



Oklahoma State Department of Health
Creating a State of Health

June 20, 2019

License Number: AL5597

Ms. Diane Cooper Timmerman-O'Connor, Administrator
The Heaven House, Llc St Clair
4613 St Clair
Oklahoma City, OK 73112

RE: Survey Event ID: YI9J11

Dear Ms. Timmerman-O'Connor:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **June 12, 2019**. No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/12/2019
NAME OF PROVIDER OR SUPPLIER THE HEAVEN HOUSE, LLC ST CLAIR			STREET ADDRESS, CITY, STATE, ZIP CODE 4613 ST CLAIR OKLAHOMA CITY, OK 73112		
(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 06/11/19 and 06/12/19. Resident census was 2. No deficient practice was cited.	C 000			

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL5597

 Provider/Supplier Name
 THE HEAVEN HOUSE, LLC ST CLAIR

Type of Survey (select all that apply)

2				
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 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

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	06/11/2019	06/12/2019	0.25	0.00	5.75	0.00	2.50	0.50
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