OKLAHOMA
State Department
of Health

**Delivery via email to:** admin@victorianestatesal.com

June 16, 2023

License Number: AL0901

Ms. Marcie Musick, Administrator
Victorian Estates
1129 Cameo Drive
Yukon, OK 73099

**RE: Survey Event ID: MAYV11**

Dear Ms. Musick:

On **May 25, 2023**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on May 25, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Victorian Estates**
**Address:** **1129 Cameo Drive**
**City, State, Zip:** **Yukon, OK 73099**
**Provider #:** **AL0901**
**Complaint #:** **OK00060474**
**Investigation Date(s):** **05/23/23 through 05/25/23**

## ALLEGATION(S)

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| 1. The facility failed to have and/or implement an infection control program for Covid-19. |
| 2. The facility failed to ensure residents were not neglected. |
| 3. The facility failed to ensure staff were qualified and/or licensed to perform their job duties. |

An unannounced on-site investigation was initiated 05/23/2023 at 11:00 a.m.

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

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

**A Summary of Complaint Investigation:**

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for staff presence, and a clean, sanitary, and homelike environment. A medication observation pass was completed. Housekeeping was observed cleaning resident rooms.

Resident records were reviewed including the service agreements, closed records, assessments, physician's orders, care plans, hospice communication visits and hospice records. The center's incident reports were reviewed, staff and resident Covid-19 testing results, and Covid-19 policies and procedures were also reviewed. Staff licensures/certifications were reviewed.

Residents were interviewed regarding wound care treatments, Covid-19 testing, and medication administration. Residents were also interviewed related to abuse and neglect, staffing, and services provided by third party providers.

Staff members were interviewed regarding the center's policy on medication administration, wound care, turn and repositioning, and obtaining physician orders. Staff were interviewed about their certifications and licensing related to their job duties.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Julie Edmiaston

Digitally signed by Julie Edmiaston
Date: 2023.05.26 12:36:17 -05'00'

Julie Edmiaston RN, BSN

Date report completed: 05/26/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | AL0901 | A. BUILDING: _____ B. WING _____ | C 05/25/2023 |

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| VICTORIAN ESTATES | 1129 CAMEO DRIVE YUKON, OK 73099 |

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| C 000 | INITIAL COMMENTS<br><br>A relicensure survey was conducted from 05/23/23 through 05/25/23. A complaint investigation (#OK00060474) was conducted in conjunction with the survey.<br><br>Listed below are abbreviations that will be used throughout this document:<br><br>AL- Assisted Living<br>ADON/ACMA- Assistant Director of Nurses/Advanced Certified Medication Aide<br>CMA- Certified Medication Aide<br>ED/DON- Executive Director/Director of Nurses<br>GM- Gram<br>HCL- Hydrochloric Acid<br>hrs- hours<br>MARs- Medication Administration Records<br>q- every<br>RN- Registered Nurse<br>tab- tablet | C 000 | | |
| C 398 SS=E | 310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE<br><br>(e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the center failed to ensure that two (#1 and #2) of two sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State | C 398 | | |

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| C 398 | Continued From page 1<br>Department of Health.<br><br>The ED/DON identified 35 residents who received food from the kitchen.<br><br>Findings:<br><br>A "Competencies for Nutrition Services Employees" policy, revised 11/2022, read in parts, "...Maintains required certifications, obtaining and renewing as needed in a timely manner..."<br><br>Dietary manager #1 had a hire date of 07/20/21.<br><br>Dietary cook #2 had a hire date of 01/18/23.<br><br>On 05/23/23 at 11:36 a.m., dietary staff files were reviewed for required training. Dietary manager #1 and cook #2 did not have documentation for completing an approved food service training program.<br><br>On 05/23/23 at 4:00 p.m., a kitchen tour was conducted and cook #2 was asked about food service training. They reported they had worked at the center for six months and had not had any food service training.<br><br>On 05/24/23 at 3:30 p.m., the ED/DON reported both of the dietary staff received their food service training today, 05/24/23.<br><br>On 05/25/23 at 10:00 a.m., the RN reported it was the center's expectation to have dietary staff trained within 30 days of hire. | C 398 | | |
| C 522 SS=E | 310:663-5-2(b) ASSESSMENT TIMEFRAMES<br><br>(b) The assisted living center shall complete the | C 522 | | |

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| C 522 | Continued From page 2 | C 522 | | |

comprehensive assessment in accordance with the following:
(1) within fourteen (14) days after admission of the resident;
(2) once every twelve (12) months thereafter; and
(3) promptly after a significant change in the resident's condition.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to complete an annual comprehensive assessment for four (#1, 2, 7, and #8) of eight residents sampled for assessments.

The "Assisted Living Resident Condition and Care Overview" report, dated 05/23/23, documented 35 residents resided in the center.

Findings:

1. Resident #1's "Assisted Living Residency Agreement," dated 09/06/18, read in part, "...The comprehensive assessment will be completed again every 12 months following your admission or promptly after a significant change in your condition..."

Resident #1's diagnoses include inflammation, allergies, agitation, and dementia.

A "Resident Assessment Form," dated 03/30/22, was documented in the clinical record. The clinical record did not contain an annual assessment for 2023.

On 05/24/23 at 9:22 a.m., the ED/DON reported

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| C 522 | Continued From page 3<br>there was not a current annual assessment for Resident #1.<br><br>2. Resident #2's "Assisted Living Residency Agreement," dated 08/05/20, read in part, "...The comprehensive assessment will be completed again every 12 months following your admission or promptly after a significant change in your condition..."<br><br>Resident #2's diagnoses include hearing loss, memory loss, and osteoarthritis.<br><br>A "Resident Assessment Form," dated 03/10/21, was documented in the clinical record. The clinical record did not contain an annual assessment for 2023.<br><br>On 05/24/23 at 9:25 a.m., the ED/DON reported there was not a current annual assessment for Resident #2.<br><br>3. Resident #7's diagnoses include transient ischemic attack, atrial fibrillation, and high blood pressure.<br><br>A "Resident Assessment Form," dated 03/29/22, was documented in the clinical record. The clinical record did not contain an annual assessment for 2023.<br><br>On 05/24/23 at 11:08 a.m., the ED/DON reported the annual assessment for Resident #7 was due in March 2023, and there was not a current annual assessment.<br><br>4. Resident #8's diagnoses include high blood pressure, dementia, and nerve pain.<br><br>A "Resident Assessment Form," dated 03/29/22, | C 522 | | |

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| C 522 | Continued From page 4<br>was documented in the clinical record. The clinical record did not contain an annual assessment for 2023.<br><br>On 05/24/23 at 11:05 a.m., the ED/DON reported there was not a current annual assessment for Resident #8. | C 522 | | |
| C 542 SS=D | 310:663-5-4(b) CONDUCT OF ASSESSMENT<br><br>(b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, it was determined the center failed to ensure a comprehensive assessment was coordinated and/or signed by an RN and/or physician for one (#5) of eight residents sampled for assessments.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 05/23/23, documented 35 residents resided in the center.<br><br>Findings:<br><br>Resident #5's "Assisted Living Residency Agreement," dated 10/11/21, read in part, "...The comprehensive assessment will be completed again every 12 months following your admission or promptly after a significant change in your condition..."<br><br>Resident #5's diagnoses included anemia, atrial fibrillation, congestive heart failure. | C 542 | | |

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| C 542 | Continued From page 5<br><br>A "Significant Change Assessment," dated 08/29/22, did not contain a signature from the RN and/or physician.<br><br>On 05/24/23 at 11:45 a.m., the ED/DON reported Resident #5's assessment had not been signed, and did not include a signature from the RN and/or physician. | C 542 | | |
| C 543 SS=D | 310:663-5-4(c) CONDUCT OF ASSESSMENT<br><br>(c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, it was determined the center failed to conduct a personal interview for one (#5) of eight residents sampled for comprehensive assessments.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 05/23/23, documented 35 residents resided in the center.<br><br>Findings:<br><br>Resident #5's "Assisted Living Residency Agreement," dated 10/11/21, read in part, "...The comprehensive assessment will be completed | C 543 | | |

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| C 543 | Continued From page 6<br>again every 12 months following your admission or promptly after a significant change in your condition..."<br><br>Resident #5's diagnoses included anemia, atrial fibrillation, congestive heart failure.<br><br>A "Significant Change Assessment," dated 08/29/22, did not document a signature from the resident and/or the resident's representative.<br><br>On 05/24/23 at 11:28 a.m., the ED/DON reported Resident #5's assessment had not been signed and did not include a personal interview with the resident or the resident's representative. | C 543 | | |
| C 910 SS=E | 310:663-9-1 NURSE<br><br>Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: | C 910 | | |

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| C 910 | Continued From page 7 | C 910 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to ensure physician orders were transcribed by a licensed nurse for one (#10) of ten sampled residents reviewed for medications.

The "Assisted Living Resident Condition and Care Overview" report, dated 05/23/23, documented 35 residents resided in the center.

Findings:

A "Medication Administration by the Assisted Living Community" policy, dated May 2019, read in part, "...The AL Community should have a formalized program of medication management oversight and review by an RN and consultant pharmacist to ensure that medication policies and procedures are appropriately implemented and followed..."

Resident #10's "Plan of Care," dated 12/12/22, read in part, "...All medications given per physician order by qualified staff..."

Resident #10's "Physician Orders," dated 05/15/23, read in part, "...Start Valacyclovir...1 GM 1 tablet orally every 8 hours, 7 days...Put on MARS 05/16/23 ADON/ACMA..." The ADON/ACMA was not qualified to document the medication from the physician's order to the MAR.

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| C 910 | Continued From page 8<br><br>Resident #10's "MAR," dated 05/15/23, read in part, "...Valacyclovir HCL tab 1 gm, 1 tab, orally Q 8 hrs x 7 days...05/16/23 ADON/ACMA..." The ADON/ACMA signed and dated the MAR underneath this medication to indicate she transcibed the medication from the physician's orders to the MAR.<br><br>On 05/23/23 at 1:59 p.m., CMA #1 administered valacyclovir [antiviral] 1 gram tablet to Resident #10 during a medication pass.<br><br>On 05/24/23 at 1:40 p.m., the ED/DON was asked if the ADON/ACMA noted physician orders. They stated, they did not. The ED/DON reported the ADON/ACMA entered orders on the medication administration record. Then the ED/DON would follow up on the orders, and "note the order." The ED/DON was asked if they noted the order before the medication was administered, they stated, "Yes." The ED/DON was asked if they had noted the order, dated 05/15/23, for resident #10's valacyclovir. They stated, "No, I did not." The ED/DON was asked to review the medication aide's job description and was asked if the job description included to note physician orders. The ED/DON stated, "I do not see where they can note orders." | C 910 | | |
| C1505 SS=E | 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care<br><br>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<br><br>63 O.S. 1-1918.(B)(5)<br>(5) Every resident shall have the right to receive | C1505 | | |

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| C1505 | Continued From page 9<br>adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the center failed to follow the center's policy, and identify close contacts/staff for residents positive for COVID-19, for three (#2, 7, and #8) of three residents sampled for infection control.<br><br>The ED/DON identified three residents who resided in the center with positive Covid-19 results in April 2023. | C1505 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C1505 | Continued From page 10<br><br>Findings:<br><br>The "Covid-19" infection control policy, effective March 2023, Revised May 2023, read in part, "...2. Utilizing the Contact Tracing Form: a. Identify those persons who have been in close contact with the positive person (less than 6 feet for more than 15 minutes (cumulative in a 24-hour period. Ex: 5 minutes 3 times). These will be close contacts. b. With the list of close contacts, identify those who had a high-risk exposure from C.1. above...Close contacts with a high-risk exposure: a. All close contacts will be tested on day 1, 3 & 5 from their last contact...Residents identified as close contacts with high-risk exposure will be monitored for signs and symptoms..."<br><br>A "Testing Log," dated 04/17/23, documented Residents #2, 7, and #8 tested positive for Covid-19.<br><br>On 05/24/23 at 8:50 a.m., the ED/DON was asked if the facility had identified close contacts of resident #2, 7, and #8 when they tested positive for Covid-19. The ED/DON reported they did not identify the close contacts for other residents or staff. The ED/DON reported the facility did not identify any close contacts with high risk of exposure to the residents who tested positive. They were asked if they identified any of the close contacts the residents dined with. They reported they did not. After reviewing testing logs, the ED/DON was asked why the facility stopped testing residents after 04/17/23 for Covid-19. The ED/DON stated the ADON had left and the ball just got dropped. The ED/DON was asked if it was the center's policy to identify close contacts related to residents who tested positive | C1505 | | |

| 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 _____ | C 05/25/2023 |

| 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 |
|---|---|---|---|---|
| C1505 | Continued From page 11<br>for Covid-19 and they stated, "Yes." | C1505 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** bratcliff@stonegatesl.com

July 5, 2023

License Number: AL0901

Ms. Brandy Ratcliff, Regional Director of Operations
Victorian Estates
1129 Cameo Drive
Yukon, OK 73099

**Survey Event ID: MAYV11**

Dear Ms. Ratcliff:

On **May 25, 2023,** a Licensure inspection and a Complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 19, 2023**.

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

Respectfully,

Tempal Killman

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

enc

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/3/2013**<br>**Facility Name:** Victorian Estates<br>**License Number:** AL0901<br>**Survey Event ID:** MAYV11<br>**Date Survey Completed: 5/25/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 398 Food Storage, Preparation and Service | Based on: record review and interview, the center failed to ensure that two (#1 and #2) of two sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed soley as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.

| **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? | Residents who reside in the facility and consume food from the kitchen have the potential to be affected by the alleged deficient practice. All dietary employee files were reviewed and anyone without evidence of having a food service training program did complete this during survey. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Residents who reside in the facility and consume food from the kitchen have the potential to be affected by the alleged deficient practice. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? | Administrator/Designee will educate the Interdisciplinary team and the dietary staff that anyone who is hired for the dietary department and prepares food will attend a food service training program prior to preparing and serving food. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Administrator/Designee will monitor all new employees hired in the dietary department to assure that they have attended a food service training program prior to preparing food. Any deficient practice that is identified will be corrected immediately.<br><br>Monitoring will be taken to the quarterly QAPI committee for any further recommendations.<br><br>Copy of the monitoring will be placed in the QAPI committee book to review and evaluate effectiveness of the plan of correction and that system remains in place.<br><br>Once substantial compliance is met this monitoring will continue quarterly to assure this system is effective. |

| | | | |
|---|---|---|---|
| OSDH Response: Element accepted Yes ☐ No ☐ | | | |
| 5. On what date will corrective action be completed? | | 7/19/2023 | |
| OSDH Response: Element accepted Yes ☐ No ☐ | | | |
| **Administrator's Signature** OAC 310:663-25-4(F) | | | **Date 7/3/2023** |
| If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted. | | | |
| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |
| Items Below Are For OSDH Use Only | | | |
| Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor | | | |
| **If Plan of Correction is unacceptable, the reasons are as follows:** Click here to enter text. **Facility in Compliance by:** Click here to enter a date. | | | |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/3/2013**<br>**Facility Name:** Victorian Estates<br>**License Number:** AL0901<br>**Survey Event ID:** MAYV11<br>**Date Survey Completed: 5/25/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 522<br>Assessment Timeframes | Based on: record review and interview, the center failed to complete an annual comprehensive assessment for four (#1, 2, 7, and #8) of eight residents sampled for assessments. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed soley as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.

| **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? | Resident #1, 2, 7, and #8 assessments have been completed and the residents had the potential be be affected by the alleged 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? | Residents who admit, reside, or have a change of condition have the potential to be affected by the alleged deficient practice. |
| 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? | RN educated the Administrator/DON and the ADON that assessments are to be completed within 14 days of admission, annually thereafter, or immediately after a change of condition. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | RN/Designee will perform an initial audit on all resident charts to determine any assessments that need to be completed. RN/Designee will perform random chart audits monthly to assure that assessments are completed within 14 days of admission, annually thereafter, and/or immediately following a change of condition.<br><br>Audits will be forwarded to the quarterly QAPI committee for any further recommendations.<br><br>Once the facility has met substantial compliance the audits will be conducted quarterly to assure that assessments are completed within 14 days of admission, annually thereafter, and immediately following a significant change.<br><br>Copies of the audit will be submitted and kept in the QAPI committee binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/19/2023 |

| | | | |
|---|---|---|---|
| OSDH Response: Element accepted Yes ☐ No ☐ | | | |
| **Administrator's Signature** Administrator signature required. OAC 310:663-25-4(F) | | **Date** Enter a date of signature. 7.023 | |
| 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.<br>Facility in Compliance by: Click here to enter a date. | | | |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/3/2013**<br>**Facility Name:** Victorian Estates<br>**License Number:** AL0901<br>**Survey Event ID:** MAYV11<br>**Date Survey Completed: 5/25/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 542 Conduct of Assessment | Based on: interview and record review, it was determined the center failed to ensure a comprehensive assessment was coordinated and/or signed by an RN and/or physician for one(#5) of eight residents sampled for assessments. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed soley as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.

| **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? | Resident # 5 chart was reviewed and a new assessment was coordinated and/or signed by the RN. The resident has the potential to be affected by the alleged 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? | Residents who reside in the facility have the potential to be affected by the alleged deficient practice. |
| 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? | RN/Designee educated the Administrator/DON and ADON that the RN and.or phsycian must coordinate and/or signed off on all assessments. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | RN/Designee will conduct an initial audit to assure that all assessments have been coordinated and/or signed by an RN. RN will conduct monthly audits to assure that assessments are coordinated and/or signed by an RN. Any deficient practice will be corrected immediately.<br><br>Audits will be taken to the quarterly QAPI committee for any further recommendations.<br><br>Once the facility establishes substantial compliance these audits will be conducted quartly.<br><br>Copies of the audits will be added to the QAPI committee binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/19/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature**<br>OAC 310:663-25-4(F) | **Date 7/3/2023** |
|---|---|

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

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/3/2013**<br>**Facility Name:** Victorian Estates<br>**License Number:** AL0901<br>**Survey Event ID:** MAYV11<br>**Date Survey Completed: 5/25/2023** |
|---|---|

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C 543 Conduct Assessment | Based on: record review and interview, it was determined the center failed to conduct a personal interview for one (#5) of eight residents sampled for comprehensive assessments. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed soley as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.

| 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? | Resident #5 chart was reviewed and a new assessment was completed with a personal interview. This resident had the potential to be affected by the alleged 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? | Residents who reside in the facility have the potential to be affected by the alleged deficient practice. |
| 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? | RN/Designee will educate the Administrator/DON and ADON that all resident assessments also includes a personal interview. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Licensed Nurse will complete an initial audit to assure that residents interviews were completed with assessments. Licensed Nurse/Designee will conduct monthly audits to assure that residents assessments included a personal interview. Any deficient practice identified will be corrected immidaitley.<br><br>Results of audits will be forearded to quarterly QAPI committee for any further recommendations.<br><br>Once the facility achieves substantial compliance the audits will be completed quarterly.<br><br>Copies of the audits will be kept in the QAPI Committee binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/19/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** Grandy Patel<br>OAC 310:663-25-4(F) | **Date 7/3/2023** |
|---|---|

| If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted. | | | |
|---|---|---|---|
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| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/3/2013**<br>**Facility Name:** Victorian Estates<br>**License Number:** AL0901<br>**Survey Event ID:** MAYV11<br>**Date Survey Completed: 7/25/2023** |
|---|---|

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C 910 Nurse | Based on: record review and interview, the center failed to ensure physician orders were transcribed by a licensed nurse for one (#10) of ten sampled residents reviewed for medications. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed soley as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.

| 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? | Resident #10 physicain orders were reviewed for correct transcription. The resident had the potential to be affected by the alleged 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? | Residents who reside in the facility and have medciaitons and/or treatment orders have the potential to be affected by the alleged deficient practice. |
| 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? | RN/Designee educated the Administrator/DON, ADON, and Certified Medications Aides to include any Advnaced Certified Medications Aides that physician orders will be transcribed then reviewed and noted by a licensed nurse prior to administration of medications and/or treatments. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Licensed Nurse/Designee will randomly audit physician orders weekly for 30 days then monthly to assure that physician orders are transcribed then reviewed and noted by a licensed nures prior to administration of medications and/or treatments. Any deficient practice identified will be corrected immediately.<br><br>Results of the audtils will be forwarded to the QAPI committee quarterly for any further recommendations.<br><br>Once the facility achieves substantial compliance the audits will be conducted quarterly.<br><br>Audits will be placed in the QAPI committee binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/19/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature**<br>OAC 310:663-25-4(F) | **Date 7/3/2023** |
|---|---|

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|---|---|---|---|
| **Addendum Date** | Enter a date of addendum. | **Submitted by** | Enter name of person submitting addendum. |
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| Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor | | | |
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| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/3/2013**<br>**Facility Name:** Victorian Estates<br>**License Number:** AL0901<br>**Survey Event ID:** MAYV11<br>**Date Survey Completed: 5/25/2023** |
|---|---|

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C 1505<br>Resident Rights | Based on: record review and interview, the center failed to follow the center's policy, and identify close contacts/staff for residents positive for COVID-19, for three (#2, 7, and #8) of three residents sampled for infection control. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed soley as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.

| 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? | Residents #2, 7, and #8 charts were reviewed. These residents had the potential to be affected by the alleged 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? | Residents who reside in the facility and had close contact with Residents #2, 7, #8 had the potential to be affected by the alleged deficient practice. |
| 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? | RN/Designee educated the Administrator/DON, ADON, and staff that conduct COVID 19 testing that when a resident/staff is identified as COVID 19 postive that contact tracing must be conducted and any close contacts will need to be tested on days 1, 3, and 5. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Licensed Nurse/Designee will conduct audits during any COVID 19 outbreak to assure contact tracing was conducted and any contacts identified will be tested on days 1, 3, and 5.<br><br>Results of the audits will be forwarded to the QAPI committee for any further recommendations.<br><br>Once the facility achieves substantial compliance the audtis will be conducted quarterly.<br><br>Copies of the audtis will be kept in the QAPI committee binder. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/19/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature**<br>OAC 310:663-25-4(F) | **Date 7/3/2023** |
|---|---|

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

OKLAHOMA
State Department of Health

**Delivery via email to:** bratcliff@stonegatesl.com; 'admin@victorianestatesal.com'

August 24, 2023

License Number: AL0901

Ms. Brandy Ratcliff, Administrator
Victorian Estates
1129 Cameo Drive
Yukon, OK 73099

**RE: Survey Event MAYV12**

Dear Ms. Ratcliff:

On **August 22, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 25, 2023,** have now been corrected effective **July 19, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL0901 | A. BUILDING: _____ B. WING _____ | R-C 08/22/2023 |

| 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<br><br>An offsite/paper revisit was conducted on 08/21/23 and 08/22/23. The facility was in substantial compliance. | {C 000} | | |

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