OKLAHOMA
State Department
of Health

Delivery via email to: dakotamcgrory@jcmh.com

October 14, 2025

License Number: AL3301

Dakota McGrory, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

Survey Event ID: 2BQT11

Dear Ms. McGrory:

On **October 8, 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.

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
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 OSDH.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,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Tamarack Retirement Center**
Address: **1224 East Tamarack Road**
City, State, Zip: **Altus, OK, 73521**
Provider #: **AL3301**
Complaint #: **OK00086429**
Investigation Dates: **10/07/25 through 10/08/25**

ALLEGATIONS
The center failed to ensure residents were free from abuse and/or injuries of unknown origin.
The center failed to ensure residents received the level of care they required.

An unannounced on-site investigation was initiated 10/07/2025 at 09:00 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the survey. Residents were observed during meals, in their rooms, while participating in activities, during transfers, and during personal care. Staff members were observed answering call lights, administering medication, serving meals, assisting with set-up of meals, and assisting residents with activities of daily living.

Sampled clinical records were reviewed for physician orders, care plans, assessments, progress notes, plan of accommodations, and activities of daily living records. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident service agreements were reviewed. Resident council minutes and grievances were reviewed.

Residents and resident family members were interviewed regarding any concerns with abuse, safety, transfers, adequate care, and staffing. Staff members were interviewed regarding abuse, injuries, reporting, and providing adequate care for dependent residents.

OKLAHOMA
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of Health

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: 10/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3301	A. BUILDING: _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

(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 (#OK00086249) was conducted on 10/07/25 through 10/08/25. Deficiencies were cited as a result of the survey. Facility Census: 47 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide	C 000		
C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3301	A. BUILDING: _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

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C5015	Continued From page 1 the resident; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure a plan of accommodation was in place for a resident who required a 2-person assist with all transfers for 1 (#1) of 3 sampled residents reviewed for transfers. The administrator identified 47 residents resided in the center. The clinical nurse director identified there were no residents with a plan of accommodation. Findings: On 10/07/25 at 11:30 a.m., Resident #1 was transferred from their recliner to their wheelchair with the assistance of CMA #1 and CNA #1.	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5015	Continued From page 2 An annual assessment, dated 08/17/25, showed Resident #1 required the assistance of one staff member with all transfers. An incident report, dated 08/29/25, showed immediate action taken for Resident #1 was to have two staff members at all times for transfers and toileting. A care plan intervention, dated 09/11/25, showed Resident #1 would have 2 staff members to assist with transfers for safety. An undated facility "RESIDENT SERVICE AGREEMENT," showed a discharge and/or transfer from the facility would be based on the ability to transfer with the assistance of one person. The administrator stated the facility did not have a plan of accommodation policy. On 10/07/25 at 11:08 a.m., CNA #1 stated Resident #1 was a 2-person assist with all transfers for safety. The CNA stated Resident #1 was the only resident in the facility required 2-person assistance with transfers. On 10/08/25 at 10:00 a.m., the clinical nurse director stated they did not understand that a plan of accommodation was needed since they were able to provide the 2-person assistance at all times to the residents. The clinical nurse director stated they thought the plan of accommodation was a 30-day notice for discharge. The clinical nurse director stated they would get a plan of accommodation in place for Resident #1.	C5015		

OKLAHOMA
State Department of Health

Delivery via email to: dakotamcgrory@jcmh.com; djmcgrory@yahoo.com

December 9, 2025

License Number: AL3301

Dakota McGrory, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

Survey Event ID: 2BQT11

Dear Mr. McGrory:

On **October 8, 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 **December 19, 2025**.

We will conduct a revisit for 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/8/2025** **Facility Name:** Tamarack Retirment Center **License Number:** AL3301 **Survey Event ID:** 2BQT11 **Date Survey Completed: 10/8/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5015	Based on: Based on observation, record review, and interviews, the facility failed to ensure a plan of accommodation was in place for a resident who required a 2-person assist with all transfers for 1 (#1) of 3 sampled residents reviewed for transfers.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional)

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? **OSDH Response: Element accepted Yes ☐ No ☐**	The facility will ensure all resident who need a plan of accommodation will have one in place in a timely manner.
2. How will other residents having the potential to be affected by the same deficient practice be identified? **OSDH Response: Element accepted Yes ☐ No ☐**	Facility will review residents through care plans and observations to determine if a plan of accommodation is needed.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? **OSDH Response: Element accepted Yes ☐ No ☐**	Effective immediately the administrator or designee will conduct rounds and care plan reviews and make observations 5 times a week for one week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved administrator/designee will conduct rounds and make observations monthly through 2 QA meetings to ensure continued compliance.
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. **OSDH Response: Element accepted Yes ☐ No ☐**	Through Quality assurance comittee The quality assurance committee will monitor the effectiveness of the plan until compliance is achieved and continue and continue to monitor for two quarters after compliance. By reviewing during Quality assurance committee Monitoring records will be kept in a plan of accommodation binder in Administrators office
5. On what date will corrective action be completed? **OSDH Response: Element accepted Yes ☐ No ☐**	12/16/2025

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/8/2025**

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.
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3301	A. BUILDING _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

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C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of	C5015		

Oklahoma State Department of Health

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	AL3301	A. BUILDING _____ B. WING _____	C 10/08/2025

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C5015	Continued From page 1	C5015		

the resident;

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure a plan of accommodation was in place for a resident who required a 2-person assist with all transfers for 1 (#1) of 3 sampled residents reviewed for transfers.

The administrator identified 47 residents resided in the center. The clinical nurse director identified there were no residents with a plan of accommodation.

Findings:

On 10/07/25 at 11:30 a.m., Resident #1 was transferred from their recliner to their wheelchair with the assistance of CMA #1 and CNA #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

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C5015	Continued From page 2	C5015		

An annual assessment, dated 08/17/25, showed Resident #1 required the assistance of one staff member with all transfers.

An incident report, dated 08/29/25, showed immediate action taken for Resident #1 was to have two staff members at all times for transfers and toileting.

A care plan intervention, dated 09/11/25, showed Resident #1 would have 2 staff members to assist with transfers for safety.

An undated facility "RESIDENT SERVICE AGREEMENT," showed a discharge and/or transfer from the facility would be based on the ability to transfer with the assistance of one person.

The administrator stated the facility did not have a plan of accommodation policy.

On 10/07/25 at 11:08 a.m., CNA #1 stated Resident #1 was a 2-person assist with all transfers for safety. The CNA stated Resident #1 was the only resident in the facility required 2-person assistance with transfers.

On 10/08/25 at 10:00 a.m., the clinical nurse director stated they did not understand that a plan of accommodation was needed since they were able to provide the 2-person assistance at all times to the residents. The clinical nurse director stated they thought the plan of accommodation was a 30-day notice for discharge. The clinical nurse director stated they would get a plan of accommodation in place for Resident #1.

OKLAHOMA
State Department of Health

Delivery via email to: dakotamcgrory@jcmh.com; djmcgrory@yahoo.com

December 22, 2025

License Number: AL3301

Dakota McGrory, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

Survey Event ID: 2BQT12

Dear Mr. McGrory:

On **December 22, 2025,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **October 8, 2025,** have now been corrected effective **December 16, 2025.**

If you have any questions concerning the information in this letter, please contact me 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
	AL3301	A. BUILDING: _____ B. WING _____	R-C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

(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 An offsite/paper revisit was conducted on 12/22/25. The facility was in substantial compliance.	{C 000}		

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