OKLAHOMA
State Department
of Health

Delivery via email to: Diane Cooper <dianecooper448@gmail.com>

April 17, 2024

License Number: AL5552

Ms. Diane Cooper, Administrator
The Heaven House, Llc
1312 Westchester Drive
Oklahoma City, OK 73120

RE: Survey Event ID: I41J11

Dear Ms. Cooper:

On **April 4, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 4, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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 _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEAVEN HOUSE, LLC	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 A relicensure survey was conducted from 04/03/24 through 04/04/24 . Facility Census: 04 The following abbreviations will be used throughout this document: CMA/MAT Certified Medical Assistant/Medication Administration Tech CMA Certified Medication Aide OSDH Oklahoma State Department of Health	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food items in the refrigerator were labeled with the date and left overs were discarded within 3 days during one of two observations made in the kitchen. The Director of Operations identified 4 Residents received nutrition from the kitchen. Findings: On 04/03/24 at 11:30 a.m., the following observations were made: a. A piece of pie in a foil pan covered with a clear plastic lid had no date labeled,	C 391		

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C 391	Continued From page 1 b. Left over jello in a clear glass pan with plastic wrap covering had no date label, c. Left over chopped peppers and onions in a clear plastic container with a red lid had no date label, e. Left over opened cole slaw dated 03/19/24, f. Left over chicken and rice soup in a plastic contained with red lid dated 03/29/24, g. Left over beans and bacon in a cottage cheese container dated 03/30/24, h. Left over chicken salad in a plastic container dated 03/21/24, i. Left over crushed pineapple in in a cottage cheese container dated 03/19/24, j. Left over crepes in a black styrofoam container had no date label, and k. Left over chicken salad with cranberries in a plastic container had no date label. On 04/03/24 at 12:45 p.m., CMA #1 was asked what the policy was for labeling items in the refrigerator and left overs. They stated leftovers should be thrown out within 3 days and all items should be labeled with the date. The CMA was shown the above items unlabeled and left overs dated beyond 3 days. CMA #1 stated the items should of been labeled and the items past 3 days should of been discarded. On 04/04/24 at 9:35 a.m., the Director of Operations was asked for policies regarding labeling items in the refrigerator and left overs. They stated they did not have policies but all staff has their food handlers certificates and should of known better.	C 391		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES	C1911		

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C1911	Continued From page 2 (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an incident involving a head injury and hospitalization was reported within 1 business day to OSDH for one (#1) of two residents sampled for timeliness of reporting incidents to OSDH. The Director of Operations identified 4 Residents resided in the facility.	C1911		

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C1911	Continued From page 3 Findings: A "Incidents/Accidents" policy, undated, read in part, "...The following critical incidents must be reported by the Administrator or Nurse via facsimile or by telephone to department of Health within one business day...all incidents if the resident sustained a head in injury..." Resident #1 was admitted 12/23/23 with diagnoses which included UTI, electrolyte imbalance, and chronic pain. Resident #1 was alert and oriented to person , place and time. A "Incident-Occurrence" report, for internal use only, dated 02/29/24, documented Resident #1 had an unwitnessed fall with a head injury and was sent to the hospital for treatment. On 04/03/24 at 12:35 p.m., a family representative stated Resident #1 had a fall with a head injury, was hospitalized, and readmitted to the center on 03/29/24. On 04/04/24 at 9:21 a.m., CMA/MAT #1 was asked about the incident on 02/29/24. CNA/MAT #1 stated Resident #1 had an unwitnessed fall, a head injury, and was sent to the hospital. They could not locate the incident report in chart or paperwork. On 04/04/24 at 9:35 a.m., the Director of Operations was asked about the incident involving Resident #1 on 02/29/24. They stated they could not locate the incident report and the proper protocol was not followed regarding reporting to OSDH.	C1911		

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 _____	04/04/2024

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OKLAHOMA
State Department
of Health

Delivery via email to: Diane Cooper <dianecooper448@gmail.com>; betty.lanning555@gmail.com

May 1, 2024

License Number: AL5552

Ms. Diane Cooper, Administrator
The Heaven House, Llc
1312 Westchester Drive
Oklahoma City, OK 73120

RE: Survey Event I41J11

Dear Ms. Cooper:

On **April 4, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 8, 2024**.

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/29/2024** **Facility Name:** HeavenHouse, LLc Westchester **License Number:** AL#5552 **Survey Event ID:** 141J11 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: interview and observation center failed to ensure refrigerated food items were labeled with the date and leftovers were discarded within 3 days

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The handeling of food and everything related to the kitchen is of great importance to Heaven House. We adhear to the labeling requirement and discarding of food after 3 days as an important and welcomed regulation and have for years. The refrigerator was addressed promptly after survey.

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?	The refrigerator has been emptied, cleaned, food items not labeled and leftovers discarded. No containers are undated or in any food containers which are not clear, covered and dated. When groceries arrive they are labeled as part of putting them away. No left overs are currently present.
OSDH Response: Element accepted Yes ☑ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All staff will complete of the State approved Food Handelers Course. Reminders are posted in the kitchen for labeling foods and correct handeling of leftovers. It will be the duty of the night shift is to check the refrigerator for dates and proper storage of food.
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?	The Food Handelers course will be requirement for all staff that prepare food. It will be a requirement for new hires to complete in the first 30 days of hiring. An Inservice will describe what is expected and will be required to watch the first week of employment for new hires. A new policy for Heaven House is enclosed.
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.	Random weekly checks by the Administrator or the DOO with staff will be done on the refrigerator contents. A form will be available to sign these checks. Staff will be written up if the refrigerator is not managed correctly. This will become a line item on the agenda of Quallity Assurance meetings. Progress will be noted there and in the weekly checks. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☑ No ☐	

5. On what date will corrective action be completed?		5/6/2024	
OSDH Response: Element accepted Yes ☑ No ☐			
Administrator's Signature Diane Cooper OAC 310:663-25-4(F)			**Date 4/29/2024**
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.			

HEAVEN HOUSE LLC

POLICY AND PROCEDURE FOR SAFE HANDELING OF FOOD

EACH NEW HIRE TO HEAVEN HOUSE, LLC WILL COMPLETE THE INSERVICE ON FOOD HANDELING THE FIRST WEEK OF BEING ON THE JOB.

ALL STAFF THAT PREPARE AND SERVE FOOD TO THE RESIDENTS MUST COMPLETE A FOOD HANDELERS TRAINING COURSE APPROVED BY THE STATE OF OKLAHOMA WITHIN 30 DAYS OF HIRE AT THE HEAVEN HOUSE.

KITCHEN REMINDERS

ALL ITEMS IN REFRIGERATOR MUST BE LABELED WITH DATE

NO LEFTOVERS CAN BE IN THE REFRIGERATOR FOR LONGER THAN 3 DAYS

***** NIGHT SHIFT CHECK THE REFRIGERATOR FOR ANY UNLABELED OR OUT OF DATE FOOD DAILY*****

NIGHT SHIFT CHECK ,SIGN OFF, AND DATE

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/29/2024** **Facility Name:** Heaven House Westchester **License Number:** AL5552 **Survey Event ID:** 141J11 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: record review and interview the center failed to ensure an incident involving a head injury and hospitalization was reported in 1 business day to OSDH

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: A faulty connection for line of fax machine did not transmit the incident report to the Administrator and human error in realizing such.

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?	Incident report process is changed to a direct call to the Administrator rather than a fax. After 4 visits by the service company the fax machine was determined to be unreliable due to service interruptions. It has been replaced and service restored to its line but intermittently not available.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A new internal process for incident reporting is in effect. The staff on shift will call the Administrator directly and advise of the incident. The administrator will write the report without the initial report being faxed from Heaven House. Administrator will fill out, complete and send into the OSDH in the required time of one business day and a final report within 5 days.
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?	A policy indicating a direct phone call to the Administrator to report an incident immediately is new procedure. This will ensure more streamlined process and take the effectiveness of equipment out of the process. Service in the area continues to be spotty for phone and fax. The new process will be posted for all staff to read.
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.	New policy and procedure will be evaluated at Quality Assurance meeting for effectiveness as far as timing of event and connection with Administrator. Internal record of events will be stored in each resident individual file. Across check with DOO and Supervisor and Administrator at Quality Assurance meeting will be line item on agenda. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed? OSDH Response: Element accepted Yes ☐ No ☐		5/8/2024	
Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)			**Date 4/29/2024**
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.			

POLICY AND PROCEDURE FOR REPORTING INCIDENTS

WHEN AN INCIDENT INVOLVING INJURY OCCURS AT THE HEAVEN HOUSE A DIRECT CALL AT ANYTIME TO THE ADMINISTRATOR MUST BE MADE. LEAVE A DETAILED MESSAGE.
THIS IS TO ENSURE THE MESSAGE IS RECEIVED AND A REPORT IS MADE WITHIN ONE BUSINESS DAY TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH.
IT IS NO LONGER NECESSARY TO FAX A REPORT.
THE INTERNAL REPORT OF THE INCIDENT IS TO BE KEPT IN THE RRESIDENT'S INDIVIDUAL FILE.

OKLAHOMA
State Department of Health

Delivery via email to: betty.lanning555@gmail.com; dianecooper448@gmail.com

May 17, 2024

License Number: AL5552

Ms. Diane Cooper, Administrator
The Heaven House, Llc
1312 Westchester Drive
Oklahoma City, OK 73120

RE: Survey Event I41J12

Dear Ms. Cooper:

On **May 16, 2024,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 4, 2024,** have now been corrected effective **May 8, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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
	AL5552	A. BUILDING: _____ B. WING _____	R 05/16/2024

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THE HEAVEN HOUSE, LLC	1312 WESTCHESTER DRIVE OKLAHOMA CITY, OK 73120

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{C 000}	INITIAL COMMENTS A follow up visit was conducted on 05/16/24. All deficiencies from the 04/04/24 survey have been corrected. Facility census: 3	{C 000}		

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