OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@dogwoodcreekok.com; kwebb@merrittproperties.net

March 27, 2023

License Number: AL5102

Ms. Dani Woodland, Administrator
Dogwood Creek Retirement Center
3230 East Shawnee Avenue
Muskogee, OK 74403

RE: Survey Event ID: 9QHM11

Dear Ms. Woodland:

On **March 22, 2023**, agents from our office concluded a State Licensure survey 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 March 22, 2023.

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 (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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, OK, 74403**
Provider #: **AL5102**
Complaint #: **OK00060054**
Investigation Date(s): **03/20/23 through 03/22/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement an effective COVID-19 infection control program.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/20/2023 at 9:00 a.m.

A sample of 12 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegations.

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C02530for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

G. Rose Dosch RN

G. Rose Dosch, RN

Date report completed: Click to enter a date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5102	A. BUILDING: _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD CREEK RETIREMENT CENTER	3230 EAST SHAWNEE AVENUE MUSKOGEE, OK 74403

(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
D 000	INITIAL COMMENTS A relicensure survey was conducted from 03/20/23 through 03/22/23. Complaint investigation (#OK00060054) was conducted in addition to the survey. No deficiencies were cited.	D 000		
C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/20/23 through 03/22/23. Complaint investigation (#OK00060054) was conducted in addition to the survey. Listed below are abbreviations that will be used throughout this document. BOM- business office manager CMA - certified medication aide CNA - certified nurse aide CPR - cardiopulmonary resuscitation DM - dietary manager DON - director of nursing OSDH- Oklahoma State Department of Health PPE - personal protective equipment PPM - parts per million	C 000		
C 391 SS=E	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, observation, and interview, the facility failed to maintain the kitchen	C 391		

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C 391	Continued From page 1 in accordance with with Chapter 257 Food Service Establishment Regulations to ensure: a. appropriate cleaning, sanitation, and storage of cooking utensils. b. the ice machine was clean and sanitary. c. food items were labeled and dated when stored in the refrigerator. d. the sanitizer dispenser was working for the dish machine. e. scoops were not stored in bins and bags of dry goods were not left open to air. The administrator identified 52 residents resided in the facility. Findings: On 03/20/23 at 9:40 a.m., a kitchen tour was conducted with the DM. The following were observed and identified at that time and were subsequently reviewed with the corporate manager. On 03/20/23 at 9:54 a.m., lunch meat was observed in the refrigerator which had been opened and wrapped up in plastic wrap. At that time the DM stated the lunch meat should have been labeled and dated when opened. On 03/20/23 at 9:58 a.m., the dry storage was observed. A large sack of corn starch was observed open to air with a cup being used as a scoop in the bag. At that time the DM stated the scoop should not have been in the bag and the bag should be in a sealed container. A cup was also observed in the flour bin. On 03/20/23 at 10:02 a.m., the ice machine was wiped with a clean white cloth from the ice drop.	C 391		

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C 391	Continued From page 2 There was a pink and brown substance on the cloth. At that time the DM stated maintenance cleaned the ice machine. The DM stated it had been cleaned since he had been at the facility which was in January. A cleaning schedule for the ice machine was not observed or provided by the kitchen staff. On 03/20/23 at 10:06 a.m., kitchen shelving, which contained clean pots and pans, and drawers, which held serving utensils, was observed to have debris on the shelving and in the drawers. The DM was asked for a cleaning schedule for the kitchen and he stated he was working on that and a blank cleaning schedule was provided. On 03/20/23 at 3:24 p.m., cook #1 was asked to check the sanitizer for the dish machine. She was observed to run the dish machine and checked the sanitizer with a strip. The sanitizer level did not register on the strip. She checked the sanitizer again and again it did not register. At that time Cook #1 stated it was checked at lunch and it was good. The "Temperature/Chemical Log" was observed to document the ppm at 100 for every shift for March 2023. On 03/22/23 at 9:14 a.m., cook #2 was asked to check the sanitizer for the dish machine. Cook #2 was observed to run the dish machine and used the strips to check the sanitizer. The strips did not register the sanitizer level. At that time, cook #2 stated reading the level was hit and miss. The "Temperature/Chemical Log" was observed to have the PPM documented 100 for every shift for March 2023. On 03/22/23 at 9:22 a.m., the DM was called and	C 391		

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C 391	Continued From page 3 he stated he had called the dish machine company yesterday. On 03/22/23 at 11:50 a.m., the corporate manager stated the kitchen should have been clean from the surfaces to the ice machine.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation, and interview, the facility failed to ensure leftover foods which were non-potentially hazardous were disposed of after 48 hours. The administrator identified 52 residents resided in the facility. Findings: On 03/20/23 at 9:53 a.m., a plastic bag in the refrigerator labeled pork which was was observed to document a date of 08/03/14. The DM stated the facility had just served the pork and the date was not correct. He stated it was served on the	C 393		

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C 393	Continued From page 4 previous Saturday. He stated the leftover could be kept three days. A container in the refrigerator, identified by the DM as raw chicken in marinade, was observed to be not labeled but dated 3/11. The DM stated it was raw chicken in marinate. He stated the date was wrong and at that time changed the 11 to a 15. He stated they could keep raw chicken in marinate five to six days.	C 393		
C 398 SS=E	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the kitchen staff responsible for food preparation had attended a food service training program approved by the OSDH. The administrator identified 52 residents resided in the facility. Findings: The Servsafe and food handlers certificates were reviewed for the kitchen staff. Server #1 did not have documentation of the proper training. On 03/22/23 at 9:36 a.m., the BOM stated he did not have any other training documentation for the	C 398		

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C 398	Continued From page 5 kitchen staff member.	C 398		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to complete a fourteen day assessment for one (#1) of 12 sampled residents. The administrator identified 52 residents resided in the facility. Findings: Resident #1 was admitted to the facility on 06/10/22. The resident's record did not contain a comprehensive fourteen day assessment. On 03/20/23 at 11:15 a.m., the facility's DON was asked about the fourteen day assessment and she stated it could not be located.	C 522		
C 952 SS=E	310:663-9-5(b) STAFF QUALIFICATIONS (b) Each assisted living center shall ensure that	C 952		

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C 952	Continued From page 6 staff members providing socialization, activity, and exercise services are qualified by training. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide evidence of state approved training for the activity director. The administrator identified 52 residents resided in the facility. Findings: The activity director was hired into her current position on 06/06/22. On 03/22/23 at 12:00 p.m., the activity director stated she had only in house training with another activities director at their sister facility. On 03/22/23 at 12:34 p.m., the BOM stated he	C 952		

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C 952	Continued From page 7 was not aware the activity director had to have a state approved training course.	C 952		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure direct care staff members were trained in CPR. The administrator identified 52 residents resided in the facility. Findings: Five direct care staff members were selected for verification of CPR training. CPR training was documented for one of five direct care staff members. On 03/21/23 at 1:15 p.m., the administrator was asked about direct care staff training in CPR. She stated there was no one on the night shift that had CPR training. She stated she knew the facility would get a deficiency cited for failure to have staff without CPR training.	C 954		

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C 954	Continued From page 8 On 03/22/23 at 9:38 a.m., the BOM was asked about CPR training for the direct care staff members and he stated he had received CPR certifications for the DON and one CMA/CNA. No other CPR training documentation was provided.	C 954		
C2530 SS=D	310:663-25-3 OUTCOME STANDARDS To the extent allowed in this Chapter, if an assisted living center provides or arranges skilled nursing care, the Department shall assess the quality of that care against applicable standards of practice specified in Appendix B. This Rule is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to ensure staff members consistently wore face masks while caring for the residents. The administrator identified 52 residents resided in the facility. Findings: A facility policy, titled "Dogwood Creek Retirement Policy and Procedure Policy: Infectious Disease Transmission Control" read in part, "...All employees are required to use personal protective equipment (PPE) as appropriate. If an employee is not using PPE when indicated, ask him/her to do so. Continued failure to use PPE will result in disciplinary action..." On 03/20/23 at 9:25 a.m., an observation was made upon entering of the facility staff members not wearing face masks or had them under their	C2530		

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C2530	Continued From page 9 chins or noses. On 03/22/23 at 9:40 a.m., the BOM was asked about staff members not wearing masks while caring for residents. He stated all staff members should have been wearing mask while working. On 03/22/23 at 10:43 a.m., the DON was asked about the staff members not wearing mask while in the facility. The DON stated all staff members should have been wearing masks while in the common areas and resident care areas.	C2530		

OKLAHOMA
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Delivery via email to: dwoodland@sandplumok.com

April 12, 2023

License Number: AL5102

Ms. Dani Woodland, Administrator
Dogwood Creek Retirement Center
3230 East Shawnee Avenue
Muskogee, OK 74403

Survey Event ID: 9QHM11

Dear Ms. Woodland:

On **March 22, 2023,** a Relicensure survey and a complaint investigation were 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 **April 17, 2023**.

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,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.04.12 11:48:16 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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D 000	INITIAL COMMENTS A relicensure survey was conducted from 03/20/23 through 03/22/23. Complaint investigation (#OK00060054) was conducted in addition to the survey. No deficiencies were cited.	D 000		4/17/23
C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/20/23 through 03/22/23. Complaint investigation (#OK00060054) was conducted in addition to the survey. Listed below are abbreviations that will be used throughout this document. BOM- business office manager CMA - certified medication aide CNA - certified nurse aide CPR - cardiopulmonary resuscitation DM - dietary manager DON - director of nursing OSDH- Oklahoma State Department of Health PPE - personal protective equipment PPM - parts per million	C 000	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. The DM will conduct a full kitchen audit no later than 4/15/2023 to ensure proper labeling, and storage as well as resolve any concerns or deficient practice in these identified areas to ensure no negative resident outcomes. 3. All kitchen/dietary staff will be in serviced by the Dietary Director/designee on the requirements for certifications/education, food storage, labeling, proper sanitation, and proper kitchen maintenance to include dishwasher testing, and temperature monitoring by 4/7/23. 4. The DM/Designee will complete weekly daily, weekly, and monthly cleaning logs to include a bi-weekly audit of all refrigerators, freezers, dry storage, ice machine and staff certifications for no less than 4 weeks and then weekly for no less than 8 weeks then PRN to ensure continued compliance by 4/17/23. This will be evident by the documentation to be kept on file for review for no less than the required record maintenance period. 5. The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other interested or vested partner. The implementation and effectiveness of these corrections will be monitored by the QAPI committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	
C 391 SS=E	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, observation, and interview, the facility failed to maintain the kitchen	C 391		

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	AL5102	A. BUILDING: _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD CREEK RETIREMENT CENTER	3230 EAST SHAWNEE AVENUE MUSKOGEE, OK 74403

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C 391	Continued From page 1 in accordance with with Chapter 257 Food Service Establishment Regulations to ensure: a. appropriate cleaning, sanitation, and storage of cooking utensils. b. the ice machine was clean and sanitary. c. food items were labeled and dated when stored in the refrigerator. d. the sanitizer dispenser was working for the dish machine. e. scoops were not stored in bins and bags of dry goods were not left open to air. The administrator identified 52 residents resided in the facility. Findings: On 03/20/23 at 9:40 a.m., a kitchen tour was conducted with the DM. The following were observed and identified at that time and were subsequently reviewed with the corporate manager. On 03/20/23 at 9:54 a.m., lunch meat was observed in the refrigerator which had been opened and wrapped up in plastic wrap. At that time the DM stated the lunch meat should have been labeled and dated when opened. On 03/20/23 at 9:58 a.m., the dry storage was observed. A large sack of corn starch was observed open to air with a cup being used as a scoop in the bag. At that time the DM stated the scoop should not have been in the bag and the bag should be in a sealed container. A cup was also observed in the flour bin. On 03/20/23 at 10:02 a.m., the ice machine was wiped with a clean white cloth from the ice drop.	C 391	See all corrections above	4/17/23

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C 391	Continued From page 2 There was a pink and brown substance on the cloth. At that time the DM stated maintenance cleaned the ice machine. The DM stated it had been cleaned since he had been at the facility which was in January. A cleaning schedule for the ice machine was not observed or provided by the kitchen staff. On 03/20/23 at 10:06 a.m., kitchen shelving, which contained clean pots and pans, and drawers, which held serving utensils, was observed to have debris on the shelving and in the drawers. The DM was asked for a cleaning schedule for the kitchen and he stated he was working on that and a blank cleaning schedule was provided. On 03/20/23 at 3:24 p.m., cook #1 was asked to check the sanitizer for the dish machine. She was observed to run the dish machine and checked the sanitizer with a strip. The sanitizer level did not register on the strip. She checked the sanitizer again and again it did not register. At that time Cook #1 stated it was checked at lunch and it was good. The "Temperature/Chemical Log" was observed to document the ppm at 100 for every shift for March 2023. On 03/22/23 at 9:14 a.m., cook #2 was asked to check the sanitizer for the dish machine. Cook #2 was observed to run the dish machine and used the strips to check the sanitizer. The strips did not register the sanitizer level. At that time, cook #2 stated reading the level was hit and miss. The "Temperature/Chemical Log" was observed to have the PPM documented 100 for every shift for March 2023. On 03/22/23 at 9:22 a.m., the DM was called and	C 391	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. All kitchen/dietary staff will be in serviced by the Dietary Director/designee on the requirements for certifications/education, food storage, labeling, proper sanitation, and proper kitchen maintenance to include dishwasher testing, and temperature monitoring by 4/7/23. 3. In an effort to provide proof of ice machine sanitation and correct the identified deficient practice, the ice machine will be included in weekly and monthly cleaning and be documented for review. Staff will completely clean the exterior with an approved disinfectant as well as all visable and/or exposed interior components with hot/sanitizer water. The monthly cleanings will include the removal of all ice and the complete cleaning of the interior and exterior. Quarterly cleanings will be conducted by a third-party vendor with documentation kept on file. This correction will be implemented no later than 4/17/23 to remain on-going as evident by the documentation to be kept for review. 4.The DM/designee will immediately conduct a through deep cleaning of the kitchen to include all shelving. The shelving will be included on the daily and weekly cleaning logs. The shelving will be cleaned daily as a part of the closing duties and weekly all items will be removed and shelving disinfected. This will be implemented no later than 4/17/23. 5. The DM/designee will monitor these corrections daily for a period of no less than 14 days, then weekly for a period of no less than 10 weeks or until continued complaince is achieved then PRN to ensure continued compliance as evident by the documentation to be kept on file for review. 5. The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other interested or vested partner. The implementation and effectiveness of these corrections will be monitored by the QAPI committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	4/17/23

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C 391	Continued From page 3 he stated he had called the dish machine company yesterday. On 03/22/23 at 11:50 a.m., the corporate manager stated the kitchen should have been clean from the surfaces to the ice machine.	C 391		4/17/23
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation, and interview, the facility failed to ensure leftover foods which were non-potentially hazardous were disposed of after 48 hours. The administrator identified 52 residents resided in the facility. Findings: On 03/20/23 at 9:53 a.m., a plastic bag in the refrigerator labeled pork which was was observed to document a date of 08/03/14. The DM stated the facility had just served the pork and the date was not correct. He stated it was served on the	C 393	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2.The DM will conduct a full kitchen audit no later than 4/15/2023 to ensure proper labeling, and storage as wel as resolve any concerns or deficient practice in these identified areas to ensure no negative resident outcomes. 3. All kitchen/dietary staff will be in serviced by the Dietary Director/designee on the requirements for certifications/education, food storage, labeling, proper sanitation, and proper kitchen maintenance to include dishwasher testing, and temperature monitoring by 4/7/23. 4. The DM/Designee will monitor these corrections daily beginning 4/15/23 for a period of no less than 14 days, then weekly for a period of 10 weeks or until continued complaince is achieved. The DM/designee will then monitor PRN to ensure on-going complaince. This will be evident by the documentation to be kept on file for review. 5.The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other interested or vested partner. The implementation and effectiveness of these corrections will be monitored by the QAPI committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	

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C 393	Continued From page 4 previous Saturday. He stated the leftover could be kept three days. A container in the refrigerator, identified by the DM as raw chicken in marinade, was observed to be not labeled but dated 3/11. The DM stated it was raw chicken in marinate. He stated the date was wrong and at that time changed the 11 to a 15. He stated they could keep raw chicken in marinate five to six days.	C 393		4/17/23
C 398 SS=E	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the kitchen staff responsible for food preparation had attended a food service training program approved by the OSDH. The administrator identified 52 residents resided in the facility. Findings: The Servsafe and food handlers certificates were reviewed for the kitchen staff. Server #1 did not have documentation of the proper training. On 03/22/23 at 9:36 a.m., the BOM stated he did not have any other training documentation for the	C 398	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. All kitchen/dietary staff will be in serviced by the Dietary Director/designee on the requirements for certifications/education, food storage, labeling, proper sanitation, and proper kitchen maintenance to include dishwasher testing, and temperature monitoring by 4/7/23. 3. The DM/designee immediately conducted an audit to verify certifications identifying all staff that were non-compliant with certification and licensing. All non-certified staff will be expected to attend a third party provided training and present their certifications either via the provided opportunities through state programs, Graves Foods, and/or online class by 4/17/23. 4. All staff who do not attend certification by the listed date of 4/17/23 will be removed from the schedule by DM/DON/designee pending their compliance by the ED. 5. Food Handlers Permits will be hung in the kitchen for easy review as well as copies of all certifications and licensures kept and monitored using a certification tracking procedure to be maintained by the DON/ designee at the front desk for review no later than 4/17/23 to remain on-going for continued complaince.	

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C 398	Continued From page 5 kitchen staff member.	C 398		4/17/23
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to complete a fourteen day assessment for one (#1) of 12 sampled residents. The administrator identified 52 residents resided in the facility. Findings: Resident #1 was admitted to the facility on 06/10/22. The resident's record did not contain a comprehensive fourteen day assessment. On 03/20/23 at 11:15 a.m., the facility's DON was asked about the fourteen day assessment and she stated it could not be located.	C 522	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 3. Dogwood Creek conducts assessments on residents based on the following schedule: Pre-admission, Admit (if longer than 30 days past initial and/or significant change has occurred), 14 day, annual, PRN based on resident need due to significant change. As this assessment was not one for which any of the current leadership was employed, the cause has not been identified; however, moving forward, in an effort to correct this identified deficient practice, all assessments will be placed in the assessment binder for review. These will be kept for the full annual period unless a new assessment is required based on significant change wherein all previous information will be filed in the resident chart. The ED/DON/Designee will monitor this monthly as evident by the documentation to be kept on file for review. 4.In an attempt to ensure compliance, the DON/ED/ designee will monitor the correction weekly and PRN beginning 4/17/23 for a period of no less than 12 weeks, then bi-monthly thereafter on an on-going basis for continued compliance. 12 weeks of audits will be maintained and kept on file for review. 5. The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other interested or vested partner. The implementation and effectiveness of these corrections will be monitored by the QAPI committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	
C 952 SS=E	310:663-9-5(b) STAFF QUALIFICATIONS (b) Each assisted living center shall ensure that	C 952	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted.	

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C 952	Continued From page 6 staff members providing socialization, activity, and exercise services are qualified by training. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide evidence of state approved training for the activity director. The administrator identified 52 residents resided in the facility. Findings: The activity director was hired into her current position on 06/06/22. On 03/22/23 at 12:00 p.m., the activity director stated she had only in house training with another activities director at their sister facility. On 03/22/23 at 12:34 p.m., the BOM stated he	C 952	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. All staff staff to include Administrative, nursing, dietary, and activities will be in-serviced on the requirements for certification, licensure, assessment schedules, and medical records by the DON/designee on or before 4/7/23. 3. The DON/designee conducted an audit on 3/28/23 to verify certifications identifying all staff that were non-compliant with certification and licensing. All non-certified staff will be expected to attend a third party provided training and present their certifications either via the provided opportunities through state programs, the community provided class, and/or online class by 4/15/23. 4. All staff who do not attend certification by the listed date of 4/15/23 will be removed from the schedule by the DON/designee until compliant. 5.The DON/designee will monitor the correction weekly and PRN beginning 4/17/23 for a period of no less than 12 weeks, then bi-monthly thereafter on an on-going basis for continued compliance. Twelve (12) weeks of audits will be maintained and kept on file for review. 6.The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other inetrested or vested partner. The implementation and effectiveness of these corrections will be monitored by the QAPI Committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	4/17/23

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C 952	Continued From page 7 was not aware the activity director had to have a state approved training course.	C 952		4/17/23
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure direct care staff members were trained in CPR. The administrator identified 52 residents resided in the facility. Findings: Five direct care staff members were selected for verification of CPR training. CPR training was documented for one of five direct care staff members. On 03/21/23 at 1:15 p.m., the administrator was asked about direct care staff training in CPR. She stated there was no one on the night shift that had CPR training. She stated she knew the facility would get a deficiency cited for failure to have staff without CPR training.	C 954	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. All staff staff to include Administrative, nursing, dietary, and activities will be in-serviced on the requirements for certification, licensure, assessment schedules, and medical records by the DON/designee on or before 4/7/23. 3. All staff who do not attend certification by the listed date of 4/17/23 will be removed from the schedule by the DON/designee until complaint. 4.The DON/designee will monitor the correction weekly and PRN beginning 4/17/23 for a period of no less than 12 weeks,then bi-monthly thereafter on an on-going basis for continued compliance. Twleve (12) weeks of audits will be maintained and kept on file for review. 5. The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other interested or Vested partner. The implementation and Effectiveness of these corrections will be monitored by the QAPI committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	

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C 954	Continued From page 8 On 03/22/23 at 9:38 a.m., the BOM was asked about CPR training for the direct care staff members and he stated he had received CPR certifications for the DON and one CMA/CNA. No other CPR training documentation was provided.	C 954		4/17/23
C2530 SS=D	310:663-25-3 OUTCOME STANDARDS To the extent allowed in this Chapter, if an assisted living center provides or arranges skilled nursing care, the Department shall assess the quality of that care against applicable standards of practice specified in Appendix B. This Rule is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to ensure staff members consistently wore face masks while caring for the residents. The administrator identified 52 residents resided in the facility. Findings: A facility policy, titled "Dogwood Creek Retirement Policy and Procedure Policy: Infectious Disease Transmission Control" read in part, "...All employees are required to use personal protective equipment (PPE) as appropriate. If an employee is not using PPE when indicated, ask him/her to do so. Continued failure to use PPE will result in disciplinary action..." On 03/20/23 at 9:25 a.m., an observation was made upon entering of the facility staff members not wearing face masks or had them under their	C2530	1. The DON/designee conducted resident rounds on 3/28/23, ensure no lasting negative affects secondary to the state identified deficiency. None were noted. 2. All staff will be re-educated on the current policy in which all staff are required to wear a mask while in common areas or conducting resident care. Additionally, staff will be required to return demonstrate and verbally indicate the proper use, wearing, and disposal of all PPE to incluxde masks by the DON/designee by 4/7/23. 3. In an attempt to prevent future policy violations, the policies and procedures will be closely reviewed and updated by the ed/designee to reflect the CDC, state, and federal guidlines in order to maintain compliance and provide th least invasive yet safe opportuities for care and infection control . 4.Masks will be monitored daily by the BOM/designee for a period of 12 weeks. Any and all staff noted to not wear or inappropriately wear PPE, specifically masks, without proper documentation will be counseled. Additional infranctions will be subject to disciplinary action up to and including termination for insubordination. This will be in effect no later than 4/7/23 to remain on-going until policy and procedural updates are available. 5.The plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the ED, DON, RCC, Maintenance Supervisor, Dietary Manager, Marketing, Activities, RN, and any other interested or Vested partner. The implementation and Effectiveness of these corrections will be monitored by the QAPI committee for no less than 90 days or until compliance in all areas is achieved as evident by the meeting minutes to be kept on file for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5102	A. BUILDING: _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD CREEK RETIREMENT CENTER	3230 EAST SHAWNEE AVENUE MUSKOGEE, OK 74403

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C2530	Continued From page 9 chins or noses. On 03/22/23 at 9:40 a.m., the BOM was asked about staff members not wearing masks while caring for residents. He stated all staff members should have been wearing mask while working. On 03/22/23 at 10:43 a.m., the DON was asked about the staff members not wearing mask while in the facility. The DON stated all staff members should have been wearing masks while in the common areas and resident care areas.	C2530	See above	4/17/23