Oklahoma State Department of Health
Creating a State of Health

August 7, 2019

License Number: AL5552
Survey Events: Q0GH11 & QPYK12

Ms. Diane Cooper Timmerman-O'Connor, Administrator
The Heaven House, Llc
1902 Elmhurst Ave
Nichols Hills, OK 73120

Dear Ms. Timmerman-O'Connor:

Enclosed is a report of complaint investigation OK00053928 and the revisit to the May 2, 2019 initial licensure survey conducted at your Residential Care facility on July 16, 2019. No deficiencies were cited, and the deficiency cited on the May 2, 2019 initial survey has been corrected.

Oklahoma Statutes 63, Section 1-840 requires 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) 820-9922.

Sincerely,

Patty Scott
Long Term Care
Oklahoma State Department of Health

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: Heaven House Westchester
Address: 1312 Westchester Dr.
City, State, Zip: Oklahoma City, OK 73120
Provider #: AL5552
Complaint #: OK00053928
Investigation Date(s): 07/16/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to serve foods that were not moldy.	US

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

An unannounced on-site investigation was initiated on Tuesday, July 16, 2019 at 11:20 a.m.

A sample of two 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 was conducted specific to moldy foods being served to the residents.

A kitchen inspection was conducted upon entry to the center. No moldy fruits or vegetables were observed. Several packages of a variety of cheeses were observed in the refrigerator. All cheese packages were within date and no mold was observed. No mold was observed on the bread products stored in the cabinet.

Both residents, who resided in the center, denied ever being served moldy food and had no complaints regarding the food.

An employee stated she went through the food in the kitchen every Thursday and discarded the food that was not fit to be served. She also stated she cooked and ate meals with the residents, so she would notice if any foods were not edible.

Determination Summary and Follow-Up Action:

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.

Teena Cornetten

Teena Cornett, RN CHFS IV

Date report completed: 07/16/2019

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
	AL5552	A. BUILDING: _____ B. WING _____	07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVEN HOUSE WESTCHESTER	1312 WESTCHESTER DRIVE OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted 07/16/19 to investigate complaint #OK00053928. Resident census was 2. No deficient practice was cited as a result of the investigation.	C 000		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5552	HEAVEN HOUSE WESTCHESTER

Type of Survey (select all that apply)

3								

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

Extent of Survey (select all that apply)

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 36967	07/16/2019	07/16/2019	0.25	0.00	0.50	0.00	1.00	0.75
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

AUG 08 2019