Oklahoma State Department of Health
Creating a State of Health

February 11, 2020

License Number: AL5532

Mr. Martin Chavarria, Administrator
Touchmark At Coffee Creek
2801 Shortgrass Road
Edmond, OK 73003

RE: Survey Event ID: JPY911

Dear Mr. Chavarria:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **January 22, 2020.** 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,

Katie Stagner

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

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
	AL5532	A. BUILDING: _____ B. WING _____	01/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK AT COFFEE CREEK	2801 SHORTGRASS ROAD EDMOND, OK 73003

(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 01/21/2020 and 01/22/2020. Resident census was 110. No deficient practice was cited.	C 000		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5532	TOUCHMARK AT COFFEE CREEK

Type of Survey (select all that apply)

2								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
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	01/21/2020	01/22/2020	0.25	0.00	12.50	0.00	5.50	0.75
2. 30875	01/21/2020	01/22/2020	0.25	0.00	12.50	0.00	5.00	0.25
3. 41872	01/21/2020	01/22/2020	0.25	0.00	12.50	0.00	2.50	0.25
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**