Delivery via email to: admin@victorianestatesal.com

March 2, 2022

License Number: AL0901

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

Survey Event ID: G4HT11

Dear Ms. Winship:

On **February 1, 2022,** 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 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 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 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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.03.02 14:17:55 -06'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT
LICENSURE

Facility: Victorian Estates
Address: 1129 Cameo Drive
City, State, Zip: Yukon, OK 73099
Provider #: AL0901
Complaint #: #OK00056548
Investigation Date(s): 01/27/22 and 02/01/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate staff to meet the needs of the residents.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 01/27/2022 at 1:35 p.m.

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

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 0544 for details.

An investigation specific to resident contracted services, incident reports, and assessments/care plans was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of th investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Julie Edmiaston RN, BSN

Date report completed: 02/03/2022

INVESTIGATIVE REPORT
LICENSURE

Facility: Victorian Estates
Address: 1129 Cameo Drive
City, State, Zip: Yukon, OK 73099
Provider #: AL0901
Complaint #: #OK00058031
Investigation Date(s): 01/27/22 and 02/01/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents received medications as prescribed.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 01/27/2022 at 1:35 p.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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505 for details.

An investigation specific to medication administered in accordance with physician's orders, assessments and/or care plans, and monthly medication administration records were conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Julie Edmiaston RN, BSN

Date report completed: 02/03/2022

INVESTIGATIVE REPORT
LICENSURE

Facility: Victorian Estates
Address: 1129 Cameo Drive
City, State, Zip: Yukon, OK 73099
Provider #: AL0901
Complaint #: #OK00058287
Investigation Date(s): 01/27/22 and 02/01/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure staff followed proper infection control procedures.	US
2. The center failed to ensure staff were qualified to perform their assigned tasks and failed to ensure proper administration of medications.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 01/27/2022 at 1:35 p.m..

A sample of five 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center's policies and procedures for infection control, laboratory results, and staff training related to infection control was conducted.

Upon entrance to the center, screening for Covid-19 and questionnaires was conducted at the front entrance. The center had performed Covid-19 testing for all residents and staff today. During the tour of the center, it was determined the residents resided in private apartments. Seven resident apartment doors were closed and

identified to be in isolation today after they had tested positive for Covid-19. The residents were isolated to each of their private apartments. The apartment doors were marked for PPE restrictions and remained closed during the survey. Supplies were observed outside of each resident apartment to include masks, gowns, and shields and/or goggles. A biohazard bag was lined in a container outside of each apartment door.

Residents were observed in the halls and dining area with masks except when eating. Residents reported they were not sick but had been tested for Covid-19 today. An ACMA (advanced certified medication aide) on duty reported she had performed a competency skill check off when she was hired. The competency skills check off included PPE, handwashing, and medication administration.

Reviewed competency skills check off for PPE, handwashing, and medication administration for staff employed for at least one year. Covid-19 testing was initiated after a family visitor notified the center; they had tested positive. Covid-19 testing records were reviewed which identified seven positive residents and three positive staff members. Reviewed positive urine culture for Vancomycin Resistant Enterococcus (VRE). The center's policy for VRE documented a resident with VRE should be placed in private room and can be safely cared for using Standard Precautions. A staff member employed at the time VRE precautions were in place stated the staff would wear gloves and wash hands when providing direct care.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Julie Edmiaston RN, BSN

Date report completed: 02/03/2022

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 02/01/2022

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	C 000		

An abbreviated survey was conducted on 01/27/22 and 02/01/22 to investigate complaint #OK00058287, #OK00056548, and OK00058031.

The Administrator identified 35 residents resided in the center.

Listed below are abbreviations that will be used throughout this document.

CMA-Certified Medication Aide
DON-Director of Nurses
MD-Doctor of Medicine
MAR-Medication Administration Record
MG-Milligrams
RN-Registered Nurse

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
C 544 SS=D	310:663-5-4(d) CONDUCT OF ASSESSMENT	C 544		

(d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following:
(1) the resident;
(2) the resident's personal physician;
(3) the resident's representative; and
(4) the Department.

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the center failed to maintain the assessments (clinical record) for one (#7) of three sampled closed records. Findings:

A policy titled, 'Retention of Protected Health Information' dated March 21, 2017, read in parts, "The facility will review state laws and regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN ESTATES	**1129 CAMEO DRIVE YUKON, OK 73099**

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C 544	Continued From page 1	C 544		

to determine Medical Record retention period and "legal age."

Res #7's contract dated July 3, 20, documented, a private 1-bedroom apartment. Plus level of care was not indicated on the contract. Signed by Res. #7's family member.

Res #7's via hand delivery letter, dated July 30, 20 documented, this is a thirty (30) day notice that we will no longer need a room at...due to Res #7's health. As discussed with...Res #7 is to be transferred to...nursing home on August 5, 20. Signed by Res. #7's family member.

Res #7's contract, dated July 3, 20, read in parts, plus level of care included limited personal care assistance with bathing up to three times per week to include shower set-up and assistance entering and exiting the shower. The contract indicated the resident would be provided with reminders and supervision with activities of daily living, including but not limited to eating, bathing, dressing, grooming, toileting, ambulating, and orientation.

On 02/01/22 at 2:26 p.m., the Administrator/DON was asked to submit the clinical record to include assessments for Res #7. She stated she could not find anything. She stated she did not have any incident reports for Res #7.

C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care	C1505		

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

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 02/01/2022

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

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C1505	Continued From page 2 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to ensure medications were administered as prescribed for one (#3) of three sampled residents with medication assistance. Findings:	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 02/01/2022

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

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C1505	Continued From page 3	C1505		

A center's policy titled, 'Medication Administration by the Assisted Living Community' dated May 2019, read in part, medications should only be administered by licensed, or unlicensed but qualified staff, trained in medication management and administration, such as RN's, LPN's, Certified Medication Aides (CMAs). Staff administering medications should have in-depth training in the use and administration of medications, and comply with the training requirements mandated by state regulations.

Res #3's physician's orders, dated 10/26/21, read in part, Amlodipine 10 mg daily and hold if systolic blood pressure less than 100 or heart rate less than 60, Colace one tablet twice daily, Metformin 500 mg tablet twice daily, Mirtazapine 7.5 mg one tablet at bedtime, Omeprazole 20 mg one capsule daily, Polyethylene Gycol mix 17 gm in 4-8 ounces by mouth every day, Senna Plus two tablets by mouth every morning, Vitamin C, 1,000 mg tablet daily.

Res #3's MAR, dated October 2021, documented the following doses of medication was not administered for the month:

Amlodipine 4 doses and one blood pressure reading.
Colace 7 doses
Metformin 6 doses
Mirtazapine 2 doses
Omeprazole 5 doses
Polyethylene Glycol 5 doses
Senna Plus 5 doses
Vitamin C 5 doses

On 02/01/22 at 2:19 p.m., the Administrator/Director of Nurses was asked about the missing doses of Res #3's medications. She

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 02/01/2022

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

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C1505	Continued From page 4	C1505		

stated nothing was charted and she did not have an explanation why the medication was not administered. She stated they did have staff shortages back then. She was asked if she reviewed the MARs for accuracy. She stated no she had not reviewed the MARs. She was asked if the resident had signed out the center on those dates when the medication had not been administered. She reviewed the sign out log and determined the resident had not signed out of the center after August 20, 21.

Res #3's MAR, dated November 2021, documented the following doses of medication was not administered for the month:

Amlodipine 1 dose and one blood pressure reading.
Colace 1 dose
Metformin 1 dose
Omeprazole 1 dose
Polyethylene Glycol 1 dose
Senna Plus 1 dose
Vitamin C 1 dose

Res #3's MAR, dated January 2022, documented the following doses of medication was not administered: Metformin 2 doses.

On 02/01/22 at 1:28 p.m., the Administrator/Director of Nurses was asked about the missing doses of Metformin. She stated they were not administered and there was no reason documented on the MAR.

At 11:50 a.m., Res #3 was asked about medications. She stated a staff member who delivers her medications would bring the wrong medications and/or forget her medications and would tell her that she had administered the

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 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 5 medications. Res #3's plan of care, reviewed and dated 03/02/21, read in part, resident to receive all medications safely and CMA to administer all meds as ordered by MD and report any findings to the DON. Res #3's annual assessment, dated 03/10/21, read in part, resident alert times three with fair judgment. Resident diagnoses included high blood pressure, depression, anxiety and Diabetes Mellitus.	C1505		

Delivery via email to: admin@victorianestatesal.com

April 6, 2022

License Number: AL0901

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

Survey Event ID: G4HT11

Dear Ms. Musick:

On **February 1, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 25, 2022**.

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 Digitally signed by Tempal Killman
Date: 2022.04.06 10:49:16 -05'00'

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

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Oklahoma State Department of Health
Creating a State of Health

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/16/22
Facility Name: Victorian Estates Assisted Living
License Number: AL-0901
Survey Event ID: G4HT11
Date Survey Completed: 2/1/22

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on observation, interview, and record review it is determined the center failed to ensure medications were administered for one (#3) of three sampled residents with medication assistance.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:
Preparation and execution of this Plan of Correction is 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.

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 #3 was evaluated with no adverse conditions related to possible omission of medications. Primary physician and family were notified.
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 receive medication have the potential to be affected by this 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?	DON/Designee will educate the facility staff on medication administration and documentation of medication as

	the medication(s) are administered per physician order. Admin/Designee to educate facility staff on resident rights
OSDH Response: Element accepted Yes No	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness. b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The DON/Designee will monitor medication administration records for completed documentation daily x 5 x 2 weeks, 3 x a week x 2 week, then weekly 2 months The DON or designee will complete random medication administration observations to ensure medications are being administered per physician order two times a week for two weeks, weekly for 4 weeks and then monthly for 2 months. Findings from monitoring will be brought to the Q.A.P.I. committee monthly for 3 months to determine if further action is necessary. Monitoring form will be maintained and kept in the QA binder
OSDH Response: Element accepted Yes No	
5. On what date will corrective action be completed?	03/25/22
OSDH Response: Element accepted Yes No	
Administrator's Signature **Marcie Musick, Administrator** 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 Oklahoma State Department of Health — Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 3/16/22 **Facility Name:** Victorian Estates Assisted Living **License Number:** AL-0901 **Survey Event ID:** G4HT11 **Date Survey Completed:** 2/1/22
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 544	Based on: Based on interview and record review it was determined that the center failed to maintain the assessment (clinical record) for one (#7) of 3 sampled closed records.
ASSISTED LIVING CENTER'S PLAN OF CORRECTION	

Assisted Living Center's Comments:
Preparation and execution of this Plan of Correction is 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.

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 #7 no longer resides in the facility
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 discharge from the facility have the potential to be affected by this 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?	RNC or Designee to complete education with DON/Adon/Admin on monitoring required assessments on admission, annually and for change in conditions as needed
OSDH Response: Element accepted Yes No	

<table>
<tr><td>4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:
a. How the correction will be evaluated for effectiveness.
b. How the correction will be incorporated into the center's quality assurance system; and
c. How monitoring records will be kept to show evidence of the correction.</td><td>DON/ADON will review the assessments on admission, annually and with a Change in Condition as needed to ensure the assessments are complete, accurate and include residents' level of care.

DON/Administrator/Designee will review residents' medical records on discharge to ensure required assessments are complete and filed in medical record

Admin/Designee will complete Random audits of closed records weekly x 90 days

Findings from monitoring will be brought to the Q.A.P.I. committee monthly for 3 months to determine if further action is necessary.

Monitoring form will be maintained and kept in the QA binder</td></tr>
<tr><td>OSDH Response: Element accepted Yes No</td><td></td></tr>
<tr><td>5. On what date will corrective action be completed?
OSDH Response: Element accepted Yes No</td><td>3/25/22
…
..</td></tr>
<tr><td colspan="2">Administrator's Signature Marcie Musick, Administrator
AC 310:663-25-4(F)</td></tr>
<tr><td>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.</td><td></td></tr>
</table>

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: admin@victorianestatesal.com

June 10, 2022

License Number: AL0901

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

Survey Event ID: G4HT12

Dear Ms. Musick:

On **June 8, 2022,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 1, 2022,** have now been corrected effective **March 25, 2022.**

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.06.10 14:29:16 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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 ______	R **06/08/2022**

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 revisit was conducted 06/08/22. All deficiencies from the 02/01/22 survey were cleared.	{C 000}		

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