OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

June 26, 2026

License Number: AL5102

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

Survey Event ID: VYY411

Dear Ms. Woodland:

On **June 19, 2026, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.**

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

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under

the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
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 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **91171**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION(S)
The center failed to follow medication administration policies and procedures.
The center failed to ensure residents' medications were not misappropriated.
The center failed to assess, monitor, and intervene in a timely manner for a resident with a significant change in condition.
The center failed to provide an environment with safe and comfortable temperatures.
The center failed to provide an environment free of bugs and insects.
The center failed to ensure that staff was qualified for their assigned tasks.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 10 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 center was conducted at arrival and throughout survey. Ambient temperatures were checked in common areas and resident rooms. Window units were observed in resident rooms and large cooler and fans were observed in common areas. Staff were observed passing medications appropriately. Facility was observed for bugs. temp and followed the menu. Ambient temperatures were taken in resident care areas. Residents were observed smoking outside appropriately.

Resident records were reviewed for appropriate qualifications to administer insulin, state las was reviewed for appropriate temperatures for resident care areas. Pest control records were reviewed. Resident records of progress notes were reviewed with orders, care plans.

Residents were asked if the temperatures have become more tolerable. They were asked about tmedication administration issues. They were asked about the procedure to get staff if they required assistance. Staff were asked about policy and procedures for temperature control, qualifications to administer insulin.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **89446**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION(S)
The center failed to ensure residents were not retaliated against.
The center failed to ensure palatable food was served according to the menu.
The center failed to ensure a safe, comfortable and homelike environment.
The center failed to have and enter text /or implement a smoking policy & procedure according to the state law.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 10 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 center was conducted at arrival and throughout survey. Food was observed to be appropriate taste and temp and followed the menu. Ambient temperatures were taken in resident care areas. Residents were observed smoking outside appropriately. Food to accommodate the menu was observed.

Resident records were reviewed for food menus. Smoking policy was reviewed.

Residents were asked if they worried about staff retaliation. They were asked if they were aware of residents smoking in the building. They were asked if the temperatures have become more tolerable. They were asked about their opinion of the food. Staff were asked about policy and procedures for temperature control, food palatability, abuse or retaliation, and smoking.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **89834**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION
The center failed to ensure residents' drug regimen was free of unnecessary psychotropic medications.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Medication administration pass was observed. Random narcotic sheets were compared to remaining count of narcotics on several different carts for different residents.

Policies were reviewed of medication administration and narcotic counts. Resident council minutes and grievances.

Pharmacist consultant was interviewed regarding if Als required appropriate diagnoses for prescribed antipsychotics. Residents were interviewed regarding any trouble receiving medications appropriately.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **90201**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION
The facility failed to to ensure a safe, clean, homelike environment.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Black mold was not observed in the facility. Was unable to see concrete under carpet.

Records were reviewed of ownership change, staff changes, Resident council minutes and grievances. Policies were reviewed.

Residents were interviewed about observations and concerns of black mold in the facility.
and if they felt more comfortable moving about through the facility. Staff were interviewed regarding known black mold in facility.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **90848**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION
The facility failed to ensure a comfortable homelike environment with air temperatures within a safe range.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Ambient temperatures were checked in all 4 hallways in 3 spots. The temperature was checked in dining room, library, and front lobby. Window units were observed in resident rooms with comfortable temperatures in all occupied temperature checked resident rooms. Fans and coolers were observed in dining room, library and throughout hall ways. Air conditioning repair men were observed inside the facility.

Records were reviewed of ownership change, staff changes, Resident council minutes and grievances. Policies were reviewed.

Residents were interviewed about the temperatures in their rooms currently, when window units were provided and if they felt more comfortable moving about through the facility. Staff were interviewed regarding the time line to have the air conditioning replaced.

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: 06/22/2026

OKLAHOMA
State Department
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INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **90887**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION(S)
The facility failed to ensure the building was maintained in good repair.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Ambient temperatures were checked in all 4 hallways in 3 spots. The temperature was checked in dining room, library, and front lobby. Window units were observed in resident rooms with comfortable temperatures in all occupied temperature checked resident rooms. Fans and coolers were observed in dining room, library and throughout hall ways. Air conditioning repair men were observed inside the facility.

Records were reviewed of ownership change, staff changes, Resident council minutes and grievances. Policies were reviewed.

Residents were interviewed about the temperatures in their rooms currently, when window units were provided and if they felt more comfortable moving about through the facility. Staff were interviewed regarding the time line to have the air conditioning replaced.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **90998**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION
The facility failed to have and/or implement an effective pest control program.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Common areas and resident rooms were observed for live bugs or pest.

Records were reviewed of pest control receipts, ownership change, staff changes, Resident council minutes and grievances. Policies were reviewed.

Residents were interviewed about seeing live pests throughout the facility. How often their room was sprayed for bugs. Staff were interviewed regarding the procedures to prevent pests from entering the facility.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **91419**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION(S)
The facility failed to provide an environment with comfortable ambient temperatures.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Ambient temperatures were checked in all 4 hallways in 3 spots. The temperature was checked in dining room, library, and front lobby. Window units were observed in resident rooms with comfortable temperatures in all occupied temperature checked resident rooms. Fans and coolers were observed in dining room, library and throughout hall ways. Air conditioning repair men were observed inside the facility.

Records were reviewed of ownership change, staff changes, Resident council minutes and grievances. Policies were reviewed.

Residents were interviewed about the temperatures in their rooms currently, when window units were provided and if they felt more comfortable moving about through the facility. Staff were interviewed regarding the time line to have the air conditioning replaced.

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: 06/22/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dogwood Creek Retirement Center**
Address: **3230 East Shawnee Avenue**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5102**
Complaint #: **91730**
Investigation Date(s): **06/18/26 through 06/19/26**

ALLEGATION(S)
The facility failed to maintain a working AC system.

An unannounced on-site investigation was initiated 06/18/2026 at 11:00 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon arrival and throughout the survey. Ambient temperatures were checked in all 4 hallways in 3 spots. The temperature was checked in dining room, library, and front lobby. Window units were observed in resident rooms with comfortable temperatures in all occupied temperature checked resident rooms. Fans and coolers were observed in dining room, library and throughout hall ways. Air conditioning repair men were observed inside the facility.

Records were reviewed of ownership change, staff changes, Resident council minutes and grievances. Policies were reviewed.

Residents were interviewed about the temperatures in their rooms currently, when window units were provided and if they felt more comfortable moving about through the facility. Staff were interviewed regarding the time line to have the air conditioning replaced.

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: 06/22/2026

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 06/19/2026

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 Complaint investigations (#OK00089446, OK00089834, OK00090201, OK00090263, OK00090848, OK00090887, OK00090998, OK00091171, OK00091419, and #OK00091730) were conducted from 06/18/26 through 06/19/26. Deficiencies were cited. Facility Census: 72	C 000		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure complete controlled medication counts by staff coming on duty and staff going off duty for 4 of 4 medication carts observed for medication management. The director of nursing identified 72 residents	C1923		

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 06/19/2026

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
C1923	Continued From page 1 received medications. Findings: A policy titled "Controlled Substances," reviewed 12/2012, read in part, "Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together." A document on medication cart #1 titled "Eight Hour Verification of Individual Resident's Controlled Drug Records" showed the following: a. on 06/15/26, 6-2 shift, no signature for on-coming nurse, b. on 06/15/26, 2-10 shift, no signature for off-going nurse, c. on 06/16/26, 6-2 shift, no signature for on-coming nurse, d. on 06/16/26, 2-10 shift, no signature for off-going nurse, e. on 06/17/26, 6-2 shift, no signature for on-coming nurse, f. on 06/17/26, 2-10 shift, no signature for off-going nurse, g. on 06/18/26, 6-2 shift, no signature for on-coming nurse, h. on 06/18/26, 2-10 shift, no signature for off-going nurse, and i. on 06/19/26, 6-2 shift, no signature for on-coming nurse. A document on medication cart #2 titled "Eight Hour Verification of Individual Resident's Controlled Drug Records" showed the following: a. on 06/14/26, 2-10 shift, no signature for off-going nurse, b. on 06/15/26, 6-2 shift, no signature for	C1923		

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 06/19/2026

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
C1923	Continued From page 2 on-coming nurse, c. on 06/15/26, 2-10 shift, no signature for off-going nurse, d. on 06/16/26, 6-2 shift, no signature for on-coming nurse, e. on 06/16/26, 2-10 shift, no signature for off-going nurse, f. on 06/17/26, 6-2 shift, no signature for on-coming nurse, g. on 06/17/26, 2-10 shift, no signature for on-coming nurse, h. on 06/17/26, 2-10 shift, no signature for off-going nurse, i. on 06/17/26, 10-6 shift, no signature for off-going nurse, j. on 06/18/26, 6-2 shift, no signature for on-coming nurse, and k. on 06/19/26, 6-2 shift, no signature for on-coming nurse. A document on medication cart #3 titled "Eight Hour Verification of Individual Resident's Controlled Drug Records" showed the following: a. on 06/08/26, 10-6 shift, no signature for on-coming nurse, b. on 06/09/26, 6-2 shift, no signature for off-going nurse, c. on 06/09/26, 10-6 shift, no signature for on-coming nurse, d. on 06/10/26, 6-2 shift, no signature for off-going nurse, e. on 06/11/26, 6-2 shift, no signature for on-coming nurse, f. on 06/11/26, 2-10 shift, no signature for off-going nurse, g. on 06/14/26, 10-6 shift, no signature for on-coming nurse, and h. on 06/15/26, 6-2 shift, no signature for off-going nurse.	C1923		

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 06/19/2026

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
C1923	Continued From page 3 A document on medication cart #4 titled "Eight Hour Verification of Individual Resident's Controlled Drug Records" showed the following: a. on 06/08/26, 10-6 shift, no signature for on-coming nurse, b. on 06/09/26, 6-2 shift, no signature for on-coming nurse, c. on 06/09/26, 6-2 shift, no signature for off-going nurse, d. on 06/09/26, 2-10 shift, no signature for off-going nurse, e. on 06/09/26, 10-6 shift, no signature for on-coming nurse, f. on 06/10/26, 6-2 shift, no signature for on-coming nurse, g. on 06/10/26, 6-2 shift, no signature for off-going nurse, h. on 06/10/26, 2-10 shift, no signature for on-coming nurse, i. on 06/10/26, 2-10 shift, no signature for off-going nurse, j. on 06/10/26, 10-6 shift, no signature for off-going nurse, k. on 06/11/26, 6-2 shift, no signature for on-coming nurse, l. on 06/11/26, 2-10 shift, no signature for off-going nurse, m. on 06/12/26, 6-2 shift, no signature for on-coming nurse, n. on 06/12/26, 2-10 shift, no signature for off-going nurse, o. on 06/14/26, 10-6 shift, no signature for on-coming nurse, and p. on 06/15/26, 6-2 shift, no signature for off-going nurse. On 06/19/26 at 10:20 a.m., the health and wellness director stated, "The weekend aides and	C1923		

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 06/19/2026

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
C1923	Continued From page 4 night shift are bad about not signing the log sheets and there has been several newer medication aides that were possibly not signing the count book." On 06/19/26 at 10:39 a.m., the director of nursing stated all four of the medication cart narcotic count books had multiple open and not signed spots on the log sheets. They stated their expectation would be the staff would count and sign the book at each shift or cart change.	C1923		

OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

July 1, 2026

License Number: AL5102

Ms. Briana Libey, Administrator
Dogwood Creek Retirement Center
3230 East Shawnee Avenue
Muskogee, OK 74403

Survey Event ID: VYY411

Dear Ms. Libey:

On June 19, 2026, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 5, 2026**.

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/26/2026** **Facility Name:** Dogwood Creek Assisted Living **License Number:** AL5102 **Survey Event ID:** VYY411 **Date Survey Completed: 6/19/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923 310:663-19-2(a)(3) Medication Administration	Based on: Based on record review and interview, the facility failed to ensure complete controlled medication counts by staff coming on duty and staff going off duty for 4 of 4 medicaiton carts observed for medication management.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Medication records were observed to be out of compliance; however, the medications were all accounted for. Deficient practice is related to documentation only.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The residents inquestion were reviewed by the RSD and consulting nurse and found to have no lasting affects of the medication record keeping deficiency as all medications were accounted for on 6/26/2026.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents whom receive medicaitons as administered by the community have the potential to be affected however, all medications were accounted for on 6/26/26 and an additional cart audit will be completed by the RN/RCD no later than 7/5/2026.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff will be inserviced o Medication Administration/Management & Resident Rights no later than 7/5/2026 by the RCD/BOM/Designee. Weekly medication cart logs to include those that are not electronic will be monitored by the DON/RCD/Designee with immediate employee coaching for any and all violations no later than 7/5/26 to remain on-going.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	This corrective action will be monitored for effectivness by the DON/RCD/Designee daily for a period of 1 week, by-weekly for a period of 3 weeks, weekly for no less than a period of 8 weeks or until compliance is met and remain on-going. This will be implemented no later than 7/5/2026. Once compliance is reached, these audits will be reviewed monthly and any outliers reported immediately to the DON/BOM/ED for corrective action. Medication documentation will be reviewed quarterly by the QA committee consisting of the RN, Director of Nursing, Resident Care Director, Business Office Manager, ED, Maintenance Supervisor, Marketing Director, Dietary Manager, and Lifestyles Director. All records will be maintained for review per the regulatory requirements.

	Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/5/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Brianna Libya	**Date 6/26/2026**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department of Health

Delivery via email to: dwoodland@sandplumok.com

July 21, 2026

License Number: AL5102

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

RE: Survey Event VYY412

Dear Ms. Woodland:

On **July 15, 2026,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **June 19, 2026,** have now been corrected effective **July 5, 2026.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5102	A. BUILDING: _____ B. WING _____	R-C 07/15/2026

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 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 07/15/26. All deficiencies from the 06/19/26 survey were cleared.	{C 000}		

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