle with him when he leaves the building and agreed to sign out.
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 negotiated risk agreements will be reviewed to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Negotiated risk agreements will be attainable to monitor and attainable for the resident to achieve. Administrator will check compliance monthly to ensure risk agreement is being followed.
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.	Administrator will audit monthly to ensure risk agreements are being followed and in compliance with plan in place. Staff will assist with ensuring residents follow risk agreement guidelines. Will be reviewed in QA to evaluate the effectiveness of compliance. Administrator will audit monthly to ensure risk agreement is in compliance. Audits will be presented in QA and kept as evidence of compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/7/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Elizabeth Whitecloud	**Date 5/11/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/11/2023** **Facility Name:** Featherstone of Ada **License Number:** AL6202 **Survey Event ID:** 90J811 **Date Survey Completed: 4/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1304	Based on: record review, observation, and interview, the center failed to assess and evaluate two sampled residents for smoking.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The Administrator discussed the smoking policy with each resident who smokes. The residents who refuse to cooperate will be given a move out notice according to the Oklahoma State Department of Health Regulations. Administrator updated smoking policy B-100. Administrator developed a Smoking Evaluation Tool for Safety.
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 resident identified to use tobacco products will be evaluated for the ability to properly adhere to facility policy and procedure and will be educated on how to practice safe smoking.
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?	We will monitor the residents engaging in smoking practice. The staff will be educated via In-Service to complete an internal incident report when a resident is found in violation of policy. The Administrator will followup of all incident reports related to smoking policy violation.
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 incident reports including those related to smoking violations will be reviewed in QA to evaluate the effectiveness of compliance. Administrator will monitor internal incident reports to folllowup and ensure compliance related to smoking policy is being followed. Will be reviewed in QA to evaluate the effectiveness of compliance. Evidence will be documented in QA meeting minutes. Administrator will monitor internal incident reports to

	folllowup and ensure compliance related to smoking policy.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/7/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Elizabeth Whitehead	**Date 5/11/2023**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/11/2023** **Facility Name:** Featherstone of Ada **License Number:** AL6202 **Survey Event ID:** 90J811 **Date Survey Completed: 4/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: record review, observation and interview the center failed to: Administer the correct dose of medication, Administer the correct dose of oxygen and failed to obtain physician orders to self-administer rescue inhaler, Prevent or reduce the potential to develop pressure ulcers, Obtain signed physician orders.

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?	LPN manager will conduct medication audit to ensure all medication dosages that are ordered to be given by medication staff are correct. LPN manager will obtain self administer orders from physician once it has been determined that resident meets criteria to self administer medications. LPN Manager will be monitoring 2 hour Reposition Log to be completed by floor staff on a daily basis. LPN Manager will ensure all orders are signed by the Physician and RN Consultant on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Medication Audits will be conducted to ensure all residents are receiving correct doses of medications. Assessment will be completed for any/all self administer of medications to ensure residents meet criteria to self administer. Residents identified that are at risk for pressure ulcers will be monitored and added to the 2 hour Respostion and Check Log Book. LPN manager will audit all charts to ensure all resident orders have required physician and RN signatures.
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?	Medication Audits will be conducted to ensure all residents are receiving correct doses of medications. Assessment will be completed for any/all self administer of medications to ensure residents meet criteria to self administer. Residents identified that are at risk for pressure ulcers will be monitored and added to the 2 hour Respostion and Check Log Book. LPN manager will ensure all residents orders have required physician and RN signatures. RN will conduct inservices for all staff administering medications, will review the 7 rights of medication administration and staff will acknowledge their

	understanding though signatures.
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.	Will monitor the medication audits and assessments for self administering medication and ensure physician and RN signatures are completed on a monthly basis. Review at quarterly QA to evaluate the effectiveness and compliance. Will monitor the medication audits and assessments for self administering medication and ensure physician and RN signatures are completed on a monthly basis. Review at quarterly QA to evaluate the effectiveness and compliance. The Administrator will followup on medication audits, self administer of medication assessments and physician/RN signatures are completed on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/7/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Elizabeth White Cloud OAC 310:663-25-4(F)	**Date 5/11/2023**
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Addendum Date Enter a date of addendum.	**Submitted by** Enter name of person submitting addendum.
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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: 5/11/2023** **Facility Name:** Featherstone of Ada **License Number:** AL6202 **Survey Event ID:** 90J811 **Date Survey Completed: 4/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 5015	Based on: record review, observation, and interview, the center failed to obtain the required signatures to implement a written plan of accommodation for one sampled resident.

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 and/or LPN manager will ensure all parties signatures are present when there is a plan of accommodation in place for a resident.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Administrator and/or LPN manager will ensure all parties signatures are present when there is a plan of accommodation in place for a resident.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Administrator will conduct a chart audit to ensure signatures are present on any/all plan of accommodations that may be put into place for residents.
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 plan of accommodations will be reviewed for signatures and be presented in QA to evaluate effectiveness of compliance. LPN Manager and/or Administrator will ensure signatures are in place for any/all plan of accommodations. Audits will be presented in QA to evaluate effectiveness of compliance. Administrator will ensure signatures are in place monthly for any/all plan of accommodations.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/7/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Elizabeth Whitecloud	**Date 5/11/2023**

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State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

July 25, 2023

License Number: AL6202

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

RE: Survey Event 90J812

Dear Ms. Whitecloud:

On **July 18, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 14, 2023,** have now been corrected effective **June 7, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6202	A. BUILDING: _____ B. WING _____	R-C 07/18/2023

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 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 07/20/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE