OKLAHOMA
State Department
of Health

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

February 5, 2024

License Number: AL5597

Ms. Betty Lanning, Director of Operations
The Heaven House, Llc
4613 St Clair
Oklahoma City, OK 73112

Survey Event ID: NX2B11

Dear Ms. Lanning:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **January 30, 2024**. No deficiencies were cited. Oklahoma Statutes 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) 426-8200.

Respectfully,

Tempal Killman

Tempal, Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Heaven House
Address: 4613 ST Clair
City, State, Zip: Oklahoma City, Ok 73112, Oklahoma
Provider #:AL5597
Complaint #: OK00061924
Investigation Date(s): 01/29/24-01/30/24

ALLEGATION(S)
The center failed to ensure medications were administered according to physicians' orders in an effort to provide optimal pain management/comfort measures.
The center failed to ensure residents' representatives were notified of a change in condition.
The center failed to ensure a refund was provided for days the resident was not at the center according to the contract and/or State Law and failed to ensure unused medications were issued to the resident/representative upon discharge.

An unannounced on-site investigation was initiated 01/29/2024 at 8:15 a.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance. Staff were observed during medication pass for pain medication.

Resident records were reviewed including, care plans, physician orders, nursing notes, hospice notes, Faxes and incident reports. Facility policy and procedures were reviewed. Records were reviewed for resident representative notifications and service contracts.

Residents were interviewed related to the provision of pain medications and family notifications.

Staff were interviewed in relation to pain medication, transfers/discharges, physician order's, medication administration records, incident reporting and discharge procedures. Staff were interviewed in relation to medication procedure for admission and discharge. Staff were interviewed in relation to refund procedures according to company contract.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/30/2024

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
	AL5597	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEAVEN HOUSE, LLC	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 complaint investigation (#OK00061924) was conducted from 01/29/24 through. No deficiencies were cited. Facility Census : 5	C 000		

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