OKLAHOMA
State Department
of Health

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

October 30, 2025

License Number: AL5532

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

RE: Survey Event ID: Z49F11

Dear Ms. Fennell:

On **October 16, 2025**, agents from our office concluded a State Licensure survey with complaints 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 **October 16, 2025**.

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 OSDH.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 73008
Provider #: AL5532
Complaint #: OK00086734
Investigation Date(s): 10/15/25-10/16/25

ALLEGATION(S)
The center failed to provide a safe environment and mental health services to prevent harm
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 10/15/2025 at 8:15 a.m.

A sample of 11 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: Observations of residents and staff were made. Records of residents' health charts, physician orders, assessments, service plans, and center policies were reviewed. Interviews with residents, families, and staff were conducted. Based on observation, interview, and record review the center is in compliance with state regulations.

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: 10/16/2025

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 #: OK00086781
Investigation Date(s): 10/15/25-10/16/25

ALLEGATION(S)
The facility failed to ensure adequate staff to provide care
The facility failed to ensure fall interventions were implemented
enter text
enter text
enter text

An unannounced on-site investigation was initiated 10/15/2025 at 8:15 a.m.

A sample of 11 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: Observations of residents and their conditions, staff to resident ratios, resident apartments, and ADLs provided were made. Records of residents' medical charts, physician orders, incident reports, center schedules, time punches, and center policies were reviewed. Interviews with residents, residents' families, and staff were conducted. Based on observation, record review, and interview, the center is in compliance with state regulations.

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: 10/16/2025

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 10/16/2025

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 relicensure survey with complaints (#OK00086734 and #OK00086781) was conducted from 10/15/25 through 10/16/25. Deficiencies were cited as a result of this survey. Facility Census: 109 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CPR- cardiopulmonary resuscitation Temp- temperature	C 000		
C 391 SS=F	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 record review and interview, the center failed to ensure food temperatures were documented and maintained. The administrator identified 109 residents resided in the center. Findings: An undated policy "Standard Food Temperatures," read in part, "Temperatures of all Touchmark-approved hot and cold foods must be	C 391		

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 10/16/2025

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 391	Continued From page 1 taken during preparation, documented on the production sheet, and kept for one year." On 10/15/25 at 8:41 a.m., the executive chef was asked for the center's food temperature documentation. They stated, "We don't have temperature logs." The executive chef was asked if they take the temperature for their prepared foods. They stated, "Yes, when it comes out of the oven, but we don't write down the temperatures." On 10/16/25 at 11:38 a.m., cook #1 was asked how they ensure food was at a safe temperature for serving. They stated, "I use a thermometer and temp it. If it's not up to temperature I leave it on the grill longer." Cook #1 was asked where they documented food temperatures. They stated, "I don't." On 10/16/25 at 11:39 a.m., the sous chef stated, "We do not use food temp logs." They were asked what the policy was for documenting and using food temperature logs. They stated, "I'm sure we're supposed to."	C 391		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

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 10/16/2025

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 954	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure CPR training was provided for 1 (CMA #3) of 5 employees sampled for training qualifications. The administrator identified 109 residents resided in the center. Findings: A review of CMA #3's employee file and training record did not show they had been provided CPR training. A "Staff Roster," dated 10/15/25, showed CMA #3 was hired at the center on 07/05/25. On 10/16/25 at 1:47 p.m., the administrator was asked for CMA #3's CPR training. They stated, "It is not in [their] file because [they] don't have it." The administrator reported all employees are assigned CPR training on hire as required, but CMA #3 had not completed their training.	C 954		

OKLAHOMA
State Department
of Health

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

November 12, 2025

License Number: AL5532

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

RE: Survey Event Z49F11

Dear Ms. Fennell:

On **October 16, 2025**, a Licensure inspection with complaint investigation 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 **November 10, 2025**.

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
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/7/2025
Facility Name: Touchmark at Coffee Creek
License Number: AL5532
Survey Event ID: Z49F11
Date Survey Completed: 10/16/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 SS=F	Based on: Record review and interview, the center failed to ensure food temperatures were documented and maintained.

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?	Staff responsible for food service were re-educated on proper temperature taking, documentation, and corrective actions if temperatures fall outside acceptable range.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No residents were identified as harmed.
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?	All culinary staff were re-trained on the following: Temperature documentation required at point of preparation and point of service, immediate corrective actions are required if temperatures fall outside safe ranges, and notification to the Executive Chef and/or shift supervisor when corrective action is taken. The training included demonstration and return demonstration of proper recording and corrective response.
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.	Enter methods to ensure corrections are sustained: Regular, monthly audits by Administrator will be implemented and documented as well as weekly audits by kitchen management. Any trends or missed documentation will be reviewed in quarterly Quality Assurance meetings. During our quarterly QA meetings, we will incorporate a section specific to State Standard readiness for all departments. Food temperature logs will be housed on a secured Teams channel for review and accessibility.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/10/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/7/2025**

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: 11/7/2025** **Facility Name:** Touchmark at Coffee Creek **License Number:** AL5532 **Survey Event ID:** Z49F11 **Date Survey Completed: 10/16/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954 SS=D	Based on: Record review and interview, the center failed to ensure CPR training was provided for 1 (CMA #3) of 5 employees sampled for training qualifications.

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?	CMA #3 completed an approved CPR training course and a copy of verification was placed in their personnel file.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit of employee personnel files was conducted by the Administrator to verify that all staff required to maintain CPR training had current certification. Any staff with expired or missing training were assigned training and given deadline to complete or were not permitted to work in resident care duties until certification was renewed.
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?	CPR training will be assigned to each caregiver on Relias yearly by TCO leadership to ensure completion.
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.	Enter methods to ensure corrections are sustained: Regular monthly audits by Administrator will be implemented and documented. During our quarterly QA meetings, we will incorporate a section specific to State Standard readiness for all departments. CPR training certificates will be housed on a secured Teams channel for review and accessibility.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/10/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required		**Date 11/7/2025**

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

November 19, 2025

License Number: AL5532

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

RE: Survey Event Z49F12

Dear Ms. Fennell:

On **November 17, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaint investigations on **October 16, 2025,** have now been corrected effective **November 10, 2025.**

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 11/17/2025

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 11/17/25. The facility was in substantial compliance.	{C 000}		

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