OKLAHOMA
State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

October 17, 2024

License Number: AL6202

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

Survey Event ID: Y20311

Dear Ms. Whitecloud:

On **October 4, 2024,** 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 no more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

1. Address how corrective action will be accomplished for affected residents.
2. Address how other residents with the potential to be affected will be identified.
3. Address measures or systemic changes to ensure the deficiency will not recur.
4. Indicate how the center plans to monitor performance to ensure corrections are sustained.
5. Include dates when corrective action will be completed for each violation; and
6. Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Featherstone AL Community Ada
Address: 1501 N Monte Vista
City, State, Zip: Ada, OK 74820
Provider #: AL6202
Complaint #: OK00067856
Investigation Date(s): 10/03/24-10/04/24

ALLEGATION(S)

The center failed to ensure adequate nutrition was provided in an effort to prevent weight loss.

An unannounced on-site investigation was initiated 10/03/2024 at 10:08 a.m.

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

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

A Summary of Complaint Investigation:

An investigation related to weight records, portion sizes, nutrition, and menus was conducted.

At the time of the survey, meals were observed to be nutritious with good portion sizes. Residents were offered seconds.

At the time of the survey, residents were ok with the meals being served to them. The residents were observed eating what was provided. The residents chose what they wanted to eat between the weekly menu and the alternative menu. The residents stated they choose daily three times a day.

At the time of the survey, staff stated they had no concerns with resident weight loss. They stated they would notify the nurse, the administrator and the dietary manager if they had concerns.

At the time of the survey, there was no deficient practice cited related to quality of care.

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: 10/11/2024

INVESTIGATIVE REPORT

Facility: Featherstone AL Community Ada
Address: 1501 N Monte Vista
City, State, Zip: Ada, OK 74820
Provider #: AL6202
Complaint #: OK00067928
Investigation Date(s): 10/03/24-10/04/24

ALLEGATION(S)
The center failed to ensure meals served residents were nutritious, palatable and in sufficient quantities.

An unannounced on-site investigation was initiated 10/03/2024 at 10:08 a.m.

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

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

A Summary of Complaint Investigation:

An investigation related to nutritious, palatable meals in sufficient quantities, test tray, menus, and resident weights were conducted.

At the time of the survey, the meals served were nutritious, palatable and in sufficient quantities.

At the time of the survey, no resident complained about weight loss or their meal not being nutritious, palatable, or in sufficient quantities.

At the time of survey, staff stated physician's wrote diet orders, a registered and licensed dietician provided menus for the center, and the staff ate at the center.

At the time of the survey, there was no deficient practice related to dietary services.

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: 10/10/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Featherstone AL Community Ada
Address: 1501 N Monte Vista
City, State, Zip: Ada, OK 44820
Provider #: AL6202
Complaint #: OK00068003
Investigation Date(s): 10/03/24-10/04/24

ALLEGATION(S)

The facility failed to assess and monitor for a resident after they experienced a fall with major injury.

An unannounced on-site investigation was initiated 10/03/2024 at 10:08 a.m.

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

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

A Summary of Complaint Investigation:

An investigation related to incident reports, falls, reportable incidents, fall policy, incident/accident policy, and resident record review was conducted.

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: 10/11/2024

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 10/04/2024

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 Complaint investigations (#OK00067856, OK00067928, and #OK00068003) were conducted on 10/03/24 and 10/04/24. Center Census: 36 Listed below are abbreviations that will be used throughout this document: ADL - activities of daily living CMA - certified medication aide CNA - certified nurse aide ER - emergency room LPN - licensed practical nurse tv - television	C 000		
C1505 SS=D	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	C1505		

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 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF ,	1501 NORTH MONTE VISTA ADA, OK 74820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 1 medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the center failed to ensure a resident who experienced a fall was assessed by a nurse for one (#1) of three residents who were sampled for incidents. The center's "Incidents/Accidents" policy, dated November 2022, read in part, "...any incident or occurrence involving a resident...is reported in full on the Incident - Occurrence Report form...any happening...which is not consistent with the routine...care of a particular resident...potential injury to a resident...any occurrence which might have a potential adverse effect on any resident...make appropriate contacts...All resident incidents/occurrences should be reported to physician and family...an investigation must be initiated within 48 hours of the occurrence by the Executive Director and/or Community Nurse..." The center's "Fall" policy, dated November 2022, read in part, "...systematically assess fall risk factors; provide guideline for fall and fall	C1505		

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 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF	1501 NORTH MONTE VISTA ADA, OK 74820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 2	C1505		

preventive interventions; and outline procedures for documentation and communication procedures...A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object...Post-Fall Management Measures to take and documentation: check vital signs...determine circumstances leading to the fall with corrections. All falls with be reported to the attending physician...and family. Complete incident report. Review fall prevention interventions and modify plan of care as indicated. Communicate to all shifts that patient has fallen. A detailed progress note should be entered into the patient's record including time of discovery, response to the event, evidence of injury and location of fall..."

Resident #1's "Contract", dated 06/08/24, read in part, "...Nursing Supervision...A Registered Nurse, Registered Nurse Consultant, or a Licensed Practical Nurse will supervise certified nursing aides...we offer...Twenty-four hour access to care giving to meet scheduled and unscheduled needs...Nursing supervision...Intermittent or unscheduled nursing care...Nurse consultant...will accept for residency people who require staff assistance to transfer and ambulate..."

Resident #1's "Admission Comprehensive Assessment", dated 06/08/24, read in part, "...admitted to the center with diagnoses to include hypertension, atherosclerotic heart disease, cerebral infarction, edema, occlusion and stenosis of bilateral carotid arteries, and atrial fibrillation...they were alert and oriented x 3 (person, place, time), confused at times, forgetful with fair judgement...they were ambulatory with a walker without staff assistance...they were incontinent of bowel and bladder, but independent

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 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF	1501 NORTH MONTE VISTA ADA, OK 74820

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C1505	Continued From page 3	C1505		

with adult briefs...required no staff assistance with ADL's..."

An incident report, dated 09/25/24, read in part, "...at 12:46 a.m. call for help...staff found resident (#1) on floor... they stated was walking with the walker to the bathroom and tripped...fell forward hitting head and hand on wooden tv stand...head and right forehead facial trauma with laceration to right hand...sent to ER...returned at 3:30 a.m. diagnosed with a nose fracture and skin tear to right hand..."

On 10/04/24 at 2:45 p.m., the administrator stated they were not notified of a fall on 09/29/24.

On 10/04/24 at 2:53 p.m., CMA #2 stated CMA #3 stated the resident had fallen earlier that day. They stated they didn't know if there were any injuries. They stated CMA #3 did not say. They stated it was a minor fall.

On 10/04/24 at 2:57 p.m., CMA #3 stated the resident had trouble getting in a chair one day (09/29/24). They stated they helped them get up in it (chair), but did not exactly fall. CMA #3 stated CMA #2 stated the resident did not get in their chair all they way and slid down and needed help getting in their chair. They stated the resident was sitting in front of the footrest of the recliner. No one was notified.

On 10/04/24 at 3:02 p.m., CNA #2 stated Resident #1 had another fall. They stated it was the same day they passed away (09/30/24). It was around lunch time (09/29/24). They stated they heard them scream. They were sitting between their recliner and AC unit. The resident stated they had stumbled over their feet. They stated they would get help. They stated they

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 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE ASSISTED LIVING COMMUNITY OF	1501 NORTH MONTE VISTA ADA, OK 74820

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 4 returned to the resident's room with CMA #3. CNA #2 stated CMA #3 asked the resident if they had hit their head. They stated, "No." They stated CMA #3 looked at the resident's back. They stated the resident did not complain of any pain. They helped them up and into their chair. No one was notified. On 10/04/24 at 4:01 p.m., the LPN stated if a resident was sitting on the floor or had a fall, it was their expectation staff would notify them, the family, the doctor, and complete an incident report. They stated if if no injury, they would monitor vital signs for 72 hours. They stated if head injury or chest pain call 911. On 10/04/24 at 4:05 p.m., the LPN stated no staff notified them of any resident sitting on the floor or fall on 09/29/24.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: elizabeth@featherstoneretirement.com

October 28, 2024

License Number: AL6202

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

Survey Event ID: Y20311

Dear Ms. Whitecloud:

On **October 4, 2024,** 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 **October 31, 2024**.

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/17/2024** **Facility Name:** Featherstone of Ada **License Number:** AL 6202-6202 **Survey Event ID:** Y20311 **Date Survey Completed: 10/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: interview and record review, the center falied to ensure a resident who experienced a fall was assessed by a nurse for one (#1) of three residents who were sampled for incidents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The 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 deficiencies or any related sanction of fine. The Center resereves 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 10/11/2024 on notification of incidents/occurrences, residents rights, wellness check documentation. Resident Care Director and Administrator to audit monthly for 6 months to ensure documentation has been completed and residents rights are being upheld. Specific Discussion added to QA meeting minutes to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident Care Director and Administrator to audit monthly for 6 months to ensure documentation has been completed and residents rights are being upheld. Specific Discussion added to QA meeting minutes 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?	Resident Care Director and Administrator to audit monthly for 6 months to ensure documentation has been completed and residents rights are being upheld. Specific Discussion added to QA meeting minutes to ensure compliance.
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.	Resident Care Director and Administrator to audit monthly for 6 months to ensure documentation has been completed and residents rights are being upheld. Resident Care Director and Administrator to audit monthly for 6 months to ensure documentation has been completed and residents rights are being upheld. Specific Discussion added to QA meeting minutes to ensure compliance. Specific Discussion added to QA meeting minutes to ensure compliance.

	Resident Care Director and Administrator to audit monthly for 6 months to ensure documentation has been completed and residents rights are being upheld.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Elizabeth Wheeler RCM	**Date 10/17/2024**

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

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

Items Below Are For OSDH Use Only

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

November 6, 2024

License Number: **AL6202**

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

Survey Event ID: Y20312

Dear Ms. Whitecloud:

On **November 4, 2024,** a complaint paper revisit was conducted for your facility by this agency. The findings of that paper revisit indicate that the deficiencies cited during your survey on **October 4, 2024,** have now been corrected effective **October 31, 2024.**

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6202	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 11/04/24. 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