OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

October 28, 2025

License Number: AL5102

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

RE: Survey Event ID: HFXY11

Dear Ms. Woodland:

On **October 21, 2025**, 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 **October 21, 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
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

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 _____	10/21/2025

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 relicensure survey was conducted from 10/20/25 through 10/21/25. Facility Census: 63 Listed below are abbreviations that will be used throughout this document. AIT - administrator in training BOM - business office manager CMA - certified medication aide DON - director of nursing QA - quality assurance	C 000		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the facility	C1110		

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C1110	Continued From page 1 failed to establish a quality assurance committee that met at least quarterly. The BOM identified 63 residents resided in the facility. Findings: A quality assurance binder was reviewed October 2024 through October 2025. There was no documentation the QA committee met at least quarterly. On 10/20/25 at 2:30 p.m., the AIT was asked for the facilities QA meeting agendas from 10/01/24 until present. No additional documentation was provided. On 10/21/25 at 11:50 a.m., the AIT stated the facility did not have a QA committee that met at least every quarter.	C1110		
C1920 SS=D	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement their policy for expired medications during observation of the medication administration refrigerator. The BOM identified 63 residents resided in the	C1920		

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C1920	Continued From page 2 facility. Findings: On 10/21/25 at 9:10 a.m., the medication administration refrigerator was observed to contain one plastic bag with five rectal suppositories for Resident #1. The plastic bag was dated 04/12/24. An undated facility policy titled "Medication Ordering," read in part, "CMA's will notify the Care Coordinator of any scripts that have expired." On 10/21/25 at 9:12 a.m., the DON was asked who was responsible for checking the dates of medication in the refrigerator. The DON stated the CMA that worked overnight was responsible for checking the dates of the medication.	C1920		

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Delivery via email to: dwoodland@sandplumok.com

November 12, 2025

License Number: AL5102

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

RE: Survey Event HFXY11

Dear Ms. Woodland:

On **October 21, 2025**, a Licensure inspection 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 3, 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,

Clorissa Nubine

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

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 10/20/25 through 10/21/25. Facility Census: 63 Listed below are abbreviations that will be used throughout this document. AIT - administrator in training BOM - business office manager CMA - certified medication aide DON - director of nursing QA - quality assurance	C 000	Response to this 2567 does not in any manner indicate agreement with the state identified deficiencies, only our desire to be in compliance with state requirements.	11/3/2025
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the facility	C1110	1. All residents were reviewed by the DON by 11/3/2025 for negative affects secondary to the state identified deficient practice. None were noted. 2. The Quality Assurance Committee addressed in the following document as QAC is comprised of the following members: Senior Executive Director Administrator Director of Nursing Resident Care Coordinator Marketing Director Dietary Director Maintenance Director RN Other participating Healthcare Partner: This includes physician, NP, PA, CNA, CMA, Etc. The OAC has been established since 2019 by the current Administrator and will remain on-going. 3. Each member will all be inserviced on the requirements of QAC by the ED/Administrator/ designee no later than 11/3/2025. Evidence of this education will be held on file for review.	

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C1110	Continued From page 1 failed to establish a quality assurance committee that met at least quarterly. The BOM identified 63 residents resided in the facility. Findings: A quality assurance binder was reviewed October 2024 through October 2025. There was no documentation the QA committee met at least quarterly. On 10/20/25 at 2:30 p.m., the AIT was asked for the facilities QA meeting agendas from 10/01/24 until present. No additional documentation was provided. On 10/21/25 at 11:50 a.m., the AIT stated the facility did not have a QA committee that met at least every quarter.	C1110	4. The QAC will meet at least quarterly & PRN to ensure an effective on-going QAPI program with documentation to be kept on file for reference and review. The first quarterly review under this established POC will be in January 2025 for the review period of October 1st, 2025 through December 31st, 2025; however, as QA documentation is available, previous data will be collected and reported to establish QAPI metrics and the initial QAC review will be the approval of this POC which will be on file for review no later than 11/3/2025. All members of the QAC are responsible for their roles within effective 11/3/2025 to remain ongoing. 5. This correction will be monitored by the ED/ Admin/DON/RN/Designee beginning 11/3/2025, weekly for a period of 4 weeks, ever other week for a period of 4 weeks, and then at least monthly for a period of at least 4 weeks until compliance is met. This will be evident by the audit logs to be kept on file for review. NOTE**The Business Office Manager, AIT, has been employed less than 3 months and is not a required member of QAPI; therefore she was not educated on the QAPI practices or where to find QAPI documents or practices. This has been discussed and rectified. 7.This Plan of Corrections will be reviewed & accepted by the QAC consisting of the ED, Administrator, DON, RCC, Marketing Director, Maintenance Director, Dietary Director, RN, and any other participating health care professional no later than 10/31/2025 and be placed on file for review.	11/3/2025
C1920 SS=D	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement their policy for expired medications during observation of the medication administration refrigerator. The BOM identified 63 residents resided in the	C1920		

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OKLAHOMA
State Department of Health

Delivery via email to: dwoodland@sandplumok.com

December 2, 2025

License Number: AL5102
Survey Event ID: HFXY12

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

Dear Ms. Woodland:

On **November 21, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **October 21, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **November 3, 2025**.

If you have any questions concerning the information in this letter, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

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

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 11/21/25. The facility was in substantial compliance.	{C 000}		