OKLAHOMA
State Department of Health

Delivery via email to: bratcliff@stonegatesl.com; survey@stonegatesl.com

July 26, 2024

License Number: AL0901

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

Survey Event ID: B9G611

Dear Ms. Ratcliff:

Enclosed is a report of the Licensure standard survey with a complaint investigation conducted at your Assisted Living facility on **July 23, 2024**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Victorian Estates
Address: 1129 Cameo Drive
City, State, Zip: Yukon, OK. 73099
Provider #: AL0901
Complaint #: OK00065638
Investigation Date: 07/22/24 through 07/23/24

ALLEGATION(S)

1. The center failed to ensure residents' representatives and hospice was notified/involved in treatment decisions for residents' who were transferred to the hospital.
2. The home failed to ensure care was coordinated with hospice and advance directives were followed according to the plan of care, advance directives and the standard of care.
3. The home failed to ensure residents/representatives were notified of rate increases according to the contract.

An unannounced on-site investigation was initiated 07/22/2024 at 9:45 a.m.

A sample of eight resident, 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 Centers for Medicare and Medicaid Services (CMS) 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, at other various times throughout the survey, and across multiple shifts. Observations were made of staff assisting residents if needed with activities of daily living, assistance with showers, interaction between resident to resident. Observations of Hospice personal interacting with Hospice residents. Vital signs being taken. Complainants called and/or family members regarding concerns.

Residents were interviewed related to concerns regarding rate increases, concerns regarding being transferred to hospital with family and/or Hospice not being contacted, any concerns with facility not following the plan of care set by facility and/or Hospice.

Resident records were reviewed including service contract, resident assessments, physician orders, care/service plan, progress notes, discharge notice and/ or rate increase, Hospice notes, and Hospice plan of care (if applicable).

Staff members were interviewed regarding the facility policy on transferring residents out to hospital and steps that staff follow during an emergent situation, does facility send out notice of rate increases, and how does staff know what resident is on Hospice. State reportable' s reviewed, facility rate increase forms reviewed for year of 2024, facility grievances, and new level of care form used to determine resident level of care.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.
Oklahoma State Department of Health
Long Term Care Service

Date report completed: 07/24/2024

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 _____	C 07/23/2024

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 from 07/22/24 through 07/23/24. A complaint investigation (#OK00065638) was conducted in conjunction with the survey. No deficiencies were cited. Facility Census: 30	C 000		

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