OKLAHOMA
State Department
of Health

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

April 11, 2024

License Number: AL5597

Ms. Diane Cooper, Administrator
The Heaven House, Llc
4613 St Clair
Oklahoma City, OK 73112

RE: Survey Event ID: F4NX11

Dear Ms. Cooper:

On **April 4, 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 **April 4, 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

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
	AL5597	A. BUILDING: _____ B. WING _____	04/04/2024

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 relicensure survey was conducted from 04/03/24 through 04/04/24. Facility Census: 3 Listed below are abbreviations that will be used throughout this documented: DOO- director of operations mg- milligram	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure: a. open food items removed from their original container had an identified use by date, b. refrigerated foods were covered, dated, and labeled, and c. gloves wear worn while handling food. The Supervisor identified three residents resided in the facility. Findings: On 04/03/24 at 9:21 a.m., the Supervisor placed two pieces of cooked bacon and one apple turnover on a plate. They were not observed to	C 391		

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 _____	04/04/2024

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 391	Continued From page 1	C 391		

wear gloves when touching the food items. They served the plate of food to Resident #3.

On 04/03/24 at 9:44 a.m., the Supervisor was observed to place two pieces of cooked bacon onto a plate. They were observed to place a piece of bread into the toaster, take the piece of bread out of the toaster, and held the piece of bread in the palm of their hand and smeared jelly on it. They were not observed to wear gloves when touching the food items. They served the plate of food to Resident #1.

On 04/03/24 at 9:55 a.m., the following were observed in the refrigerator:

a. an undated blue bell sherbet rainbow container which contained mashed potatoes,

b. an undated, uncovered, not labeled container which contained half pears in liquid,

c. an undated, not labeled ziplock bag that contained a plastic container with shredded meat, and

d. undated, not labeled green container with pieces of watermelon.

On 04/03/24 at 10:05 a.m., the Supervisor removed a container of sour cream from the refrigerator. They were observed to open the container, stir the sour cream with their finger, and put their finger in their mouth. They were observed to put the lid on the sour cream container, and placed it in the refrigerator.

On 04/03/24 at 10:06 a.m., the Supervisor stated items should have a label of what it was and a date on them.

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 _____	04/04/2024

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 391	Continued From page 2 On 04/03/24 at 1:10 p.m., the DOO stated food in the refrigerator should have a label and date on them. They were asked when were gloves worn when preparing food. They stated, "We weren't told we had to." The DOO was asked if staff can touch sour cream. They stated, "No, not with their hands."	C 391		
C 398 SS=D	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff responsible for food preparation had attended a food service training program approved by the Oklahoma State Department of Health. The Supervisor identified three residents resided in the facility. Findings: Employee files were reviewed. There was no documentation staff had attended a training program approved by the Oklahoma State Department of Health. On 04/04/24 at 11:50 a.m., the Supervisor stated	C 398		

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 _____	04/04/2024

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 398	Continued From page 3 the DOO stated staff had only had an inservice regarding food safety. They were asked if a training program had been attended. They stated, "No."	C 398		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (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 resident assessments were coordinated and signed by a registered nurse, or the resident's physician for one (#1) of three sampled residents whose assessments were reviewed. The Supervisor identified three residents resided in the facility. Findings: Resident #1's annual assessment, dated 08/28/23, did not contain the signature of a registered nurse or the resident's physician. On 04/03/24 at 1:10 p.m., the DOO stated the nurse and supervisor were to sign the assessments when the assessments were completed. They were asked to review Resident #1's assessment. They stated, "This isn't signed by anyone."	C 542		

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 _____	04/04/2024

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
C1921	Continued From page 4	C1921		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered for one (#3) of two sampled residents whose's medication were observed during medication pass. The Supervisor identified three residents resided in the facility. Findings: Resident #3 had diagnoses which included Down Syndrome. Resident #3's April 2024 physician's orders documented Tylenol 500 mg was to be administered four times a day as needed. On 04/03/24 at 8:59 a.m., the Supervisor was observed to prepare medications for Resident #3. They were observed to put two Tylenol 500 mg tablets into the medication cup. They were observed to administer the medications to the resident. On 04/03/24 at 1:10 p.m., the DOO was asked how staff ensured medications were administered as ordered. They stated they followed the MAR.	C1921		

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 _____	04/04/2024

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
C1921	Continued From page 5 On 04/03/24 at 1:13 p.m., the Supervisor stated they administered two tablets of Tylenol to Resident #3 this morning. On 04/03/24 at 1:14 p.m., the DOO was observed to review Resident #3's MAR. They stated it documented to administer one table four times a day. The Supervisor stated the family wanted Resident #3 to receive two tablets of Tylenol three times a day. On 04/03/24 at 1:18 p.m., the Supervisor stated they were wanting on the physician to clarify the order.	C1921		

OKLAHOMA
State Department
of Health

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

April 26, 2024

License Number: AL5597

Ms. Diane Cooper, Administrator
The Heaven House, Llc
4613 St Clair
Oklahoma City, OK 73112

RE: Survey Event F4NX11

Dear Ms. Cooper:

On **April 4, 2024**, 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 **April 23, 2024**.

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) 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: 4/15/2024
	Facility Name: HeavenHouse, LLC St. Clair
	License Number: AL 5597
	Survey Event ID: F4NX11
	Date Survey Completed: 4/4/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: based on observation and interview center failed to ensure 1. Open food items removed from their original container had an identified use date 2.refrigerated foods were covered labeled and dated 3. Gloves were worn when handeling food

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The handeling of food and everything related to the kitchen is of great importance to Heaven House. The behavior of the supervisor on several occasions during the surveyor time there can be attributed to total nervousness.

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 refrigerator has been cleaned and all undated food has been discarded. No containers are undated or in any food container which is not clear, covered and dated. Gloves and hairnets are worn. Reminder signs are posted.
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 supervisor has been written up as an internal disciplinary action. She has signed the report and agrees with the behavior cited. An Inservice is required and staff will be required to attend a State approved Food Handeler course. Signs reminding staff of gloves and hairnets will also be posted in the kitchen.
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 Food Handelers Class will become necessary for all staff that prepare food. It will be a new requirement for new hires to complete in the first 3 months of hiring. An Inservice will describe what is expected and will be required to read the first week on the job.
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.	Random weekly checks by the Administrator and DOO along with the supervisor will be done on the refrigerator contents. A form will be available to initial these checks. Visual checks will also be done for gloves and hairnets. Supervisor or any other staff will be written up if the visual checks or refrigerator is not done to the standards of Heaven House.This will be a line item at Quality Assurance meetings. Progress will be noted there. Additionally Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		4/23/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Diane Cooper OAC 310:663-25-4(F)			**Date** Enter a date of signature.
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: 4/4/2024** **Facility Name:** Heaven House ST.Clair **License Number:** AL5597 **Survey Event ID:** F4NX11 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C398	Based on: record review and interview facility failed to ensure staff responsible for food preparation had attended a food service training program approved by the Oklahoma State Dept. of Health

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	**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?	House Supervisor has completed the 360 Training Learn to Serve Food Handler Training course with acreditied hours for Oklahoma ANAB. She is certified for 2 years. Her certificate is in her file. Other staff are set to complete the course also.
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 new policy stating that all staff will complete an approved Food Handelers Training course with in 3 months of hire with Heaven House is in place. New hires must complete the Food Handeling Inservice in the first week on the job.
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 required extra training in Food Handeling will benefit not only the residents but the staff as well. Heaven House is particular about the kitchen and this training will be most beneficial.
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.	Supervisor and DOO will ensue that all staff complete the State approved Food Handelers Training. They will assist in helping a new employee with the enrollment and make sure they have completed both the early Inservice and the training in a timely fashion. A cross check of this process by the administrator and RN will take place at the Quality Assurance Meetings. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/23/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 4/15/2024**

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.			

HEAVEN HOUSE, LLC

POLICY AND PROCEDURE FOR FOOD HANDELERS TRAINING

ALL STAFF THAT PREPARE AND SERVE FOOD TO THE RESIDENTS MUST COMPLETE A FOOD HANDELERS TRAINING COURSE APPROVED BY THE STATE OF OKLAHOMA WITHIN 3 MONTHS OF HIRE AT THE HEAVEN HOUSE.

ADDITIONALLY A NEW HIRE WILL COMPLETE THE INSERVICE ON FOOD HANDELING WITH IN ONE WEEK OF HIRE AT THE HEAVEN HOUSE.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/15/2024** **Facility Name:** HeavenHouse, LLC St. Clair **License Number:** AL5597 **Survey Event ID:** F4NX11 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542	Based on: record review and interview the facility failed to ensure resident assessments were coordinated and signed by a registerd nurse or resident's physician for #1 of 3 sampled residents whose assessments were reviewed

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	**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 has been signed by the RN, residents' son, POA along with the house Supervisor and the Director of Operations. It was determined all were present at the time assessment was conducted. All signatures signed April 4, 2024
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 assessments for all other residents have been checked for missing signatures. All are complete. Addditionally RN, supervisor , DOO and Administrator agree to cross check assessments for identify missing signatures at the time of completion.
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?	More accuracy and crosschecking between staff will help ensure this does not happen. It should be completed and signed at the time of asssessmnent. All agree.
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.	Each residents file is part of the monthly QA meeting. This is just one of the things we check. It is listed under asssessments and care plans on the agenda. The RN, DOO, supervisor and Administraotr are all present at those meeetings. We will be more effective in checking if we are all crosschecking the files. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/4/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Diane Cooper** OAC 310:663-25-4(F)	**Date 4/15/2024**

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.			

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/15/2024** **Facility Name:** Heaven House St.Clair **License Number:** AL5597 **Survey Event ID:** F4NX11 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1921	Based on: observation, interview and record review facility failed to ensure medications were administered as ordered for one #3 of two sampled residents whose medications were observed during medication pass

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Residents' Tylenol order has been changed often

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?	Residents physician has orderd the 500mg Tylenol to be given routine rather than 4 times in 24 hours PRN. The order reads administer one tablet 4 times per day.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents PRN meds have been checked by the RN for confusion in administering. There are no other medications for anyone else that have been changed often in the past. All residents medications are clear and no questions. Supervisor and RN have conferred.
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?	Clarity on PRN medications have been discussed with staff by RN. RN will be sure that staff is clear when med changes come in for each resident.
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.	Supervisor and other staff will have RN go over PRN meds for each resident monthly or with any change. If there is confusion or a question staff may ask RN for clarity.RN will ensure all staff is aware of changes as the come up and physician orders are received by fax. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Diane Cooper OAC 310:663-25-4(F)	**Date 4/15/2024**

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.

OKLAHOMA
State Department of Health

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

May 17, 2024

License Number: AL5597

Ms. Diane Cooper, Administrator
The Heaven House, Llc
4613 St Clair
Oklahoma City, OK 73112

RE: Survey Event F4NX12

Dear Ms. Cooper:

On **May 16, 2024,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 4, 2024,** have now been corrected effective **April 23, 2024.**

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
	AL5597	A. BUILDING: _____ B. WING _____	R 05/16/2024

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 follow up visit was conducted on 05/16/24. All deficiencies from the 04/04/24 survey have been corrected. Facility census: 5	{C 000}		

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