
Delivery via email to: amber@featherstoneretirement.com

August 13, 2026

License Number: AL0703

Ms. Amber Barber, Administrator
Featherstone Assisted Living Community Of Durant
1919 University Blvd
Durant, OK 74701

Survey Event ID: Y8E411

Dear Ms. Barber:

On **August 4, 2026**, 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 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. 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: IDRCoordinator@health.ok.gov

Or mail 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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Featherstone AL Durant
Address: 1919 University Blvd
City, State, Zip: Durant, OK 74701
Provider #: AL0703
Complaint #: OK00087492
Investigation Date(s): 08/03/26 and 08/04/2026

ALLEGATION(S)
The center failed to ensure menus were followed and/or there was sufficient food for three days
The center failed to ensure the administrator was available for the day to day operations.
The center failed to maintain adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 08/03/2026 at 11:00a.m.

A sample of 7 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: Observations of staff to resident ratio, staff to resident interactions, food storage and preparation, meal service, and appearance of residents were made. Records of incident reports, resident health charts, service plans, assessments, menus, and center policies were reviewed. Interviews with residents, the ombudsman, staff, and family members regarding staffing and food service were conducted.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/06/2026

INVESTIGATIVE REPORT

Facility: Featherstone AL Durant
Address: 1919 University Blvd
City, State, Zip: Durant, OK 74701
Provider #: AL0703
Complaint #: OK00088989
Investigation Date(s): 08/03/26 and 08/04/2026

ALLEGATION(S)
The facility failed to ensure licensed staff was administering medications to residents.
The facility failed to ensure staff was licensed to administer medications.

An unannounced on-site investigation was initiated 08/03/2026 at 11:00 a.m.

A sample of 7 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: Observations of staff to resident interactions, medication passes, and appearance of residents were made. Records of employee files and certifications according to the Oklahoma Nurse Aide and Non-technical Services Worker Registry were reviewed. Interviews with residents, the ombudsman, staff, and family members were conducted.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/06/2026

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701		
(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 relicensure survey with complaints (#OK00088989 and #OK00087492) was conducted from 08/03/26 through 08/04/26. Deficiencies were cited. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. DON - director of nursing VTE - venous thromboembolism	C 000		
C 319 SS=E	OS 1-890.3(A)(11) Admission Criteria Provisions requiring assisted living centers to make available to residents upon admission a consumer information pamphlet that contains information about venous thromboembolism (VTE) including, but not limited to, risk factors and recognition of the signs and symptoms of VTE; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to provide a venous thromboembolism (VTE) educational pamphlet to 3 (#7, 8, and #9) of 3 sampled residents reviewed for VTE education. The director of nursing identified 30 residents resided in the center. Findings: An admission assessment for Resident #7, dated 07/13/26, showed the resident was admitted on	C 319		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
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C 319	Continued From page 1 07/13/26. There was no documentation to show Resident #7 was provided a brochure about the signs and symptoms of VTE upon admission to the center. An admission assessment for Resident #9, dated 07/21/26, showed the resident was admitted on 07/21/26. There was no documentation to show Resident #9 was provided a brochure about the signs and symptoms of VTE upon admission to the center. An admission assessment for Resident #8, dated 07/28/26, showed the resident was admitted on 07/28/26. There was no documentation to show Resident #8 was provided a brochure about the signs and symptoms of VTE upon admission to the center. On 08/03/26 at 4:30 p.m., the DON stated they had not provided a brochure or education about VTE to the residents admitted to the center after 07/01/26. The DON stated they did not know anything about the requirement to provide a VTE brochure to residents admitted after 07/01/26. On 08/04/26 at 4:30 p.m., the administrator stated they were not aware of the regulation to provide VTE information to residents admitted after 07/01/26.	C 319		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements.	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
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C 391	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. food was labeled and dated; and b. expired foods were discarded in 1 of 1 sample refrigerator observed. The director of nursing identified 30 residents received nutrition from the kitchen. Findings: On 08/03/26 at 11:00 a.m., a tour of the kitchen was conducted. The following observations were made in the reach in refrigerator: a. an open (to air) package of bacon on the bottom shelf of the refrigerator had not been labeled or dated, b. a one-gallon zip lock bag with thawed chicken products on the top shelf of the refrigerator had not been labeled or dated, c. a one-gallon zip lock bag of dark meat patties on the second shelf of the refrigerator had not been labeled or dated, d. three one-gallon milk containers had not been labeled or dated, and e. two five-pound containers of chicken salad had not been labeled or dated. On 08/03/26 at 11:00 a.m., a tour of the kitchen was conducted. The following observations were made in the reach in freezer:	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 3 a. a three-gallon container of vanilla flavor of ice cream had not been dated, b. four two-gallon size zip lock bags of garlic bread had not been labeled or dated, c. two two-gallon zip lock bags of broccoli had not been labeled or dated, d. two five-pound bags of pot pie filling had not been dated, and e. an unsealed bag of chicken patties had not been labeled or dated. On 08/03/26 at 11:00 a.m., a tour of the kitchen was conducted. The following observations were made in the dry storage: a. a one-pound six-ounce can of baking powder had an expiration date of 04/22/26, b. a 15 fluid ounce jar of sandwich spread had on expiration date of 03-04-26, c. a one-pound package of opened hamburger buns had not been labeled or dated, d. an open three-pound container of pink powder mix had not been labeled or dated, e. an open package of dry lemonade drink mix had not been labeled or dated, and f. an open (to air) five-pound package of granulated sugar had not been labeled or dated. A policy titled "Kitchen Policy and Procedure C-350," dated 03/2019, read in part, "3. Raw	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701		
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C 391	Continued From page 4 meat is never to be stored above cooked food, fruits or vegetables"...4. All containers must be labeled with the contents and date food items were placed in storage"...7. All dry foods must be dated and stored in a temperature-controlled environment." On 08/03/26 at 11:29 a.m., Cook #1 stated all food items should have been labeled with an open and use by date. Cook #1 stated on the day the food delivery truck came, they were supposed to date everything.	C 391		
C 533 SS=E	OS 1-890.3(A)(1) Assessment Form A uniform comprehensive resident screening instrument to measure the needs and capabilities of residents in all setting and to determine appropriate placements of residents. Such assessment shall include screening for the signs and symptoms of venous thromboembolism (VTE) and techniques for providing an emergency response. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to assess residents for signs and symptoms of venous thromboembolism (VTE) for 3 (#7, 8, and #9) of 3 sampled residents reviewed for VTE assessments. The director of nursing identified 30 residents resided in the center. Findings: A preadmission assessment for Resident #7,	C 533		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER FEATHERSTONE ASSISTED LIVING COMMUNITY OF			STREET ADDRESS, CITY, STATE, ZIP CODE 1919 UNIVERSITY BLVD DURANT, OK 74701		
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C 533	Continued From page 5 dated 07/13/26, showed the resident was admitted on 07/13/26. The assessment did not show the resident had been assessed for signs and symptoms of VTE. A preadmission assessment for Resident #9, dated 07/21/26, showed the resident was admitted on 07/21/26. The assessment did not show the resident had been assessed for signs and symptoms of VTE. A preadmission assessment for Resident #8, dated 07/28/26, showed the resident was admitted on 07/28/26. The assessment did not show the resident had been assessed for signs and symptoms of VTE. On 08/03/26 at 4:30 p.m., the DON stated residents admitted to the center after 07/01/26 had not been assessed for VTE. The DON stated they were not aware of the requirement to assess residents for VTE. On 08/04/26 at 5:00 p.m., the administrator stated they were not aware of the regulation to assess residents admitted after 07/01/26 for VTE.	C 533			

Delivery via email to: amber@featherstoneretirement.com

August 20, 2026

License Number: AL0703

Ms. Amber Barber, Administrator
Featherstone Assisted Living Community Of Durant
1919 University Blvd
Durant, OK 74701

Survey Event ID: Y8E411

Dear Ms. Barber:

On **August 4, 2026**, a Relicensure survey with 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 in a timely manner. **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 **August 20, 2026**.

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

Respectfully,



Tempal Killman, Enforcement Analyst II
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: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNITY OF

**1919 UNIVERSITY BLVD
DURANT, OK 74701**

(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 relicensure survey with complaints (#OK00088989 and #OK00087492) was conducted from 08/03/26 through 08/04/26. Deficiencies were cited. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. DON - director of nursing VTE - venous thromboembolism	C 000		
C 319 SS=E	OS 1-890.3(A)(11) Admission Criteria Provisions requiring assisted living centers to make available to residents upon admission a consumer information pamphlet that contains information about venous thromboembolism (VTE) including, but not limited to, risk factors and recognition of the signs and symptoms of VTE; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to provide a venous thromboembolism (VTE) educational pamphlet to 3 (#7, 8, and #9) of 3 sampled residents reviewed for VTE education. The director of nursing identified 30 residents resided in the center. Findings: An admission assessment for Resident #7, dated 07/13/26, showed the resident was admitted on	C 319		

Oklahoma State Department of Health

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

[Signature]

TITLE

Executive Director

(X6) DATE

8/17/2026



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: August 17, 2026

Facility Name: Featherstone Assisted Living

License Number: AL0703-0703

Survey Event ID: Y8E411

Date Survey Completed: 8-4-2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C533

Based on: Based on record review and interview, the center failed to assess residents for signs and symptoms of venous thromboembolism (VTE) for 3 (#7, #8, and #9) of 3 sampled residents reviewed for VTE assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this Plan of Correction does not constitute an admission or agreement with the cited deficiency. The center submits this plan to demonstrate corrective action and ongoing compliance.

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The DON/Designee will ensure Residents #7, #8, and #9 receive a documented screening for signs and symptoms of venous thromboembolism (VTE). Each resident will also receive education regarding VTE warning signs/symptoms and techniques for obtaining an emergency response. Documentation of the screening and education will be placed in each resident record. Any resident exhibiting signs or symptoms concerning for VTE will receive prompt nursing assessment and appropriate provider/emergency follow-up according to facility policy.

The DON/Designee will review the records of all residents admitted on or after July 1, 2026, to identify any resident who may have been affected by the same deficient practice. The review will verify completion and documentation of VTE signs/symptoms screening and VTE emergency-response education. Any missing screening, education, or documentation identified during the review will be corrected promptly.

Effective immediately, the facility will incorporate a standardized VTE screening and education process into the preadmission/admission assessment process. The resident assessment and admission checklist will require documentation of screening for VTE signs and symptoms and education on techniques for obtaining an emergency response. Licensed nursing and admission staff responsible for resident assessments/admissions will be in-serviced on the requirement, the facility VTE screening tool, required education, and documentation expectations. The DON/Designee will verify required VTE documentation during admission chart review before the admission record is considered complete.

Sustained correction: The Administrator/DON or designee will audit 100% of applicable new admissions for completed VTE screening and documented VTE emergency-response education daily for 7 days, then weekly for 3 weeks, then monthly for 3 months. If no new admission occurs during an audit period, the audit will be documented as not applicable and the next applicable admission will be reviewed.

Effectiveness: The corrective action will be considered effective when audits demonstrate 100% completion and documentation of the required VTE screening and education. Any omission will be corrected immediately, and the responsible staff member will receive re-education as indicated.

Quality Assurance: Audit results and any identified trends will be reviewed through the facility Quality Assurance process. The Administrator/DON will report compliance findings and implement additional corrective action if sustained compliance is not demonstrated.

Monitoring records: Completed audit tools, staff education records, resident screening/education documentation, and Quality Assurance review records will be retained by the facility as evidence of sustained correction.

8/20/2026

Administrator's Signature: <u><i>[Signature]</i></u> OAC 310:663-25-4(F)		Date: <u>8/17/2026</u>	
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: August 17, 2026

Facility Name: Featherstone Assisted Living

License Number: AL0703-0703

Survey Event ID: Y8E411

Date Survey Completed: 8-4-2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: Based on observation, record review, and interview, the center failed to ensure: a. food was labeled and dated; and b. expired foods were discarded in 1 of 1 sample refrigerator observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this Plan of Correction does not constitute an admission or agreement with the cited deficiency. The center submits this plan to demonstrate corrective action and ongoing compliance.

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature:

Date: 8/17/2026

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The Dietary Manager/Designee will immediately remove and discard all expired food identified during the survey and will properly label and date, or discard when the date cannot be verified, all food items identified as unlabeled or undated. The reach-in refrigerator, freezer, and dry-storage areas will be inspected to verify that opened, prepared, and stored foods are labeled and dated and that expired foods are removed. Any concern for a resident potentially affected by unsafe food will be reported to nursing for assessment and appropriate provider follow-up.

All residents who receive food from the facility kitchen have the potential to be affected by the same deficient practice. The Dietary Manager/Designee will complete a 100% inspection of the reach-in refrigerator, freezer, and dry-storage areas to identify unlabeled, undated, improperly stored, or expired food. Any item that is expired or cannot be safely identified or dated will be discarded, and all remaining applicable foods will be labeled and dated according to facility policy.

Effective immediately, the facility will reinforce its food labeling, dating, storage, and expiration-date procedures. Dietary staff will be in-serviced on labeling food with the contents and appropriate open/prepared/use-by date, checking manufacturer expiration dates, discarding expired foods, and maintaining safe food-storage practices. The Dietary Manager/Designee will add a food-storage check to the kitchen opening/closing routine and will verify compliance after food deliveries and during routine kitchen rounds. Staff will correct any deficiency when identified before the food is served or remains in storage.

Sustained correction: The Administrator/Dietary Manager or designee will audit the refrigerator, freezer, and dry-storage areas for proper food labeling, dating, storage, and expiration-date compliance daily for 7 days, then weekly for 3 weeks, then monthly for 3 months. Any noncompliant food item will be corrected or discarded immediately, and the responsible staff member will be re-educated as indicated.

Effectiveness: The corrective action will be considered effective when audits demonstrate 100% compliance with food labeling, dating, storage, and expiration-date requirements. Any deficient finding will be corrected immediately and included in follow-up monitoring.

Quality Assurance: Audit results and identified trends will be reviewed through the facility Quality Assurance process. The Administrator/Dietary Manager will report compliance findings and implement additional corrective action or staff education if sustained compliance is not demonstrated.

Monitoring records: Completed food-storage audit tools, dietary in-service records, corrective-action documentation, and Quality Assurance review records will be retained by the facility as evidence of sustained correction.

OAC 310:663-25-4(F)			
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: August 17, 2026

Facility Name: Featherstone Assisted Living

License Number: AL0703-0703

Survey Event ID: V8E411

Date Survey Completed: 8-4-2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C319

Based on: Based on record review and interview, the center failed to provide a venous thromboembolism (VTE) educational pamphlet to 3 (#7, #8, and #9) of 3 sampled residents reviewed for VTE education.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this Plan of Correction does not constitute an admission or agreement with the cited deficiency. The center submits this plan to demonstrate corrective action and ongoing compliance.

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature:

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The Nurse Manager/Designee will immediately provide Residents #7, #8, and #9 with a consumer information pamphlet regarding venous thromboembolism (VTE), including VTE risk factors and recognition of signs and symptoms. Receipt of the VTE information will be documented in each resident's record using the facility VTE education acknowledgement/admission documentation. Any resident questions or concerns identified during education will be addressed and referred to the resident's provider as appropriate.

All residents admitted to the center on or after July 1, 2026 have the potential to be affected. The nurse manager/designee will complete a 100 % audit of residents that admitted on or after July 1, 2026 to verify that the required VTE pamphlet was provided to them. Any resident found after July 1, 2026 without the pamphlet will be provided one immediately.

Effective immediately, the facility admission process will include the VTE consumer information pamphlet as required. The VTE pamphlet is the pamphlet provided by the CDC and located on their website. Admission packet will be reviewed for completion before the admission process is considered complete.

Sustained correction: The Administrator/Nurse Manager or designee will audit 100% of new admissions for VTE pamphlet documentation for 7 days, then weekly for 3 weeks, then monthly for 3 months. If no admission occurs during a monitoring period, the audit tool will document "no new admissions." Any missing pamphlet or documentation will be corrected immediately and the responsible staff member will be re-educated.
Effectiveness: The corrective action will be considered effective when audits demonstrate 100% compliance that each new resident received the required VTE consumer information pamphlet upon admission and the resident record contains documentation of receipt/education.
Quality Assurance: Audit results and any identified trends will be reviewed through the facility Quality Assurance process. The Administrator/Nurse Manager will implement additional education or corrective action if sustained compliance is not demonstrated.
Monitoring records: Completed VTE admission audit tools, VTE education acknowledgements, revised admission checklists, staff in-service records, corrective-action documentation, and Quality Assurance review records will be retained by the facility as evidence of sustained correction.

8/20/2026

Date: 8/17/2026

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.

Delivery via email to: amber@featherstoneretirement.com

August 28, 2026

License Number: AL0703

Ms. Amber Barber, Administrator
Featherstone Assisted Living Community Of Durant
1919 University Blvd
Durant, OK 74701

Survey Event ID: Y8E412

Dear Ms. Barber:

On **August 25, 2026**, a revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **August 4, 2026**, have now been corrected effective **August 20, 2026**.

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 II
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: AL0703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/25/2026
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FEATHERSTONE ASSISTED LIVING COMMUNITY OF **1919 UNIVERSITY BLVD**
DURANT, OK 74701

(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 08/25/26. All deficiencies from the 08/04/26 survey were cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE