OKLAHOMA
State Department
of Health

Delivery via email to: cstroman@dogwoodcreekok.com

July 2, 2025

License Number: AL5102

Ms. Charlisa Stroman, Administrator
Dogwood Creek Retirement Center
3230 East Shawnee Avenue
Muskogee, OK 74403

Survey Event ID: JT4411

Dear Ms. Stroman:

On **June 16, 2025**, 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.

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. 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 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
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Dogwood Creek Retirement Center
Address:3230 E Shawnee Rd.
City, State, Zip: Muskogee, Ok, 74403
Provider #: AL5102
Complaint #: OK00073985
Investigation Date(s): 05/28/25-05/30/25, 06/02/25-06/03/25, 06/09/25, 06/11/25 and 06/16/25

ALLEGATION(S)
The facility failed to ensure residents were not sexually abused.
The center failed to ensure the right to choose the location for dining and failed to ensure accommodation of needs for residents with oxygen.

An unannounced on-site investigation was initiated 05/28/2025 at 1:45p.m..

A sample of 3 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 at entrance, and at various times throughout the survey.

Physician orders, nursing notes, incident reports and grievances were reviewed. Infection Control policy and procedures were reviewed. Care plans were reviewed. Resident handbook was reviewed.

Resident and staff interactions were observed.

Resident portable oxygen machines were observed.

Residents were asked if they felt safe.

Residents were asked about reporting grievances.

Residents were asked if they had any issues with portable oxygen machines.

Residents were asked if their choices of meals being served to their room was honored.

Residents were asked if they had any concerns.

Staff were asked about resident rights with meals and portable oxygen machines according to company policy 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: 06/23/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Dogwood Creek Retirement Center
Address:3230 E Shawnee Rd.
City, State, Zip: Muskogee, Ok, 74403
Provider #: AL5102
Complaint #: OK00082970
Investigation Date(s): 05/28/25-05/30/25, 06/02/25-06/03/25, 06/09/25, 06/11/25 and 06/16/25

ALLEGATION(S)
The facility failed to ensure residents where not sexually abused.

An unannounced on-site investigation was initiated 05/28/2025 at 1:45p.m..

A sample of 3 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 at entrance, and at various times throughout the survey.

Physician orders, nursing notes, incident reports and grievances were reviewed. Abuse and incident reporting policy and procedures were reviewed. Care plans were reviewed.

Resident and staff interactions were observed.

Residents were asked if they felt safe.

Residents were asked about reporting incidents.

Residents were asked if they had any concerns.

Staff were asked about abuse and reporting incidents according to company policy and procedures.

OKLAHOMA
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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: 06/23/2025

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 06/16/2025

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
C 000	INITIAL COMMENTS A complaint investigation (#OK00073985 and #OK00082970) was conducted from 05/28/25 through 05/30/25, 06/02/25 though 06/03/25, 06/09/25, 06/11/25, and 06/16/25 . Deficiencies were cited as a result of the survey. Facility Census: 70 Listed below are abbreviations that will be used throughout this document: CNA-certified nursing assistant DON-director of nursing Q2hrs-every two hours Res-resident	C 000		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set	C1512		

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C1512	Continued From page 1 forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 06/03/25, an Immediate Jeopardy (IJ) was	C1512		

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C1512	Continued From page 2 determined to exist related to the facility's failure to ensure residents were protected from sexual abuse. On 06/03/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 06/03/25 at 4:55 p.m., the administrator and DON were notified of the immediate jeopardy situation. The immediate Jeopardy template was provided to the administrator. On 06/16/25 at 11:15 a.m., the facility's plan of removal was accepted by the Oklahoma State Department of Health. The plan of removal, read in part, "At approximately 14:59 [2:59 p.m.], staff notified the DON, [name-deleted] that Resident #2"..."and Resident #1"..."kissing" in the library and that staff had witness Resident #2 asking Resident #1 to go to [their] room. At that time, [name-deleted], DON, educated staff that "hopefully, once we get [them] established with [name-delete facility], things can be better". Staff then suggested Q2hr checks to which [name-deleted DON] agreed. At approximately 15:56 [3:56 p.m.], [name-deleted] Administrator was notified that upon answering a call light, Resident #1 was found in the bathroom of resident #1's apartment sans [sic] clothing on lower body. They assisted the resident and immediately notified the Administrator who educated staff to keep Resident #2 in their room, provide care and meal in room, under supervision, until further instruction. [Name-deleted administrator] then immediately responded to the community. Upon [their] arrival [they] immediately notified the	C1512		

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C1512	Continued From page 3 Executive Director, [name-deleted] at 16:36 [4:35 p.m.]. [Name-deleted] then contacted the resident's family and advised them of the need for immediate removal from the premises pending investigation @ 16:43 [at 4:43 p.m.]. [Name-deleted] then notified the responsible party for resident #1 and offered to send resident out for further evaluation. POA declined but responded to community where the resident was evaluated but had no recollection of the event in question. There were no physical signs of injury and the resident was eager to "get to dinner". At 17:16 [5:15 p.m.], resident #2 was removed from the community by family. State reporting to include APS and the [local police department] was initiated. Family was notified of the investigative findings and that resident #2 would not be allowed to return to the building. Family made arrangements to empty resident #2's apartment the following weekend without resident #2 in attendance. All documentation completed in the state Advantage system [Name-deleted] and the resident was discharged. Resident #2 did not return to the facility and never will. Resident #1 is still being monitored for lasting negative effects. None have been noted to date. In servicing was provided to all staff on prompt reporting of any suspected abuse and/or potential therein as well as the need for immediate intervention." On 06/16/25 all components of the plan of removal were verified and lifted to be completed and the immediacy was effective 06/16/25 at 11:20 a.m. Facility staff were interviewed in person. The in services were conducted over abuse and incident reporting. Facility staff were able to communicate incident and abuse reporting. Staff was able to identify abuse and	C1512		

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C1512	Continued From page 4 incident reporting process and procedures. They were also able to identify and communicate 2 hour checks/safety rounds and updated care plans. Based on record review and interview, the facility failed to ensure residents were protected from sexual abuse for 2 (#1 and #2) of 3 sampled residents who were reviewed for abuse. The DON identified 70 residents resided in the facility. Findings: An undated facility policy titled "Abuse," read in part, "Every resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends or other individuals." An incident report, dated 12/01/24, read in part, "It was reported to staff by another resident that [Resident #2] had forcefully pulled resident in when [they] went to shake [their] hand to express [their]gratitude and kissed [them] and during the kiss placed [their] tongue inside of the residents mouth." An incident report, dated 05/29/25, read in part, "I, [name-deleted administrator] received a call at 3:57pm stating that [Resident #1] was found in [room deleted] [Resident #2's] apartment bathroom undressed from the waist down. [Resident #1] was having problems getting dressed and [Resident #2] was in [their] wheelchair in the bathroom with [Resident #1]."	C1512		

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C1512	Continued From page 5 Resident #1 physicians order, dated 06/02/25, read in part "Alzheimer's dementia with behavioral disturbances and depression." A undated group chat note at 10:03 a.m., read in part, "please keep an eye on [them] [they] are trying to convince [room deleted] to go [their] apartment and trying to get [them] alone has made out with [them] today." A 6:00 a.m. - 2:00 p.m. shift report, dated 05/26/25, read in part,"about 1:30"..."[laundry aide #1] notified us that [Resident #1] & [Resident #2] were making out in library and headed to a room." A Oklahoma DHS note, dated 05/27/25 at 12:21 p.., read in part,"upon responding to a call light to members apartment, member was found in bathroom with another less cognitive resident. The second female was naked from the waist down and confused on how to redress hence pulling the cord for assistance. Upon entrance to the apartment [Resident #2] began pleading for staff not to report as "[They] had issues in the past" and knew [they] was not supposed to "do it", referring to previous reported concern wherein the member forcefully kissed another female resident who reported it as unwanted as documented in December 2024."..."[They] further explained that [they] assisted with disrobing and they 'touched each other to orgasm but not inside. [They]then stated that the female got up and went to the bathroom where [they] became confused about how to redress and "[they pulled the light which is how we got caught." On 06/02/25 at 4:03 p.m., CNA #2 stated last week Resident #2 had Resident #1 in the bathroom naked. Resident #2 knew what they	C1512		

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C1512	Continued From page 6 were doing. On 06/02/25 at 4:10 p.m., the administrator stated they received a phone call that Resident #1 was in Resident #2's bathroom naked from the waist down. On 06/02/25 at 4:27 p.m., the administrator stated we have not done in-services or QAPI yet. On 06/03/25 at 9:44 a.m., Resident #3 stated they did not feel safe around Resident #2. On 06/03/25 at 10:19 a.m., CNA #1 stated Resident #2 was handsy with Resident #1 that day and tried to get Resident #1 to come into Resident #2's room on 05/29/25. Laundry aide #1 came reported they saw Resident #2 and Resident #1 kissing in the library earlier. On 06/03/25 at 10:22 a.m., the DON stated we didn't get to do rounds or document the safety checks for the incident 05/29/25. On 06/03/25 at 10:35 a.m., laundry aide #1 stated they saw Resident #2 and Resident #1 kissing in the library after lunch. On 06/03/25 at 1:56 p.m., the DON stated after the lunch incident on 05/29/25, they just separated Resident #1 and Resident #2 and they did not put them under supervised watch. After the second incident that day we have no documentation for safety watch/rounds either.	C1512		

OKLAHOMA
State Department of Health

Delivery via email to: cstroman@dogwoodcreekok.com

July 14, 2025

License Number: AL5102

Ms. Charlisa Stroman, Administrator
Dogwood Creek Retirement Center
3230 East Shawnee Avenue
Muskogee, OK 74403

Survey Event ID: JT4411

Dear Ms. Stroman:

On **June 16, 2025,** 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 **July 9, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 000	INITIAL COMMENTS A complaint investigation (#OK00073985 and #OK00082970) was conducted from 05/28/25 through 05/30/25, 06/02/25 though 06/03/25, 06/09/25, 06/11/25, and 06/16/25 . Deficiencies were cited as a result of the survey. Facility Census: 70 Listed below are abbreviations that will be used throughout this document: CNA-certified nursing assistant DON-director of nursing Q2hrs-every two hours Res-resident	C 000	Response to the 2567 with a POC does not indicate agreement with the cited deficiencies, only the desire of Dogwood to comply with the state and federal governing bodies to promote health and wellness to those we serve.	7/9/2025
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set	C1512		

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C1512	Continued From page 1 forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 06/03/25, an Immediate Jeopardy (IJ) was	C1512		7/9/2025

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 06/16/2025

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
C1512	Continued From page 2 determined to exist related to the facility's failure to ensure residents were protected from sexual abuse. On 06/03/25 at 2:45 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 06/03/25 at 4:55 p.m., the administrator and DON were notified of the immediate jeopardy situation. The immediate Jeopardy template was provided to the administrator. On 06/16/25 at 11:15 a.m., the facility's plan of removal was accepted by the Oklahoma State Department of Health. The plan of removal, read in part, "At approximately 14:59 [2:59 p.m.], staff notified the DON, [name-deleted] that Resident #2"..."and Resident #1"..."kissing" in the library and that staff had witness Resident #2 asking Resident #1 to go to [their] room. At that time, [name-deleted], DON, educated staff that "hopefully, once we get [them] established with [name-delete facility], things can be better". Staff then suggested Q2hr checks to which [name-deleted DON] agreed. At approximately 15:56 [3:56 p.m.], [name-deleted] Administrator was notified that upon answering a call light, Resident #1 was found in the bathroom of resident #1's apartment sans [sic] clothing on lower body. They assisted the resident and immediately notified the Administrator who educated staff to keep Resident #2 in their room, provide care and meal in room, under supervision, until further instruction. [Name-deleted administrator] then immediately responded to the community. Upon [their] arrival [they] immediately notified the	C1512		7/9/2025

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C1512	Continued From page 3 Executive Director, [name-deleted] at 16:36 [4:35 p.m.]. [Name-deleted] then contacted the resident's family and advised them of the need for immediate removal from the premises pending investigation @ 16:43 [at 4:43 p.m.]. [Name-deleted] then notified the responsible party for resident #1 and offered to send resident out for further evaluation. POA declined but responded to community where the resident was evaluated but had no recollection of the event in question. There were no physical signs of injury and the resident was eager to "get to dinner". At 17:16 [5:15 p.m.], resident #2 was removed from the community by family. State reporting to include APS and the [local police department] was initiated. Family was notified of the investigative findings and that resident #2 would not be allowed to return to the building. Family made arrangements to empty resident #2's apartment the following weekend without resident #2 in attendance. All documentation completed in the state Advantage system [Name-deleted] and the resident was discharged. Resident #2 did not return to the facility and never will. Resident #1 is still being monitored for lasting negative effects. None have been noted to date. In servicing was provided to all staff on prompt reporting of any suspected abuse and/or potential therein as well as the need for immediate intervention." On 06/16/25 all components of the plan of removal were verified and lifted to be completed and the immediacy was effective 06/16/25 at 11:20 a.m. Facility staff were interviewed in person. The in services were conducted over abuse and incident reporting. Facility staff were able to communicate incident and abuse reporting. Staff was able to identify abuse and	C1512		7/9/2025

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C1512	Continued From page 4 incident reporting process and procedures. They were also able to identify and communicate 2 hour checks/safety rounds and updated care plans. Based on record review and interview, the facility failed to ensure residents were protected from sexual abuse for 2 (#1 and #2) of 3 sampled residents who were reviewed for abuse. The DON identified 70 residents resided in the facility. Findings: An undated facility policy titled "Abuse," read in part, "Every resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends or other individuals." An incident report, dated 12/01/24, read in part, "It was reported to staff by another resident that [Resident #2] had forcefully pulled resident in when [they] went to shake [their] hand to express [their]gratitude and kissed [them] and during the kiss placed [their] tongue inside of the residents mouth." An incident report, dated 05/29/25, read in part, "I, [name-deleted administrator] received a call at 3:57pm stating that [Resident #1] was found in [room deleted] [Resident #2's] apartment bathroom undressed from the waist down. [Resident #1] was having problems getting dressed and [Resident #2] was in [their] wheelchair in the bathroom with [Resident #1]."	C1512	**NOTE** The incident on 12/1/24 was not only investigated and reported, the incident was determined to be a misunderstanding amongst the residents as resident#2 believed they were in a relationship. This was confirmed at the time by the reporting party. At the conclusion of the investigation all parties involved agreed that the situation had been sufficiently managed \and a risk agreement was conducted along with the CM from MSU and resident #2 in an effort to prevent future incidents as we were advised to observe Resident #2 rights and they did not believe he qualified for eviction. 1. All 70 residents residing at the facility on 5/29/25 had the potential to be affected by the cited deficient practice. The DON/RN evaluated all remaining residents between 5/30-6/4/25 for negative side affects, none were noted. 2. All staff are inserviced quarterly on resident abuse and neglect to include sexual abuse. In an effort to refresh staff education and improve advocacy in light of the incident, the next scheduled inservice was set for abuse and neglect on 6/13/25; however, secondary to the state entrance,said inservicing was expedited and completed by the DON/ Administrator by 6/11/25. This along with the already executed plan of removal cleared the threat of IJ. This inservice will be repeated educated quarterly and PRN on an on-going to empower resident advocacy and safety. The 6/11/25 inservice is on file for review.	7/9/2025

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C1512	Continued From page 5 Resident #1 physicians order, dated 06/02/25, read in part "Alzheimer's dementia with behavioral disturbances and depression." A undated group chat note at 10:03 a.m., read in part, "please keep an eye on [them] [they] are trying to convince [room deleted] to go [their] apartment and trying to get [them] alone has made out with [them] today." A 6:00 a.m. - 2:00 p.m. shift report, dated 05/26/25, read in part,"about 1:30"..."[laundry aide #1] notified us that [Resident #1] & [Resident #2] were making out in library and headed to a room." A Oklahoma DHS note, dated 05/27/25 at 12:21 p.., read in part,"upon responding to a call light to members apartment, member was found in bathroom with another less cognitive resident. The second female was naked from the waist down and confused on how to redress hence pulling the cord for assistance. Upon entrance to the apartment [Resident #2] began pleading for staff not to report as "[They] had issues in the past" and knew [they] was not supposed to "do it", referring to previous reported concern wherein the member forcefully kissed another female resident who reported it as unwanted as documented in December 2024."..."[They] further explained that [they] assisted with disrobing and they 'touched each other to orgasm but not inside. [They]then stated that the female got up and went to the bathroom where [they] became confused about how to redress and "[they pulled the light which is how we got caught." On 06/02/25 at 4:03 p.m., CNA #2 stated last week Resident #2 had Resident #1 in the bathroom naked. Resident #2 knew what they	C1512	3.For the portection of our residents and to prevent future incident, any incident of reported abuse and/or resident safety concern will be addressed immediately. Residents who report sexual and/or contact romantic in nature and/or verbal or physical agression will be immediately separated and monitored until resolution is made ensuring all residents safety beginning 6/11/2025. Staff have been educated via inservicing (6/11/2025) by the DON/Admin on the immediate reporting and resident safety requirements. This includes any form of physical interaction between any resident to remain on-going. 4. As the plan of removal was accepted and all terms of the proposed IJ to include education were completed prior to state exit, in an effort to ensure internal policies and procedures as well as state and federal regulations are upheld, on-going monitoring of all incident reports, reports of abuse of any nature, and state reportables of any type will be reported immediately and also reviewed daily for 30 days, bi weekly for 4 weeks, and weekly for no less than 4 weeks by the ED/Admin.This will be evident by both the completed audit forms to be kept on file for review and improved response to incidents as well as a proven record of r esidents freefrom abuse. Audits will be implemented no later than 7/9/2025. 5. This POC was approved by the QAPI team consisting of the RN, DON, MaintDir., Marketing Dir., Dietary Manager, Administrator, Executive Director, and any other involved provider with vested interest on 7/9/2025 to be reviewed for effectivness at the 3rd quarter QAPI meeting no later than Oct.31, 2025.	7/9/2025

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C1512	Continued From page 6 were doing. On 06/02/25 at 4:10 p.m., the administrator stated they received a phone call that Resident #1 was in Resident #2's bathroom naked from the waist down. On 06/02/25 at 4:27 p.m., the administrator stated we have not done in-services or QAPI yet. On 06/03/25 at 9:44 a.m., Resident #3 stated they did not feel safe around Resident #2. On 06/03/25 at 10:19 a.m., CNA #1 stated Resident #2 was handsy with Resident #1 that day and tried to get Resident #1 to come into Resident #2's room on 05/29/25. Laundry aide #1 came reported they saw Resident #2 and Resident #1 kissing in the library earlier. On 06/03/25 at 10:22 a.m., the DON stated we didn't get to do rounds or document the safety checks for the incident 05/29/25. On 06/03/25 at 10:35 a.m., laundry aide #1 stated they saw Resident #2 and Resident #1 kissing in the library after lunch. On 06/03/25 at 1:56 p.m., the DON stated after the lunch incident on 05/29/25, they just separated Resident #1 and Resident #2 and they did not put them under supervised watch. After the second incident that day we have no documentation for safety watch/rounds either.	C1512	**Note** Safety rounds were not conducted as immediately after the incident, resident#2 was put on one to one watch until his family came and removed him from the community which was within 1 hour of notification. Resident #1 was assisted on a one to one basis until family came to assess and visit. No further contact was available for any resident with resident #2. The DON in question is no longer with Dogwood Creek. Her failure to uphold the poloicies and procedures noted.	

OKLAHOMA
State Department of Health

FINAL DETERMINATION
USPS Tracking # 9589 0710 5270 2318 8424 85

September 2, 2025

License Number: AL5102

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

Survey Event ID: JT4412

Dear Ms. Woodland:

A revisit conducted **August 25, 2025**, revealed that your facility corrected deficiencies effective **July 11, 2025**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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	AL5102	A. BUILDING: _____ B. WING _____	R-C 08/25/2025

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DOGWOOD CREEK RETIREMENT CENTER	3230 EAST SHAWNEE AVENUE MUSKOGEE, OK 74403

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{C 000}	INITIAL COMMENTS A revisit was conducted on 08/25/25. All deficiencies from 06/16/25 survey were cleared.	{C 000}		

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