

Delivery via email to: dianeconnor448@gmail.com; betty.lanning555@gmail.com;

December 8, 2022

License Number: AL5538

Ms. Diane Cooper Timmerman-O'Connor, Administrator
The Heaven House, LLC
3141 Elmwood
Oklahoma City, OK 73116

RE: Survey Event ID: Z66811

Dear Ms. Timmerman-O'Connor:

On **November 21, 2022**, 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 November 21, 2022.

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 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 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 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,

Lisa Calvin

Lisa Calvin, Enforcement 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: AL5538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2022
NAME OF PROVIDER OR SUPPLIER THE HEAVEN HOUSE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3141 ELMWOOD OKLAHOMA CITY, OK 73116		
(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
N 000	Initial Comments A relicensure survey was conducted 11/21/22.	N 000		
N1105 SS=D	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure each long term care aide certification was current and not expired for one (#2) of six sampled LTCA's employed by the center. Findings:	N1105		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2022
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N1105	Continued From page 1 On 11/21/22 at 1:50 p.m., the director of operations stated they had contacted LTCA #2 about their expired 10/31/22 long term care aide certification. The director of operations stated LTCA #2 had not updated their application with the Oklahoma Nurse Aide Registry. On 11/21/22 at 3:20 p.m., the director of operations stated LTCA #2 should have filed their application to renew their LTCA certification with the Oklahoma Nurse Aide Registry.	N1105		
C 000	INITIAL COMMENTS A relicensure survey was conducted 11/21/22.	C 000		

Delivery via email to: dianeconnor448@gmail.com

December 20, 2022

License Number: AL5538

Ms. Diane Cooper Timmerman-O'Connor, Administrator
The Heaven House, LLC
3141 Elmwood
Oklahoma City, OK 73116

RE: Survey Event Z66811

Dear Ms. Timmerman-O'Connor:

On **November 21, 2022**, 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 **January 1, 2023**.

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: 2022.12.20 13:15:11 -06'00'

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

enc

December 14, 2022

TO:
LISA CALVIN
[LTCE enforcement@health.ok.gov](mailto:LTCE_enforcement@health.ok.gov)
PLAN OF CORRECTION

FROM:
HEAVEN HOUSE, LLC
AL5538
3141 ELMWOOD AVE
DIANE OCONNOR ADMINISTRATOR

5 PAGES

Oklahoma State Department of Health

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2022
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NAME OF PROVIDER OR SUPPLIER

THE HEAVEN HOUSE, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

**3141 ELMWOOD
OKLAHOMA CITY, OK 73116**

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C 000	INITIAL COMMENTS A relicensure survey was conducted 11/21/22.	C 000		

OSDH DEFICIENCIES AND FACILITY PLAN OF CORRECTION

DATE SURVEY COMPLETED: November 21, 2022

Current date: December 12, 2022

Facility Name: The Heaven House LLC, 3141 ELMWOOD OKLAHOMA CITY, OK 73116

License Number: AL5538-5538

Survey ID: Z66811

SUMMARY STATEMENT OF DEFICIENCIES

ID PREFIX TAG: N1105 310:677-11-1	Deficiencies
General Requirements LTC The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of in-service training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) <u>Ensure that each nurse aide certification is current and not expired.</u>	This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure each long term care aide certification was current and not expired for one (#2) of six sampled LTCA's employed by the center.

Findings

On 11/21/22 at 1:50 p.m., the director of operations stated they had contacted LTCA #2 about their expired 10/31/22 long term care aide certification. The director of operations stated LTCA #2 had not updated their application with the Oklahoma Nurse Aide Registry.

On 11/21/22 at 3:20 p.m., the director of operations stated LTCA #2 should have filed their application to renew their LTCA certification with the Oklahoma Nurse Aide Registry.

Director of operations comment: The LTCA without certification registration was not assigned to direct resident care.

PROVIDER'S PLAN OF CORRECTION

COMPLETE DATE

The director of operations - immediately notified LTCA that OSDH certification and registration is a work requirement. - verified no adverse effects to current residents between 10/31/22 and 11/21/22. Residents were interviewed and observed. LTCA was not assigned to direct care role. - verified LTCA met certification and registration requirements. Documents were sent by fax to OSDH. - reminded all LTCA that a current certification and registration is a work requirement. - The policy and procedure for documentation of current certification and registration will be reviewed at the next QA meeting December 19, 2022. - The director of operations will provide a list of LTCA's with upcoming expired certification dates at each quarterly QA meeting. Tentative dates for 2023 QA meetings are the 3rd Monday of 3rd month in the quarter.	November 21, 2022
	November 21, 2022
	November 23, 2022
	December 5, 2022
	December 19, 2022
	March 20, June 19, September 18, December 18
The director of operations and RN Supervisor will track LTCA's expiration dates. Nurse aides will be notified within 20 days of expiration that current certification and registration is a work requirement.	Monthly starting January 1, 2023.

OSDH DEFICIENCIES AND FACILITY PLAN OF CORRECTION

12/14/2022



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: Click here to enter a date.

Facility Name: Click here to enter facility name.

License Number: Click here to enter assisted living center's license number.

Survey Event ID: Click here to enter Survey Event ID from cover letter and STATE FORM.

Date Survey Completed: Click here to enter a date from Box X3 on STATE FORM.

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: Enter ID Prefix
Tag from Column X4 on
STATE FORM.

Based on: Click here to enter "Based On" statement which follows "This REQUIREMENT is not met as evidenced by:" in the Summary of Deficiencies column on the STATE FORM.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Administrator signature required

OAC 310:663-25-4(F)

Donna Cooper Shuler

Date Enter a date of signature.

12.14.22

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.

Delivery via email to: dianeconnor448@gmail.com; dianecooper448@gmail.com;
betty.lanning555@gmail.com

January 26, 2023

License Number: AL5538

Ms. Diane Cooper Timmerman, Administrator
The Heaven House, LLC
3141 Elmwood
Oklahoma City, OK 73116

RE: Survey Event Z66812

Dear Ms. Cooper Timmerman:

On **January 24, 2023**, 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 **November 21, 2022**, have now been corrected effective **December 14, 2022**.

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/24/2023
NAME OF PROVIDER OR SUPPLIER THE HEAVEN HOUSE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3141 ELMWOOD OKLAHOMA CITY, OK 73116		
(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
{N 000}	Initial Comments An offsite/paper revisit was conducted on 01/24/23. The facility was in substantial compliance.	{N 000}		
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 01/24/23. 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