

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

March 13, 2024

License Number: AL5538

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

RE: Survey Event ID: R07711

Dear Ms. Timmerman-Cooper:

On **February 28, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **February 28, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,



Lisa Calvin, 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: AL5538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2024
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
C 000	INITIAL COMMENTS A relicensure survey was conducted from 02/27/24 through 02/28/24. Facility Census: 05 Listed below are abbreviations that will be used throughout this document. AC - before meals BID - twice a day QD - every day PRN - as needed hrs - hours mg - milligrams MAT - medication aide technician CNA - certified nurse aide CPR - cardiopulmonary resuscitation RN - registered nurse	C 000		
C 371 SS=F	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on record review and interview the center failed to complete bed rail safety assessments for four (#1, 3, 4, and #5) of four sampled residents with bed rails in use.	C 371		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 371	Continued From page 1 The Director of Operations identified 5 residents resided in the facility. There were four residents that used bed rails. Findings: 1. Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. On 02/27/24 at 9:15 a.m., Res #1 was observed in bed, asleep with two upper bed rails raised. On 02/28/24 at 6:50 a.m., Res #1 was observed in bed asleep with two upper bed rails raised. 2. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. On 02/28/24 at 6:51 a.m., Res #3 was observed in bed asleep with two upper bed rails raised. 3. Resident #4 had diagnoses that included dementia and edema. On 02/28/24 at 6:52 a.m., Res #4 was observed asleep in bed, fully dressed, with two upper bed rails raised. 4. Resident #5 had diagnoses that included Alzheimer's and depression. On 02/27/24 at 9:16 a.m., Res #5 was observed in bed, asleep with two upper bed rails raised. On 02/28/24 at 6:53 a.m., Res #5 was observed asleep in bed with two upper bed rails raised. There was no documentation in the clinical records that bed rail safety assessments had	C 371		

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C 371	Continued From page 2 been completed for Resident #1, #3, #4, or #5. On 02/28/24 at 10:57 a.m., the Director of Operations stated that safety assessments for the use of bed rails had not been completed for Resident #1, #3, #4, nor #5.	C 371		
C 372 SS=F	310:663-3-6(b) MANAGEMENT OF RISK (b) The assisted living center shall specify the cause for concern, discuss the concern with the resident and representative, if any, and attempt to negotiate a written agreement that minimizes risk and adverse consequences and offers alternatives while respecting resident preferences. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to negotiate a written agreement with the resident/resident's representative for the use of bed rails for four (#1, 3, 4, and #5) of four sampled residents with bed rails in use. The Director of Operations identified 5 residents resided in the facility. There were four residents that used bed rails. Findings: 1. Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. On 02/27/24 at 9:15 a.m., Res #1 was observed in bed, asleep with two upper bed rails raised.	C 372		

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C 372	Continued From page 3 On 02/28/24 at 6:50 a.m., Res #1 was observed in bed asleep with two upper bed rails raised. 2. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. On 02/28/24 at 6:51 a.m., Res #3 was observed in bed asleep with two upper bed rails raised. 3. Resident #4 had diagnoses that included dementia and edema. On 02/28/24 at 6:52 a.m., Res #4 was observed asleep in bed, fully dressed, with two upper bed rails raised. 4. Resident #5 had diagnoses that included Alzheimer's and depression. On 02/27/24 at 9:16 a.m., Res #5 was observed in bed, asleep with two upper bed rails raised. On 02/28/24 at 6:53 a.m., Res #5 was observed asleep in bed with two upper bed rails raised. There was no documentation in the clinical records that the facility had negotiated a written agreement with the resident/resident's representative for the use of bed rails for Resident #1, #3, #4, or #5. On 02/28/24 at 10:57 a.m., the Director of Operations acknowledged there was no written agreement negotiated with the resident/resident's representative for the use of bed rails.	C 372		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT	C 542		

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C 542	Continued From page 4 (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive assessment was coordinated by an RN or physician for one (#1) of five sampled residents whose comprehensive assessments were reviewed. The Director of Operations identified five residents resided in the facility. Findings: Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. A significant change assessment for Resident #1, dated 09/20/23, did not contain the signature of a registered nurse or physician after the assessment was completed. On 02/27/24 at 2:27 p.m., the Director of Operations reported the facility did not have a written policy regarding required signatures of a registered nurse or physician on comprehensive assessments. They stated, "We follow the State regulations." The Director of Operations was asked to review the assessment referenced above and acknowledged they did not contain the required signatures of a registered nurse or physician after the assessments were completed.	C 542		

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C 543	Continued From page 5	C 543		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive assessment included a personal interview for one (#2) of five sampled residents whose comprehensive assessments were reviewed. The Director of Operations identified five residents resided in the facility. Findings: Resident #2 had diagnoses that included mild-moderate vascular dementia. An initial assessment for Resident #2, dated 02/06/23, did not include a resident or representative interview. On 02/27/24 at 2:27 p.m., the Director of Operations reported the facility did not have a written policy regarding required signatures of a registered nurse or physician on comprehensive assessments. They stated, "We follow the State regulations." The Director of Operations was asked to review the assessment referenced	C 543		

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C 543	Continued From page 6 above and acknowledged it did not contain the required signature for the resident or representative interviewed.	C 543		
C 544 SS=E	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident's completed initial assessments were available to the State agency upon request for three (#1, 3, and #4) of five sampled residents whose initial assessments were reviewed. The Director of Operations identified five residents resided in the facility. Findings: 1. Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. 2. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. 3. Resident #4 had diagnoses that included dementia and edema. No initial assessments were found in the clinical	C 544		

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C 544	Continued From page 7 records for Resident's #1, 3, or #5. On 02/27/24 at 2:30 p.m., the Director of Operations was asked to provide the initial assessments for Resident #1, 3, and #5. On 02/28/24 at 12:00 p.m., the Director of Operations stated they did not know where the initial assessments for Resident #1, 3, and #5 could be, and they were unable to locate them.	C 544		
C 940 SS=F	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents received nutritionally sound options approved by the registered dietitian for breakfast and lunch for five (#1, 2, 3, 4, and #5) of five sampled residents whose meal options were reviewed. The Director of Operations identified five residents resided in the facility. Findings: A January 2024 menu listed only meal options for the dinner meal for each day of the month. A February 2024 menu listed only meal options for the dinner meal for each day of the month.	C 940		

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C 940	Continued From page 8 Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. Resident #2 had diagnoses that included mild-moderate vascular dementia. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. Resident #4 had diagnoses that included dementia and edema. Resident #5 had diagnoses that included Alzheimer's and depression. On 02/27/24 at 2:30 p.m., the Director of Operations was asked to produce the menus for the breakfast and lunch meals for January 2024 and February 2024. They stated the facility did not use set menus for any meal except dinner. The Director of Operations was asked if the facility was able to ensure the residents received nutritionally sound diets if the breakfast and lunch menus were not approved by the registered dietitian. They stated no, but we've always done it this way.	C 940		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

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C 954	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained in CPR and First Aid for two (RN #1 and Helper #1) of five staff reviewed for CPR and First Aid training. The Director of Operations identified five residents resided in the facility. Findings: A review of the personnel files for RN #1 and Helper #1 revealed no documentation they had received CPR or first aid training. On 02/27/24 at 12:15 p.m., the Director of Operations was asked to provide documentation of CPR and first aid training for RN #1 and Helper #1. On 02/28/24 at 12:00 p.m., the Director of Operations stated RN #1 and Helper #1 did not have documentation of current CPR and first aid training.	C 954		
C 962 SS=F	310:663-9-6(b) MINIMUM STAFF FOR SERVICES (b) A continuum of care facility or assisted living center that has only one direct care staff member on duty shall: (1) Disclose the one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the	C 962		

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C 962	Continued From page 10 assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a written plan in place for addressing how emergency situations, including resident falls, will be handled for five (#1, 2, 3, 4, #5) of five sampled residents during periods when only one direct-care staff member is on duty. The Director of Operations identified five residents resided in the facility. Findings: Title 310. Chapter 663-9-6-1(b)(ii) regulates, "...An assisted living facility that has only one direct care staff member on duty shall...Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including falls, during periods when the assisted living facility has only one direct-care staff member on duty." The "Online Time and Attendance" schedule,	C 962		

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C 962	Continued From page 11 dated 02/01/24 through 02/28/24, documented one CNA/MAT and one Helper worked the day shift, one CNA/MAT and one Helper worked the evening shift, and one CNA/MAT worked the overnight shift Monday through Friday of each week. Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. Resident #2 had diagnoses that included mild-moderate vascular dementia. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. Resident #4 had diagnoses that included dementia and edema. Resident #5 had diagnoses that included Alzheimer's and depression. On 02/28/24 at 9:35 a.m., the Director of Operations was asked to describe the duties assigned to a Helper and explained that the Helper was not authorized to provide any type of direct care to the residents. On 02/28/24 at 10:39 a.m., the Director of Operations was asked to provide a copy of the facility's emergency plan for when there was only one direct-care staff on duty. They stated the facility had no emergency plan in place specific to one-person staffing. The Director of Operations was asked if they had submitted an emergency plan for one direct-care staffing to the Department for approval. They stated they had not.	C 962		

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C1304	Continued From page 12	C1304		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure all services in the resident's Plan of Accommodation were being provided for three (#1, 3, and #4) of three residents with Plans of Accommodations in place. The Director of Operations identified five residents resided in the facility. Findings: A "Plan of Accommodation for Residents with Additional Care Needs (to Remain as a Resident in the Heaven House Assisted Living center)" policy, dated 09/12/23, read in parts, "...If a Heaven House resident develops a disability or a condition that is inconsistent with the facility's	C1304		

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 02/28/2024
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
C1304	Continued From page 13 admission and retention criteria, a written plan of accommodation must be developed and implemented..." 1. Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. The "Plan of Accommodation" for Resident #1, dated 09/13/23, read in parts, "...Additional services needed include: another staff person (certified nursing assistant) to assist with personal care, transfers, ambulation, meals, etc)..." The care plan, dated 09/20/23, documented Resident #1 would receive two-person assistance for transfers and toileting when needed. 2. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. The "Plan of Accommodation" for Resident #3, dated 09/13/23, read in parts, "...Additional services needed include: another staff person (certified nursing assistant) to assist with personal care, transfers, ambulation, meals, etc)..." The care plan, dated 09/18/23, documented Resident #3 had poor trunk control, was unable to stand or bear weight, and needed total assistance for transfers. 3. Resident #4 had diagnoses that included dementia and edema. The "Plan of Accommodation" for Resident #4, dated 09/13/23, read in parts, "...Additional services needed include: another staff person (certified nursing assistant) to assist with personal care, transfers, ambulation, meals, etc)..."	C1304		

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 02/28/2024
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
C1304	Continued From page 14 On 02/27/24 at 3:42 pm, the Director of Operations was asked if the facility had begun staffing any shifts with two certified nursing assistants. They stated no and acknowledged that the accommodation of an additional certified nursing assistant to assist with personal care and transfers for Residents #1, #3, and #4 had not been implemented.	C1304		
C1505 SS=E	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 of such actions unless adjudged to be mentally incapacitated.	C1505		

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 02/28/2024
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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C1505	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow-up on recommendations from quarterly pharmacist reviews for two (#1 and #3) of five sampled residents whose quarterly pharmacy consults were reviewed. The Director of Operations identified five residents resided in the facility. Findings: A "Documentation and Communication of Consultant Pharmacist Recommendations" policy, undated, read in part, "...The consultant pharmacist documents potential or actual medication-related...findings for prescriber and/or nursing review...these recommendations should enable a response before the next medication regimen review...and prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record..." 1. Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. A "Quarterly Pharmacy Review", dated 08/21/23, read in part, "Be sure and keep Acetaminophen under 3000mg/24hrs from all sources."	C1505		

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 02/28/2024
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
C1505	Continued From page 16 The physician orders, dated February 2024, documented current order for Acetaminophen 1000mg TID. 2. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. A "Quarterly Pharmacy Review", dated 04/27/23, read in part, "Do we still need Atarax and Claritin routinely- it's a lot of antihistamine- could cause confusion in the elderly...Do we still need Pepcid and Prilosec routinely..." A "Quarterly Pharmacy Review", dated 08/21/23, read in parts, "...Do we still need Atarax and Claritin? Both antihistamines...Do we need both Pepcid and Prilosec routinely?..." A "Quarterly Pharmacy Review", dated 12/12/23, read in parts, "...Do we need Atarax and Claritin?...Do we still need Pepcid and Prilosec?..." The physician orders, dated February 2024, documented current orders for Atarax 50mg BID, Claritin 10mg QD, Pepcid AC 10mg QD, and Prilosec 40mg QD. There was no documentation on the consultant pharmacist review reports or elsewhere in the medical records of Resident #1 nor Resident #3 that the recommendations had been reviewed or addressed by the prescriber or the registered nurse. On 02/27/24 at 12:20 p.m., the Director of Operations was asked how pharmacy reviews were handled and stated, "The pharmacy consultant generates the reports and gives them	C1505		

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 02/28/2024
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
C1505	Continued From page 17 to the MAT to file." When asked if pharmacy reviews were forwarded to the physician or the RN the Director of Operations stated they did not know. They reviewed the pharmacy consultants' recommendations noted above and acknowledged the facility policy had not been followed.	C1505		
C1920 SS=F	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the safe administration of medications by unlicensed staff by not including the reason for use of routine and as needed medications on the Medication Administration Record and Physician Order for five (#1, 2, 3, 4, and #5) of five sampled resident's whose Medication Administration Records and Physician Orders were reviewed. The Director of Operations identified five residents resided in the facility. Findings: A "Prescriber Medication Orders" policy, undated, read in parts, " ...Medication orders specify the following ...Diagnosis or indication for use ...PRN (as needed) orders clearly delineate the condition for which they are being administered ..."	C1920		

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 02/28/2024
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
C1920	Continued From page 18 Resident #1 had diagnoses that included senile degeneration of the brain and failure to thrive. Resident #2 had diagnoses that included mild-moderate vascular dementia. Resident #3 had diagnoses that included dementia, anxiety, and chronic pain. Resident #4 had diagnoses that included dementia and edema. Resident #5 had diagnoses that included Alzheimer's and depression. A review of the physician orders and the medication administration records for Resident #1, #2, #3, #4, and #5 revealed that the diagnoses, or indications for use, for routine medications; and the conditions for which PRN medications were to be administered, were not always specified. On 02/27/24 at 12:15 p.m., the Director of Operations was asked to review how medication orders were written on the physician's orders and medication administration records for Resident #1, #2, #3, #4, and #5. After reviewing the orders, the Director of Operations acknowledged they were not written according to facility policy and did not ensure the safe administration of the medications by unlicensed staff.	C1920		
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	C1972		

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 02/28/2024
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
C1972	Continued From page 19 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 facility failed to ensure employees received abuse prevention training within 90 days of employment nor annually for five (RN #1, Helper #1, CNA/MAT #1, CNA/MAT #2, and CNA/MAT #3) of five staff reviewed for abuse training. The Director of Operations identified five residents resided in the facility. Findings: RN #1 had a hire date of 07/27/22. Helper #1 had a hire date of 07/29/22. CNA/MAT #1 had a hire date of 05/09/15. CNA/MAT #2 had a hire date of 11/13/23. CNA/MAT #3 had a hire date of 01/02/24. There was no documentation in the employment files that RN #1, Helper #1, CNA/MAT #1, CNA/MAT #2, or CNA/MAT #3 had received abuse training within 90 days of hire nor within the last year. On 02/27/24 at 2:30 p.m., the Director of Operations was asked to provide documentation	C1972		

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 02/28/2024
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
C1972	Continued From page 20 that the employees listed above had received abuse training within 90 days of their hire and annually. On 02/28/24 at 12:00 p.m., the Director of Operations stated they were unable to find any abuse training upon hire for RN #1, Helper #1, CNA/MAT #1, CNA/MAT #2, and CNA/MAT #3 and the facility had not had an in-service for abuse training within the last year.	C1972		

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

April 1, 2024

License Number: AL5538

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

RE: Survey Event R07711

Dear Ms. Timmerman-O'Connor:

On **February 28, 2024**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1304:** This plan of correction does not address how the plan of accommodations are individualized if they all say "May" include. How would representatives know when you will provide one on one supervision or any of the services listed under "May" include?
- **C1505:** This POC does not address how the facility is ensuring the pharmacy review is acted upon. Who is ensuring the facility receives a response from the provider? This plan only addresses sending the recommendations to the provider.

Please provide an AMENDED plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,



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: 3/26/2024

Facility Name: Heaven House elmwood 3141 Elmwood OKC, OK 73116

License Number: AL5538

Survey Event ID: RO7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C371

Based on: interview and record review the facility failed to ensure bed rail safety assessments for four (#1,#3,#4 and #5 where bedrails were used

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 Diane Cooper

OAC 310:663-25-4(F)

Date 3/26/2024

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

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

C371

Heaven House Bed Rails Risk Assessment Form

Name:

Date:

Date of Birth:

Room #

Section 1 – Overview**Comments**

Is the person likely to fall from the bed?	Yes	No	
Turn all the bed safety management methods than consider?	Yes	No	
All Falls management strategies been considered?	Yes	No	
How's the risk and benefits of bed rails been explained to resident/family	Yes	No	

"No" Answers indicate that the person is not appropriate for provision Bed rails, until all above have been considered

Section 2 – Bed Occupant Factors**Comments**

Does the bed of prince have any of the following – • restlessness which could result in injury?	Yes	No	
• Confusion?	Yes	No	
• Difficulty communicating?	Yes	No	
• Impaired/restricted mobility	Yes	No	
• Involuntary or repetitive movements	Yes	No	
• Tissue viability impairment?	Yes	No	
• Is the person likely to get out of bed unsupervised for any reason?	Yes	No	

C371

• Is the person likely to climb over the bed rails?	Yes	No	
• Could the persons physical build, increase the risk of entrapment	Yes	No	
• Could use of bed rails increase agitation or confusion?	Yes	No	
• Could the bedrails increase the risk of injury?	Yes	No	
• Could bed rails be used as a method of restraint?	Yes	No	

"Yes" Answers may indicate that alternative bed management methods are more appropriate e.g. bed wedges (if person still at risk from falls from bed).

Section 3 – Equipment Factors

Comments

Have environmental factors been considered?	Yes	No	
Has interaction with other equipment been considered?	Yes	No	
Is the bed to which the bed rails are to be fit it in good condition?	Yes	No	
Is the mattress the correct size to fit the bed?	Yes	No	

"No" answers may indicate that a review of equipment is appropriate.

Section 4 – Assessment Recommendations

Comments

Are bed rails recommended?	Yes	No	
Has resident/family agreed to their use?	Yes	No	

If resident is unable to consent due to lack of mental capacity, please discuss with family to decide what is in the patient's best interest.

Assessor Signature _____ Title: _____ Date _____

Resident / Family _____ Date _____



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/26/2024

Facility Name: Heaven House elmwood 3141 Elmwood OKC, OK 73116

License Number: AL5538

Survey Event ID: RO7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C372

Based on: interview and record review the facility failed to negotiate a written agreement with the resident's representative for the use of bedrails for four sampled residents #1,#3,#4 and #5 where bedrails are in use.

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 Diane Cooper

OAC 310:663-25-4(F)

Date 3/26/2024

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

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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: 3/22/2024

Facility Name: HeavenHouse, LLC 3141 Elmwood OKc OK 73116

License Number: AL 5538

Survey Event ID: RO7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542Conduct
of Assessment

Based on: Based on Record review and interview, the facility failed to ensure the comprehensive assessment was signed by an RN or physician for one of 5 (#1) residents whose comprehensive assessments were reviewed

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The significant change assessment for 09/20/23 did not have the signature of the RN or the residents physician

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 Diane Cooper

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #1 physician has signed the the assessment dated 09/20/23.

The records for all residents have been checked and examined by the DoO and the house supervisor and the administrator. All signatures are in place and current.

Supervisors are to check all documents before QA meetings to prepare to report anything missing or what might be currently due such as annual assessment update, contract update or signatures needed. ★

The Director of Operations will go over documents monthly to check to assure nothing is due or missing. She will work with the house supervisor to ensure everything is up to date. This will be reported at the monthly Quality Assurance meeting. It will be crosschecked by the Administrator and RN. This monthly check by supervisor, DoO and RN and Administrator will be effective crosscheck. It will be evaluated to see if system is effective at QA meetings and will become a regular part of those meetings which are most often monthly.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

3/22/2024

Date 3/22/2024

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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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: Maerch 22, 2024

Facility Name: Heaven House, LLC 3141xElmwood OKC, OK 73116

License Number: AL 5538

Survey Event ID: RO7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543

Based on: record review and interview, the facility failed to ensure the comprehensive assessment included a personal interview for one (#2) of five sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is our policy to have a family member present when an assessment is conducted when a resident has cognitive decline. All our assessments are signed by a family member and our RN.

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 Diane Cooper

OAC 310:663-25-4(F)

Date 3/25/2023

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			
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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: 3/26/2022

Facility Name: Heaven House Elmwood 3141 Elmwood OKC Ok 73116

License Number: AL 5538

Survey Event ID: RO 7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C544 Conduct
of Assessment

Based on: record review and interview the facility failed to ensure the residents completed initial assessments were available to the state agency upon request for three (#1,#3,and #4) #5 was mentioned on page 7. Need clarification but possible typo.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Initial Assessments missing from our files for any residents is of great concern for Heave House. This has never happened in 14 years of business.

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 ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The initial assesments that are missing from the files at the Heaven House are for resident #1 and resident #4. Resident #2 #3 and #5 are all present. Families have been notified they are missing.

All other initial assessment are found to be present in the files of each resident including resident #1 and #3 and #5

RN has begun scanning all assessments and other documents and keeping a computerized file for each resident.

By using computerized files incidents such as this will be non existant ,safe and at no risk of anything being taken out of a file or removed from Heaven House altogether. This will be much more effective in protection of information on each resident. Additionally files will be unable to be acessed by anyone except the RN unless the file is shared with another Heaven House staff member. That will be at the discretion of the RN.This will be a topic at QA meetings that is the conveyences and the effetiveness of this new plan to computerized all documents.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

3/23/2024

Administrator's Signature Diane Cooper

OAC 310:663-25-4(F)

Date 3/26/2024

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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OKLAHOMA
State Department
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/27/2023

Facility Name: HeavenHouse Elmwood 3141 Elmwood OKC, OK 73116

License Number: AL 5538

Survey Event ID: RO7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C940 Dietary
Consultant

Based on: based on record review and interview the facility failed to ensure residents received nutritionally sound options approved by the dietician for breakfast and lunch

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Heaven House takes very seriously the nutrition of all residents. We work closely with our dietician on staff. Residents eat very well nutritious foods and are thriving despite their mental capacities

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 Diane Cooper

OAC 310:663-25-4(F)

Date 3/27/2024

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

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Submitted by

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/26/2024

Facility Name: Heaven House Elmwood 3141 Elmwood OKC, OK 73116

License Number: AL 5538

Survey Event ID: RO7711

Date Survey Completed: 2/28/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954

Based on: record review and interview center failed to ensure staff were trained in CPR and First Aid for two RN #1 and Helper #1

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 Diane Cooper

OAC 310:663-25-4(f)

Date 3/26/2024

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