OKLAHOMA
State Department
of Health

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

November 7, 2025

License Number: AL5538

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

RE: Survey Event ID: 1JJ211

Dear Ms. Cooper:

On **October 27, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 27, 2025**.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5538	A. BUILDING: _____ B. WING _____	10/27/2025

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 A relicensure survey was conducted on 10/27/25. Facility Census: 4 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a comprehensive assessment was completed every 12 months for 1 (#2) of 2 sampled residents reviewed for comprehensive assessments. The director of operations identified four residents resided in the center. Findings: A "Comprehensive Assessment," dated 09/29/24, showed Resident #2 was admitted to the center on 09/20/24 with diagnoses to include dementia, congestive heart failure, and hypertension. The	C 522		

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 _____	10/27/2025

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C 522	Continued From page 1 comprehensive assessment showed Resident #2 required the assistance of one staff member for all activities of daily living. A review of Resident #2's medical record did not contain a comprehensive assessment for September 2025. On 10/27/25 at 10:33 a.m., the director of operations was asked for Resident #2's most recent comprehensive assessment. They stated it would be in their chart if they had one. The director of operations was asked if they had a comprehensive assessment for September 2025. They stated, "No, I do not."	C 522		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the resident's	C 532		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 532	Continued From page 2 status for 1 (#1) of 2 sampled residents reviewed for assessment accuracy. The director of operations identified four residents resided in the center. Findings: On 10/27/25 at 8:11 a.m., Resident #1 was observed lying in bed with their eyes closed. A Hoyer/mechanical lift was observed in the resident's room. On 10/27/25 at 8:49 a.m., CMA #1 and CMA #2 were observed transferring Resident #1 from a Hoyer lift into a chair in the living room. CMA #1 and CMA #2 assisted Resident #1 by lowering the Hoyer lift and removing the sling from behind the resident. A "Comprehensive Assessment," dated 12/12/24, showed Resident #1 was admitted to the center on 12/09/24 with diagnoses to include muscle weakness, venous thrombosis, and iron deficiency. The comprehensive assessment showed Resident #1 was chairfast and required the assistance of one staff member for transfers. A "Physician's Note," dated 10/15/25, read in part, "[Resident #1] is nonambulatory and unable to assist in transfers. [Resident #1] required hoyer lift for transfers as [they are] unable to assist." On 10/27/25 at 8:41 a.m., CMA #1 was asked how Resident #1 transferred. They stated, "We use the Hoyer lift with two of us [staff]. We tried to transfer [them] without it when [they] first got here, but [they] couldn't stand." On 10/27/25 at 10:47 a.m., the director of	C 532		

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C 532	Continued From page 3 operations was asked if Resident #1 had always needed to be transferred with a Hoyer lift. They stated, "When [they] first came we tried with one person, but it was too hard. [They] got a lift put into place." The director of operations was asked if a significant change assessment was completed. They stated, "No, because there wasn't really a change." The director of operations was asked if Resident #1's current comprehensive assessment reflected their current transferring abilities. They stated, "No."	C 532		
C5020 SS=D	63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up 3. 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 the assisted living center and any of the following: a. the personal or attending physician of the resident, b. a home care agency, c. a hospice, or d. other designated persons; The plan of accomodation shall be reviewed at least quarterly by a licensed health care professional. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a plan of accommodation was updated and reviewed quarterly for 1 (#1) of 2 sampled residents reviewed for plans of accommodation. The director of operations identified four residents	C5020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5020	Continued From page 4 resided in the center. Findings: A "Comprehensive Assessment," dated 12/12/24, showed Resident #1 was admitted to the center on 12/09/24 with diagnoses to include muscle weakness, venous thrombosis, and iron deficiency. The comprehensive assessment showed Resident #1 was chairfast. A "Plan of Accommodation Agreement," dated 01/02/25, read in part, "The personal or attending physician of the resident, a representative of the assisted living center, 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." On 10/27/25 at 10:50 a.m., the director of operations was asked what Resident #1's plan of accommodation was used for. They stated, "The [Hoyer] lift." The director of operations was asked how often they reviewed plans of accommodations. They stated, "Yearly." The director of operations stated they were not aware plans of accommodations were to be updated and reviewed quarterly.	C5020		

OKLAHOMA
State Department of Health

Delivery via email to: dianecooper448@gmail.com

November 25, 2025

License Number: AL5538

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

RE: Survey Event 1JJ211

Dear Ms. Cooper:

On **October 27, 2025,** 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:

- **C522:** The plan of correction needs to reflect comprehensive assessments, not care plans.
- **C5020:** The plan of correction needs to address plan of accommodation, not assessments.

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

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/18/2025** **Facility Name:** The Heaven House - Elmwood **License Number:** AL5538 **Survey Event ID:** 1JJ211 **Date Survey Completed: 10/27/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 522	Based on: record review and interview, the center failed to ensure a comprehensive assessment was completed every 12 months for 1 (#2) of 2 sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center failed to have an up-to-date assessment on one resident which has been corrected and actions in place to ensure this does not occur again.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The residents care plan was updated immediately upon identification of the deficiency. The plan now reflects the residents current needs, preferences, and services provided.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All other residents' care plan were reviewed to ensure they are current, complete, and updated within the required timeframe. Any care plans that were outdated were updated.
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?	We have put measures in place to make sure this doesn't occur again by having our house RN check routinely for an updates, the matter was disscused in our QA meetings and other staff member are aware and are told to inform the RN of any needed changes. The RN will do routine checks on the residents and care plans to make sure their plan of care is current.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	We will implement ongoing monitoring to ensure that resident care plans are completed and updated within required timeframes. The RN will conduct monthly audits of all resident care plans for six months. After six months, if sustained compliance is demonstrated, audits will continue quarterly. The results of the monthly audits will be reviewed to verify that all residents have current care plans, no missed or overdue care plans, and staff responsible for updating care plans are consistenly meeting expectations. Audit findings, trends, and any identified issues will be reported and discussed in the QA meetings. There will also be reviews of audit outcomes, monitor for recurring issues, direct additional corrective actions, if needed, and

	determine whether policy or workflow changes should be implemented to prevent recurrence. All audit tools, audit results, corrective actions, staff education logs, and QA mettings will be maintained in the facility QA records, stored in a secure location, and available to demonstrate sustained compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Diane Cooper OAC 310:663-25-4(F)	**Date 11/18/2025**

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

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

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/17/2025** **Facility Name:** The Heaven House **License Number:** AL5538 **Survey Event ID:** 1JJ211 **Date Survey Completed: 10/27/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 532	Based on: observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the residents status for 1 (#1) of 2 sampled residents reviewed for assessment accuracy.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Our facility failed to ensure a resident assessment accurately reflected current status for 1 of the residents reviewed for assessment accuracy.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The assessment for the resident was immediately reviewed and updated to accurately reflect the residents current physical, cognative, and functional status. The residents care plan was revised to align with the corrected assessment. Staff responsible for the resident's care were notified of the changes and provided instruction on the updated care needs.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The RN completed a review of all resident assessments updated within the past 30 days to identify any inaccuracies. Any inaccuracies found were corrected. No other inaccuracies were found.
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?	To ensure resident assessments consistently and accurately reflect resident status the following corrective actions were implemented. Staff re-education- all care staff and RN were notified of regulatory requirments for accurate assessments, documentation of changes in condition, timely and accurate updates to care plans/assessments. A review of all current residents and their assessments match their needs. The need for notification to the RN of any changes in conditions of any resident. And lastly to implement a check list ensuring that wach completed resident assessment corresponds accurately to their assessments and care plans.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and	The administrator will audit 5 resident assessments per week for 8 weeks to ensure accuracy and alignment with their needs. After 8 weeks audits will occur monthly for 3 months. Any issues identified through audtis will be addressed with immediate retraining or corrective action.

c. How monitoring records will be kept to evidence the correction.	Sustained 100% compliance in the audits over three consective months will be the benchmark for effectiveness. Findings will be reviewed during monthly QA meetings. The results and trends will be discussed and review for any futher changes if needed. Records will be kept in the facility in a secure location easily assessed by employees as needed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2025
OSDH Response: Element accepted Yes ☐ No ☐	

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

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

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

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/17/2025** **Facility Name:** The Heaven House- Elmwood **License Number:** AL5538 **Survey Event ID:** 1JJ211 **Date Survey Completed: 10/27/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 5020	Based on: record review and interview, the facility failed to ensure a plan of accommodation was updated and reviewed quarterly for 1 (#1) of 2 sampled residents reviewed for plans of accommodation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The residents assessment was immediately corrected to accurately document that the resident requires a Hoyer/medical lift with two person assistance for all transfers.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The residents care plan and assessment were updated to align with the accurate transfer status of needing two people to transfer instead of one. All staff involved in the residents care were notified of the updated transfer requirements.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A complete audit of all resident assessments was completed to verify accuracy of documented transfer level, mobility status, and equipment needs. Any discrepancies found during the audit were corrected immediately, and related care plans were updated.
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 RN will review all newly completed and updated assessments for accuracy before they are finalized in the chart. Staff will also receive refresher training on proper documentation of resident functional status, safe transfer procedures, and the requirement to report any changes of resident conditions immediately. In the QA meeting this month staff were reminded that any resident requiring a medical lift must have a two person assist and it must be documented.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RN will conduct monthly audits of resident assessments for three months to confirm accuracy of transfer level and equipment requirements. If 100% accuracy is achieved for three consecutive months, audits will continue quarterly. Any inaccuracies found during audits will trigger immediate correction and staff re-education. Sustained 100% compliance in the audits over three consecutive months will be the benchmark for effectiveness.

	The QA meetings will review audit results, trends, and any identified issues will be brought up and solved. Assessment accuracy and transfer related documentation will be a standing QA agenda for the next six months. QA will review audit outcomes, staff education completion, any incidents or near-misses related to transfers will be reported. Corrective action will be taken if any inaccuracies arise. All assessment audits, corrective actions, staff training logs, and QA meetings will be maintained in the facilitys QA file. The records will be stored securely and retained according to state regulartory requirments.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/17/2025**

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

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

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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.

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

December 2, 2025

License Number: AL5538

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

RE: Survey Event 1JJ211

Dear Ms. Cooper:

On **October 27, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your Amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 17, 2025**.

We will conduct a revisit for your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/18/2025** **Facility Name:** The Heaven House - Elmwood **License Number:** AL5538 **Survey Event ID:** 1JJ211 **Date Survey Completed: 10/27/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522	Based on: record review and interview, the center failed to ensure a comprehensive assessment was completed every 12 months for 1 (#2) of 2 sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center failed to have an up-to-date assessment on one resident which has been corrected and actions in place to ensure this does not occur again.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The residents assessment was updated immediately upon identification of the deficiency. The assessment now reflects the residents current needs, preferences, and services provided.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All other residents' assessments were reviewed to ensure they are current, complete, and updated within the required timeframe. Any assessments that were outdated were updated.
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?	We have put measures in place to make sure this doesn't occur again by having our house RN check routinely for an updates, the matter was disscused in our QA meetings and other staff member are aware and are told to inform the RN of any needed changes. The RN will do routine checks on the residents and assessments to make sure their assessment is current.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	We will implement ongoing monitoring to ensure that resident assessment are completed and updated within required timeframes. The RN will conduct monthly audits of all resident assessments for six months. After six months, if sustained compliance is demonstrated, audits will continue quarterly. The results of the monthly audits will be reviewed to verify that all residents have current assessments, no missed or overdue assessments, and staff responsible for updating care plans are consistenly meeting expectations. Audit findings, trends, and any identified issues will be reported and discussed in the QA meetings. There will also be reviews of audit outcomes, monitor for recurring issues, direct additional corrective actions, if needed, and

	determine whether policy or workflow changes should be implemented to prevent recurrence. All audit tools, audit results, corrective actions, staff education logs, and QA mettings will be maintained in the facility QA records, stored in a secure location, and available to demonstrate sustained compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/18/2025**

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

Addendum Date	12/1/2025	**Submitted by**	Rebeka Simms

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/17/2025** **Facility Name:** The Heaven House **License Number:** AL5538 **Survey Event ID:** 1JJ211 **Date Survey Completed: 10/27/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 532	Based on: observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the residents status for 1 (#1) of 2 sampled residents reviewed for assessment accuracy.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Our facility failed to ensure a resident assessment accurately reflected current status for 1 of the residents reviewed for assessment accuracy.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The assessment for the resident was immediately reviewed and updated to accurately reflect the residents current physical, cognative, and functional status. The residents care plan was revised to align with the corrected assessment. Staff responsible for the resident's care were notified of the changes and provided instruction on the updated care needs.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The RN completed a review of all resident assessments updated within the past 30 days to identify any inaccuracies. Any inaccuracies found were corrected. No other inaccuracies were found.
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?	To ensure resident assessments consistently and accurately reflect resident status the following corrective actions were implemented. Staff re-education- all care staff and RN were notified of regulatory requirments for accurate assessments, documentation of changes in condition, timely and accurate updates to care plans/assessments. A review of all current residents and their assessments match their needs. The need for notification to the RN of any changes in conditions of any resident. And lastly to implement a check list ensuring that wach completed resident assessment corresponds accurately to their assessments and care plans.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and	The administrator will audit 5 resident assessments per week for 8 weeks to ensure accuracy and alignment with their needs. After 8 weeks audits will occur monthly for 3 months. Any issues identified through audtis will be addressed with immediate retraining or corrective action.

c. How monitoring records will be kept to evidence the correction.	Sustained 100% compliance in the audits over three consective months will be the benchmark for effectiveness. Findings will be reviewed during monthly QA meetings. The results and trends will be discussed and review for any futher changes if needed. Records will be kept in the facility in a secure location easily assessed by employees as needed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/17/2025
OSDH Response: Element accepted Yes ☐ No ☐	

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

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

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

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 11/17/2025
	Facility Name: The Heaven House- Elmwood
	License Number: AL5538
	Survey Event ID: 1JJ211
	Date Survey Completed: 10/27/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 5020	Based on: record review and interview, the facility failed to ensure a plan of accommodation was updated and reviewed quarterly for 1 (#1) of 2 sampled residents reviewed for plans of accommodation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The residents assessment was immediately corrected to accurately document accommodations that the resident requires a Hoyer/medical lift with two person assistance for all transfers.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The residents care plan and assessment were updated to align with the accurate accommodations of needing two people to transfer instead of one. All staff involved in the residents care were notified of the updated accommodations.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A complete audit of all resident assessments was completed to verify accuracy of documented accommodations including but not limited to : transfer level, mobility status, and equipment needs. Any discrepancies found during the audit were corrected immediately, and related assessments were updated.
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 RN will review all newly completed and updated assessments for accuracy before they are finalized in the chart. Staff will also receive refresher training on proper documentation of resident functional status, safe transfer procedures, and the requirement to report any changes of residents' accommodations immediately. In the QA meeting this month staff were reminded that any resident requiring new accommodations such as a medical lift must have a two person assist and it must be documented.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RN will conduct monthly audits of resident assessments for three months to confirm accuracy of accomodations. If 100% accuracy is achieved for three consecutive months, audits will continue quarterly. Any inaccuracies found during audits will trigger immediate correction and staff re-education. Sustained 100% compliance in the audits over three consecutive months will be the benchmark for effectiveness.

	The QA meetings will review audit results, trends, and any identified issues will be brought up and solved. Assessment accuracy and accommodation documentation will be a standing QA agenda for the next six months. QA will review audit outcomes, staff education completion, any incidents or near-misses related to accommodations will be reported. Corrective action will be taken if any inaccuracies arise. All assessment audits, corrective actions, staff training logs, and QA meetings will be maintained in the facilitys QA file. The records will be stored securely and retained according to state regulartory requirments.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 11/17/2025**

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

Addendum Date	12/1/2025	**Submitted by**	Rebeka Simms

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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

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

December 9, 2025

License Number: AL5538

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

RE: Survey Event 1JJ212

Dear Ms. Cooper:

On **December 8, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 27, 2025,** have now been corrected effective **November 17, 2025.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5538	A. BUILDING: _____ B. WING _____	R 12/08/2025

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 An offsite/paper revisit was conducted on 12/08/25. The facility was in substantial compliance.	{C 000}		

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