



Oklahoma State Department of Health  
Creating a State of Health

January 9, 2020

License Number: AL5102

Mr. Zachary Henson, Administrator  
Dogwood Creek Retirement Center  
3230 East Shawnee Avenue  
Muskogee, OK 74403

**Survey Event ID: 1PYR11**

Dear Mr. Henson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **January 2, 2020**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Katie Stagner  
Long Term Care Enforcement Reviewer  
Oklahoma State Department of Health

Board of Health

Gary Cox, JD  
Commissioner of Health

Timothy E Starkey, MBA (*President*)  
Edward A Legako, MD (*Vice-President*)  
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO  
Terry R Gerard II, DO  
Charles W Grim, DDS, MHSA

R Murali Krishna, MD  
Ronald D Osterhout  
Charles Skillings

[www.health.ok.gov](http://www.health.ok.gov)  
An equal opportunity  
employer and provider





**INVESTIGATIVE REPORT  
LICENSURE**

**Facility:** Dogwood Creek Retirement Center  
**Address:** 3230 East Shawnee Avenue  
**City, State, Zip:** Muskogee, Ok 74403  
**Provider #:** AL5102  
**Complaint #:** OK00054550  
**Investigation Date(s):** 01/02/20

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center neglected to provide services to avoid unnecessary physical harm.	US

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

An unannounced on-site investigation was initiated on Thursday, January 2, 2020 at 10:57 a.m.

A sample of 7 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 Description of Significant Findings Related to Each Allegation is Provided Below:**

**Allegation #1:** Deficient practice was unsubstantiated related to this allegation.

An investigation specific to pest control services to prevent bed bugs was conducted.

Five residents' visible skin areas were observed and did not have bed bug bites or rashes. Two residents were unavailable for observation. Five apartments were inspected for bed bugs with a housekeeper; no live bed bugs were observed.

Residents who were alert and oriented to person, place and time stated they had not seen any bed bugs and did not have any bites. One resident stated he had bed bugs in his apartment in the past, but his apartment had been

treated twice. That resident did not have live bed bugs and did not have bed bug bites at the time of the survey. Five employees stated they had not seen any live bed bugs since the last treatment for bed bugs was done in October 2019.

The sampled residents' records did not indicate the residents had rashes or bed bug bites. The pest control logs documented the center had been treated for bed bugs in June, July, September and October of 2019. Five apartments along with an additional area had been sprayed for bed bugs and two apartment had been heat treated for bed bugs.

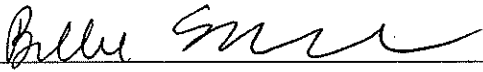
At the time of the investigation, the center provided effective pest control to prevent bed bugs.

**Determination Summary and Follow-Up Action:**

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Billie Seeman, RN Clinical Health Facility Surveyor

Date report completed: 01/06/2020

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>AL5102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/02/2020</b>
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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

(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	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated survey was conducted on 01/02/20 to investigate complaint #OK00054550. Current census was 48. No deficient practice was cited.</p>	C 000		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

# STATE WORKLOAD REPORT

Provider/Supplier Number AL5102	Provider/Supplier Name DOGWOOD CREEK RETIREMENT CENTER
------------------------------------	-----------------------------------------------------------

Type of Survey (select all that apply)

3				
---	--	--	--	--

- |                           |                         |                     |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification   |
| B Dumping Investigation   | F Inspection of Care    | J Sanctions/Hearing |
| C Federal Monitoring      | G Validation            | K State License     |
| D Follow-up Visit         | H Life Safety Code      | L CHOW              |
| M Other                   |                         |                     |

Extent of Survey (select all that apply)

--	--	--	--	--

- A Routine/Standard Survey (all providers/suppliers)  
 B Extended Survey (HHA or Long Term Care Facility)  
 C Partial Extended Survey (HHA)  
 D Other Survey

## SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1 <i>W</i> 36191	01/02/2020	01/02/2020	0.50	0.00	4.75	0.00	4.00	5.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00 Total RO Supervisory Review Hours..... 0.00

Total SA Clerical/Data Entry Hours..... 0.00 Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

JAN 10 2020 *jm*