OKLAHOMA
State Department
of Health

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

September 28, 2023

License Number: AL5538

Ms. Diane O'Connor, Administrator
The Heaven House, Llc
3141 Elmwood
Oklahoma City, OK 73116

**Survey Event ID: 4K5W11**

Dear Ms. O'Connor:

On **September 12, 2023,** 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

## INVESTIGATIVE REPORT

**Facility:** **The Heaven House, LLC**
**Address:** **3141 Elmwood**
**City, State, Zip:** **Oklahoma City, OK 73116**
**Provider #:** **AL5538**
**Complaint #:** **OK000**
**Investigation Date(s):** **09/11/23 and 09/12/23**

### ALLEGATIONS

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| The center failed to provide wound care according to physician's orders. |
| The center failed to provide timely incontinent care for dependent residents. |
| The center failed to ensure staff were properly trained to administer and monitor medications. |

An unannounced on-site investigation was initiated 09/11/2023 at 12:30 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 Summary of Complaint Investigation:**
Observations were made throughout the investigation. Residents were observed in common areas, dining room, and bedrooms. Staff were observed providing personal care and transfers of dependent residents. Staff were observed to provide incontinent care. Home Health was observed providing wound care. Staff were observed to respond to chair alarm and bells to assist and provide care. A medication observation pass was completed.

Resident care plans, physician order, assessments, policies and procedures, ADL care sheets, medication administration records, home heath wound communication sheets, progress notes, and service contracts were reviewed. Staff certifications and skills updates were reviewed.

Staff were interviewed regarding residents' level of care for assistance, discharge criteria, plan of accommodations, safe transfers, half rails, use of lifts, staff assessments of wound care, and medications.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 09/13/2023

# INVESTIGATIVE REPORT

**Facility:** **The Heaven House, LLC**
**Address:** **3141 Elmwood**
**City, State, Zip:** **Oklahoma City, OK 73116**
**Provider #:** **AL5538**
**Complaint #:** **OK00061294**
**Investigation Date(s):** **09/11/23 and 09/12/23**

## ALLEGATIONS

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| The facility failed to ensure necessary equipment was available to perform safe transfers. |
| The facility failed to ensure residents were not restrained. |
| The facility failed to ensure adequate staff to safely meet the needs of the residents. |

An unannounced on-site investigation was initiated 09/11/2023 at 12:30 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 Summary of Complaint Investigation:**
Observations were made throughout the investigation. Residents were observed in common areas, dining room, and bedrooms. Staff were observed providing personal care and transfers of dependent residents. Observations were made of half bed rails on resident's beds. Staff were observed to respond to chair alarm and bells to assist and provide care.

Resident care plans, physician order, assessments, policies and procedures, ADL care sheets, medication administration records, and service contracts were reviewed.

Staff were interviewed regarding residents' level of care for assistance, safe transfers, bed rails, use of lifts and staffing.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 09/13/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

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| C 000 | INITIAL COMMENTS<br><br>Complaint investigations (#OK00060078 and #OK0006129) were conducted conducted on 09/11/23 and 09/12/23.<br><br>The following abbreviations will be used throughout this document.<br><br>ADL's - activities of daily living<br>CMA - certified medication assistant<br>CNA - certified nursing assistant<br>LOTA - left open to air<br>LPN - Licensed Practical Nurse<br>MAR - medication administration record<br>mg - milligram<br>ml - milliliters<br>RN - Registered Nurse<br>SUSP - suspension | C 000 | | |
| C1505 SS=D | 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care<br><br>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<br><br>63 O.S. 1-1918.(B)(5)<br>(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 | C1505 | | |

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| C1505 | Continued From page 1<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the center failed to:<br>a. provide assistance with toileting every two hours for a resident who was dependent on staff for one (#2) of three sampled residents reviewed for assistance with ADL's,<br>b. monitor and assess wounds weekly, and ensure unqualified staff did not perform dressing changes for one (#2) of one sampled resident reviewed for wound care, and<br>c. ensure a proper dosage of medication was administered according to the physician order for one (#2) of two sampled residents reviewed for medication administration.<br><br>The Director of Operations identified five residents who resided in the center. The "Resident Care and Information" report, dated 09/12/23, documented three residents needed assistance with toileting, transfers, and dressing. | C1505 | | |

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| C1505 | Continued From page 2<br><br>Findings:<br><br>An undated "Personal Care Services" policy read in part, "...to provide personal care and support to residents who are unable to manage independently...at any point during residency when a resident's functional status changes, his/her ability to live independently should be assessed using the Comprehensive Assessment form. The service plan will reflect the needed assistance with all Activities of Daily Living..."<br><br>A "Wound Management Care Plan" dated 02/27/23, read in part, "...the RN assess the wound and monitors/supervises the wound care provided by the licensed nurse. The nurse follows physician orders for wound management. The RN documents wound management and progress in the nurse notes section of the resident clinical record..."<br><br>Resident #2 had diagnoses which included, dementia, anxiety, chronic pain, unsteady gait, and fall risk.<br><br>Resident #2's "SERVICE AGREEMENT", dated 09/29/20, read in parts,"...Incontinence care...Included reminding or assisting a resident every two to four hours with toileting and providing assistance with personal hygiene and incontinence products..."<br><br>The clinical health record from December 2022 through March 2023 had one "HOME HEALTH AND HOSPICE REPORT", dated 03/31/23, which documented wound care had been provided by home health.<br><br>A "Significant Change Assessment", dated | C1505 | | |

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| C1505 | Continued From page 3<br><br>03/17/23, documented Resident #2 was alert and oriented to person, was confused, required staff assistance of one for bathing, eating, dressing, transferring, toileting, ambulation and was incontinent of bowel and bladder and needed total assist with incontinent care.<br><br>A "Care Plan", dated 03/27/23, documented Resident #2 was a fall risk, required total assist for transfers, was incontinent and was to be checked every two hours for incontinence.<br><br>The center's physician's order did not document an order for wound care.<br><br>A "Nurse Notes", dated 05/18/23, read in parts, "...this patient return from ER after been sent out for abnormal lab results...[right] foot was OTA this nurse placed a Dry gauze [and] rewrapped foot..." There was no description of the wound documented.<br><br>A "Nurses Notes", dated 8/24/23, read in part, "No significant changes since last visit. Home health progress notes reviewed..."<br><br>There was no other progress notes documented from 05/18/23 through 08/24/23 related to Resident #2's wound.<br><br>Eighteen "HOME HEALTH AND HOSPICE REPORT" communication forms, dated 08/02/23 through 09/11/23, documented Resident #2's wound had been measured one time on 09/06/23.<br><br>A "Physician Order", dated 09/2023, read in part, " ...MEGACE 40MG/ML ORAL SUSP TAKE 10ML BY MOUTH DAILY ..."<br><br>On 09/11/23 at 12:39 p.m., Resident #2 was | C1505 | | |

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| C1505 | Continued From page 4<br>observed to be sitting in the common area in front of the television.<br><br>On 09/11/23 at 2:12 p.m., staff was observed to bring resident #2 out of the dining room into the common area. They were not observed to assist the Resident #2 to the toilet.<br><br>On 09/11/23 at 4:14 p.m., CMA #1 and Helper #3 were observed to transfer Resident #2 with the use of a gait belt and physical assist under the residents arms to the bed. Resident #2 was not observed to bear weight and had minimal left toe touch. Resident #2 had been incontinent of bowel and bladder. CMA #2 provided peri care.<br><br>On 09/11/23 at 4:23 p.m., CMA #1 and Helper #3 were observed to transfer Resident #2 back to their wheelchair with the use of a gait belt and maximum assist under the residents arms. Resident #2 was not observed to bear any weight during the transfer. CMA #1 was asked if the Resident required maximum assist with that transfer. They stated, "Yes."<br><br>No staff were observed to offer assistance with toileting or check and change Resident #2 from 12:39 p.m., to 4:23 p.m.<br><br>On 09/11/23 at 3:10 p.m., home health LPN #2 was observed to remove the dressing from Resident #2's right foot and stated, "That's not the dressing I left on it the other day." Wound care was observed. LPN #2 was asked how often the wound is measured. They stated weekly on Fridays.<br><br>On 09/11/23 at 3:53 CMA #1 was asked to describe how much assistance Resident #2 required. They stated Resident #2 was a two | C1505 | | |

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| C1505 | Continued From page 5<br>person assist for everything except for feeding.<br><br>On 09/12/23 at 10:05 a.m., CMA #1 was observed to prepare Resident #2's medications for administration. CMA #1 was observed to pour Megace liquid 30 ml's in one cup and 10 ml's in another cup. Prior to administration the CMA was asked to review the physician order for the dosage. They were asked what the order documented. CMA #1 stated, "Ok, just 10 ml. I almost did too much." CMA #1 was observed to pour the 30 ml into the sink then administer the 10 ml's of Megace to Resident #2.<br><br>On 09/12/23 at 10:17 a.m., The Director of Operations was notified and was asked to review the MAR. They stated that it would be written as a medication error.<br><br>On 09/12/23 at 11:08 a.m., the Director of Operations was asked how often should residents who required assistance with toileting be checked. They stated every two hours.<br><br>On 09/12/23 at 12:23 p.m., the Director of Operations was asked how were they aware of Residents #2's wound care progression. They stated "Our nurses should be documenting it in the progress notes."<br><br>ON 09/12/23 at 12:34 p.m., the Director of Operations was shown the clinical health record for Resident #2 from November 2022 through March 2023. They were asked how were they aware of the wound care being provided if there was only one wound care note from home health. They stated, "Home health didn't give good notes, our nurses should be documenting it in the progress notes." | C1505 | | |

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| C1505 | Continued From page 6<br>The center did not provide any progress notes from November 2022 through March 2023.<br><br>On 09/12/23 at 12:41 p.m., the Director of Operations was asked where the documentation was that staff nurses had been assessing the wound weekly. They stated in the progress notes.<br><br>There was no documentation weekly wound assessments had been completed by the facility staff in the progress notes dated 05/18/23 through 08/24/23.<br><br>On 09/12/23 at 12:57 p.m., CMA #1 was asked why Resident #2's dressing was not the same one that home health had put on Friday. CMA #1 stated, over the weekend they had called to check on the residents and the staff had stated the dressing was off. CMA #1 stated, "I dressed it Monday." They were asked what they used for the dressing. They stated they had seen home health change the dressing. CMA #1 stated they had used maxorb, put optifoam over that, and then wrapped it with gauze. CMA #1 was asked why didn't staff notify home health services over the weekend the dressing had come off. They stated they should have.<br><br>On 09/12/23 at 1:22 p.m., the RN #1 was asked where Resident #2's documentation the wound had been monitored by them or the LPN on a weekly basis. They stated "I do monthly skin assessments." They were asked where that documentation was located. They stated, "It is not here, I can go look at home."<br><br>On 09/12/23 at 1:35 p.m., RN #1 was asked if the dressing comes off and there is no nurse in the facility, what should staff do. They stated staff should call the nurse on call and they would | C1505 | | |

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| C1505 | Continued From page 7<br>come. They were asked if unlicensed staff should reapply dressings. They stated no, they should just cover it.<br><br>On 09/12/23 at 1:39 p.m. RN #1 was asked if the policy for wound care was the current policy. They stated, no they had a different policy and they would have to go to their house to get it. | C1505 | | |
| C1512 SS=E | 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect<br><br>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<br><br>63 O.S. 1-1918.(B)(12)<br>(12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;<br><br>Title 43A O.S. 10-103. Definitions | C1512 | | |

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| C1512 | Continued From page 8<br>8. "Abuse" means causing or permitting:<br>a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or<br>b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult;<br><br>10. "Neglect" means:<br>a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,<br>b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or<br>c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview, the center failed to ensure half rails were not used as a restraint and follow the facility policy for use of half rails for three ( #1, 2, and #3) of three sampled residents reviewed for the use of half rails.<br><br>The Director of Operations identified five residents who resided in the center. | C1512 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEAVEN HOUSE, LLC | 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 |
|---|---|---|---|---|
| C1512 | Continued From page 9<br><br>Findings:<br><br>An undated, "[NAME OF FACILITY] WILL NOT ALLOW THE USE OF BEDRAILS", read in parts, "THE USE OF BEDRAILS IS NOT PERMISSIBLE IN THE HEAVEN HOUSE. BEDRAILS ARE AGAINST STATE REGULATIONS FOR ASSISTED LIVING HOMES. HOWEVER IN THE EVENT THAT A RESIDENT DECLINES IN MOBILITY AND MAY REQUIRE BEDRAILS FOR BED MOBILITY, POSITIONING IN BED OR PHYSICAL ALIGNMENT WHILE LYING DOWN THEY MAY BE USED. IF THIS THE CASE ONLY SHORT RAILS MAY BE USED. THE RESIDENT'S NEED FOR BEDRAILS FOR THESE REASONS MUST BE ADDRESSED AND BE PART OF THE RESIDENT'S ASSESSMENT AND SUBSEQUENT CARE PLAN. BEDRAILS MAY NEVER BE USED FOR RESTRAINT IN THE HEAVEN HOUSE..."<br><br>1. Resident #1 had diagnoses which included dementia, failure to thrive, high blood pressure, and chronic pain.<br><br>A "Care Plan", dated 03/22/23, documented the resident had a history of falls, used a walker, was occasionally incontinent of bladder, and was to be checked and changed every two hours. The care plan did not document the use of half side rails.<br><br>A "Significant Change Assessment", dated 03/22/23, documented the resident was standby assistance with walker and required the assistance of one staff for bathing, eating, dressing, transferring toileting, and ambulation. The assessment did not document the use of half rails. | C1512 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEAVEN HOUSE, LLC | 3141 ELMWOOD OKLAHOMA CITY, OK 73116 |

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|---|---|---|---|---|
| C1512 | Continued From page 10<br><br>September 2023's "Physician Orders" did not have an order for the use of half rails.<br><br>At 4:01 p.m., half side rails were observed on Resident #1's bed.<br><br>On 09/12/23 at 10:58 a.m., the Director of Operations was shown the policy for the use of bed rails. They were asked if Resident #1 had a physician order for the use of the rails, the care plan documented the use of the rails, and the assessment document the use of the rails. After review of the documents, they stated, "No."<br><br>2. Resident #2 had diagnoses which included dementia, anxiety, chronic pain, unsteady gait, and fall risk.<br><br>A "Care Plan", dated 03/27/23, documented Resident #2 was a fall risk, required total assist for transfers, was incontinent ,and was to be checked every two hours for incontinence. The care plan did not document bed rails were in use.<br><br>A "Significant Change Assessment", dated 03/27/23, documented Resident #2 was alert to person, was confused, required staff assistance of one for bathing, eating, dressing, transferring, toileting, ambulation and was incontinent of bowel and bladder and needed total assist with incontinent care.<br><br>September 2023's "Physician Orders", did not have an order for the use of half rails.<br><br>At 4:04 p.m., Resident #2's bed was observed to have one half rail on the right side. CMA #1 stated the other rail was broke. | C1512 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEAVEN HOUSE, LLC | 3141 ELMWOOD OKLAHOMA CITY, OK 73116 |

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|---|---|---|---|---|
| C1512 | Continued From page 11<br><br>On 09/12/23 at 11:03 a.m., the Director of Operations was shown the policy for the use of bed rails. They were asked if Resident #2 had a physician order for the use of the rails, the care plan documented the use of the rails, and the assessment document the use of the rails. After review of the documents, they stated, "No."<br><br>3. Resident #3 had diagnoses which included atrial fibrillation, edema, high blood pressure, and psychosis.<br><br>A "Care Plan", dated 03/27/23, documented Resident #3 needed total assistance for transfers, used a wheelchair, was incontinent of bowel and bladder, and was to be checked every two hours for incontinence. The care plan did not document bed rails were in use.<br><br>A "Significant Change Assessment", dated 03/27/23, documented the resident required assistance of one staff for bathing, eating, dressing, transferring, toileting and ambulation. The assessment did not document the use of half rails.<br><br>September 2023's "Physician Orders" did not have an order for the use of half rails.<br><br>On 09/11/23 at 4:00 p.m., CMA #1 was asked if any residents used side rails. They stated, "Yes." Resident #3's bed was observed to have bilateral half rails in the down position on the bed. CMA #1 was asked why did they used the rails. They stated they were used to keep the resident from getting out of bed and positioning.<br><br>On 09/12/23 at 10:55 a.m., the Director of Operations was shown the policy for the use of bed rails and was asked if Resident #3 had a | C1512 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE HEAVEN HOUSE, LLC | 3141 ELMWOOD OKLAHOMA CITY, OK 73116 |

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|---|---|---|---|---|
| C1512 | Continued From page 12<br>physician order for the use of the rails, the care plan document the use of the rails, and the assessment document the use of the rails. After review of the documents, they stated, "No." | C1512 | | |
| C5015 SS=D | 63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation<br><br>If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria:<br><br>1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity;<br><br>2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; | C5015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

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| THE HEAVEN HOUSE, LLC | 3141 ELMWOOD OKLAHOMA CITY, OK 73116 |

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|---|---|---|---|---|
| C5015 | Continued From page 13 | C5015 | | |

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the center failed to ensure a resident who met the centers discharge criteria had a plan of accommodation in place for one (#2) of three sampled residents reviewed for plan of accomodations.

The Director of Operations identified five residents resided in the center.

Findings:

An undated, "PLAN OF ACCOMMODATION" policy, read in part, "...Then a resident of the [name of facility] exceeds the criteria of the [name of facility] contract in terms of care needs and evacuation capabilities in order for that resident to remain at the [name of facility] a Plan of Accommodation may be put in place...

Resident #2 had diagnoses which included, dementia, anxiety, chronic pain, unsteady gait, and fall risk.

Resident #2's "SERVICE AGREEMENT", dated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEAVEN HOUSE, LLC | 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 |
|---|---|---|---|---|
| C5015 | Continued From page 14<br><br>09/29/20, read in parts,"...Each existing resident must meet the following criteria...Demonstrated ability to bear weight, transfer and ambulate...Must be capable of self preservation with a verbal prompt to evacuate the home in an emergency...When a resident no longer qualifies for residency, the Administrator or Nurse, will discuss with the resident and/or family the challenges...in meeting the resident's needs..."<br><br>A "Significant Change Assessment", dated 03/17/23, documented Resident #2 was alert to person, was confused and required staff assistance of one for bathing, eating, dressing, transferring, toileting, and ambulation, was incontinent of bowel and bladder, and needed total assist with incontinent care.<br><br>A "Care Plan", dated 03/27/23, documented Resident #2 was a fall risk, required total assist for transfers, was incontinent, and was to be checked every two hours for incontinence.<br><br>On 09/11/23 at 2:23 p.m., CMA #1 and Helper #3 were observed to transfer Resident #2 to their wheelchair with the use of a gait belt and maximum assist under the resident's arms. Resident #2 was not observed to bear any weight during the transfer. CMA #1 was asked if the Resident required maximum assist with that transfer. They stated, "Yes."<br><br>On 09/11/23 at 2:37 p.m., the Director of Operations was asked if Resident #2 had a plan of accommodation. They stated, "No."<br><br>On 09/11/23 at 3:53 CMA #1 was asked to describe how much assistance Resident #2 required. They stated Resident #2 was a two person assist for everything except for feeding. | C5015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | C 09/12/2023 |

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| THE HEAVEN HOUSE, LLC | 3141 ELMWOOD OKLAHOMA CITY, OK 73116 |

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|---|---|---|---|---|
| C5015 | Continued From page 15<br><br>On 09/11/23 at 4:14 p.m., CMA #1 and Helper #3 were observed to transfer Resident #2 with the use of a gait belt and physical assist under the resident's arms to the bed. Resident #2 was not observed to bear weight and had minimal left toe touch. Resident #2 had been incontinent of bowel and bladder. CMA #2 provided peri care.<br><br>On 09/12/23 at 11:12 a.m., the Director of Operations was shown the significant change assessment for Resident #2 and was asked how many staff Resident #2 required for transfers. They stated two. They were asked if the assessment was accurate. They stated, "No." The Director of Operations was asked how would one staff be able to evacuate Resident #2 by them self. They stated, the resident was easier to get out of bed than in bed.<br><br>On 09/12/23 at 11:33 a.m., the Director of Operations was asked if Resident #2 met discharge criteria. They stated, "Yes." | C5015 | | |

OKLAHOMA
State Department
of Health

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

October 16, 2023

License Number: AL5538

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

**Survey Event ID: 4K5W11**

Dear Ms. Timmerman-O'Connor:

On **September 12, 2023,** 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 **October 5, 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,

Lisa Calvin

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

| OKLAHOMA State Department of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 10/8/2023**<br>**Facility Name:** Heaven House, Elmwood<br>**License Number:** AI 5538<br>**Survey Event ID:** 4K5W11<br>**Date Survey Completed: 9/12/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C~~5015~~ 1505<br>Residents's Rights Medical Care | Based on: Obaervation, interview and record review the center failed to a) provide assistance with toileting every two hours for a resident who was dependent on staff for 1 of 3 residents sampled, b) monitor and assess wounds weekly and ensure unqualified staff did not perform dressing changes for 1 or 3 sampled residents c) ensure proper dosage of medication was administered according to the physicans order for 1 or 3 sampled residents. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Heaven House is committed to provide the best of care for all our residents. When a survey is taking place in our small homes it is a disruption and distraction for caregivers and throws routine off. We are confident that our normal practices are excellent and on any given day our 5 residents are given utmost care.

| **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) RN, house supervisor and Director of Operations have discussed the policies and procedures, and care plan and service agreement and will provide oral and written reminders to all staff to make sure each resident continues to be toileted on the 2 hour required schedule.<br>b)wound care policy, procedures and documentation materials were reviewed and found adequate in content. They have been posted for review and signatures. An oral reminder to all staff and CNA# 1 about contacting Home Health nurse if resident's wound becomes uncovered at any time. Medication administration polcy and procedures were reviewed and found adequate in content. Written reminders for safe medication administration will be posted in the medication preparation area. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | House supervisor, RN and Director of Operations will continue to remind staff of the above posted requirments for care of residents. CNA#1 was aware of near medication error. She was advised of avoiding distractions and other factors affecting safe medication preparation. Safe Meidcation practices will remain posted in med area. A new form for visitation from outside services has been created. We have spoken to all outside service people that visit about a more detailed description of the wound care and other services provided. The RN will coordinate weekly with Resident#2 Home Health nurse and be present for wound care and documentation and signature on visitation form. All visitation forms will be signed by the Heaven House RN or LPN. Resident #2 Home Health company has provided all records of her wound care this year. E mails are attached to Plan of Correction. |

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| | |
| 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? | Weekly, the nurse will identify residents needing skilled nursing wound care. Weekly the house supervisor and nurse will verify documentation of wound assessment by Home Health nurse of AL nurse. Skin observation and wound care progress notes are archived monthly with resident's clinical record. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Quality Assurace meetings monthly will document ongoing staff observations, interviews and record reviews related to each of these corrective actions. In QA meetings at discussion of each resident information will be shared and action and changes made when needed. Outside service companies forms will be reviewed weekly by Heaven House nurses for accuratcy and detailed information about a residents care by such companies.<br><br>Enter methods to evaluate for effectiveness:<br><br>Enter methods to incorporate into QA system:<br><br>Enter methods to keep monitoring records: |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 10/5/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** Diane Cooper<br>OAC 310:663-25-4(F) | **Date 10/9/2023** |

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.

# HOME HEALTH AND OR HOSPICE VISATATION REPORT

**DATE**_____ **TIME**_____
**COMPANY**_____

**RESIDENT**_____**ROOM**_____
**VITALS**
**BP**_____/_____**PULSE**_____**TEMPERATURE**_____
**FSBS**_____**INSULIN GIVEN**_____
**PAIN SCALE**_____

**DETAILS OF SKILLS PERFORMED:**

_____
_____
_____
_____

**COMMENTS OR CONCERNS:**

_____
_____
_____
_____

**SIGNATURE**_____
**HOME HEALTH OR HOSPICE**

**SIGNATURE**_____
**HEAVEN HOUSE NURSE**

| OKLAHOMA State Department of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 10/4/2023**<br>**Facility Name:** HEAVEN HOUSE ELMWOOD<br>**License Number:** AL 5538<br>**Survey Event ID:** 4K5W11<br>**Date Survey Completed: 9/12/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C1512<br>RESIDENTS RIGHTS – Absue and Neglect | Based on: observation, record review, and interview the center failed to ensure half rails were not used as a restraint and follow the facility policy for use of half rails for 3 (#1,2,3)sampled residents reviewed for the use of half rails. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: The Heaven House never uses devices of any kind for restraint of a resident. It is against our policy and we take that very seriously.

| **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? | We have obtained signed doctors orders for each of the sampled residents (#1,2, and 3) stating that half rails are used for bed positioning only due to decrease in mobility.They are attached to each residents care plan. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | Whenever a resident of the Heaven House declines in mobility and the need for half rails is recommended by staff, hospice or Home Health a doctors signed order will be obtained and attached to the resident's care plan. The rails may also be part of the Plan of Accomodation. |
| 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? | Heaven House will not allow half rails with out the order from the Hospice doctor or the resident's primary doctor when rails are needed. Additionally, the current policy will be changed to include a doctor's signed order for short rails must be present with the residents current assessment and care plan along with Plan of Accomodation. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The house supervisor, Director of Operations, RN and LPN will check residents records to keep them current. The change will be effective if the order from the doctor coincides with the need and presence of such rails. It will be added as a line item on the monthly Quality Assurance meeting at which time the residents who have rails record will be checked for accuracy.The records for this will be kept in the resident's book of records and will be available easily for accuracy.<br><br>Enter methods to evaluate for effectiveness:<br><br>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? | 9/13/2023 ~~for~~ (#1&2)<br>9/14/2023 for resident #3 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** Diane Cooper<br>OAC 310:663-25-4(F) | **Date 10/4/2023** |

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 ADDITION

October 4, 2023

ADDITION TO THE HEAVEN HOUSE POLICY ON SHORT BEDRAILS

.....IN ORDER FOR A RESIDENT TO BE ALLOWED TO HAVE SHORT BEDRAILS IT MUST BE LISTED ON THE PLAN OF ACCOMODATION FOR SAID RESIDENT AND HAVE A DOCTORS ORDER WHICH IS SIGNED.

| OKLAHOMA State Department of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 10/4/2023**<br>**Facility Name:** HEAVEN HOUSE ELMWOOD<br>**License Number:** AL 5538<br>**Survey Event ID:** 4K5W11<br>**Date Survey Completed: 9/12/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 5015 CARE AND SERVICES – PLAN OF ACCOMODATION | Based on: observation, record review, and interview, the center failed to ensure a resident who met the center's discharge criteria had a plan of accommodation in place for one #2 of three sampled residents reviewed for plan of accomodations. |

**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** | **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? | An updated Plan of Accomodation form was created. It has been signed by all required parties for one of three residents #2 who meets the discharge criteria for the home. It is in place with the residents documents. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | We have secured, additionally, a Plan of Acccomodation for each of the other two sampled residents. When a resident declines to the point of exceeding the discharge criteria the Administrator will facilitate a consensus with family of the resident or residents representative as to the need for a Plan of Accomodation based on self preservation and the need for additional services that are required for the resident to remain in place. |
| 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 Plan of Accomodation has always been an important part of the Aging in Place concept. We will include the Plan of Accomodation form in the move in packet given to resident's representive and discuss the possible need and criteria. We will make clear of its importance and need as the resident continues to age and may have more needs than the current staus at move in. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | At monthly Quality Assurance meetings as discussion of each resident comes up their mobility, changes, quality of life, will determine if it is time for Plan of Accomodation. Family will be informed and the physician, assisted living center representative and resident representative will sign the form describing the additional services resident now requires. House supervisor will be able to describe easily the condition that is consistant with the facility's discharge criteria. As the Owner Administrator I feel the Plan of Accomodation is a great way for all to be more |

| | |
|---|---|
| | comfortable as a resident continures to decline.<br>Enter methods to evaluate for effectiveness:<br>Enter methods to incorporate into QA system:<br>Enter methods to keep monitoring records: |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 9/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | |
|---|---|
| **Administrator's Signature** **Diane Cooper**<br>OAC 310:663-25-4(F) | **Date 10/4/2023** |

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 Assisted Living, LLC**
**Policy and Procedure**

**Title: Plan of Accommodation for Residents with Advanced Care Needs**

**Policy:** If a Heaven House resident develops a disability or a condition that is inconsistent with the facility's admission and retention criteria, a written plan of accommodation must be developed and implemented.

**Procedure:** The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine reasonable and necessary accommodations and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity.

All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident.

See page two: **Plan of Accommodation Agreement**

The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation and shall include

a. assisted living center administrative representative
a. attending physician of the resident
b. home care agency nurse, applicable
c. hospice nurse, if applicable
d. Heaven House manager

If the parties identified in paragraph 1 fail to reach a consensus on a plan of accommodation, the assisted living center shall give written notice to the resident, the legal representative or the resident or such persons as are designated in the resident's contract with the assisted living center, of the termination of the residency of the resident in the assisted living center in accordance with the provisions of the resident's contract with the assisted living center. Such notice shall not be less than thirty (30) calendar days prior to the date of termination, unless the assisted living center or the personal or attending physician of the resident determines the resident is in imminent peril or the continued residency of the resident places other persons at risk of imminent harm;

If any party identified in paragraph 1 determines that the plan of accommodation is not being met, such party shall notify the other parties and a meeting shall be held between the parties within ten (10) business days to re-evaluate the plan of accommodation.

**Approved by**

**Administrator** **Date**

**Operations Director** **Date**

# Heaven House Assisted Living, LLC

## Plan of Accommodation for Residents with Additional Care Needs

This addendum is required by the Oklahoma Department of Health when the resident's needs exceed the criteria for assisted living admission and retention. Approval and implementation of this addendum allows the resident to continue living at Heaven House.

Additional services needed include

- another staff person (certified nursing assistant) to assist with personal care, transfers, ambulation, meals, etc)
- scheduled skilled nursing services that may require home healthcare, palliative care, or hospice referrals
- environmental accommodations such as electric hospital bed with rails, over-bed table, enhanced lighting,
- safety precautions such as bed and chair alarms, room monitors
- more frequent assessment, care planning, intervention, and documentation by staff and Nurse.

**Significant changes in the resident's status and needs will continue to be communicated in a timely manner to the healthcare team, including the resident and family.**

**The accommodation service plan for Daralene Carson is approved by the following:**

**Person** **Date**

Resident or legal representative

Heaven House Administrator

Heaven House Director of Operations

Heaven House manager

Heaven House Nurse

Physician:

OKLAHOMA
State Department
of Health

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

December 20, 2023

License Number: AL5538

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

**Survey Event ID: 4K5W12**

Dear Ms. Cooper-O'Connor:

On **December 15, 2023,** 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 **September 12, 2023,** have now been corrected effective **October 5, 2023.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
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 |
|---|---|---|---|
| | AL5538 | A. BUILDING: _____ B. WING _____ | R-C 12/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE HEAVEN HOUSE, LLC | 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 |
|---|---|---|---|---|
| {C 000} | INITIAL COMMENTS<br><br>A revisit was conducted 12/15/23. All deficiencies from the 09/12/23 survey were cleared. | {C 000} | | |

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