OKLAHOMA
State Department
of Health

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

November 7, 2025

License Number: AL5552

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

RE: Survey Event ID: ZK5C11

Dear Ms. Cooper:

On **October 22, 2025**, 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 **October 22, 2025**.

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 _____	10/22/2025

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 on 10/22/25. Facility Census: 5 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide DON - director of nursing lpm - liters per minute mcg- micrograms mg- milligram	C 000		
C 921 SS=D	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a CNA had a current certification to administer medications for 2 (#2 and #3) of 2 sampled residents reviewed for medication administration. The director of operations identified five residents resided in the center. Findings: 1. On 10/22/25 at 9:26 a.m., CNA #1 was observed preparing and administering medications to Resident #3. CNA #1 prepared and administered:	C 921		

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C 921	Continued From page 1 a. tadalafil 5mg 1 tablet (a phosphodiesterase type 5 inhibitor), b. furosemide 40mg 1 tablet (a diuretic), c. potassium 99mg 1 tablet (an electrolyte supplement), d. finasteride 5mg 1 tablet (a 5-alpha reductase inhibitor), e. aspirin 81mg 1 tablet (anti-platelet agent), f. docusate 100mg 1 capsule (a laxative), g. eliquis 5mg 1 tablet (an anticoagulant), h. tamsulosin 0.4mg 1 tablet (an alpha-1 adrenoceptor antagonist), i. metformin 500mg 1 tablet (a biguanide), j. mucinex 400mg 1 tablet (an expectorant), k. carbidopa/levodopa 25-100mg 1 1/2 tablets (an antiparkinson agent), and l. tylenol 325mg 2 tablets (an analgesic). A "Comprehensive Assessment," dated 10/02/25, showed Resident #3 was admitted to the center on 10/02/25 with diagnoses to include atrial fibrillation, chronic cough, and stroke. A "Medication List," dated September 2025, showed Resident #3 was prescribed: a. tadalafil 5mg 1 tablet daily b. furosemide 40mg 1 tablet daily c. potassium 99mg 1 tablet daily d. finasteride 5mg 1 tablet daily e. aspirin 81mg 1 tablet daily f. docusate 100mg 1 capsule twice daily g. eliquis 5mg 1 tablet twice daily h. tamsulosin 0.4mg 1 tablet daily i. metformin 500mg 1 tablet at breakfast and 1/2 tablet at dinner j. mucinex 400mg 1 tablet daily k. carbidopa/levodopa 25-100mg 1 1/2 tablets three times daily l. tylenol 325mg 2 tablets every 6 hours as needed	C 921		

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C 921	Continued From page 2 2. On 10/22/25 at 9:53 a.m., CNA #1 was observed preparing and administering medications to Resident #2. CNA #1 prepared and administered: a. calcium 600mg 1 tablet (a mineral supplement), b. buspirone 5mg 1 tablet (an anxiolytic), c. eliquis 5mg 1 tablet (an anticoagulant), d. gabapentin 300mg 1 capsule (an anticonvulsant), e. keppra 500mg 1 tablet (an anticonvulsant), f. tolterodine 4mg 1 tablet (an anticholinergic), g. cephalexin 500mg 1 capsule (an antibiotic), h. flonase 50mcg 1 spray each nostril (a corticosteroid), and i. adult multi vitamin gummies 1 gummy (vitamin and mineral supplement). A "Comprehensive Assessment," dated 10/02/25, showed Resident #2 was admitted to the center on 09/25/25 with diagnoses to include deep vein thrombosis, anxiety, and chronic kidney disease. A "Medication List," dated September 2025, showed Resident #2 was prescribed: a. calcium 600mg 1 tablet daily, b. buspirone 5mg 1 tablet three times daily, c. eliquis 5mg 1 tablet twice daily, d. gabapentin 300mg 1 capsule three times daily, e. keppra 500mg 1 tablet twice daily, f. tolterodine 4mg 1 tablet daily, g. cephalexin 500mg 1 capsule twice daily, h. flonase 50mcg 1 spray each nostril daily, and i. adult multi vitamin gummies 1 gummy daily. A review of CNA #1's employee file showed their medication administration certification was effective 09/16/24. The medication administration certificate expired on 09/16/25.	C 921		

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C 921	Continued From page 3 On 10/22/25 at 12:38 p.m., CNA #1 was asked when they completed their medication administration update. They stated, "I have not. I thought it was expiring in January." CNA #1 stated they knew their medication administration certificate was to be renewed every 12 months. On 10/22/25 at 12:45 p.m., the director of operations was asked when CNA #1's medication administration certificate was due for expiration. They checked CNA #1's employee file and stated, "It's expired now."	C 921		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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 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	C1505		

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C1505	Continued From page 4 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure proper signage indicating oxygen in use for 1 (3) of 3 sampled residents reviewed for oxygen use. The director of operations identified five residents resided in the center and 1 resident required oxygen therapy. Findings: On 10/22/25 at 10:53 a.m., Resident #3 was observed in their room wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator was on 2.5 lpm. There was no signage indicating oxygen was in use. A "Comprehensive Assessment," dated 10/02/25, showed Resident #3 was admitted to the center on 10/02/25 with diagnoses to include atrial fibrillation, chronic cough, and stroke. An "Oxygen Therapy Care Plan," dated 10/02/25, read in part, "Oxygen in use sign will be displayed in view to provide awareness of flammable devices." On 10/22/25 at 10:53 a.m., Resident #3's family member was asked how often Resident #3 utilized their oxygen. They stated, "All the time." On 10/22/25 at 11:05 a.m., the director of operations was asked what the center's policy was pertaining to oxygen in use signs. They	C1505		

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C1505	Continued From page 5 stated, "We usually have it posted. [Resident #3] is fairly new and it slipped through the cracks." The director of operations was asked if there were any oxygen in use signs. They stated, "No."	C1505		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a medication was administered only on a physician's order for 1 (#3) of 3 sampled residents reviewed for medication administration. The director of operations identified five residents resided in the center and one resident required oxygen therapy. Findings: On 10/22/25 at 10:53 a.m., Resident #3 was observed in their room wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator was on 2.5 lpm. An untitled document, dated September 2025, showed Resident #3's medication orders. There was no order for oxygen. A "Comprehensive Assessment," dated 10/02/25, showed Resident #3 was admitted to the center on 10/02/25 with diagnoses to include atrial fibrillation, chronic cough, and stroke.	C1921		

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C1921	Continued From page 6 An "Oxygen Therapy Care Plan," dated 10/02/25, read in part, "Oxygen therapy is a treatment that delivers oxygen gas for you to breathe." On 10/22/25 at 10:53 a.m., Resident #3's family member was asked how often Resident #3 utilized their oxygen. They stated, "All the time." On 10/22/25 at 11:05 a.m., the director of operations was asked for the most recent medication orders for Resident #3. They stated they had provided the most recent orders. They were asked if Resident #3 utilized oxygen. They stated, yes. The director of operations was asked if they had a physician's order for Resident #3's oxygen. They stated, "I do not."	C1921		
C1972 SS=F	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 4 (CNA #1, CMA #2 and #3, and DON) of 5 sampled employees whose records were reviewed for abuse training. The director of operations identified five residents resided in the center.	C1972		

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	AL5552	A. BUILDING: _____ B. WING _____	10/22/2025

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C1972	Continued From page 7 Findings: 1. A review of CNA #1's employee file showed they were hired on 08/28/24. There was no documentation of abuse training within 90 days of their hire. 2. A review of CMA #2's employee file showed they were hired on 08/22/24. There was no documentation of abuse training within 90 days of their hire. 3. A review of CMA #3's employee file showed they were hired on 05/06/25. There was no documentation of abuse training within 90 days of their hire. 4. A review of the DON's employee file showed they were hired on 02/20/25. There was no documentation of abuse training within 90 days of their hire. On 10/22/25 at 12:23 p.m., the director of operations was asked for the abuse training within 90 days of hire for CNA #1, CMA #2 and #3 as well as the DON. On 10/22/25 at 12:32 p.m., the director of operations stated they could not find the abuse training for the selected employees. They were asked if abuse training within 90 days of hire should have been provided. The director of operations stated, "We do it, we are just not organized here."	C1972		

OKLAHOMA
State Department
of Health

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

November 25, 2025

License Number: AL5552

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

RE: Survey Event ZK5C11

Dear Ms. Cooper:

On **October 22, 2025**, 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 **November 7, 2025**.

We will conduct a revisit for 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: 11/20/2025** **Facility Name:** The Heaven House **License Number:** AL5552 **Survey Event ID:** ZK5C11 **Date Survey Completed: 10/22/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921	Based on: observation, record review, and interview, the center failed to ensure a CNA had a current certification to administer medictians for 2 (#2and #3) of 2 samples residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: CNA was permitted to administer medications while their medication administration certification was expired.

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 CNA with the expired medication administration certification was immediately removed from all medication related duties upon discovery. The CNA was instructed to complete renewal requirements and provide valid documentation of current certification before any further medication administration duties could resume. All medications previously administered by this CNA were reviewed by the nurse to ensure there were no medication erros or adverse outcomes. No medication errors were identified. If any had been found, apporopriate follow-up, documentation, and reporting procdures would have been completed.
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 full audit of all staff responsible for medication administration was completed to ensure each had a current, valid certification. Employee files were reviewed for accuracy, including expiration dates of certifications and required training. No other staff were found to have expired credentials.
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?	Our facility has implemented a tracking system for all assisted living houses to track certifications, specifically certiciation type, date issued and expiration dates, and required renewal deadlines. Supervisors will complete monthly audits of all certification lists to ensure compliance. Policy was updated and disseminated to all staff reinforcing that staff may not perform any medication-related tasks without certification, and doing so will result in discplinary action. Annual inservice training will include a section on maintaining active credentials.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	The administrator will conduct monthly verification that all medication-certified personnel remain current. A quarterly audit report will be reviewed during QA

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.	meetings. Any lapse in certification identified during these audits will be addressed immediately and documented. Monitoring will continue indefinitely as part of standard compliance procedures. Quarterly audits will be performed and analized. The audit reports will be reviewed during QA meetings and discussed with staff. Administrators will keep record of each employee in each house in a safe, secure location that is accessible to Administrators and staff- upon request.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/7/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/20/2025**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 11/20/2025
	Facility Name: The Heaven House
	License Number: AL5552
	Survey Event ID: ZK5C11
	Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: observation, record review, and interview, the center failed to ensure proper signage indicating oxygen in use for 1 (3) of 3 sampled residents reviewed for oxygen use.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Our facility did not have proper signage indicating oxygen in use for 1 of 3 sampled residents using oxygen.

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?	Upon notice of the deficiency, staff immediately placed clearly visible "Oxygen in Use" signage on the resident's door and in the room as required. The resident and their family were informed of the correction. A safety check was completed to ensure all oxygen equipment wwas functioning properly and positioned safely.
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 facility wide audit of all residents who use oxygen was conducted the same way. All rooms were checked to ensure appropriate signage was posted according to regulations. NO additional rooms were found to be missing signage.
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?	Our facility revised its Oxygen policy to specify exactly where and how signage must be posted. "Oxygen in Use" signs were restocked and stored in a designated location easily accessible to staff. A reminder was added to the new admission checklist requiring staff to post signage immediately when oxygen therapy begins. All staff involved in resident care received in-service training on oxygen safety, signage requirments, and emergency precautions.
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 Administrator will perform weekly safety rounds for 8 weeks to verify all residents receiving oxygen have proper signage posted. Signs are visible, legible, and in good condition. After 8 weeks if there are no deficiencies, monitoring will continue monthly as part of routine safety checks. To evaluate for effectiveness administration will review the audits and see if the new changes were effective. If any changes need to be made they will be made.

	Results of audits will be reviewed during QA meetings, and any issues will be addressed immediately. Records will be held at each facility in a secure binder and retained for 12 months for surveyor review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/20/2025**

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 11/20/2025
	Facility Name: The Heaven House
	License Number: AL5552
	Survey Event ID: ZK5C11
	Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1921	Based on: observation, record review, and interview, the center failed to ensure a medication was administered only on a physician's order for 1 (#3) of 3 sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility failed to obtain and maintain current physician orders for residents receiving oxygen therapy.

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?	A current physician order for oxygen therapy (including flow rate, delivery method, frequency, and parameters) was immediately obtained for the affected resident. The order was entered into the residents MAR and care plan updated accordingly. Nursing staff verified that the resident's oxygen device settings matched the physician order.
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 facility wide audit was completed for all residents currently receiving oxygen to ensure each has: a valid, signed physician order, correct flow rate and delivery method documented, and appropriate "oxygen in use" signage posted as required. Any missing or incomplete orders were corrected immediately.
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?	Update the policy on oxygen use and require physician orders before initating oxygen therapy with detailed order requirements (flow rate, delivery method, titration parameters, frequency, duration, and PRN criteria). Nursing staff and caregivers had an inservice on requirement for a signed physician order prior to administering oxygen, documentation procedures, and safety requirements (including signage, storage, tubing checks). Admission checklist updated to include confirmation of a physician order for any resident admitted with oxygen.
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	To ensure the corrections are sustained weekely oxygen audits for four weeks will be conducted by the RN and administrators and then monthly audits for an additional three month. Each audit will verify a valid physician order is present, requirements match the residents acutal oxygen settings, and that documentation is complete and up to date.

c. How monitoring records will be kept to evidence the correction.	To evaluate effectiveness audits will be reviewed and evaluated for compliance. If these audits show compliance and no deficiencies then no new further actions are required and the new current steps implemented will continue. All completed audit forms will be kept in the a finder at each house for 12 months, results will be reviewed in the monthly QA meetings. If any deficiency is identified, immediate correction will occur and additional staff retraining will be completed. Records will be kept in each facility in a secure location where staff can access the records and refer to if needed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/5/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/20/2025**

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.

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Facility in Compliance by: Click here to enter a date.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 11/20/2025
	Facility Name: The Heaven House
	License Number: AL5552
	Survey Event ID: ZK5C11
	Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1972	Based on: record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 4 (CNA #1, CMA #2, and #3 and DON) of 5 sampled employee whose records were reviewed for abuse training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility failed to ensure staff were educated on abuse within 90 days of hire for 4 eomployees.

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 employees indentified during the survey who did not receive abuse training within 90 days were immediately scheduled for and completed the required training. Certificates of completion were placed in each employee's file. The Administrator reviewed all staff to confirm completion.
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 full audit of all current employee personnel files was completed to verify compliance with abuse training timelines. Any staff identified as missing abuse training or documentation were immediately assigned and completed the training.
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 facility implemented the following changes: First, updated the new hire checklist to require abuse training to be complete within the first 30 adys and no later than 90 days from hite as required. Secondly administrtors were re-educated on the requirments to ensure that no employee works beyond 90 days without this mandatory training. Thirdly abuse training was incorporated into monthly QA meetins to ensure compliance.
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.	To ensure ongoing compliance the facility will have monthly audits of employee files by the administrator for three months then quarterly for six months. Each audit will confirm new hires completed abuse training within required timelines and that certificates and documentation are placed in personnel files. Audits will be reviewed and evaluated to confirm that the 90-day abuse abuse training is consistenly met for new hires.

	Results will be reviewed during QA meetings each month and details on compliance will be discussed. Any missing or late training identified during audits will be corrected immediately and reviewed for process failure. Additional staff re-education will be provided as needed. Audits will be files in a binder with all the staff files and kept while employeed,
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/1/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/20/2025**

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Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department of Health

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

December 5, 2025

License Number: AL5552

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

RE: Survey Event ZK5C12

Dear Ms. Cooper:

On **December 4, 2025,** 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 **October 22, 2025,** have now been corrected effective **November 7, 2025.**

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 12/04/2025

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 An offsite/paper revisit was conducted on 12/04/25. 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