



Oklahoma State Department of Health
Creating a State of Health

September 26, 2019

License Number: AL5544

Ms. Diane Cooper Timmerman-O'Connor, Administrator
Heaven House Georgia
8501 North Georgia
Oklahoma City, OK 73114

RE: Survey Event ID: WUOQ11

Dear Ms. Timmerman-O'Connor:

On **August 19, 2019**, 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 August 19, 2019.

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

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

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

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;

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- (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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

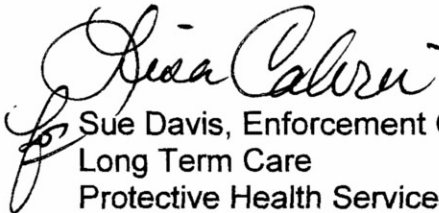
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5544	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 08/19/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HEAVEN HOUSE GEORGIA

**8501 NORTH GEORGIA
OKLAHOMA CITY, OK 73114**

(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 re-licensure survey was conducted 08/19/19. Resident census was 5. The following deficient practice was cited.	C 000		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure the hot water available for resident use did not exceed 115 degrees F (Fahrenheit). This failed practice had the potential for more than minimal harm, at a pattern. Findings: On 08/19/19, the following hot water temperatures were obtained: Resident #1 and #2's bathroom - 136.0 degrees F Resident #4's bathroom - 132.8 degrees F All three residents had cognitive impairment and were only oriented to themselves. None of them were able to be interviewed. At 12:10 p.m., the director of operations was	C 701		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2019
NAME OF PROVIDER OR SUPPLIER HEAVEN HOUSE GEORGIA		STREET ADDRESS, CITY, STATE, ZIP CODE 8501 NORTH GEORGIA OKLAHOMA CITY, OK 73114		
(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 701	Continued From page 1 informed of the hot water temperatures in the resident rooms. She stated that was too hot.	C 701		

STATE WORKLOAD REPORTProvider/Supplier Number
AL5544Provider/Supplier Name
HEAVEN HOUSE GEORGIA

Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	08/19/2019	08/19/2019	0.25	0.00	3.50	0.00	4.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

SEP 26 2019 *jm*



Oklahoma State Department of Health
Creating a State of Health

October 10, 2019

License Number: AL5544

Ms. Diane Cooper Timmerman-O'Connor, Administrator
Heaven House Georgia
8501 North Georgia
Oklahoma City, OK 73114

RE: Survey Event WUOQ11

Dear Ms. Timmerman-O'Connor:

On August 19, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **October 16, 2019**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/KS

Board of Health

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Commissioner of Health

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Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/2/2019

Facility Name: THE HEAVEN HOUSE, GEORGIA

License Number: AL5544

Survey Event ID: WUOQ11

Date Survey Completed: 8/19/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 701

Based on: OBSERVATION AND INTERVIEW IT WAS DETERMINED CENTER FAILED TO ENSURE THE HOT WATER AVAILABLE FOR RESIDENT USE DID NOT EXCEED 115 DEGREES

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The home has two hot water tanks and this one on the south hall had been installed only 2 weeks before the survey.

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:
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.

OSDH Response: Element accepted Yes

☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Temperature was adjusted immediately after the survey. The readings were inconsistent daily. Therefore, a tempering valve has been installed on the hot water tank. The readings have now been consistently under 115 degrees.

The home's other hot water tank, in the north hall, which services 3 other residents has never had an issue with inconsistent readings. The kitchen and utility room readings have been acceptable also.

Staff will continue to monitor the readings produced in residents' rooms of both hot water tanks. Readings will be reported to house supervisor and administrator. Action will be taken if needed.

Monitoring readings with the new tempering valve will continue to be a daily routine for the next 2 weeks to ensure it is set and the temperature is consistently acceptable. The results of the readings will be shared and discussed at the Quality Assurance meeting for this month. The meeting is scheduled for October 16, 2019. House Supervisor will keep the log of all temperatures in the house, as is done, but will emphasize the daily readings of the new hot water tank and its new valve for accuracy.

The correction was completed on 10/16/2019

For the purpose of this template, the QAA team

will be responsible for the monitoring of the

OCT 07 2019

☐ No ☐			
Administrator's Signature Diane Cooper Timmerman O'Connor OAC 310.663-25-4(F)		Date 10/2/2019	
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: Enter date of survey Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Enter text			
Facility in Compliance by: Enter date			

OCT 07 2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5544	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2019
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NAME OF PROVIDER OR SUPPLIER HEAVEN HOUSE GEORGIA	STREET ADDRESS, CITY, STATE, ZIP CODE 8501 NORTH GEORGIA OKLAHOMA CITY, OK 73114
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OCT 07 2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5544	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED 08/19/2019
NAME OF PROVIDER OR SUPPLIER HEAVEN HOUSE GEORGIA		STREET ADDRESS, CITY, STATE, ZIP CODE 8501 NORTH GEORGIA OKLAHOMA CITY, OK 73114		
(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 701	Continued From page 1 informed of the hot water temperatures in the resident rooms She stated that was too hot.	C 701		

OCT 07 2019



Oklahoma State Department of Health
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December 12, 2019

License Number: AL5544

Ms. Diane Cooper Timmerman-O'Connor, Administrator
Heaven House Georgia
8501 North Georgia
Oklahoma City, OK 73114

RE: Survey Event WUOQ12

Dear Ms. Timmerman-O'Connor:

On **October 28, 2019**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 19, 2019**, have now been corrected effective **October 16, 2019**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Board of Health

Gary Cox, JD
Commissioner of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5544	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/28/2019
NAME OF PROVIDER OR SUPPLIER HEAVEN HOUSE GEORGIA			STREET ADDRESS, CITY, STATE, ZIP CODE 8501 NORTH GEORGIA OKLAHOMA CITY, OK 73114		
(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 completed on 10/28/19. Census was 24. All deficient practice was cleared.	{C 000}			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number
AL5544

Provider/Supplier Name
HEAVEN HOUSE GEORGIA

Type of Survey (select all that apply)

2	D			
---	---	--	--	--

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
---	--	--	--	--

- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	10/28/2019	10/28/2019	0.00	0.00	0.00	0.00	0.00	0.00
2. 41872	10/28/2019	10/28/2019	0.25	0.00	0.50	0.00	0.50	0.25
3.								
4.								
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8.								
9.								
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11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours.....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No