OKLAHOMA
State Department of Health

Delivery via email to: samghosn@gmail.com; lisa.brookridge@gmail.com

November 17, 2025

License Number: AL1603

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

Survey Event ID: 4VWV11

Dear Mr. Ghosn:

On **October 28, 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: 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
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of Health

INVESTIGATIVE REPORT

Facility:	**The Chateau**
Address:	**6302 Southwest Lee Boulevard**
City, State, Zip:	**Lawton, OK, 73505**
Provider #:	**AL1603**
Complaint #:	**OK00080863**
Investigation Dates:	**10/27/25 through 10/28/25**

ALLEGATIONS
The center failed to protect residents from verbal and physical abuse.
The center failed to provide ADL assistance to dependent residents.
The center failed to protect residents' right to voice grievances without fear of retaliation.

An unannounced on-site investigation was initiated 10/27/2025 at 8:50 a.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:

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, and during medication pass. Staff members were observed answering call lights, administering medication, serving meals, and assisting residents with activities of daily living.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident council minutes, grievances, and in-services were reviewed.

Residents were interviewed regarding any concerns with abuse, staff providing required assistance, feeling safe in the facility, and knowledge for filing a grievance. Staff members were interviewed about providing assistance for residents with activities of daily living, knowledge of abuse and reporting, and process for filing a grievance.

OKLAHOMA
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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: 10/29/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Chateau of Lawton
Address: 6302 Southwest Boulevard
City, State, Zip: Lawton, OK., 73505
Provider #: AL1603
Complaint #: OK00085358
Investigation Date(s): 10/27/25 – 10/28/25

ALLEGATION(S)
The facility failed to ensure that residents were in a safe, clean, homelike condition.
The facility failed to provide a clean, sanitary environment free of offensive odors, mice excrements/urine, and insects.

An unannounced on-site investigation was initiated 10/27/2025 at 8:50 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed in their rooms, in common areas, during activities, and while receiving care. All units, common areas, dining areas, and the kitchen were observed for cleanliness and evidence of pests.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Facility policies and procedures were reviewed. Incident reports and grievance logs were reviewed. Housekeeping schedules were reviewed.

Residents were interviewed regarding any complaints or concerns regarding a clean environment and issues related to pests. Staff members were interviewed regarding housekeeping schedules. Staff were interviewed regarding pest control measures. The facility had no documentation of pest control invoices. Pest control invoices were requested and not provided.

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

OKLAHOMA
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Date report completed: 10/29/2025

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 10/28/2025

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
C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00080863 and #OK00085358) was conducted from 10/27/25 through 10/28/25. Deficiencies were cited as a result of the survey. Facility Census: 25 Listed below are abbreviations that will be used throughout this document. DON - director of nursing HR - human resources OSDH - Oklahoma State Department of Health PCA - patient care assistant	C 000		
C 391 SS=F	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 and interview, the facility failed to prevent conditions that could attract pests in kitchen. The administrator reported 25 residents resided in the facility. Findings: On 10/27/25 at 9:15 a.m., an initial tour was conducted in the kitchen. Food crumbs, plastic	C 391		

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C 391	Continued From page 1 utensils, and a whole onion were located under the shelves where dry goods were stored. On 10/27/25 at 9:15 a.m., the head cook was made aware of the observations. They stated the floors were swept and mopped daily. On 10/27/25 at 3:05 p.m., the administrator reported seasonal spraying for pest control was done at the facility and cubes for mice and rats were in place throughout the building.	C 391		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to OSDH for 1 (#1) of 3 sampled residents reviewed for abuse. The DON identified 25 residents resided in the facility. Findings: An undated policy titled "Reporting Suspected	C1914		

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C1914	Continued From page 2 Abuse or Misappropriation of a Resident's Property," showed all reports of allegations and incidents of resident abuse (either physical, emotional, or fiduciary), neglect, harassment, or mistreatment must be reported to the administrator/assistant administrator within 24 hours of occurrence or discovery. The policy showed an immediate investigation must be made with recommendations for corrective action within three working days. The policy showed a report would be made via facsimile or by telephone to the OSDH within one departmental business day of the reportable incident's discovery. A care plan, dated 12/31/24, showed Resident #1 required one staff assistance with activities of daily living. A 14-day comprehensive assessment, dated 01/14/25, showed Resident #1 was admitted to the facility on 12/31/24 with diagnoses which included macular degeneration and right hip contracture. The assessment showed the resident was alert and oriented to person, place, and time, was forgetful at times, and was hard of hearing. A home healthcare complaint investigation, dated 04/10/25, showed Resident #1 reported to a home healthcare worker an allegation of abuse by facility staff on 03/28/25. The investigation showed the home healthcare worker reported the abuse allegation to the home healthcare agency. The investigation showed the home healthcare agency and the facility's DON conducted an investigation with the resident on 04/03/25. The investigation showed the home healthcare agency reported the abuse allegation to the OSDH medical facilities on 04/11/25.	C1914		

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C1914	Continued From page 3 On 10/27/25 at 3:45 p.m., Resident #1 reported they had no complaints about abuse from staff members. The resident reported they were as nice to staff as they were to them. The resident reported being very hard of hearing. The resident reported staff provided assistance with activities of daily living when needed. The resident reported being independent most of the time. On 10/27/25 at 4:00 p.m., the DON reported not being aware of the resident's complaint until 04/03/25. The DON reported the complaint was investigated with the home healthcare agency regional clinical administrator and no abuse was found. The DON reported the home healthcare regional clinical administrator reported they were going to send the investigation results to the state. The DON reported trying to contact the state to get clarification if they needed to send in a state reportable for this incident and received no call back. The DON reported they had not reported since the home healthcare agency was reporting the incident.	C1914		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files.	C1972		

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C1972	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 1 (Cook #1) of 5 sampled employees whose records were reviewed for abuse training. The DON identified 25 residents resided in the facility. Findings: Cook #1's employee file was reviewed. The file showed a hire date of 02/06/25. There was no documentation available for abuse training in the employee's file. On 10/28/25 at 11:00 a.m., the HR staff member reported cook #1 had not received abuse training within 90 days of hire. The HR staff member reported the training should have been completed, but was not aware of why it had not been done.	C1972		
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	C5015		

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C5015	Continued From page 5 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 the resident; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an accommodation agreement was completed for: a. a resident that required injections performed	C5015		

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C5015	Continued From page 6	C5015		

by a third-party provider for 1 (#4) of 1 sampled resident reviewed for diabetic services; and

b. a resident requiring wound care by a third-party provider for 1 (#7) of 1 sampled resident reviewed for wound care.

The DON reported two residents in the facility required injections and two required wound care.

Findings:

An undated facility residency agreement showed the move-out/discharge criteria documented if there were resident needs that could not be met by in the facility and were better served in a different setting a move may be in order. The agreement showed their move-out decisions were made in consultation with family members and were based on whether the facility could continue to appropriately meet the residents' needs as their care needs changed with the progression of disease. The agreement showed the following criteria could result in a resident discharge: a. If the resident needs skilled nursing care for wounds the facility could not provide, and the needs could not be met by third party such as home health and b. If the resident needed skilled nursing care for diabetic needs the facility could not provide, and the needs could not be met by third party such as home health or hospice.

The facility had no policy for plan of accommodations.

1. A physician order for Resident #4, dated 10/06/25, showed the resident was to receive insulin injections and had a diagnosis of diabetes mellitus.

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C5015	Continued From page 7 Resident #4's clinical record was reviewed. A plan of accommodation was not located in the record regarding insulin injection services. On 10/27/25 at 3:30 p.m., the DON reported home health agencies provide insulin injections. The DON reported they were not aware a plan of accommodation was needed to reflect the services provided by the home health agency. 2. A plan of accommodation for Resident #7, dated 06/21/25, showed not to be specific for wound care and whom would perform the wound care. The plan of accommodation was not signed by the physician. A home health certification and plan of care, dated 10/02/25, showed Resident #7 had a stage 2 pressure ulcer to the coccyx which required home health to provide the skilled nursing treatment. The home health certification showed a skilled nurse was to cleanse with sterile normal saline, pat dry with 4 by 4, apply Medihoney (wound treatment) to wound bed, and over with bordered foam dressing one to two times weekly until healed. A significant change comprehensive assessment, dated 10/18/25, showed Resident #7 had diagnoses which included dementia and Alzheimer's disease and was admitted to the facility on 08/01/24. The assessment showed the resident was alert and oriented to person and place, the resident required one staff assistance with activities of daily living, and the resident required home health for special treatments. On 10/27/25 at 10:30 a.m., the DON reported Resident #7 required wound care that was conducted by the resident's home healthcare agency.	C5015		

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C5015	Continued From page 8 On 10/27/25 at 3:30 p.m., the DON reported not being aware a plan of accommodation was needed specific to the resident's wound care being performed by home health and that it was required to be signed by the resident's physician.	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 screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section.	C6000		

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C6000	Continued From page 9 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		

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C6000	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct an offender registry check and a criminal history background check upon hire for 1 (PCA #1) of 5 sampled employee files reviewed for required screenings. The DON identified 25 residents resided in the facility. Findings: An undated policy titled "Background Check," showed background checks of new employees would be conducted before the first day of assigned work. The policy showed background check results would be documented in the employee's file and kept confidential. PCA #1's employee file was reviewed. The file did not contain a criminal history background check or an offender registry check. The file showed a hire date of 05/01/25. On 10/28/25 at 11:00 a.m., HR staff reported no offender registry check or criminal history background check had been conducted for PCA #1. The HR staff member reported the checks should have been completed on hire and they were not aware why they had not been conducted.	C6000		

OKLAHOMA
State Department of Health

Delivery via email to: samghosn@gmail.com; lisa.brookridge@gmail.com

December 4, 2025

License Number: AL1603

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

Survey Event ID: 4VWV11

Dear Mr. Ghosn:

On **October 28, 2025,** a Relicensure survey with 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 in a timely manner. **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 10, 2025**.

We will conduct a revisit 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

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 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00080863 and #OK00085358) was conducted from 10/27/25 through 10/28/25. Deficiencies were cited as a result of the survey. Facility Census: 25 Listed below are abbreviations that will be used throughout this document. DON - director of nursing HR - human resources OSDH - Oklahoma State Department of Health PCA - patient care assistant	C 000		
C 391 SS=F	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 and interview, the facility failed to prevent conditions that could attract pests in kitchen. The administrator reported 25 residents resided in the facility. Findings: On 10/27/25 at 9:15 a.m., an initial tour was conducted in the kitchen. Food crumbs, plastic	C 391		

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C 391	Continued From page 1 utensils, and a whole onion were located under the shelves where dry goods were stored. On 10/27/25 at 9:15 a.m., the head cook was made aware of the observations. They stated the floors were swept and mopped daily. On 10/27/25 at 3:05 p.m., the administrator reported seasonal spraying for pest control was done at the facility and cubes for mice and rats were in place throughout the building.	C 391	Cleaning Log for daily	
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to OSDH for 1 (#1) of 3 sampled residents reviewed for abuse. The DON identified 25 residents resided in the facility. Findings: An undated policy titled "Reporting Suspected	C1914		

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C1914	Continued From page 2 Abuse or Misappropriation of a Resident's Property," showed all reports of allegations and incidents of resident abuse (either physical, emotional, or fiduciary), neglect, harassment, or mistreatment must be reported to the administrator/assistant administrator within 24 hours of occurrence or discovery. The policy showed an immediate investigation must be made with recommendations for corrective action within three working days. The policy showed a report would be made via facsimile or by telephone to the OSDH within one departmental business day of the reportable incident's discovery. A care plan, dated 12/31/24, showed Resident #1 required one staff assistance with activities of daily living. A 14-day comprehensive assessment, dated 01/14/25, showed Resident #1 was admitted to the facility on 12/31/24 with diagnoses which included macular degeneration and right hip contracture. The assessment showed the resident was alert and oriented to person, place, and time, was forgetful at times, and was hard of hearing. A home healthcare complaint investigation, dated 04/10/25, showed Resident #1 reported to a home healthcare worker an allegation of abuse by facility staff on 03/28/25. The investigation showed the home healthcare worker reported the abuse allegation to the home healthcare agency. The investigation showed the home healthcare agency and the facility's DON conducted an investigation with the resident on 04/03/25. The investigation showed the home healthcare agency reported the abuse allegation to the OSDH medical facilities on 04/11/25.	C1914	Policy – make copy Show were we f/u	

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C1914	Continued From page 3 On 10/27/25 at 3:45 p.m., Resident #1 reported they had no complaints about abuse from staff members. The resident reported they were as nice to staff as they were to them. The resident reported being very hard of hearing. The resident reported staff provided assistance with activities of daily living when needed. The resident reported being independent most of the time. On 10/27/25 at 4:00 p.m., the DON reported not being aware of the resident's complaint until 04/03/25. The DON reported the complaint was investigated with the home healthcare agency regional clinical administrator and no abuse was found. The DON reported the home healthcare regional clinical administrator reported they were going to send the investigation results to the state. The DON reported trying to contact the state to get clarification if they needed to send in a state reportable for this incident and received no call back. The DON reported they had not reported since the home healthcare agency was reporting the incident.	C1914		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files.	C1972	Policy on training	

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C1972	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 1 (Cook #1) of 5 sampled employees whose records were reviewed for abuse training. The DON identified 25 residents resided in the facility. Findings: Cook #1's employee file was reviewed. The file showed a hire date of 02/06/25. There was no documentation available for abuse training in the employee's file. On 10/28/25 at 11:00 a.m., the HR staff member reported cook #1 had not received abuse training within 90 days of hire. The HR staff member reported the training should have been completed, but was not aware of why it had not been done.	C1972		
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	C5015	already in place HH. Hospice - 3rd party	

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C5015	Continued From page 5 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 the resident; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an accommodation agreement was completed for: a. a resident that required injections performed	C5015		

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C5015	Continued From page 6	C5015		

by a third-party provider for 1 (#4) of 1 sampled resident reviewed for diabetic services; and

b. a resident requiring wound care by a third-party provider for 1 (#7) of 1 sampled resident reviewed for wound care.

The DON reported two residents in the facility required injections and two required wound care.

Findings:

An undated facility residency agreement showed the move-out/discharge criteria documented if there were resident needs that could not be met by in the facility and were better served in a different setting a move may be in order. The agreement showed their move-out decisions were made in consultation with family members and were based on whether the facility could continue to appropriately meet the residents' needs as their care needs changed with the progression of disease. The agreement showed the following criteria could result in a resident discharge: a. If the resident needs skilled nursing care for wounds the facility could not provide, and the needs could not be met by third party such as home health and b. If the resident needed skilled nursing care for diabetic needs the facility could not provide, and the needs could not be met by third party such as home health or hospice.

The facility had no policy for plan of accommodations.

1. A physician order for Resident #4, dated 10/06/25, showed the resident was to receive insulin injections and had a diagnosis of diabetes mellitus.

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C5015	Continued From page 7 Resident #4's clinical record was reviewed. A plan of accommodation was not located in the record regarding insulin injection services. On 10/27/25 at 3:30 p.m., the DON reported home health agencies provide insulin injections. The DON reported they were not aware a plan of accommodation was needed to reflect the services provided by the home health agency. 2. A plan of accommodation for Resident #7, dated 06/21/25, showed not to be specific for wound care and whom would perform the wound care. The plan of accommodation was not signed by the physician. A home health certification and plan of care, dated 10/02/25, showed Resident #7 had a stage 2 pressure ulcer to the coccyx which required home health to provide the skilled nursing treatment. The home health certification showed a skilled nurse was to cleanse with sterile normal saline, pat dry with 4 by 4, apply Medihoney (wound treatment) to wound bed, and over with bordered foam dressing one to two times weekly until healed. A significant change comprehensive assessment, dated 10/18/25, showed Resident #7 had diagnoses which included dementia and Alzheimer's disease and was admitted to the facility on 08/01/24. The assessment showed the resident was alert and oriented to person and place, the resident required one staff assistance with activities of daily living, and the resident required home health for special treatments. On 10/27/25 at 10:30 a.m., the DON reported Resident #7 required wound care that was conducted by the resident's home healthcare agency.	C5015		

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C5015	Continued From page 8 On 10/27/25 at 3:30 p.m., the DON reported not being aware a plan of accommodation was needed specific to the resident's wound care being performed by home health and that it was required to be signed by the resident's physician.	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 screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section.	C6000	Policy	

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C6000	Continued From page 9 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		

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C6000	Continued From page 10	C6000		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to conduct an offender registry check and a criminal history background check upon hire for 1 (PCA #1) of 5 sampled employee files reviewed for required screenings.

The DON identified 25 residents resided in the facility.

Findings:

An undated policy titled "Background Check," showed background checks of new employees would be conducted before the first day of assigned work. The policy showed background check results would be documented in the employee's file and kept confidential.

PCA #1's employee file was reviewed. The file did not contain a criminal history background check or an offender registry check. The file showed a hire date of 05/01/25.

On 10/28/25 at 11:00 a.m., HR staff reported no offender registry check or criminal history background check had been conducted for PCA #1. The HR staff member reported the checks should have been completed on hire and they were not aware why they had not been conducted.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11-21-2025** **Facility Name:** The Chateau of Lawton **License Number:** AL 1603 **Survey Event ID:** 4VWV11 **Date Survey Completed:** 10/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1972 SS=D	**Based on:** record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 1 (cook #1) of 5 sampled employees whose records were reviewed for abuse training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Matter has already been corrected).

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?	New Hire Policy in place for all new employees. No employee will be put onto schedule until the new hire employee check list is completed and that includes "Resident Abuse/Neglect Policy and Prodedure".
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	H.R. will doing all checks herself and ensure everything is completed before a new employee is put onto schedule.
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?	H.R. will be handling checks herself and will assure all documents, forms and training are completed before putting on schedule
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.	H.R. will ensure the Employee Packet checklist is completed before allowing new employees to start at the facility. If the employee packet is missing anything then they will not be a candidate for our facility until the packet checklist is fully completed and this will be done by H.R.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Dec 10, 2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	Sam Choen	**Date** Enter a date of signature.	11-21-2025

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.

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.

POLICY AREA	Employment
TITLE OF POLICY	3.64 New Hire Policy
REGULATORY REFERENCE (if any)	
EFFECTIVE/REVISED DATE	11/5/2025

POLICY: The Chateau of Lawton will ensure qualified employees will be required to complete a new hire packet with required information before being allowed to begin working.

PROCEDURE:

1. Application to be completed with copy of driver's license and social security card to be included.
2. Background check needs to be completed on new hire though OKScreen.
    a. If fingerprinting is determined necessary for an employee to continue the background check, an employee must complete IdentoGO fingerprinting services, off site, prior to start date.
3. Employee packet includes the following:
    a. W-4
    b. State withholding
    c. Direct deposit authorization
    d. Oklahoma new hire reporting form
    e. Brookridge new hire information form
    f. Employment eligibility verification form (I-9)
    g. Resident abuse/ neglect policy and procedure- training and signature pages
    h. Resident rights sheet
    i. Hepatitis b exposure sheet
    j. Employee policy sheet
    k. Compensation form
    l. Call-in policy
    m. HIPPA information and testing packet
    n. Bloodborne pathogens and test packet
4. Each employee should also complete testing of:
    a. TB test- preformed on job site by director of nursing
    b. CPR/ First Aid certification- completed by nationalcprfoundation.com
    c. Food handler's license- completed by efoodtrainer.com
        i. Excluding housekeeping and maintenance positions.
5. A monthly employee audit will be performed by HR.
    a. HR will keep an up to date spreadsheet showing compliance.
    b. If an employee is shown not to be in compliance, they will be taken off the schedule until all items are up to date.

Each employee must complete the following before being released to position of hire.

Revised 12/15/24 TR

Brookridge Employee Packet Checklist

Name:	**Department:**
Hire Date:	**Seperation Date:**

		Comments
Application/Resume		
Drivers Licence		
Social Sercurty Card		
Background Check		
Consent and Release Form		
Final Results		
Letter of Clearance		
W-4 (give to payroll)		
Withholding Oklahoma		
New Hire Reporting		
New Hire Information		
I-9 Form		
EMPLOYEE PACKET		
Resident Abuse/Neglect		
Signature page		
Signed Compensation Form		
Privacy, Confidentialy/HIPPA		
HIPPA Test		
Resident Rights		
Blood Pathogens		
Test		
Hepatitis B Exposure		
Call In Policy		
Parking/Smoking Policy		
License		
TB Test - Annual		
CPR/1st Aid Certification		
Food Handlers Certification		
		License and certifications are filed by expiration dates.

BROOKRIDGE

Resident Abuse/Neglect Policy and Procedure

Policy: It is the policy of this facility to ensure all residents are free from mistreatment, neglect, abuse and misappropriation of resident property. The facility also ensures it will obtain the history of any potential resident form family/referring agency to detect the possibility of unusual behavior patterns for consideration of admission.

Procedure: The facility will implement the seven (7) components as required to obtain compliance.

1) **Screening:** The facility will perform screening of all prospective non-licensed personnel by providing the bureau the information to conduct a criminal arrest check. Brookridge offers temporary employment until the arrest check can be complete. The facility informs the prospective employee that relevant information relating to him/her will be forwarded to the bureau within 72 hours after the date of the accepted temporary employment. Brookridge does not hire on permanent basis until results of an arrest is received. The bureau will conduct a criminal arrest check within 5 days of receiving the request. If the results of a check reveal that the subject person has been convicted of the following offenses:

A) ASSAULT, BATTERY, OR ASSAULT & BATTTERY WITH A DANGEROUS WEAPON

B) AGGRAVATED ASSAULT & BATTERY

C) MURDER OR ATTEMPTED MURDER W/A DANGEROUS WEAPON

D) MANSLAUGHTER, EXCEPT INVOLUNTARY MANSLAUGHTER

E) INDECENT EXPOSURE AND INDECENT EXHIBITING

F) CHILD ABUSE

G) PANDERING

H) ABUSE, NEGLECT, OR FINANCIAL EXPLOITATION OF ANY PERSON ENTRUSED TO HIS/HER CARE OR POSSESSION

I) BURGLARY IN THE FIRST OR SECOND DEGREE

J) ROBBERY IN THE FIRST OR SECOND DEGREE

K) ROBBERY OR ATTEMPTED ROBBERY WITH A DANGEROUS WEAPON OR INITIATION FIREARM

L) ARSON IN THE FIRST OR SECOND DEGREE

M) UNLAWFUL POSSESSION OR DISTRIBUTION, OR INTENT TO DISTRIBUTE UNLAWFULLY, SCHEDULE 1 THRU V DRUGS AS INDETIFIED BY THE UNIFORM CONTROLLED DANGEROUS SUBTANCES ACTS

N) GRAND LARCENY OR:

O) PETTY LARCENY OR SHOPLIFTING WITHIN THE PAST SEVEN (7) YEARS

BROOKRIDGE INC. MAY ALSO OBTAIN INFORMATION FROM FORMER EMPLOYERS AND/OR CURRENT EMPLOYERS OR OBTAIN INFORMATION FROM TH PROPER LICENSING AGENCIES OR REGISTRIES

2) Training: Potential employees will be given the information pertaining to abuse upon hire and periodically thereafter. The facility will have in-service periodically to ensure all staff knows the procedures for reporting, recognizing, and free from reprisal.

3) Prevention: The facility will give the family/staff information on how and whom they may report concerns to such as incidents and grievances without fear of retribution. Staff has and will continue to be informed that no staff member is exempt from being reported. The facility will monitor residents with behaviors that might constitute conflict or anger towards another resident, such residents will be moved away from other residents, MD and family contacted, and possibly transferred to outside facility for further evaluation. The facility ansures the resident/family staff a safe home environment and free from harm's way

The facility has implemented a system for staff reporting of suspicious occurrences, bruising of unknown origin, pattern and trending. An incident report will be made and turned into the facility RN for further investigation on probable cause for harm. The facility will treat alleged violations just the same. All allegations will also be turned into the proper agencies. If the investigation concludes a staff member is responsible, reports will be made to the nurse registry, nursing board, licensing board or proper agencies. Staff member will be terminated. In the event the investigation is a resident to resident situation the resident in question will be either moved away from other residents or MD order will be obtained to send for further

evaluation. MD will be notified. The families of all residents involved will be notified and assured the safety of their family member from harm's way.

4, 5, 6) Identify, Investigate and Protect: The facility has implemented a system for staff reporting of suspicious occurrences, bruising of unknown origin, pattern, and trending. An incident report will be made and turned in to the facility RN for further investigation on probable cause for harm. The facility will treat alleged violations just the dame. All allegations will also be turned in to the proper agencies. If the investigation concludes a staff member is responsible, reports will be made to the proper agencies. Staff member will be terminated. In the event the investigation is a resident to resident situation, the resident in question will be either moved away from other residents or MD order will be obtained to send for further evaluation. MD will be notified. The families of all residents involved will be notified and assured the safety of their family member from harm's way.

7) Reporting/Response: The facility will assure alleged incidents and substantiated incidents are turned into the proper state agencies and all necessary action will be taken concluding the investigation.

The facility will also review policies and procedures, interventions QA minutes to assure all preventative measures have been taken and compliance is met.

Resident Abuse/Neglect Policy and Procedure

Employee Acknowledgement Form

I have received, read and understand The Resident Abuse/Neglect Policy and Procedure (Attached)

_____ _____

Employee Signature Employee Name (Print)

_____

Date

BROOKRIDGE

7802 NW Quanah Parker Trailway

Lawton, Oklahoma 73505

(580)-536-9700

BROOKRIDGE

Compensation Form

BrookRidge employees cannot accept any compensation from residents for work done on or off the clock. Accepting money from residents for work or favors can result in the termination of your employment at BrookRidge.

BrookRidge employees cannot enter the facility off the clock to provide care or perform any favors for the residents without written permission from Sam.

Thank you for cooperating with BrookRidge company policy.

I, _____ (PRINT NAME), certify that I have read and acknowledge this BrookRidge company policy.

_____ _____

Employee Signature Date

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11-21-2025** **Facility Name:** The Chateau of Lawton **License Number:** AL 1603 **Survey Event ID:** 4VWV11 **Date Survey Completed:** 10/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C6000 SS=D	**Based on:** Record review and interview, the facility failed to conduct an offender registry check and a criminal history background check upon hire for 1 (PCA #1) of 5 sampled employee files reviewed for required screening.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Matter has already been corrected).

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?	New Hire Policy in place for all new employees. No employee will be put onto schedule until the offender registry and criminal background checks are back..
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	H.R. will doing all background and registry checks herself and ensure everything is back before a new employee is put onto schedule.
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?	H.R. will be handling all registry and background checks herself and will assure all documents, forms and training are completed before putting on schedule
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.	H.R. will ensure the Employee Packet checklist is completed before allowing new employees to start at the facility. If the employee packet is missing anything then they will not be a candidate for our facility until the packet checklist is fully completed and this will be done by H.R.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Dec 10, 2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	Sam Lhosn	**Date** Enter a date of signature.	11-21-2025

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.

Items Below Are For OSDH Use Only

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