Oklahoma State Department of Health
Creating a State of Health

December 23, 2019

License Number: AL0901

Ms. Latasha Winship, Administrator
Victorian Estates
1129 Cameo Drive
Yukon, OK 73099

RE: Survey Event ID: 0RRJ11

Dear Ms. Winship:

On **December 10, 2019,** agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on December 10, 2019.

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

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

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

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

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

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

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

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

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

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL0901	A BUILDING. _____ B. WING _____	12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN ESTATES	1129 CAMEO DRIVE YUKON, OK 73099

(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 was conducted 12/09/19 and 12/10/19. Resident census was 30. The following deficient practices were cited.	C 000		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure insulin injection sites were documented for 2 (#2 and #8) of 2 sampled residents who were administered insulin per home health nurses. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #2	C1923		

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

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C1923	Continued From page 1 Resident #2 was admitted to the center 10/28/16 with diagnoses to include diabetes mellitus. The resident had a physician's order for Levemir (insulin) twice daily and Humalog (insulin) twice daily if the resident's blood sugar results met the parameters the physician had put in place. The resident's home health notes were reviewed and the site of the insulin injection was only documented twice by the home health nurses since 11/01/19. Resident #8 Resident #8 was admitted to the center 04/08/19 with diagnoses to include diabetes mellitus. The resident had a physician's order for insulin to be administered twice daily by injection. The resident's home health notes were reviewed and the insulin injection site was not documented at least 12 times from 11/21/19 to 12/15/19. On 12/10/19 at 11:00 a.m., the licensed practical nurse was asked where the home health nurses documented the insulin injection sites for residents #2 and #8. She looked at the home health notes and stated they did not document the injection sites.	C1923		
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.	C1951		

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C1951	Continued From page 2 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure insulin administration times were recorded for 2 (#2 and #8) of 2 sampled residents who were receiving insulin injections per home health nurses. This failed practice had the potential for more than minimal harm. Findings: Resident #2 Resident #2 was admitted to the center 10/28/16 with diagnoses to include diabetes mellitus. The resident had a physician's order for Levemir (insulin) twice daily and Humalog (insulin) twice daily if the resident's blood sugar results met the parameters the physician had put in place. The resident's home health notes were reviewed. The dates of the insulin injections was documented, but the times were not documented since at least 11/01/19. Resident #8 Resident #8 was admitted to the center 04/08/19 with diagnoses to include diabetes mellitus. The resident had a physician's order for insulin to be administered twice daily by injection. The resident's home health notes were reviewed and the times for the insulin injections were not documented at least since 11/01/19. On 12/10/19 at 11:00 a.m., the licensed practical nurse was asked what time the home health	C1951		

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C1951	Continued From page 3 nurses administered the insulin for residents #2 and #8. She looked at the home health notes and stated the home health nurses did not document the insulin injection times.	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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C5010	Continued From page 4	C5010		

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the center failed to ensure the coordination of care and services between the center and third party providers (home health), for 1 (#2) of 2 sampled residents who received finger stick blood sugars (FSBS) and the administration of insulin by the third party providers. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings:

Resident #2 was admitted to the center 10/28/16 with diagnoses to include diabetes mellitus. The center had a physician's order, dated 09/12/17, for Levemir (insulin) 26 units to be administered SQ (subcutaneously under the skin) at bedtime per home health and an order, dated 08/31/18, for Levemir 10 units SQ every morning per home health. The center also had an order for escitalopram (antidepressant), dated 09/30/19, 20 mg (milligrams) by mouth at bedtime.

Resident #2 had home health orders, for home health certification period from 10/17/19 to 12/15/19, for Humalog (insulin) twice daily, dose dependent upon results of blood sugar as follows:
Blood sugar 70-150 mg/dl (milligrams per deciliter) give 0 units
151-200 mg/dl give 6 units
201-300 mg/dl give 12 units
301-400 mg/dl give 20 units
401-500 mg/dl give 25 units and
over 501 mg/dl give 35 units.

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C5010	Continued From page 5 The resident also had a home health order for the same certification period for Levemir 10 units SQ twice daily and for escitalopram 5 mg by mouth daily. Home health notes were reviewed with the LPN. Twice within the last wo weeks, resident #2 should have gotten Humalog according to FSBS results. On 11/30/19 her FSBS result was 177. The resident should have received 6 units of Humalog, but the home health nurse documented no Humalog was given. Also on 12/5/19, the resident's blood sugar result was 238 and the home health nurse documented no Humalog was given. She should have received 12 units of Humalog. The LPN stated the center did not have the Humalog sliding scale order and should have coordinated with home health to ensure the resdient received the Humalog as ordered. On 12/10/19 at 11:00 a.m., the licensed practical nurse was asked about the discrepancy in the center's orders and the home health orders for the resident's insulin. She looked at the orders and stated the center had old orders for insulin that should have been updated when the home health orders changed. She was not sure why the discrepancy with the escitalopram orders.	C5010		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL0901	VICTORIAN ESTATES

Type of Survey (select all that apply)

2

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

Extent of Survey (select all that apply)

A

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 36967	12/09/2019	12/10/2019	0.25	0.00	9.00	0.00	3.00	2.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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

Oklahoma State Department of Health
Creating a State of Health

January 8, 2020

License Number: AL0901

Ms. Latasha Winship, Administrator
Victorian Estates
1129 Cameo Drive
Yukon, OK 73099

RE: Survey Event 0RRJ11

Dear Ms. Winship:

On December 10, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 7, 2020**.

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

Sincerely,

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

SD/jt

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted 12/09/19 and 12/10/19. Resident census was 30. The following deficient practices were cited.	C 000	**Preparation and execution of this Plan of Correction are not an admission or agreement by the provider of the truth of the allegations in the statement of deficiencies. This Plan of Correction is prepared and executed solely as it is required by state and federal law. Please accept this Plan of Correction as our Credible Allegation of Compliance.	
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure insulin injection sites were documented for 2 (#2 and #8) of 2 sampled residents who were administered insulin per home health nurses. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #2	C1923	01/07/20 C1923 How Corrective Action Will Be Accomplished for those Residents Affected. Resident #2 & #8's Home Health providers were contacted to inform them of the requirement for documenting injection sites at time of administration of insulin or any injection. How Facility Will Identify Other Residents Potentially Affected: All other residents receiving injections /insulin were audited for documentation of injection sites. What Measures will be put into Place to Ensure Deficient Practice does not Recur A letter was mailed to each Home Health Provider informing them of the requirement for documenting injection sites at time of administration of insulin or any injection. How the Facility will Monitor its Corrective Actions to Ensure that the Deficient Practice Will Not Recur: The DON or designee will monitor documentation of injections 2xweekly and call the home health if a site is not documented. The QAPI committee will evaluate audits monthly make any additional recommendations to the plan as needed. RECEIVED JAN -7 2020 Long Term Care	

Oklahoma State Department of Health

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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.	C1951	RECEIVED JAN - 7 2020 Long Term Care	01-07-20

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C1951	Continued From page 2 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure insulin administration times were recorded for 2 (#2 and #8) of 2 sampled residents who were receiving insulin injections per home health nurses. This failed practice had the potential for more than minimal harm. Findings: Resident #2 Resident #2 was admitted to the center 10/28/16 with diagnoses to include diabetes mellitus. The resident had a physician's order for Levemir (insulin) twice daily and Humalog (insulin) twice daily if the resident's blood sugar results met the parameters the physician had put in place. The resident's home health notes were reviewed. The dates of the insulin injections was documented, but the times were not documented since at least 11/01/19. Resident #8 Resident #8 was admitted to the center 04/08/19 with diagnoses to include diabetes mellitus. The resident had a physician's order for insulin to be administered twice daily by injection. The resident's home health notes were reviewed and the times for the insulin injections were not documented at least since 11/01/19. On 12/10/19 at 11:00 a.m., the licensed practical nurse was asked what time the home health	C1951	C1951 How Corrective Action Will Be Accomplished for those Residents Affected: Resident #2 & #8's Home Health providers were contacted to inform them of the requirement for documenting the time of injections & injection sites at time of administration of insulin or any injection. How Facility Will Identify Other Residents Potentially Affected: All other residents receiving injections /insulin were audited for documentation of injection sites and times of administration. What Measures will be put into Place to Ensure Deficient Practice does not Recur: A letter was mailed to each Home Health Provider informing them of the requirement for documenting injection sites and times of administration at time of administration of insulin or any injection. How the Facility will Monitor its Corrective Actions to Ensure that the Deficient Practice Will Not Recur: The DON or designee will monitor documentation of injections 2xweekly and call the home health if a site is not documented or the time of administration. The QAPI committee will evaluate audits monthly make any additional recommendations to the plan as needed.	

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C1951	Continued From page 3 nurses administered the insulin for residents #2 and #8. She looked at the home health notes and stated the home health nurses did not document the insulin injection times.	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010	C5010 How Corrective Action Will Be Accomplished for those Residents Affected· Resident #2's physician & Home Health Provider were contacted regarding clarification orders for insulin/FSBS and the residents medical record was updated. How Facility Will Identify Other Residents Potentially Affected· All other residents receiving insulin were audited for current orders with home health orders; if a discrepancy was noted, the physician and home health were contacted for clarification. What Measures will be put into Place to Ensure Deficient Practice does not Recur: A letter was mailed to each Home Health Provider informing them of the requirement to notify the facility of any change in physician's orders so that our care is coordinated and our records match. All home health orders were audited to ensure both sets of orders are updated the same. Each month the DON or designee will review home health orders to ensure coordination of care is accurate. How the Facility will Monitor its Corrective Actions to Ensure that the Deficient Practice Will Not Recur: The DON or designee will monitor documentation of insulin & injections 2xweekly and call the home health if a site or time is not documented. All monthly orders will be reviewed monthly to ensure coordination of care. The QAPI committee will evaluate audits monthly make any additiona recommendations to the plan as needed.	01-07-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0901	A. BUILDING _____ B. WING _____	12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN ESTATES	1129 CAMEO DRIVE YUKON, OK 73099

(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
C5010	Continued From page 4	C5010		

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the center failed to ensure the coordination of care and services between the center and third party providers (home health), for 1 (#2) of 2 sampled residents who received finger stick blood sugars (FSBS) and the administration of insulin by the third party providers. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings:

Resident #2 was admitted to the center 10/28/16 with diagnoses to include diabetes mellitus. The center had a physician's order, dated 09/12/17, for Levemir (insulin) 26 units to be administered SQ (subcutaneously under the skin) at bedtime per home health and an order, dated 08/31/18, for Levemir 10 units SQ every morning per home health. The center also had an order for escitalopram (antidepressant), dated 09/30/19, 20 mg (milligrams) by mouth at bedtime.

Resident #2 had home health orders, for home health certification period from 10/17/19 to 12/15/19, for Humalog (insulin) twice daily, dose dependent upon results of blood sugar as follows:
Blood sugar 70-150 mg/dl (milligrams per deciliter) give 0 units
151-200 mg/dl give 6 units
201-300 mg/dl give 12 units
301-400 mg/dl give 20 units
401-500 mg/dl give 25 units and
over 501 mg/dl give 35 units.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0901	A. BUILDING _____ B. WING _____	12/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C5010	Continued From page 5 The resident also had a home health order for the same certification period for Levemir 10 units SQ twice daily and for escitalopram 5 mg by mouth daily. Home health notes were reviewed with the LPN. Twice within the last wo weeks, resident #2 should have gotten Humalog according to FSBS results. On 11/30/19 her FSBS result was 177. The resident should have received 6 units of Humalog, but the home health nurse documented no Humalog was given. Also on 12/5/19, the resident's blood sugar result was 238 and the home health nurse documented no Humalog was given. She should have received 12 units of Humalog. The LPN stated the center did not have the Humalog sliding scale order and should have coordinated with home health to ensure the resdient received the Humalog as ordered. On 12/10/19 at 11:00 a.m., the licensed practical nurse was asked about the discrepancy in the center's orders and the home health orders for the resident's insulin. She looked at the orders and stated the center had old orders for insulin that should have been updated when the home health orders changed. She was not sure why the discrepancy with the escitalopram orders.	C5010		

Oklahoma State Department of Health
Creating a State of Health

January 23, 2020

License Number: AL0901

Ms. Latasha Winship, Administrator
Victorian Estates
1129 Cameo Drive
Yukon, OK 73099

RE: Survey Event 0RRJ12

Dear Ms. Winship:

On **January 9, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 10, 2019,** have now been corrected effective **January 7, 2020.**

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL0901	A. BUILDING _____ B. WING _____	R 01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN ESTATES	1129 CAMEO DRIVE YUKON, OK 73099

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{C 000}	INITIAL COMMENTS A follow-up visit was conducted on 01/09/2020. Resident census was 31. All deficient practice was cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL0901	VICTORIAN ESTATES

Type of Survey (select all that apply)

2	D			

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	01/09/2020	01/09/2020	0.25	0.00	1.50	0.00	4.00	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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