OKLAHOMA
State Department
of Health

Delivery via email to: jenna.fennell@touchmark.com

August 18, 2026

License Number: AL5532

Jenna Fennell, Administrator
Touchmark At Coffee Creek
2801 Shortgrass Road
Edmond, OK 73003

Survey Event ID: SUWI11

Dear Ms. Fennell:

On **July 23, 2026,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the 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. 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 will be completed for each violation; and
(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 a 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Touchmark at Coffee Creek**
Address: **2801 Shortgrass Road**
City, State, Zip: **Edmond, OK. 73003**
Provider #: **AL5532**
Complaint #: **OK00087096**
Investigation Date(s): **07/20/26-07/23/26**

ALLEGATION(S)
The facility failed to intervene in a timely manner.
The facility failed to ensure fall interventions were implemented.
The facility failed to ensure residents were free from abuse.
The facility failed to ensure adequate staff to meet the needs of residents.

An unannounced on-site investigation was initiated 07/20/2026 at 11:30 a.m.

A sample of six 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 statutes, rules and regulations of the State of Oklahoma 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 and throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. diagnoses, physician orders, nurse notes, plan of care, plan of service, and assessments were reviewed. Facility policies and incident reports were reviewed.

Residents, family, and staff were interviewed regarding timely care after a fall, fall interventions, abuse, and adequate staff.

The attached State form, Statement of Deficiencies, 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: 08/05/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Touchmark at Coffee Creek**
Address: **2801 Shortgrass Road**
City, State, Zip: **Edmond, OK. 73003**
Provider #: **AL5532**
Complaint #: **OK00087607**
Investigation Date(s): **07/20/26-07/23/26**

ALLEGATION(S)
The facility failed to protect residents from physical and psychosocial abuse by staff.

An unannounced on-site investigation was initiated 07/20/2026 at 11:30 a.m.

A sample of six 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 statutes, rules and regulations of the State of Oklahoma 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 and throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. diagnoses, physician orders, nurse notes, plan of care, plan of service, and assessments were reviewed. State incident reports for abuse were reviewed. Employee records were reviewed.

Residents and staff were interviewed regarding abuse.

The attached State form, Statement of Deficiencies, 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: 08/05/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Touchmark at Coffee Creek**
Address: **2801 Shortgrass Road**
City, State, Zip: **Edmond, OK. 73003**
Provider #: **AL5532**
Complaint #: **OK00091787**
Investigation Date(s): **07/20/26-07/23/26**

ALLEGATION(S)
The facility failed to assess, monitor, and intervene after a change in condition.

An unannounced on-site investigation was initiated 07/20/2026 at 11:30 a.m.

A sample of six 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 statutes, rules and regulations of the State of Oklahoma 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 and throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Residents were observed during meals. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. diagnoses, physician orders, physician progress notes, nurse notes, lab/x-ray reports, and plan of care were reviewed. State incident reports with investigations were reviewed. Facility policies and procedures were reviewed.

Residents were interviewed regarding staff assessing, monitoring, and intervening after a change. Staff were interviewed regarding assessing, monitoring, and intervening residents after a change in condition. Staff were interviewed regarding facility policies and procedures.

The attached State form, Statement of Deficiencies, 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: 08/05/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Touchmark at Coffee Creek**
Address: **2801 Shortgrass Road**
City, State, Zip: **Edmond, OK. 73003**
Provider #: **AL5532**
Complaint #: **OK00092125**
Investigation Date(s): **07/20/26-07/23/26**

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.

An unannounced on-site investigation was initiated 07/20/2026 at 11:30 a.m.

A sample of six 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 statutes, rules and regulations of the State of Oklahoma 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 and throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. diagnoses, physician orders, nurse notes, video recordings, plan of care, and assessments were reviewed. Facility policies were reviewed. Quality Assurance agendas were reviewed. State incident reports with investigations were reviewed.

Residents and family were interviewed regarding abuse. Staff were interviewed regarding abuse.

The attached State form, Statement of Deficiencies, 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: 08/05/2026

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 _____	C 07/23/2026

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 Complaint investigations (#OK00087096, OK00087607, OK00091787, and #OK00092125) were conducted from 07/20/26 through 07/23/26. Deficiencies were cited. Facility Census: 111	C 000		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	C1505		

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 _____	C 07/23/2026

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
C1505	Continued From page 1 failed to assess, monitor, and intervene for 1 (#2) of 4 sampled residents reviewed for a change in condition. The executive director identified 111 residents resided in the facility. Findings: An assessment for Resident #2, dated 02/23/26, showed the resident's cognitive status as fair with confusion. The assessment showed a diagnosis of altered mental status. A policy titled "Nursing Activities in AL Community - Best Practice," dated 05/01/26, read in part, "Assess health care and nursing needs, consult with the physician and/or nurse practitioner, and assess change of resident condition." A combined initial/final incident report, dated 06/19/26, showed an allegation of neglect. The report showed Resident #2 was observed choking in the dining room during meal service. The staff immediately responded and administered back blows to dislodge the suspected airway obstruction. The report showed Resident #2 expelled the food contents and was able to breathe. The staff requested nursing assistance via walkie talkie with no response. Staff contacted the nurse via cell phone. The report showed the nurse did not assess Resident #2 in person and instructed the staff not to complete an incident report. On 07/23/26 at 2:22 p.m., the executive director stated the nurse on call should have assessed the resident in person, contacted the physician, completed an incident report, and initiated alert charting/monitoring for delayed complications per	C1505		

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 _____	C 07/23/2026

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
C1505	Continued From page 2 facility protocol.	C1505		
C1916 SS=D	310:663-19-1(f) REPORTS TO THE DEPARTMENT (f) Each continuum of care facility and assisted living center shall report allegations and occurrences of resident abuse, neglect, or misappropriation of resident's property by a nurse aide to the Nurse Aide Registry by submitting a completed "Notification of Nurse Aide Abuse, Neglect, Mistreatment or Misappropriation of Property" form (ODH Form 718), which requires the following: (1) facility/center name, address and telephone; (2) facility type; (3) date; (4) reporting party name or administrator name; (5) employee name and address; (6) employee certification number; (7) employee social security number; (8) employee telephone number; (9) termination action and date (if applicable); (10) other contact person name and address; and (11) the details of the allegation or occurrence of abuse, neglect, or misappropriation of resident property. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Oklahoma Nurse Aide Registry for 1 (#1) of 3 sampled residents reviewed for abuse. The executive director identified 111 residents resided in the facility.	C1916		

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 _____	C 07/23/2026

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
C1916	Continued From page 3 Findings: An admission assessment for Resident #1, dated 10/06/25, showed the resident's cognitive functional status as fair. The assessment showed Res #1's had diagnoses which included depression and agitation. An initial incident report, dated 11/12/25, showed an allegation of abuse/mistreatment. The report showed Resident #1 reported to Caregiver A that Caregiver B had grabbed their finger and squeezed it really hard. Resident #1 reported they were afraid of Caregiver B and asked Caregiver A to keep them safe. The report did not show the nurse aide registry was notified. A final incident report received by the Oklahoma State Department of Health, dated 12/02/25, did not show the nurse aide registry was notified of the allegation. A policy titled "Prevention of Abuse," revised 07/09/26, read in part, "Any team member who is suspected of exploiting or abusing a resident mentally, physically, financially or sexually, will be placed immediately on unpaid leave of absence until an investigation is completed. The results of all investigations will be reported to the appropriate enforcement agencies." On 07/23/26 at 2:22 p.m., the executive director stated they were told they did not have to report the certified nursing assistant to the nurse side registry because the incident was unsubstantiated.	C1916		

OKLAHOMA
State Department of Health

Delivery via email to: jenna.fennell@touchmark.com

September 2, 2026

License Number: AL5532

Jenna Fennell, Administrator
Touchmark At Coffee Creek
2801 Shortgrass Road
Edmond, OK 73003

Survey Event ID: SUWI11

Dear Ms. Fennell:

On **July 23, 2026,** a complaint investigation was conducted at your Assisted Living Center. 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 **September 7, 2026**.

We will conduct a revisit 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/31/2026** **Facility Name:** Touchmark at Coffee Creek **License Number:** AL5532 **Survey Event ID:** SUWI11 **Date Survey Completed: 7/23/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on record review and interview, the facility failed to assess, monitor, and intervene for 1 (#2) of 4 sampled residents reviewed for a change in condition.

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 resident identified in the survey finding was assessed following the choking event when details were made aware, and appropriate follow-up was completed to ensure the resident's immediate health and safety needs were addressed. The resident's current diet, swallowing status, physician orders, and plan of care were reviewed and updated as indicated. Appropriate notifications were completed in accordance with facility policy. Appropriate corrective action was taken to address the action of the nurse involved.
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 Registered Nurse reviewed residents identified as having swallowing difficulties, altered diets, aspiration precautions, or other known choking risks to ensure appropriate physician orders, dietary instructions, interventions, and care-plan information were present and communicated to direct-care staff.
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?	Licensed nursing staff will complete a "Promoting Safe Eating" virtual course and be re-educated on the facility's emergency procedures and appropriate response to a resident experiencing an airway obstruction.
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.	The Administrator will monitor compliance with emergency-response procedures through review of resident incidents involving choking, aspiration, or other emergency events. Reviews will be conducted weekly for four weeks and monthly for three months. Reviews will be conducted weekly for four weeks and monthly for three months. The review will evaluate whether staff recognized the emergency, initiated appropriate interventions, activated emergency medical services when indicated, completed required notifications and documentation, and followed the resident's orders

	and plan of care. Trends and audit findings will be reviewed through our Quarterly QA process to determine the effectiveness of the corrective measures and whether additional intervientions are necessary. Weekly/Monthly audits will be documented and filed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/7/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required **Date 9/1/2026**

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/31/2026** **Facility Name:** Touchmark at Coffee Creek **License Number:** AL5532 **Survey Event ID:** SUWI11 **Date Survey Completed: 7/23/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1916	Based on: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Oklahoma Nurse Aide Registry for 1 (#1) of 3 sampled residents reviewed for abuse.

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 Administrator immediately reviewed the circumstances involving the resident(s) identified in the survey. The identified deficient practice was corrected, and the resident was assessed to ensure that all current health, safety, and care needs were appropriately addressed. Necessary physician, responsible-party, or other notifications were completed as applicable.
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 Administrator completed a review of residents who had the potential to be affected by the same deficient practice cited under C1916. Relevant resident records, care practices, orders, assessments, service plans, incident documentation, and/or staff practices were reviewed.
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?	Nurses and Health Services Management were educated regarding facility policy, Oklahoma assisted-living requirements, appropriate resident care and safety practices, documentation requirements, and expectations for reporting concerns to nursing/administration.
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.	Staff responsible for the identified area were re-educated regarding facility policy, Oklahoma assisted-living requirements, appropriate resident care and safety practices, documentation requirements, and expectations for reporting concerns to nursing/administration. Staff competency will be validated when applicable to the cited practice. Reviews will be conducted weekly for four weeks and monthly for three months. The review will evaluate whether staff recognized the emergency, initiated appropriate interventions, activated emergency medical services when indicated, completed required notifications and documentation, and followed the resident's orders

	and plan of care. Trends and audit findings will be reviewed through our Quarterly QA process to determine the effectiveness of the corrective measures and whether additional intervientions are necessary. Weekly/Monthly audits will be documented and filed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/7/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 9/1/2026**

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: jenna.fennell@touchmark.com

October 8, 2026

License Number: AL5532

Jenna Fennell, Administrator
Touchmark At Coffee Creek
2801 Shortgrass Road
Edmond, OK 73003

RE: Survey Event SUWI12

Dear Ms. Fennell:

On **October 8, 2026,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **July 23, 2026,** have now been corrected effective **September 7, 2026.**

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
	AL5532	A. BUILDING: _____ B. WING _____	R-C 10/08/2026

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 An offsite/paper revisit was conducted on 10/08/26. All deficiencies from the 07/23/26 survey were cleared.	{C 000}		

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