



Oklahoma State Department of Health
Creating a State of Health

March 4, 2019

License Number: AL7211

Mr. Adam Bechtold, Administrator
Forest Hills Assisted Living Retirement And Care
4304 West Houston
Broken Arrow, OK 74012

RE: Survey Event ID: D6MU11

Dear Mr. Bechtold:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **February 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,

Kay Determan
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: AL7211	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2019
NAME OF PROVIDER OR SUPPLIER FOREST HILLS ASSISTED LIVING RETIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 4304 WEST HOUSTON BROKEN ARROW, OK 74012		
(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 on 2/11/19 and 2/12/19. The census was 50. No deficient practice was cited.	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 AL7211	Provider/Supplier Name FOREST HILLS ASSISTED LIVING RETIREMENT AND CARE
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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 01 1. 32588	02/11/2019	02/12/2019	0.25	0.00	7.50	0.00	4.50	1.00
2. 18873	02/11/2019	02/12/2019	0.25	0.00	7.50	0.00	4.00	0.00
3.								
4.								
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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

MAR 05 2019 *Jm*