OKLAHOMA
State Department of Health

Delivery via email to: mharper@moradalawton.com

July 10, 2024

License Number: AL1602

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

Survey Event ID: B5JX11

Dear Mr. Harper:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **July 2, 2024**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Southeast Hunting Circle**
City, State, Zip: **Lawton, OK, 73501**
Provider #: **AL1602**
Complaint #: **OK00065503**
Investigation Dates: **07/01/24 through 07/02/24**

ALLEGATIONS
1.The center failed to ensure residents were not physically, verbally, or psychosocially abused.
2.The center failed to ensure residents did not elope and failed to ensure safe transfer techniques were utilized according to the plan of care and the standard of care.
3.The center failed to have and/or implement an effective infection control program during the provision of incontinent care.
4.The center failed to maintain necessary equipment to ensure safe, comfortable room temperatures.
5.The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 07/01/2024 at 9:00 a.m.

A sample of four 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:

Tours of the facility were conducted throughout the survey. The facility was observed for adequate staff. Residents were observed for being safe and comfortable. Staff were observed for ensuring a safe and comfortable environment. Staff observed for interactions with residents, assisting residents with activities of daily living, following and implementing policy and procedures for infection control and safe techniques during resident care, and ensuring a safe and comfortable environment.

Resident records were reviewed including contracts, assessments, care plans, physician orders, and progress notes. Facility policy and procedures, monitoring logs, in-services, staff employment files, staffing schedules, facility drills, service repair estimates, service invoices and receipts, grievances, resident council meeting minutes, and incident reports were reviewed.

Residents, residents' representatives, and staff were interviewed and asked about abuse, accident hazards, infection control, physical environment, and nursing services.

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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: 07/03/2024

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State Department
of Health

INVESTIGATIVE REPORT

Facility: **Morada Lawton**
Address: **3610 Southeast Hunting Circle**
City, State, Zip: **Lawton, OK, 73501**
Provider #: **AL1602**
Complaint #: **OK00065635**
Investigation Dates: **07/01/24 through 07/02/24**

ALLEGATION
1.The center failed to maintain necessary equipment to ensure a safe, comfortable, and homelike environment.

An unannounced on-site investigation was initiated 07/01/2024 at 9:00 a.m.

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

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

A Summary of Complaint Investigation:

Tours of the facility were conducted throughout the survey. Residents were observed for being safe and comfortable. Staff were observed for ensuring a safe and comfortable environment.

Resident records were reviewed including contracts, assessments, care plans, physician orders, and progress notes. Facility monitoring logs, repair estimates, service invoices and receipts, incident reports, grievance, and resident council meeting minutes were reviewed.

Residents, residents' representatives, and staff were interviewed and asked about the physical environment.

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: 07/03/2024

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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 07/02/2024

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 (#OK00065503 and #OK00065635) were conducted from 07/01/24 through 07/02/24. No deficiencies were cited. Facility Census: 76	C 000		

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