



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
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5532	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/22/2020
NAME OF PROVIDER OR SUPPLIER TOUCHMARK AT COFFEE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 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		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE WORKLOAD REPORT
 Provider/Supplier Number
 AL5532

 Provider/Supplier Name
 TOUCHMARK AT COFFEE CREEK

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								
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