OKLAHOMA
State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

August 24, 2023

License Number: AL6202

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

Survey Event ID: WGVT11

Dear Ms. Whitecloud:

On **August 8, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on 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 will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 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

INVESTIGATIVE REPORT

Facility: **Featherstone Assisted Living Community of Ada**
Address: **1501 North Monte Vista**
City, State, Zip: **Ada, OK 74820**
Provider #: **AL6202**
Complaint #: **OK00060660**
Investigation Date(s): **08/07/23 and 08/08/23**

ALLEGATION(S)

The facility failed to assess, monitor, and intervene in a timely manner and failed to ensure medications were administered according the physicians' orders.
The facility failed to ensure therapeutic diets were provided according to the physician's orders and/or the residents' preferences and failed to serve adequate portion sizes.
The facility failed to ensure a clean, comfortable, and homelike environment.
The facility failed to ensure adequate staff to care for dependent residents.
The facility failed to ensure the right to privacy, failed to ensure residents are served food according to preferences and failed to notify residents' representative regarding a change in condition.

An unannounced on-site investigation was initiated 08/07/2023 at 11:30 a.m.

A sample of eight 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 Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and throughout the investigation. The lunch meal was observed with adequate portions. Special diets were observed for appropriate preparation as ordered by the physician. The special diets were observed as sugar-free or reduced concentrated sweets and ground diets. Alternate menus were reviewed. An environmental tour included mini refrigerators, checking room temperatures, and included an inspection for water leaks. A medication administration pass was observed.

Sampled clinical records were reviewed for physician orders, care plans, assessments, and weights. Facility menus were reviewed for therapeutic diets and food choices. Facility policies and procedures were reviewed for incident/accident reporting. Incident reports were reviewed for the past five months. Maintenance logs were reviewed. Sampled resident contracts were reviewed for contracted services.

Residents were interviewed regarding receiving therapeutic diets as ordered. Residents were interviewed regarding food choices and substitutions, as well as warm and palatable meals. Residents and family members were interviewed regarding assistance with activities of daily living in a timely manner. Staff members were interviewed related to therapeutic diets, adequate portions, and ensuring residents received diets per physician orders.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/10/2023

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	AL6202	A. BUILDING: _____ B. WING _____	C 08/08/2023

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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 A complaint investigation (#OK00060660) was conducted on 08/07/23 and 08/08/23. Listed below are abbreviations that will be used throughout this document: CNA - Certified Nurse Aide Department - Oklahoma State Department of Health LPN - Licensed Practical Nurse MAT - Medication Administration Technician MG/ML - Milligrams/Milliliter OTC - Over the counter PO - By mouth PRN - As needed Q - Every QID - Four times daily VO/RB - Verbal Order/Read Back W - with	C 000		
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 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to: a. ensure a functional emergency call light system was in place for two (#2 and #5) of eight sampled residents contracted to receive a prompt response for emergencies and requests for assistance; and b. defrost a refrigerator to keep food properly stored for one (#2) of eight sampled residents contracted to receive ordinary and reasonable care to protect from any danger or injury. The "Assisted Living Resident Condition and Care Overview" report, dated 08/07/23, documented 29 residents resided at the center. Findings: A "Service Agreement" for Resident #2, dated 12/21/22, read in part, " ...Resident Rights ...Receive a prompt response to emergency calls and requests for assistance ...Admission Waiver: Featherstone agrees to exercise such ordinary and reasonable care toward the resident to protect him/her from any danger or injury that might be reasonably anticipated but assumes no liability as such ..." An "Individualized Plan of Service" for Resident #2, dated 12/23/22, read in part, "...Staff assist w/mobility: occasional ...staff assist w/transfers occasional ...Check for wet clothing/linen, incontinence products ..." A "Resident Assessment Form" for Resident #2, dated 01/06/23, read in part, "...Alert, oriented x3,	C1304		

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C1304	Continued From page 2	C1304		

confused at times, Judgment: Good...List number of persons required to assist resident with Activities of Daily Living to include: Bathing (1), Eating (0), Dressing (1), Transferring (0), Toileting (0), Ambulation (1)..."

A "Maintenance Log", dated 06/01/23, read in part, "...[Resident #2's location] ...call button doesn't work ...Completed by/Date: [Blank]..."

On 08/07/23 at 2:20 p.m., Resident #2's room was observed with the LPN/Nurse Manager. The resident's refrigerator was observed not to close completely and did not have a tight seal. The LPN/Nurse Manager stated they would get maintenance to defrost it right away. There was a large chunk of ice built up in the top portion of the freezer. The refrigerator was packed with various foods.

On 08/07/23 at 2:43 p.m., maintenance was asked how often they checked the resident's refrigerators. They stated they had not checked the refrigerators. They stated they just started working in housekeeping two weeks ago, and they thought housekeeping used to do that once a week. They were asked if they felt it was important to check the refrigerators. They stated, "Yes, the food could spoil."

On 08/07/23 at 2:55 p.m., maintenance removed spoiled food from Resident #2's refrigerator. They were asked if it was spoiled, and they stated, "Yes, I can tell by looking at it." CNA #2 was observed to assist and was asked if the food was spoiled. They stated, "Yes," and were observed to empty a bowl of spoiled sliced watermelon into the trash.

On 08/07/23 at 3:05 p.m., the administrator was

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C1304	Continued From page 3	C1304		

asked who owned the appliances. They reported the microwave and refrigerator belonged to the facility.

On 08/07/23 at 3:13 p.m., Resident #2 requested some ice. The resident was informed to request assistance from the staff, so they rang the call light at that time.

On 08/07/23 at 3:24 p.m., no staff had answered the call light.

On 08/07/23 at 3:35 p.m., CNA/MAT #1 was asked if there was a call light going off in the building. They stated, "No, you will hear it ding." Resident #2's call light was not functioning properly at that time.

On 08/07/23 at 3:37 p.m., CNA/MAT #1 was asked to trigger the call light in Resident #2"s room. The call light did not sound at the nurse's station. CNA/MAT #1 stated, "I don't think it's working." CNA/MAT #1 returned to Resident #2's room to put a new cord on the call light. She reported a new cord was placed but the call light still was not working.

On 08/07/23 at 4:00 p.m., LPN/Nurse Manager reported they had already identified an issue with resident #5's call light. They identified it only sounded at the nurse's station and did not light up at the nurse's station. They went room to room at that time until they found which call light was sounding at the nurse's station, but did not light up. They were asked when they discovered resident #5's call light did not light up at the nurse's station. They reported on 07/11/23, before they went on a leave of absence. They added this to the maintenance log book to repair.

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C1304	Continued From page 4 On 08/08/23 at 7:40 a.m., maintenance was asked about the work order dated 06/01/23 for resident #2's call light. They stated they put a new cord on it. They were asked if they tested it afterwards and they stated, "Yes." They reported it was lighting up at the nurse's station then and they were going to have to call an electrician.	C1304		
C1912 SS=E	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and,	C1912		

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C1912	Continued From page 5 (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to report illnesses as specified by the Department for five (#2, 5, 6, 7, and #8) of five sampled residents reviewed with physician orders for symptoms of a communicable disease. The "Assisted Living Resident Condition and Care Overview" report, dated 08/07/23, documented 29 residents resided at the center. Findings: The center's procedure titled, "Incidents/Accidents", updated November 2022, read in part, "An injury, or any occurrence which might have a potential adverse effect on any resident, including: exit seeking behavior, resident-to-resident contact, a fall, fracture, skin tear, burn or communicable illness; and other similar events...The staff person who witnesses the event, or is first upon the event, completes the Incident-Occurrence Report...All resident incidents/occurrences should be reported to physician and family as soon as possible...An	C1912		

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C1912	Continued From page 6	C1912		

investigation must be initiated within 48 hours of the occurrence by the Executive Director and/or Community Nurse..."

1. A "Written Order" dated 07/17/23, for Resident #2, read in part, "...Order: hold Victoza 3-4 days, no milk for 48 hours and she can have Imodium as directed today..."

A Medication Administration Record for July 2023, for Resident #2, read in part, "Antidiarrheal cap 2 mg, take 2 tablets after 1st dose of loose stool then 1 tablet after that. Do not exceed 4 tablets in 24 hours..." The resident received the medication from staff on 07/20/23 and 07/21/23, and the directions matched the OTC box located on the medication cart.

A clarification "Written Order" dated 08/08/23, for Resident #2, read in part, "...Order: Imodium as directed as needed PRN for diarrhea..." The order was received on the day of survey as a clarification order for the antidiarrheal medication administered on 07/20/23 and 07/21/23.

On 08/07/23 at 3:21 p.m., resident #2 was asked about being sick recently. They stated, "Worst I ever had, I was sicker than a dog and it lasted a good week."

2. A "Doctor's Medication Orders" for Resident #5, read in part, "...VO/RB...May give Zofran 4 mg PO 1-tab Q 8 hours as needed for nausea/vomiting-May give Imodium PO 1-tab QID as needed for diarrhea..."

On 08/08/23 at 8:54 a.m., Resident #5 reported she had diarrhea symptoms recently and their family member picked up their medication.

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C1912	Continued From page 7 3. A "Doctor's Medication Orders" for Resident #6, read in part, "...VO/RB...May give Zofran 4 mg PO 1-tab Q 8 hours as needed for nausea/vomiting-May give Imodium PO 1-tab QID as needed for diarrhea..." On 08/08/23 at 09:10 a.m., Resident #6 was asked about a recent illness and they denied having a recent illness. They were asked if they knew what year it was and they stated, "No, and I don't care." 4. A "Doctor's Medication Orders" for Resident #7, read in part, "...VO/RB...May give Zofran 4 mg PO 1-tab Q 8 hours as needed for nausea/vomiting-May give Imodium PO 1-tab QID as needed for diarrhea..." On 08/08/23 at 9:05 a.m., Resident #7 did not remember if they had a stomach bug last week. 5. A "Hospice/Terminal Patient" form for Resident #8, read in part, "...Promethazine 25 mg/ml to inner wrist every 4 hours as needed for nausea..." On 08/08/23 at 9:15 a.m., the LPN/nurse manager was asked if they notified the family of her illness. They stated hospice would have notified them because they ordered the medications. On 08/08/23 at 9:30 a.m., the dietary manager was asked about the communicable illness. They reported three or four people got sick so they tried to stop the spread. They stated they shut the dining room down and served to-go containers to the residents in their rooms. They reported they did that for a week and a few days, and reported no one else had gotten sick since then.	C1912		

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C1912	Continued From page 8 On 08/08/23 at 12:20 p.m., the administrator was asked about any outbreaks at the center. They stated they had a "stomach bug" and they stated they shut down the dining room. They were asked if they reported the outbreak and they stated, no, they did not because they were told not to. They were asked what kind of symptoms the residents had, and they reported vomiting and diarrhea. They were asked who told them not to report the illness outbreak and they stated, "The RN consultant."	C1912		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to document all services related to resident-to-resident contact and communicable illness for one (#2) of two sampled residents reviewed for incidents/accidents. The "Assisted Living Resident Condition and Care Overview" report, dated 08/07/23, documented 29 residents resided at the center. Findings: The center's procedure titled, "Incidents/Accidents," updated November 2022, read in part, "...An injury, or any occurrence which	C1951		

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C1951	Continued From page 9	C1951		

might have a potential adverse effect on any resident, including: exit seeking behavior, resident-to-resident contact...The staff person who witnesses the event, or is first upon the event, completes the Incident-Occurrence Report...All resident incidents/occurrences should be reported to physician and family as soon as possible...An investigation must be initiated within 48 hours of the occurrence by the Executive Director and/or Community Nurse..."

On 08/07/23 at 12:28 p.m., the LPN/Nurse manager was asked about Resident #2's progress notes. They stated they would be under "tab #7 if they have any," and reported Resident #2 did not have any.

On 08/07/23 at 1:28 p.m., the administrator was asked if they were aware of a resident who had wandered into Resident #2's room. They reported they had a facility report related to that. The facility report was requested and the administrator returned and stated they had told the staff to do a report and they did not do one. They stated it was reported they found Resident #5 in Resident #2's bed and they had to call the staff and redirect Resident #5 to their apartment. They stated Resident #5 had dementia.

On 08/07/23 at 3:05 p.m., the administrator was asked if Resident #2 was one of the residents with a communicable disease and they reported they were. They were asked if the family was notified and they reported they were notified. They were asked if this information was documented and they stated, "I don't have any documentation on it, we delivered meals for a week in their rooms." They were asked if they made notification to family members related to the outbreak. They stated the LPN/nurse

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 _____	C 08/08/2023

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
C1951	Continued From page 10	C1951		

manager called families, they got Imodium and nausea medications, and monitored the residents. They were asked where family notification was documented and the administrator reported they would have to ask the LPN/Nurse manager.

On 08/07/23 at 3:10 p.m., the LPN/Nurse manager was asked if they contacted the resident's physicians and family members related to the resident's illness. They stated, "I just have the orders" and reported they had no documentation related to notification of the families. They were asked if it would be the center's policy to notify the family and they reported yes, that was the policy.

On 08/07/23 at 3:21 p.m., Resident #2 was asked if the center contacted their family about their illness. The resident reported their family was not contacted for about two days but the family showed up at the center to visit and they were informed then.

On 08/08/23 at 7:45 a.m., Resident #2 was asked if another resident had come into their room unannounced. They stated the lady next door had come into her room.

On 08/08/23 at 1:49 p.m., the administrator was asked if they had notified Resident #2's POA of the resident-to-resident contact. They stated they had discussed it on the phone with Resident #2's POA. They were asked if this was charted in the resident's clinical record. They stated, "We don't do progress notes here." They were asked if they charted care plan conferences, and stated, "No Ma'am." They were asked if they had documentation that they had spoken with resident's family members or POA and reported

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 _____	C 08/08/2023

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
C1951	Continued From page 11 they did not have that documentation. The administrator stated Resident #2's family member was here the following day and had informed the administrator of the incident and then the administrator went to the staff. They were asked if they had in-serviced the staff related to reporting events and reported they had not. They were asked if they had investigated and stated they had not.	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

September 8, 2023

License Number: AL6202

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

Survey Event ID: WGVT11

Dear Ms. Whitecloud:

On **August 8, 2023,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 21, 2023**.

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

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/6/2023** **Facility Name:** Featherstone of Ada **License Number:** AL6202 **Survey Event ID:** WGVT11 **Date Survey Completed: 8/8/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1304	Based on: observation, record review, and interview, the center failed to: A. ensure a functional emergency call light system was in place for two (#2 and #5) of eight sampled residents contracted to receive a prompt response for emergencies and requests for assistance; and B. defrost a refrigerator to keep food properly stored for one(#2) of eight sampled residents contracted to receive ordinary and reasonable care to protect from any danger or injury.

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?	A. US Security Alert of Ada was contacted and service call is scheduled for September 7th or 8th for both #2 and #5. #2 and #5 added to 2 hour log checks. B. Administrator updated Housekeeping and Maintenance flowsheet to be completed daily and turned in weekly.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Call systems will be repaired and will continue to review maintenance checklists to ensure proper functionality. Housekeeping will turn in flowsheet to Administrator weekly. Administrator will verify monthly that all services are being met to satisfaction.
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?	Call system will be repaired and maintenance will check system and report any malfunction immediately to Administrator. Housekeeping will complete flowsheet daily and turn into Administrator weekly.
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.	Call systems will be checked monthly by maintenance to ensure proper functionality. Housekeeping will turn in flowsheet to Administrator weekly. Administrator will verify monthly that all services are being met to satisfaction. Administrator will verify monthly that all services are being met to satisfaction. Will be reviewed in QA to evaluate the effectiveness of compliance. Evidence will be documented in QA minutes.

		Administrator will monitor Housekeeping flowsheet and maintenance call light check off to follow-up and ensure compliance of resident contracted services.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/21/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	~~Administrator signature required~~ Elizabeth Stuckey LRN		**Date 9/6/2023**
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: 9/6/2023

Facility Name: Featherstone of Ada

License Number: AL6202

Survey Event ID: WGVT11

Date Survey Completed: 8/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1912	Based on: record review and interview, the center failed to report illnesses as specified by the Department for five (#2, 5, 6, 7, and #8) of five sampled residents reviewed with physician orders for symptoms of communicable disease.

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?	Inservice was conducted on 8/11/2023 Incident/occurrence reporting. State Form 283 completed late for communicable disease on 9/01/2023.Nurse Manager and RN Consultant were educated on what incidents are reportable. OSDH communication regarding state reportables was reviewed by Administrator, RN Consultant and Nurse Manager. Nurse Manager will notify Administrator immediately of communicable disease. Administrator will add specific discussion to QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Incident/Occurrence forms will be audited monthly by Administrator to ensure all reporting has been completed.
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 add specific discussion to QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; 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.	Monthly Audits will be conducted by Administrator to ensure compliance. Monthly Audits will be conducted by Administrator to ensure compliance. Administrator will add specific discussion to QA minutes. Nurse Manager will keep progress notes on all residents for any significant change of condition. Monthly Audits will be conducted by Administrator to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/21/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. **Date 9/6/2023**

OAC 310:663-25-4(F)

10012013

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: 9/6/2023

Facility Name: Featherstone of Ada

License Number: AL6202

Survey Event ID: WGVT11

Date Survey Completed: 8/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1951	Based on: record review and interview, the center falied to document all services related to resident-to-resident contact and communicable illness for one #2 of two sampled residents reviewed for incidents/accidents.

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?	Nurse manager will keep progress notes on all residents for any significant change of condition. Inservice was conducted on 8/11/2023 for Incident/Occurrence reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Incident/Occurrence forms will be audited monthly by Adminstrator to ensure all reporting has been completed.
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?	Incident/Occurrence forms will be audited monthly by Adminstrator to ensure all reporting has been completed. Incident/Occurrence will be discussed in QA meetings.
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.	Incident/Occurrence forms will be audited monthly by Adminstrator to ensure all reporting has been completed. Incident/Occurrence will be discussed in QA meetings. Audit Forms will be reviewed in QA to evaluate the effectiveness of compliance. Evidence will be documented in QA minutes. Nurse Manager will keep progress notes on all residents for any significant changes or conditions. Monthly Audits will be conducted by Administrator to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/21/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Elizabeth Whitelaw RCM **Date 9/6/2023**

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

Delivery via email to: elizabeth@featherstoneretirement.com

December 6, 2023

License Number: AL6202

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

Survey Event ID: WGVT12

Dear Ms. Whitecloud:

On **November 29, 2023,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 8, 2023,** have now been corrected effective **September 21, 2023.**

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

Respecfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6202	A. BUILDING: _____ B. WING _____	R-C 11/29/2023

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 11/29/23. 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