OKLAHOMA
State Department
of Health

Delivery via email to: mharper@moradalawton.com

December 12, 2024

License Number: AL1602

Mr. Micah Harper, Administrator
Morada Lawton
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: O9G411

Dear Mr. Harper:

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

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00067312**
Investigation Date(s): **12/02/24, 12/03/24, 12/04/24, and 12/06/24**

ALLEGATION(S)
The center failed to ensure food was served under sanitary conditions.
The center failed to ensure an effective pest control program and failed to ensure a clean, comfortable and homelike environment

An unannounced on-site investigation was initiated 12/02/2024 at 8:00 a.m.

A sample of seven 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 was conducted upon entrance to include the assisted living kitchen and dining area. Residents were observed in the dining area finishing up breakfast. Staff were observed cleaning the tables in the dining area and common areas of the center. Staff were observed assisting residents with musical activities, exercise, and dining services. Staff were observed plating meals for lunch. Observed staff deliver covered meals to the memory care unit and to resident rooms in assisted living. Pest control measures observed at the center and no bugs were observed during survey.

Menus, assessments, and care plans were reviewed. Physician orders were reviewed. Resident contracts and food service training records were reviewed. In-service training records were reviewed. Pest control records were reviewed and invoices reviewed.

Staff were interviewed related to dementia training and food service delivery. Resident and resident families were interviewed related to food and voiced no concerns.

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
State Department
of Health

Date report completed: 12/09/2024

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INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00067850**
Investigation Date(s): **12/02/24, 12/03/24, 12/04/24 and 12/06/24**

ALLEGATION(S)
The center failed to ensure interventions were in place to prevent falls.
The center failed to ensure residents were provided assistance with ADL care.

An unannounced on-site investigation was initiated 12/02/2024 at 8:00 a.m.

A sample of seven 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 was conducted throughout the survey in the assisted living and on the memory care unit. Residents were observed in the dining area finishing up breakfast. Staff were observed in the dining area and common areas of the center. Staff were observed assisting residents with musical activities, exercise, and dining services. Staff were observed rounding and providing assistance for incontinent care. Fall prevention mats were in place for residents at high risk for falls.

Physician orders, assessments, and care plans were reviewed. Staffing schedules and credentials for both certified medication aides and advanced certified medication aides were reviewed. In-service training records were reviewed. Fall risk assessments were reviewed. Incident reports and state reportable events were reviewed.

Staff were interviewed related to fall precautions and residents were observed fully dressed with socks and shoes. Families were interviewed via telephone and in person related to care and voiced no concerns. Residents voiced no concerns.

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: 12/09/2024

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00068056**
Investigation Date(s): **12/02/24, 12/03/24, 12/04/24, and 12/06/24**

ALLEGATION(S)
The facility failed to ensure residents were served palatable meals and that staff followed sanitation policies and procedures.
The facility failed to provide a clean and sanitary environment.
The facility failed to ensure residents were not left soiled and wet for extended periods.

An unannounced on-site investigation was initiated 12/02/2024 at 8:00 a.m.

A sample of seven 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 was conducted throughout the survey in the assisted living and on the memory care unit. Residents were observed in the dining area finishing up breakfast. Staff were observed in the dining area and common areas of the center. Staff were observed assisting residents with musical activities, exercise, and dining services. Staff were observed providing care and providing incontinent rounds on the memory care unit.

Physician orders, assessments, and care plans were reviewed. Staffing schedules and credentials for both certified medication aides and advanced certified medication aides were reviewed. In-service training records were reviewed. Treatment administration records for care were reviewed. Menus, assessments, and care plans were reviewed. Resident contracts and food service training records were reviewed.

Staff were interviewed related to policy and procedure for incontinent care and checks. Families were interviewed related to incontinent care, falls, and medications and voiced no concerns.

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

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Date report completed: 12/09/2024

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INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00068892**
Investigation Date(s): **12/02/24, 12/03/24, 12/03/24, and 12/06/24**

ALLEGATION(S)
The center failed to ensure adequate staff to meet the needs of the residents and failed to ensure call lights were answered in a timely manner.

An unannounced on-site investigation was initiated 12/02/2024 at 8:00 a.m.

A sample of seven 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 was conducted throughout the survey in the assisted living and on the memory care unit. Residents were observed in the dining area finishing up breakfast. Staff were observed in the dining area and common areas of the center. Staff were observed assisting residents with musical activities, exercise, and dining services. Staff were observed providing care and providing incontinent rounds on the memory care unit.

Physician orders, assessments, and care plans were reviewed. Staffing schedules and credentials for both certified medication aides and advanced certified medication aides were reviewed. In-service training records were reviewed. Treatment administration records for care were reviewed.

Staff were interviewed related to policy and procedure for incontinent care and checks. Families were interviewed related to incontinent care, falls, and medications and voiced no concerns.

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: 12/09/2024

OKLAHOMA
State Department
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INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Southeast Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00073438**
Investigation Date(s): **12/02/24, 12/03/24, 12/04/24 and 12/06/24**

ALLEGATION(S)
The center failed to ensure medications were administered according to the physicians' orders and failed to ensure qualified staff administered medications
The center failed to ensure medications were not misappropriated.

An unannounced on-site investigation was initiated 12/02/2024 at 08:00 a.m.

A sample of seven 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 was conducted throughout the survey in the assisted living and on the memory care unit. Residents were observed in the dining area finishing up breakfast. Staff were observed in the dining area and common areas of the center. Staff were observed assisting residents with musical activities, exercise, and dining services. A medication pass was observed with staff.

Physician orders, assessments, and care plans were reviewed. Staffing schedules and credentials for both certified medication aides and advanced certified medication aides were reviewed. In-service training records were reviewed. Medication handling policy and procedure was reviewed. Medication administration records were reviewed. Narcotic records were reviewed during medication pass and random narcotic counts were conducted. In-services related to medication ordering and policy were reviewed.

Staff were interviewed related to policy and procedure for handling medications and narcotics. Families were interviewed related to medications and voiced no concerns.

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
State Department
of Health

Date report completed: 12/09/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Southeast Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00074083**
Investigation Date(s): **12/02/24, 12/03/24, 12/04/24 and 12/06/24**

ALLEGATION(S)
The facility failed to ensure a door was secure, and provide supervision to prevent an elopement.

An unannounced on-site investigation was initiated 12/02/2024 at 8:00 a.m.

A sample of seven 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 was conducted throughout the survey in the assisted living and on the memory care unit. Residents were observed in the dining area finishing up breakfast. Staff were observed in the dining area and common areas of the center. Staff were observed assisting residents with musical activities, exercise, and dining services. A medication pass was observed with staff. Staff were observed providing rounds for incontinent care.

Incident reports, assessments, and care plans were reviewed. Physician orders were reviewed. Resident contracts and staffing schedules were reviewed. In-service training records were reviewed. Elopement and care plan policy and procedures were reviewed. Visitor sign in logs were reviewed. Elopement drill and risk assessments were reviewed. Treatment administration records were reviewed.

Staff were interviewed related to dementia training and elopement procedures. Staff explained elopement policy and procedures. Resident and resident families were interviewed related to care services and voiced no concerns.

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: 12/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS Complaint investigations (#OK00067312, OK00067850, OK00068056, OK00068892, OK00073438, and #OK00074038) were conducted on 12/02/24, 12/03/24, 12/04/24, and 12/06/24. Facility Census: 80 Listed below are abbreviations that will be used throughout this document. AL - assisted living CMA - certified medication aide CNA - certified nurse aide DSC - dietary service coordinator etc - et cetera HCL - hydrochloric acid HWD - health and wellness director MAR - medication administration record mg - milligram NMDA - N-methyl-D-asparate tab - tablet VS - vital signs	C 000		
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 and interview, the center failed to ensure the kitchen was maintained to promote food safety and sanitation. The HWD identified 80 residents resided in the	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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 391	Continued From page 1 assisted living center. Findings: On 12/02/24 at 8:10 a.m., a tour of the kitchen was conducted. The following observations were made: a. there was a trash can in the kitchen area without a lid, b. there was a scoop noted inside of the flour, c. there was a scoop (wet) on top of the ice machine, and d. two boxes of thickened liquid were stored on the floor. On 12/02/24 at 11:43 a.m., CNA #2 was observed plating soup for lunch with their hair outside of the hairnet. They reported their hair would always fall outside of the hair net. On 12/16/24 at 10:15 a.m., DSC reported corporate was still updating dietary policy and procedures. They reported the policy was to wear hair nets when preparing foods and store boxes six inches off the floor. The policy was not to store ice scoops on the top of the ice machine or store scoops inside of the flour. They stated they have an ice scoop on the wall, but if they used the big one it was supposed to go through the dishwasher. They stated the ice scoop should be covered. They reported the trash can should also be covered.	C 391		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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 552	Continued From page 2 The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to update and revise a plan of care related to an elopement for one (#4) of one resident reviewed for elopement. The HWD identified 16 residents resided in the memory care unit. Findings: An "Assessment/Service Plan" policy, dated 07/01/21, read in part, "Service plan: A written description of the medical care, supervision, or nonmedical care needed by a resident. Procedure Resident/Responsible Party: The Resident and/or Responsible Party will participate in each Assessment and the development of their Service Plan. Staff: The Staff will review and follow the Service Plan developed by the Community and Resident and/or Responsible Party." An "Elopements" policy, dated 06/07/24, read in part, "If the resident's physician deems the resident can remain in the Community, the resident's Plan of Care will be adjusted, and all changes immediately implemented to prevent further elopements."	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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 552	Continued From page 3 Resident #4's plan of care, dated 06/01/24, listed nothing on the care plan related to elopement. Resident #4's "Elopement Risk Evaluation Assessment", dated 06/13/24, documented an overall score of 40. Guidelines for interpreting scores: 40 and above high risk for elopement. Resident #4's "Incident Report Form", dated 11/25/24, documented the resident was seen knocking on egress door at the end of 200 hall around 3:20 a.m. It documented the resident was let in by AL staff, VS obtained and they were walked back to memory care. It documented the resident was placed on hourly checks. A treatment administration record, dated November 2024, documented: a. assist with frequent checks every one hour until 11/28/24 for safety/location 6:00 a.m.-1:30 p.m. November 25th through November 28th for day shift were blank and contained no staff initials, b. assist with frequent checks every one hour until 11/28/24 for safety/location 2:00 p.m.-9:30 p.m. November 25th through November 28th for evening shift and contained no staff initials, and c. assist with frequent checks every one hour until 11/28/24 for safety/location 10:00 p.m.-5:30 a.m. November 25th through November 27th were blank for night shift and November 28th was the only night that had been initialed by the staff. On 12/02/24 at 8:42 a.m., the HWD reported they did not have hourly rounding sheets. They reported staff only signed off once per shift for the hourly rounding performed. The HWD agreed that one hour charting was not documented per shift. The treatment administration record did not	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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 552	Continued From page 4 document the staff had rounded on the resident hourly. They reported the plan of care was not updated or revised after the elopement on 11/25/24.	C 552		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to notify the responsible family member/person in case of an emergency as outlined in the service contract for one (#4) of one resident reviewed for elopement. The administrator identified 16 residents resided in the memory care unit. Findings.	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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
C1304	Continued From page 5 Resident #4's, "Assisted Living Residency Agreement", dated 05/13/24, read in part, "Health Care Provider Authorization. You agree to allow us to contact a responsible family member/person, health care provider, or any designated person listed in your records: (1) if it is necessary in our judgment to advise them of your situation, (2) to arrange for required health care services and assistance or (3) in case of an emergency." An "Elopements" policy, dated 06/07/24, read in part, "Residents will be screened prior to admission for significant elopement risk. The policy also read, "Notify the resident's family and/or responsible party." The policy also read, "If the resident's physician deems the resident can remain in the Community, the resident's Plan of Care will be adjusted, and all changes immediately implemented to prevent further elopements." Resident #4's "Elopement Risk Evaluation Assessment" dated 06/13/24, documented an overall score of 40. Guidelines for interpreting scores: 40 and above high risk for elopement. Resident #4's "Incident Report Form", dated 11/25/24, documented the resident was seen knocking on egress door at the end of 200 hall around 3:20 a.m. It documented the resident was let in by AL staff, VS obtained and they were walked back to memory care. It documented the resident was placed on hourly checks. On 12/03/24 at 12:14 p.m., Resident #4's family member was contacted via telephone and was asked about Resident #4's elopement. They reported the resident was locked in the memory care unit and could not get out. They were not	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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
C1304	Continued From page 6 aware of the Resident's 4's elopement or about the resident following anyone out of the center. On 12/03/24 at 12:57 p.m., the HWD was asked who notified the responsible family member for the elopement on 11/25/24. They reported CMA #3 documented a time the family member was contacted, but there was no response documented. On 12/06/24 at 10:50 a.m., the HWD reported CMA #3 called the family member related to the elopement and reported there was no way to leave a message on the phone, so they actually did not speak with Resident #4's family member.	C1304		
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	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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
C1505	Continued From page 7 medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the center failed to: a. ensure availability of medications for administration for one (#3) of two sampled residents reviewed for medications; and b. ensure infection control measures were maintained during medication administration for one (#3) of two sampled residents reviewed for medications. The HWD identified 80 residents resided in the center. Findings: A "Medication Handling" policy, dated 06/07/24, read in part, "If a medication is contaminated (such as being dropped, getting wet, etc.) note the contamination on the MAR. a. Use the next available dose. b. Contact the pharmacy for a	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

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C1505	Continued From page 8	C1505		

replacement medication if necessary."

A "Medication Orders" policy, dated 06/07/24, read in part, "Complete physician's orders will be received for all medications stored, administered, and/or provided with assistance to residents."

A "Medication Services" policy, dated 06/07/24, read in part, "Have the ability to provide twenty-four (24) hour emergency service including delivery of medications seven (7) days a week. The policy also read, "The Community's preferred pharmacy will be used in the event that medications are needed on an emergency basis when the resident's pharmacy of choice is unable to provide them."

Resident #3 had diagnoses which included unspecified dementia with behavioral disturbance, repeated falls, and pain in left knee.

A "Physician Order", dated 08/19/24, documented memantine (NMDA antagonist)tab HCL 10 mg take 1 tablet by mouth 2 times a day.

A "Medication Administration Record", dated November 2024, documented 14 doses of physician ordered medications were not administered.

A "Medication Administration Record", dated December 2024, documented 35 doses of physician ordered medications were not administered. Resident #3 had been out of memantine 10 mg for three days.

On 12/02/24 at 9:35 a.m., a medication pass was observed with CMA #1 and Resident #3. CMA #1 dropped resident's quetiapine (antipsychotic medication) 12.5 mg on the medication cart and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(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
C1505	Continued From page 9 picked it up with their long finger nails. Resident #3 did not receive memantine on 12/02/24 as physician ordered. CMA #1 reported they documented it was not on the medication cart and reported they should not have just picked up the medication with their hands. On 12/04/24 at 11:53 a.m., HWD verified Resident #3's missed doses of medication for November and December 2024. They reported the medication should have been mail ordered or delivered from the hospice agency depending on the medication. They reported there was no system in place to get medications if their pharmacy did not deliver.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: MICAH HARPER <mharper@moradalawton.com>

January 2, 2025

License Number: AL1602

Mr. Micah Harper, Administrator
Morada Lawton
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: O9G411

Dear Mr. Harper:

On **December 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 **February 14, 2025**.

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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/26/2024** **Facility Name:** Morada Lawton **License Number:** AL1602 **Survey Event ID:** O9G411 **Date Survey Completed: 12/6/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: Based on observation and interview, the center failed to ensure the kitchen was maintained to promote food safety and sanitation.

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?	On 12/18/24, DCS educated dining staff specific to use of hairnets, food storage, covering trash can and proper storage of scoops. In-service documentation includes excerpts from Chapter 257 and signatures of staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Center will provide re-education to dining staff through an in-service related to citation and daily (Sunday, Monday, Thursday, Friday and Saturday) rounds conducted by DCS or designee. DCS will report observations to ED during 1:1.
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.	ED or designee will review rounds weekly monitoring for trends for a period of 4 weeks and on a monthly basis after compliance is met. Those rounding sheets will be housed in a special binder marked "Dining Rounds". Findings will be discussed at the quarterly QA meeting. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/14/2025
OSDH Response: Element accepted Yes ☑ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/26/2024**

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: 12/26/2024
Facility Name: Morada Lawton
License Number: AL1602
Survey Event ID: O9G411
Date Survey Completed: 12/6/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552	Based on: Based on record review and interview, the center failed to update and revise a plan of care related to an elopement for one (#4) of one resident reviewed for elopement.

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?	Divisional Director of Resident care provided education to HWD on 12/20/24 regarding elopement policy and documentation. HWD to review care plans of memory care residents specific to elopement score and will update care service plans accordingly. This will be accomplished by 1/10/24.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Within 24 hours of elopement/event the resident will be reassessed and careplan updated for wandering and elopement risk, along with interventions. Elopement Risk Evaluation will be completed within 24 hours.
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.	ED or designee will review weekly monitoring for trends for a period of 4 weeks and on a monthly basis after compliance is met. Those reviews will be housed in a special binder marked "Plan of Care". Findings will be discussed at the quarterly QA meeting. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/14/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. **Date 12/26/2024**
OAC 310:663-25-4(F)

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.
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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: 12/26/2024** **Facility Name:** Morada Lawton **License Number:** AL1602 **Survey Event ID:** O9G411 **Date Survey Completed: 12/6/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: Based on record review and interview, the center failed to notify the responsible family member/person in case of an emergency as outlined in the service contract for one (#4) of one resident reviewed for elopement.

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?	On 1/3/24, HWD will educate clincal staff specific to voice-to-voice reporting of incidents to responsible parties. In-service documentation includes excerpts from Morada's Clinical Policy on Incident Reporting and signatures of staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Center will provide re-education to clinical staff regarding incident reporting to responsible parties. HWD will review all incident reports and note compliance of having voice-to-voice notification with responsible party
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.	ED or designee will review weekly monitoring for trends for a period of 4 weeks and on a monthly basis after compliance is met. Those reviews will be housed in a special binder marked "Incident Notifications". Findings will be discussed at the quarterly QA meeting. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/14/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/26/2024**

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.

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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: 12/26/2024** **Facility Name:** Morada Lawton **License Number:** AL1602 **Survey Event ID:** O9G411 **Date Survey Completed: 12/6/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on observation, record review and interview the center failed to: a. ensure availability of medications for administration for one (#3) of two sampled residents reviewed for medications; and b. ensure infection control measures were maintained during medication administration for one (#3) of two sampled residents reviewed for medications.

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?	On 1/3/25, HWD will educate Medication Technicians specific to re-ordering of medication and infection control during medication administration. In-service documentation includes excerpts from Morada's Clinical Policies and signatures of staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Center will provide re-education to Medication Technician staff through an in-service related to citation. DHW will audit medication reorders on a weekly basis ensuring medcations are in-house. If medication is pending delivery by third-party and not by residence's preferred pharmacy, DHW will stat order medication from residence's preferred pharmacy that will be billed by ancillary charge to resident's account. DHW will also observe and update skills check for Medication Technicians to be completed by 1/10/25. DHW will report observations to ED during 1:1.
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.	ED or designee will review weekly monitoring for trends for a period of 4 weeks and on a monthly basis after compliance is met. Those rounding sheets will be housed in a special binder marked "Medication Audit". Findings will be discussed at the quarterly QA meeting. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/14/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date 12/26/2024**
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.
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If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: MICAH HARPER <mharper@moradalawton.com>

February 14, 2025

License Number: AL1602

Mr. Micah Harper, Administrator/Executive Director
Morada Lawton
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: O9G412

Dear Mr. Harper:

On **February 14, 2025,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **December 6, 2024,** have now been corrected effective **February 14, 2025.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	R-C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAWTON	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 02/14/25. The facility was in substantial compliance.	{C 000}		

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