OKLAHOMA
State Department
of Health

Delivery via email to: samghosn@gmail.com

March 21, 2024

License Number: AL1603

Mr. Sam Ghosn, Administrator
The Chateau
6302 Southwest Lee Boulevard
Lawton, OK 73505

Survey Event ID: DF1J11

Dear Mr. Ghosn:

On **March 6, 2024,** 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 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: IDRCoordinator@health.ok.gov

Or mail 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 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Chateau**
Address: **6302 Southwest Lee Boulevard**
City, State, Zip: **Lawton, OK 73505**
Provider #: **AL 1603**
Complaint #: **OK00061664**
Investigation Date(s):

ALLEGATION(S)

The facility failed to ensure a working communication system for residents to call the nursing staff for assistance and failed to have and/or implement an effective pest program.

An unannounced on-site investigation was initiated 02/28/2024 at 12:45 p.m.

A sample of eight 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:

The environment was observed upon entry and throughout the investigation to be clean and orderly. Call systems were in place for residents to alert staff of requested needs. Areas at risk for pests were observed.

Record reviews were conducted on policies, maintenance logs, and cleaning lists.

Residents were asked if there were any concerns regarding a call system in place to notify staff if they had needs between routine rounds. Residents were asked if there were any concerns of pests.

Staff were asked if there had ever been concerns regarding call systems not in working order or pests within the facility.

The attached Statement of Deficiencies, Form 2567 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: 03/11/2024

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INVESTIGATIVE REPORT

Facility: **The Chateau**
Address: **6302 Southwest Lee Boulevard**
City, State, Zip: **Lawton, OK 73505**
Provider #: **AL 1603**
Complaint #: **OK00062149**
Investigation Date(s): **02/28/24 thru 03/06/24**

ALLEGATION(S)

The facility failed to ensure residents were not involuntarily discharged.
The facility failed to ensure hospice services were received according to the residents' and/or the representatives' request.

An unannounced on-site investigation was initiated 02/28/2024 at 12:45 p.m.

A sample of eight 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:

Residents were observed upon entry and throughout the investigation to be clean, well-groomed and appropriately dressed for the season. Hospice and Home Health staff were observed to enter the facility and provide cares to residents.

Record reviews were completed on resident medical records, assessments, care plan, physician orders, medication administration, resident risk assessments, negotiation agreements, plan of accommodations, third party care plans, facility policies and procedures, incident reports and reportable events, and admission and discharges.

Residents and family were asked if there were any concerns the resident's needs were not being met by staff, and if the care required had been identified to meet discharge criteria what was in place or had been offered. Residents and family were asked if they had been informed of circumstances if the resident requested hospice services.

Staff were asked if residents had been assessed for an increase risk due to a need for a higher level of care, and if referral are made to Home Health or Hospice services. Staff were asked if assessments

were completed for significant changes of conditions to verify the increase level of care required, a risk assessment completed for identified increased levels of care, a negotiation agreement had been completed and signed by staff and resident or representative, a plan of accommodation was signed in agreement by staff and resident or representative, and a system in place for monitoring of the services provided by third parties.

The attached Statement of Deficiencies, Form 2567 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: 03/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1603	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU	6302 SOUTHWEST LEE BOULEVARD LAWTON, OK 73505

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 02/28/24 through 03/06/24. Complaint investigations (#OK00061664, and #OK00062149) were conducted in conjunction with the survey. Facility Census: 26 The following abbreviations were used in writing this report: CMA - Certified Medication Aide DON - Director of Nurses F - Fahrenheit LPN - Licensed Practical Nurse POC - Plan of Care	C 000		
C 371 SS=E	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to identify risks and implement a risk assessment for: a. a resident receiving hospice services and wound treatment for one (#1) of one sampled residents that received hospice services, and b. residents that received home health services	C 371		

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C 371	Continued From page 1	C 371		

for increased level of care and wound treatments for three (#2, #4, and #6) of three sampled residents that received home health services.

The "Assisted Living Resident Condition and Care Overview", dated 02/28/24, documented one resident received hospice services and 18 residents received home health services.

The DON identified the census was 26.

Findings:

1. Resident #1 had diagnosis to include dementia; traumatic subdural hemorrhage, and altered skin integrity.

A "Hospice POC Report", documented Resident #1 was admitted to hospice services on 10/11/23.

The clinical record did not contain documentation the facility had identified risks to the resident or implement a risk assessment prior to a hospice consultation and services added.

On 03/05/24 at 11:00 a.m., staff assisted with Hospice to position resident for skin care. Resident #1 had a small open area on the left buttock that was not covered with a dressing. The Resident's left ankle had an undated dressing that was removed by the hospice LPN. The bony area of the outer left ankle had an open area approximately 1 inch across, with a darkened circumference of the outer tissue. The hospice LPN stated the area was red upon admit to hospice, the wound had not been staged by a physician, and Resident #1 does prefer to lie on their left side.

On 03/06/24 at 10:00 a.m., the DON stated

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C 371	Continued From page 2 Resident #1 had been changed from Home Health Services to Hospice services due to a significant change of condition. The DON stated a risk assessment had not been initiated or completed. 2. Resident #2 had diagnosis to include basal cell carcinoma, and dementia. A "Home Health Updated Plan of Care Report", documented Resident #2 was admitted to Home Health services on 01/10/24. The clinical record did not contain documentation the facility had identified risks to the resident or implement a risk assessment prior to Home Health consultation and services added. On 02/29/24 and 03/01/24, Resident #2 was observed to be seated in a blue geri-chair for the noon meals meals. On 03/06/24, the DON stated Resident #2 required a higher level of care but a risk assessment had not been initiated prior to Resident #2 being admitted to Home Health services on 01/10/24. 3. Resident #4 had diagnosis to include cellulitis, dementia, a history of a fall with a fracture, and an open wound to the left lower leg. A "Home Health Update Plan of Care Report", documented Resident #4 was admitted to Home Health services on 02/09/24. On 02/28/24 at 12:55 p.m., Resident #4 was observed in the common area, seated in a wheelchair. Resident #4 had black bruising to their right face and head.	C 371		

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C 371	Continued From page 3 The clinical record did not contain documentation the facility had identified risks to the resident or implement a risk assessment prior to Home Health consultation and services added. On 03/06/24 at 1015 a.m., the DON stated Resident #2 is frequently on Home Health services per their request, and risk assessments have not been completed. 4. Resident #6 had diagnosis for ulcerative colitis, dementia, and a Stage-2 pressure ulcer of the right buttock. A "Home Health Updated Plan of Care Report", documented Resident #6 was admitted to Home Health services on 02/22/24. The clinical record did not contain documentation the facility had identified risks to the resident or implement a risk assessment prior to Home Health consultation and services added. On 03/01/24 at 10:15 a.m., the DON was observed to perform a skin audit for Resident #6. Resident #6 had two open areas on the inside buttocks, one on each buttock that was approximately 0.25 inch wide and one inch long. The wounds appear to be in alignment with the open areas. On 03/06/24 at 10:05 a.m., the DON stated they had not known of the required forms and a risk assessment had not been completed prior to Home Health services provided.	C 371		
C 372 SS=E	310:663-3-6(b) MANAGEMENT OF RISK	C 372		

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C 372	Continued From page 4 (b) The assisted living center shall specify the cause for concern, discuss the concern with the resident and representative, if any, and attempt to negotiate a written agreement that minimizes risk and adverse consequences and offers alternatives while respecting resident preferences. This Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to ensure a written negotiation agreement was in place prior to initiating hospice or home health services for: a. a resident receiving hospice services and wound treatment for one (#1) of one sampled residents that received hospice services, and b. residents that received home health services for increased level of care and wound treatments for three (#2, #4, and #6) of three sampled residents that received home health services. The "Assisted Living Resident Condition and Care Overview", dated 02/28/24, documented one resident received hospice services and 18 residents received home health services. The DON identified the census was 26. Findings: 1. Resident #1 had diagnosis to include dementia; traumatic subdural hemorrhage, and altered skin integrity. A "Hospice POC Report" documented Resident #1 was admitted to hospice services on 10/11/23.	C 372		

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C 372	Continued From page 5 The clinical record did not contain a written negotiation for hospice services. On 02/28/24 at 2:40 p.m., the DON stated Resident #1 is the last resident to receive hospice services as the facility has determined the need for hospice services is criteria for involuntary discharge from the facility. On 02/29/24 at 9:05 a.m., the Administrator stated the facility will no longer accept hospice services for their residents, the facility has determined if a resident required or elected hospice services they would receive a letter of discharge and be required to move into a long term care facility. On 02/29/24 at 12:06 p.m., Resident #1 was observed for the noon meal and required full assistance of staff for fluid and nutritional intake. On 03/05/24 at 11:00 a.m., staff assisted with Hospice to position resident for skin care. Resident #1 had a small open area on the left buttock and an open wound on the left outer ankle. On 03/06/24 at 10:00 a.m., the DON stated Resident #1 or her representative had not been provided a written negotiation contract. 2. Resident #2 had diagnosis to include basal cell carcinoma, and dementia. A "Home Health Update POC Report", documented Resident #2 was admitted to Home Health services on 01/10/24. The clinical record did not contain a written	C 372		

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C 372	Continued From page 6 negotiation for Home Health Services. On 02/29/24 and 03/01/24, Resident #2 was observed to be seated in a blue geri-chair for the noon meals meals. On 03/06/24, the DON stated Resident #2 required a higher level of care but a written negotiation contract had not been completed or provided to the resident or representative prior to Resident #2 being admitted to Home Health services on 01/10/24. 3. Resident #4 had diagnosis to include cellulitis, dementia, a history of a fall with a fracture, and an open wound to the left lower leg. A "Home Health Updated POC Report", documented Resident #4 was admitted to Home Health services on 02/09/24. On 02/28/24 at 12:55 p.m., Resident #4 was observed in the common area, seated in a wheelchair. Resident #4 had black bruising to their right face and head. The clinical record did not contain a written negotiation for Home Health. On 03/06/24 at 1015 a.m., the DON stated Resident #2 is frequently on Home Health services per their request, and netogiation contracts had not been completed. 4. Resident #6 had diagnosis for ulcerative colitis, dementia, and a Stage-2 pressure ulcer of the right buttock. A "Home Health Update POC Report", documented Resident #6 was admitted to Home	C 372		

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C 372	Continued From page 7 Health services on 02/22/24. The clinical record did not a written negotiation contract for Home Health. On 03/01/24 at 10:15 a.m., the DON was observed to perform a skin audit for Resident #6. Two open areas were on the inside buttocks, one on each buttock that was approximately 0.25 inch wide and one inch long. The wounds appear to be in alignment with the open areas. On 03/06/24 at 10:05 a.m., the DON stated they had not known of the required forms and a negotiation contract had not been completed prior to Home Health services provided.	C 372		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure: a. refrigerated foods were covered, dated, and labeled, b. frozen raw meats were thawed in the refrigerator or under cold running water, c. the ice machine was maintained to have a clean inside surface, and d. a trash can were equipped to have a lid. This affected 26 residents that resided in the facility.	C 391		

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C 391	Continued From page 8 Findings: A "Temperature Control Log" for the month of February 2024, did not contain documentation temperatures for the dish machine, refrigerator, freezer or hot food holder on seven of 28 days. A "Temperature Log", dated 02/19/24 through 02/25/24, did not contain documentation of food temperatures on the holding table for five of seven days. On 02/28/24 at 1:15 p.m., observations in the kitchen included: 1. Two packages of raw meat, labeled "Rump Roast", were in a pan of cool water inside the sink. The water faucet was not running. 2. Inside the three-door refrigerator: there were four pitchers of liquids that were not labeled, a container of cranberry juice did not have an opened date, two single-serve bowls of salad were not covered or labeled, and a package of hamburger meat labeled sell by 02/17/24 was a dark brown on one end. At 1:30 p.m., cook #2 was asked how the dish machine worked and if testing was completed to ensure proper chemicals and temperatures were maintained. Cook #2 stated, "I don't test anything, just know when it comes on. At 1:33 p.m., cook #2 was shown a brown substance on the inside ledge of the ice machine. Cook #2 stated, "That's gross", and they did not know if or when the ice machine was cleaned. Cook #2 was asked how raw, frozen meats should be thawed. They stated the meat should have been in the refrigerator but was not, so they placed it in a pan of water in the sink. Cook #1	C 391		

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C 391	Continued From page 9 was shown the contents of the refrigerator that were not covered, and/or labeled. They stated "We usually do but the labels must have washed off. The salads should have been thrown away." Cook #2 was asked how to determine if the hamburger meat was ok to serve. Cook #2 stated, "I wouldn't use the hamburger that is brown." They acknowledged the hamburger should have had labels regarding if it had been frozen and thawed and how long it had been in the refrigerator. On 03/5/24 at 10:30 a.m., a large trash can was positioned beside the stainless steel work station. The trash can did not have a lid and a lid was not observed to be near the trash can. On 03/05/24 at 11:00 a.m.,Cook #1 was asked if the trash can had a lid. They stated, "Not since I started here last October."	C 391		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a significant change of status	C 522		

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THE CHATEAU	6302 SOUTHWEST LEE BOULEVARD LAWTON, OK 73505

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C 522	Continued From page 10	C 522		

assessment for three (#1, #2, and #4) of four sampled residents reviewed for hospice and home health services.

The "Assisted Living Resident Condition and Care Overview", dated 02/28/24, documented one resident received hospice services and 18 residents received home health services.

The DON stated the facility census was 26.

Findings:

1. Resident #1 had diagnoses to include dementia, amnesia, and traumatic subdural hemorrhage.

An "Annual Assessment", dated 08/29/23, documented Resident #1 required one staff assist with bathing, eating, dressing, transfers, toileting, and ambulation, and the resident was on Home Health services.

A "Hospice POC Report", dated 02/28/24, documented hospice services were initiated on 10/11/23.

A significant change of assessment had not been completed prior to Resident #1's referral for hospice services.

On 03/06/24 at 10:00 a.m., the DON was asked if a significant change of condition assessment was completed prior to hospice services. They stated, "No."

2. Resident #2 had diagnoses to include basal cell carcinoma.

A "Fourteen Day Assessment", dated 10/26/23

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C 522	Continued From page 11	C 522		

documented Resident #2 required one person assistance for bathing, dressing, transfers, toileting, and ambulation, and was receiving home health services.

A "Care Plan Meeting" form, dated 02/28/24, documented the reason for the meeting was due to the resident now required, "...Higher level of care..."

A significant change assessment had not been completed prior to the care plan meeting on 02/28/24.

On 03/04/24 at 2:55 p.m., the DON stated a significant change assessment had not been completed prior to the care plan meeting.

3. Resident #4 had diagnoses to include cellulitis, dementia and diabetes mellitus.

A "Significant Change Assessment", dated 05/10/23, documented Resident #4 required a one person assistance for bating, dressing, transfers, toileting, and ambulation. The assessment documented Resident #4 was receiving additional treatments, procedures or other services.

A "Home Health Updated Plan of Care Report", dated 02/28/24, documented Resident #4 had home health services initiated on 02/09/24.

A significant change of status assessment had not been completed prior to Resident #4's referral for home health services.

On 03/06/24 at 10:15 a.m., the DON stated Resident #4 fluctuates with their decision for home health services and has been frequently on

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C 522	Continued From page 12 and off home health services. The DON stated significant change assessments were not completed.	C 522		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure water temperatures did not exceed 115 degrees F. The DON stated 26 residents resided in the facility. Findings: On 03/05/23 at 12:14 p.m., the following water temperatures were obtained: a. 121.4 degrees F in room 131, b. 122.1 degrees F in room 134, c. 121.2 degrees F in room 123, d. 124.1 degrees F in room 117, and e. 124.0 degrees F in room 109.	C 701		

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C 701	Continued From page 13 On 03/05/24 at 2:00 p.m., the House Supervisor stated the facility had recent plumbing repairs that required the water heaters to be emptied. They were not aware the temperatures were above the required levels and a system was not in place for additional monitoring after the plumbing repairs.	C 701		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 14	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure hand hygiene was conducted during medication administration for five (#7, 12, 13, 14, and #15) of five sampled residents observed during medication administration.

The DON stated 26 residents resided in the facility.

Findings:

On 03/01/24 at 7:20 a.m., without washing or sanitizing their hands, CMA #1 obtained a lidocaine pain patch, enter the room for Resident #12, remove an old patch from the resident's left hip, place the new patch on the resident's right hip, and dated the new patch. CMA returned to the medication cart.

On 03/01/24 at 7:30 a.m., without washing or sanitizing their hands, CMA #1 prepared medications for Resident #13, determined Resident #13 needed to receive medications after the breakfast meal, and placed the cup of medications in a drawer of the medication cart.

On 03/01/24 at 7:35 a.m., without washing or sanitizing their hands, CMA #1 prepared and administered medications to Resident #14. CMA #1 provided cues and reminders. With bare

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C1505	Continued From page 15	C1505		

hands, CMA #1 continued to encourage resident #14 to take a vitamin that was new to the resident. The resident continued to refuse and the medication was removed. The CMA returned to the medication cart and placed the vitamin in a cup, and gave the cup with the vitamin to the house supervisor. CMA #1 returned to the medication cart to review orders.

On 03/01/24 at 7:50 a.m., without washing or sanitizing their hands, CMA #1 entered the room for Resident #15, donned gloves, and administered insulin subcutaneously, then returned to the medication cart.

On 03/01/24 at 8:05 a.m., without washing or sanitizing their hands, CMA #1 prepared medications for Resident #7, and entered the resident room, and obtained a blood pressure. Resident #7 requested milk to be provided to take medications. Without washing or sanitizing their hands, or donning gloves, CMA #1 used their bare fingers to brush all of the pills and capsules into the medication cup, walk to the kitchen to request milk, return to the resident room, administer the medications, and return to the medication cart.

On 03/01/24 at 8:10 a.m., without washing or sanitizing their hands, CMA #1 obtained the cup of medications prepared earlier for Resident #13 and administered the medications.

CMA #1 did not wash or sanitize their hands during the medication pass provided to five residents observed during medication administration.

On 03/01/24 at 8:15 a.m., CMA #1 was asked what the facility policy was for washing or

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C1505	Continued From page 16 cleaning hands during medication administration. They stated should wash or use sanitizer after two residents. CMA #1 was asked if she had washed or sanitized their hands at any time during the medication administration. They stated, "No." On 03/01/24 at 1:20 p.m., the DON was informed of the observations during medication administration. They stated there is sanitizer and should be used between each resident with hands washed after the 3rd application of sanitizer.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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C5010	Continued From page 17	C5010		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to coordinate care with third party providers for:
a. a resident receiving hospice services and wound treatment for one (#1) of one sampled residents that received hospice services, and
b. residents that received home health services for increased level of care and wound treatments for three (#2, #4, and #6) of three sampled residents that received home health services.

The "Assisted Living Resident Condition and Care Overview", dated 02/28/24, documented one resident received hospice services, 18 residents received home health services, there are no pressure wounds in the building but five residents are receiving skin treatment for other skin conditions.

The DON identified the census was 26.

Findings:

1. Resident #1 had diagnosis to include dementia; traumatic subdural hemorrhage, and altered skin integrity.

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C5010	Continued From page 18 A "Hospice POC Report", documented Resident #1 was admitted to hospice services on 10/11/23. An "Annual Assessment", dated 08/29/24, documented Resident #1 was receiving home health care, there were no wounds and their skin was clean, dry and intact. An undated "Resident Roster" form provided by the facility on 02/28/24 did not identify Resident #1 to have wounds. The clinical record contained no documentation of communication or coordination of care between the facility and hospice. On 03/04/24 at 3:05 p.m., the DON was asked if Resident #1 had any open areas on their skin. They stated "I don't know." The DON was asked to show Resident #1's skin to the surveyor. The resident had a small open area on the left buttock and an undated dressing was in place on the left outer ankle. The DON stated they were not sure what caused the area on the ankle, but cannot remove the dressing per the facility policy. They stated hospice staff will be in to see the resident on 03/05/24. On 03/05/24 at 11:00 a.m., in the presence of the DON, staff assisted with Hospice to position resident for skin care. Resident #1 had a small open area on the left buttock that was not covered with a dressing. The Resident's left ankle had an undated dressing that was removed by the hospice LPN. The bony area of the outer left ankle had an open area approximately 1 inch across, with a darkened circumference of the outer tissue. The hospice LPN stated the area was red upon admit to hospice, the wound had not been staged by a physician, and Resident #1	C5010		

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C5010	Continued From page 19 does prefer to lie on their left side. On 03/06/24 at 10:00 a.m., the DON was asked how the provision of care provided by hospice staff was being monitored. They stated, "We have their plan of care." No further documentation was provided to support communication or coordination of care. 2. Resident #2 had diagnosis to include basal cell carcinoma, and dementia. A "Care Plan," dated 10/26/2,3 did not address hospice services A "Home Health Updated Plan of Care Report", documented Resident #2 was admitted to Home Health services on 01/10/24 and would continue through 03/09/24. The clinical record did not contain documentation of communication or coordination of care between the facility and home health staff. On 02/29/24 and 03/01/24, Resident #2 was observed to be seated in a blue geri-chair for the noon meals meals. On 03/06/24, the DON stated Resident #2 had been on home health for wound care but the wound has healed. The DON was unable to state why the resident continued to have home health services and stated Resident #2 required a higher level of care and waiting for a bed in long term care. 3. Resident #4 had diagnosis to include cellulitis, dementia, a history of a fall with a fracture, and an open wound to the left lower leg.	C5010		

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C5010	Continued From page 20 A "Care Plan", dated 11/03/23, had not been updated to address Resident #4 had been provided home health services. A "Home Health Update Plan of Care Report", documented Resident #4 was admitted to Home Health services on 02/09/24, for treatments to a wound on the left lower leg. The services were to be continued through 04/08/24. On 02/28/24 at 12:55 p.m., Resident #4 was observed in the common area, seated in a wheelchair. Resident #4 had black bruising to their right face and head. The clinical record did not contain documentation the facility had communicated or coordinated care with home health. On 03/06/24 at 1015 a.m., the DON stated Resident #2 is frequently on Home Health services per their request, and not certain why home health is in place at this time. 4. Resident #6 had diagnosis for ulcerative colitis, dementia, and a Stage-2 pressure ulcer of the right buttock. A "Home Health Updated Plan of Care Report", documented Resident #6 was admitted to Home Health services on 02/22/24, for a Stage-2 pressure ulcer of the right buttock. The clinical record did not contain documentation the facility had identified risks to the resident or implement a risk assessment prior to Home Health consultation and services added. On 03/01/24 at 10:15 a.m., the DON was	C5010		

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C5010	Continued From page 21 observed to perform a skin audit for Resident #6. Resident #6 had two open areas on the inside buttocks, one on each buttock that was approximately 0.25 inch wide and one inch long. The wounds appear to be in alignment with the open areas. The DON was asked how they coordinate care with home health. They stated the facility staff do weekly skin audits. The DON was asked if a resident has opened wounds, how does the facility provide monitoring to ensure the care is provided by a third party provider. The DON stated the outside providers are supposed to complete a communication form but that is not being done.	C5010		
C5015 SS=E	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	C5015		

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C5015	Continued From page 22 attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to initiate and update an accommodation of needs contract for:
a. a resident receiving hospice services and wound treatment for one (#1) of one sampled residents that received hospice services, and
b. residents that received home health services for increased level of care and wound treatments for three (#2, #4, and #6) of three sampled residents that received home health services.

The "Assisted Living Resident Condition and Care Overview", dated 02/28/24, documented one resident received hospice services and 18 residents received home health services.

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C5015	Continued From page 23 The DON identified the census was 26. Findings: 1. Resident #1 had diagnosis to include dementia; traumatic subdural hemorrhage, and altered skin integrity. An "Annual Assessment", dated 08/29/23, documented Resident #1 required one person assistance for bathing, eating, dressing, transferring, toileting, and ambulation, and received home health services. A "Hospice POC Report", documented Resident #1 was admitted to hospice services on 10/11/23. A "Plan of Accommodation", dated 10/11/23, read in parts, "...additional services will be provided...due to...condition consistent with discharge criteria...identify necessary intervention...medication, cognitive function and skin integrity...Home Health or Hospice referral to provide intermittent skilled care...Director of nursing...responsible for assuring compliance with the plan of accommodation. A Registered Nurse will review the plan of accommodation at least quarterly..." The Plan of Accommodation did not identify if Resident #1 required Hospice or Home Health Care. The clinical record did not contain documentation the Plan of Accommodation had been reviewed or updated quarterly. On 03/06/24 at 10:00 a.m., the DON stated Resident #1 had been changed from Home	C5015		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU	6302 SOUTHWEST LEE BOULEVARD LAWTON, OK 73505

(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
C5015	Continued From page 24 Health Services to Hospice services due to a significant change of condition. The DON stated they had not been aware the Plan of Accommodation was required. 2. Resident #2 had diagnosis to include basal cell carcinoma, and dementia. A "Home Health Updated Plan of Care Report", documented Resident #2 was admitted to Home Health services on 01/10/24. The clinical record did not contain documentation a Plan of Accommodation had been initiated. On 03/06/24, the DON stated Resident #2 required a higher level of care and a care plan meeting was conducted but no forms had been completed. 3. Resident #4 had diagnosis to include cellulitis, dementia, a history of a fall with a fracture, and an open wound to the left lower leg. A "Home Health Update Plan of Care Report", documented Resident #4 was admitted to Home Health services on 02/09/24. The clinical record did not contain a Plan of Accommodation contract. On 03/06/24 at 1015 a.m., the DON stated Resident #2 is frequently on Home Health services per their request, and forms had not been completed. 4. Resident #6 had diagnosis for ulcerative colitis, dementia, and a Stage-2 pressure ulcer of the right buttock.	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1603	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU	6302 SOUTHWEST LEE BOULEVARD LAWTON, OK 73505

(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
C5015	Continued From page 25 A "Home Health Updated Plan of Care Report", documented Resident #6 was admitted to Home Health services on 02/22/24. The clinical record did not contain a Plan of Accommodation contract. On 03/06/24 at 10:05 a.m., the DON stated they had not known of the required forms therefore, forms had not been completed.	C5015		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1603	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU	6302 SOUTHWEST LEE BOULEVARD LAWTON, OK 73505

(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
C6000	Continued From page 26 screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services.	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1603	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHATEAU	6302 SOUTHWEST LEE BOULEVARD LAWTON, OK 73505

(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
C6000	Continued From page 27	C6000		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a criminal history background and an offender registry check were updated upon re-hire for one (#4) of six staff reviewed for screening requirements.

The DON stated the facility census is 26.

Findings:

An OK-Screen form, dated 04/19/23, documentation a criminal history background check and an offender registry check had been completed for Staff #4.

An undated employee list provided by the facility, documented Staff #4 had been hired on 12/26/23.

On 03/06/24 at 9:50 a.m., the DON stated Staff #4 had worked at the facility, left for about six weeks and returned. They were not certain if an updated background check had been completed upon re-hire.

On 03/06/24 at 10:45 a.m., the House Supervisor stated Human Resources could not verify if the background checks had been updated at the time of rehire for Staff #4. They stated they did verify Staff #4 had actually returned as of 09/01/23.

No further information was provided.

OKLAHOMA
State Department
of Health

Delivery via email to: samghosn@gmail.com; angela1.chateau@gmail.com

April 11, 2024

License Number: AL1603

Mr. Sam Ghosn, Administrator
The Chateau
6302 Southwest Lee Boulevard
Lawton, OK 73505

Survey Event ID: DF1J11

Dear Mr. Ghosn:

On **March 6, 2024,** 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 **April 26, 2024**.

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,

Tempal Killman

Tempal Killman, 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: 3/27/2024** **Facility Name:** Chateau of Lawton **License Number:** AL 1603 **Survey Event ID:** DF1J11 **Date Survey Completed: 3/6/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C371	Based on: The facility failed to identify risks and implement a risk assessment for: (A) a resident receiving hospice services and wound treatment for one (1) of one sampled residents that received home health services for increased level of care and wound treatments for three (#2, #4, and #6) of three sampled residents that received home health services.

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?	All residents have been identified and level of care assessment form completed alon with change of assessment on all effected residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents will be monitored on a daily basis by nursing staff and report to LPN. All nursing staff inserviced 3/27/24 on reporting changes noted on residents to LPN in a prompt manner.
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?	Nursing staff will monitor residents and LPN & RN will update accordingly.
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.	Any changes will have a Risk assessment completed. LPN,House Supervisor and RN will monitor to make sure all assessments are current and up to date. A calendar log is being used , all residents that need to have assessments updated. LPN will communicate with nursing on any significant changes noticed on all residents. RN & LPN will review any significant changes on all residents and bring to Q&A meeting Quartly. Q&A notes will be maintained by House Supervisor to ensure all preventative measures are effective for all resident.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/26/2624
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. SAM CHOSN	**Date** Enter a date of signature.	3-27-2024

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/27/2024** **Facility Name:** Chateau of Lawton **License Number:** AL 1603 **Survey Event ID:** DF1J11 **Date Survey Completed: 3/6/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C372	Based on: The facility failed to ensure a written negotiation agreement was in place prior to initiating hospice or home health sevices for (a) a resident receiving hospice services and wound treatment for one (#1) of one sampled residents that received home health services and (b) residents that received home health services for increased level of care and wound treatments for three (#2, #4, and #6) of three sampled residents that received home healthy services.

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?	RN and LPN educated discussing the concern with the resident and representative to attempt to negotiate a written agreement while repecting resident preference. A level of care assessment form has been completed on all residents effected.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	LPN will monitor promtness and timeliness of assessments as well as when they are due, significant change and make appointment with resident and represenitive in a care plan meeting as respecting resient.
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?	LPN has created a calendar with all updated assessments that will need to be done and give to RN to be completed as well as reviewed to make sure that any significant changes are identified on all existing residents and monitor all new residents coming in are identified on a timely manner.
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.	LPN ,House Supervisor, and RN will monitor residents assessments and will keep up to date. The facility has a calendar log that allows LPN and RN to know the assessments needed and any significant changes that may a rise. RN and LPN will review significant changes, level of care assessments, on existing residents and new admits Quartely at Q&A meeting. Q&A notes will be maintained by House Supervisor to ensure residents are properly assessed.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		4/26/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) SAM GHOSN		**Date** Enter a date of signature. 3-27-2024	
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.			