
Delivery via email to: mharper@moradalawton.com

October 31, 2025

License Number: AL1602

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

RE: Survey Event ID: QG5U11

Dear Mr. Harper:

On **October 15, 2025**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 15, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 (attached). 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 and monitoring will be completed for each violation;
- (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 virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,



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

Enclosure

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602/ALC
Complaint #: OK00075515
Investigation Dates: 10/09/25, 10/13/25 through 10/15/25

ALLEGATIONS
The center failed to ensure medication with administered as ordered by the physician.
The center failed to have adequate staff to meet the needs of the residents.
The center failed to assess, monitor and/or intervene for a resident who was in pain.
The center failed to have an effective pest control program to prevent the harborage of bed bugs.

An unannounced on-site investigation was initiated 10/09/2025 at 08:30 a.m.

A sample of twelve 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 center was conducted upon entrance and throughout the survey. Residents were observed during meals, in their rooms, while participating in activities, during medication pass, and during personal care. 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, assessments, medication administration records, and service agreements. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident council minutes and grievances were reviewed.

Residents and family members were interviewed regarding any concerns with pest in the center, adequate staffing, adequate care, and receiving medication as ordered by the physician. Staff members were interviewed about pest control, scheduling of qualified staff, ability to provide adequate care, and the process for administering medication.



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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00079402
Investigation Dates: 10/09/25, and 10/13/25 through 10/15/25

ALLEGATION(S)
The center failed to ensure medications were not misappropriated.
The center failed to ensure residents were interviewed in a safe manner to prevent harm and in accordance with the plan of care.
The center failed to ensure residents were not above the level of care that the center could provide and/or failed to ensure a Plan of Accommodation was in place for a resident who was above the level of care the center could provide.
The center failed to ensure residents were provided care according to their plan of care and/or contract.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of twelve 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 center was conducted upon entrance and throughout the survey. Residents were observed during meals, in their rooms, while participating in activities, during medication pass, and during personal care. Staff members were observed answering call lights, administering medication, serving meals, feeding residents, and assisting residents with activities of daily living.

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

Residents and family members were interviewed regarding any concerns with staffing, adequate care, transfer assistance, and receiving medications as ordered by the physician. Staff members



were interviewed about misappropriation of medication, ability to provide adequate care, and ability to provide safe transfers for residents who require assistance.

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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL 1602
Complaint #: OK00079487
Investigation Date(s): 10/09/25, 10/13/25 – 10/15/25

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to ensure residents did not elope.
The center failed to ensure adequate supervision to prevent falls with major injury.
The center failed to ensure residents' property was not misappropriated
The center failed to ensure medications were administered according to the physicians' orders.
The center failed to ensure residents' medications were not misappropriated.
The center failed to ensure palatable food was provided.
The center failed to ensure a clean, comfortable and homelike environment.
The center failed to ensure adequate nutrition was provided.
The center failed to ensure residents' representatives were notified of a change in condition.
The center failed to ensure residents/representatives had the right to choose who they wanted to be notified of changes in residents' care.
The center failed to ensure adequate staff was provided to meet the needs of the residents.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 investigation. Residents were observed during meals, while receiving medications, while receiving care from staff members, and while participating in activities. Residents were observed for adequate supervision to ensure safety. The facility was observed for a clean, sanitary and homelike environment. Staff members were observed for providing care to dependent residents as required. Staff were observed for assessment and monitoring of residents with intervention as needed. Staff were observed for treatment of residents with kindness, dignity, and respect. Sample meal trays were received for palatable and nutritional food served.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and service agreements. Facility policies and procedures were reviewed. Incident reports were reviewed. Medication administration and treatment administration records were reviewed. Employee records and staff in-service training was reviewed.

Residents were interviewed regarding care provided, medication administration, meal service, and housekeeping services. Residents were interviewed regarding the facility grievance process and procedures. Residents were interviewed regarding supervision to ensure safety. Staff members were interviewed regarding medication administration, infection control policies and procedures, and notification to families and/or representatives. Staff were interviewed regarding providing ADL assistance for dependent residents. Administrative staff were interviewed regarding grievance policies and procedures.

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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL 1602
Complaint #: OK00079655
Investigation Date(s): 10/09/25, 10/13/25 – 10/15/25

ALLEGATION(S)
The center failed to protect residents, legal surrogates, and family members rights to voice grievances without the fear of retaliation.
The center failed to ensure residents were provided ample time to consume their meals.
The center failed to provide a clean, sanitary, homelike environment.
The center failed to follow infection control policies and procedures.
The center failed to provide ADL assistance to dependent residents.
The center failed to ensure residents were not administered the incorrect medication as retaliation by staff.
The center failed to notify family/legal surrogate of a significant change in the residents' condition.
The center neglected to provide adequate supervision.
The center failed to treat residents and families/legal surrogates with dignity and respect.
The center failed to protect residents from misappropriation of property.
The center failed to provide adequate supervision to resident injuries.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 investigation. Residents were observed during meals, while receiving medications, while receiving care from staff members, and while participating in activities. Residents were observed for adequate supervision to ensure safety. The facility was observed for a clean, sanitary and homelike environment. Staff members were observed for providing care to dependent residents as required. Staff were observed for assessment and monitoring of residents with intervention as needed. Staff were observed for treatment of residents with kindness, dignity, and respect. Sample meal trays were received for palatable and nutritional food served.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments,



and service agreements. Facility policies and procedures were reviewed. Incident reports were reviewed. Medication administration and treatment administration records were reviewed. Employee records and staff in-service training was reviewed.

Residents were interviewed regarding care provided, medication administration, meal service, and housekeeping services. Residents were interviewed regarding the facility grievance process and procedures. Residents were interviewed regarding supervision to ensure safety. Staff members were interviewed regarding medication administration, infection control policies and procedures, and notification to families and/or representatives. Staff were interviewed regarding providing ADL assistance for dependent residents. Administrative staff were interviewed regarding grievance policies and procedures.

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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL 1602
Complaint #: OK00081101
Investigation Date(s): 10/09/25, 10/13/25 – 10/15/25

ALLEGATION(S)
The facility failed to ensure residents and family members on behalf of residents can voice grievances without the fear of retaliation.
The facility failed to provide adequate supervision to ensure resident safety.
The facility failed to ensure residents were not administered non-prescribed medications in retaliation.
The facility failed to notify families/legal surrogates of a significant change in residents' condition.
The facility failed to provide a clean, sanitary, and homelike environment with equipment in proper working order.
The facility failed to follow infection control policies and procedures.
The facility failed to ensure residents were provided adequate time to consume their meals to maintain nutrition.
The facility failed to ensure meals were palatable.
The facility failed to provide ADL assistance for dependent residents.
The facility failed to assess, monitor and intervene in a timely manner.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 investigation. Residents were observed during meals, while receiving medications, while receiving care from staff members, and while participating in activities. Residents were observed for adequate supervision to ensure safety. The facility was observed for a clean, sanitary and homelike environment. Staff members were observed for providing care to dependent residents as required. Staff were observed for assessment and monitoring of residents with intervention as needed. Sample meal trays were received for palatable and nutritional food served.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments,

and service agreements. Facility policies and procedures were reviewed. Incident reports were reviewed. Medication administration and treatment administration records were reviewed. Employee records and staff in-service training was reviewed.

Residents were interviewed regarding care provided, medication administration, meal service, and housekeeping services. Residents were interviewed regarding the facility grievance process and procedures. Residents were interviewed regarding supervision to ensure safety. Staff members were interviewed regarding medication administration, infection control policies and procedures, and notification to families and/or representatives. Staff were interviewed regarding providing ADL assistance for dependent residents. Administrative staff were interviewed regarding grievance policies and procedures.

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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00082828
Investigation Date(s): 10/09/25 and 10/13/25-10/15/25

ALLEGATION(S)
The facility failed to ensure adequate nursing staff available to meet the residents needs.
The facility failed to ensure qualified staff completed admission assessments.
The facility failed to ensure adequate staff to answer call lights in a timely manner.
The facility failed to ensure adequate staff to prevent falls.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 investigation. Residents were observed during meals, during medication administration, while participating in activities, and while receiving care. Staff members were observed for answering call lights in a timely manner. Staff were observed for supervision of residents to prevent falls.

Sampled clinical records were reviewed for physician orders, care plans, assessments, and progress notes. Staffing schedules and employee files were reviewed. Admission assessments were reviewed. Incident reports and grievance logs were reviewed. Facility policies and procedures were reviewed.

Residents were interviewed regarding availability of staff to meet their needs. Residents were interviewed regarding call lights and interventions to prevent falls. Staff members were interviewed regarding adequate staffing to meet the needs of residents. Staff were interviewed regarding assessment requirements.

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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00082907
Investigation Dates: 10/09/25, and 10/13/25 through 10/15/25

ALLEGATIONS
The center failed to ensure a nurse was on staff to oversee the day to day clinical operations
The center failed to ensure residents were not admitted who required a level of care above the care the center staff was able to provide.
The center failed to provide necessary medical equipment to ensure safe transfers were provided.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of twelve 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 center was conducted upon entrance and throughout the survey. Residents were observed during meals, in their rooms, while participating in activities, and during personal care. 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, assessments, and service agreements. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident council minutes and grievances were reviewed.

Residents and family members were interviewed regarding any concerns with staffing, adequate care, and safety. Staff members were interviewed about the scheduling of qualified staff, the ability to provide adequate care, and the ability to provide safe transfers for residents who require assistance.



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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00083111
Investigation Dates: 10/09/25, and 10/13/25 through 10/15/25

ALLEGATION
The facility failed to have adequate staffing to meet the needs of residents.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of twelve 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:

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, assessments, medication and treatment administration records, and activities of daily living records. Incident reports and service agreement contracts were reviewed. Facility policies and procedures were reviewed. Resident council minutes and grievances were reviewed.

Residents were interviewed regarding any concerns with staffing and receiving medications as ordered. Staff members were interviewed about adequate staffing and the process to administer resident medications as ordered.

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: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton

Address: 3610 Southeast Huntington Circle

City, State, Zip: Lawton, Ok. 73501

Provider #: AL1602

Complaint #: OK00085140

Investigation Date(s): 10/09/25 and 10/13/25 through 10/15/25

ALLEGATION(S)

The facility failed to ensure allegations of abuse (restraints) were reported in a timely manner.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 Centers for Medicare and Medicaid Services (CMS) 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:

Facility incident reports, which included reports that were required to be reported to the state and other required agencies, were reviewed. Fax receipts were reviewed. Facility policies and procedures were reviewed. Staff trainings were reviewed.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton

Address: 3610 Southeast Huntington Circle

City, State, Zip: Lawton, Ok. 73501

Provider #: AL1602

Complaint #: OK00086721

Investigation Date(s): 10/09/25 and 10/13/25 through 10/15/25

ALLEGATION(S)

The facility failed to protect residents from abuse and failed to follow requirements for reporting abuse.
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An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 Centers for Medicare and Medicaid Services (CMS) 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 during meals, during medication administration, while receiving treatments, while participating in activities, and while receiving assistance with activities of daily living. Residents were observed to interact with staff members and fellow residents. Staff were observed for treating residents with dignity and respect.

Sampled clinical records were reviewed for physician orders, care plans, assessments, medication administration records, and treatment administration records. Facility incident reports, which included reports that were required to be reported to the state and other required agencies, were reviewed. Fax receipts were reviewed. Grievance logs were reviewed. Facility policies and procedures were reviewed. Staff in-service training was reviewed.

Residents were interviewed regarding being treated with dignity and respect. Residents were interviewed regarding abuse allegations of any type. Residents were interviewed regarding reporting and identifying abuse. Family members were interviewed regarding abuse of their loved ones. Staff members were interviewed regarding preventing, identifying, and reporting of abuse. Staff were interviewed regarding facility policies and procedures related to abuse and/or neglect.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton

Address: 3610 Southeast Huntington Circle

City, State, Zip: Lawton, Ok. 73501

Provider #: AL1602

Complaint #: OK00086861

Investigation Date(s): 10/09/25 and 10/13/25 through 10/15/25

ALLEGATION(S)

The facility failed to ensure adequate supervision to prevent an elopement.

The facility failed to administer medications as ordered by the physician.
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The facility failed to maintain a clean, homelike environment.
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The facility failed to file an incident report for missing resident.
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An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 Centers for Medicare and Medicaid Services (CMS) 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 during meals, during medication administration, while participating in activities, and while receiving assistance with activities of daily living. Staff members were observed assisting residents and interacting with them in a dignified and respectful manner. The facility housekeepers were observed to be cleaning residents' rooms and common areas. The building was observed to be clean. Residents' rooms were observed clean and containing their own items decorating the rooms.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and medication administration records. Incident reports were reviewed. The facility sign-in book was reviewed. Facility policies and procedures were reviewed. Staff in-service training was reviewed.

Residents and family were interviewed regarding supervision if needed, medications, and a safe and clean environment.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton

Address: 3610 Southeast Huntington Circle

City, State, Zip: Lawton, Ok. 73501

Provider #: AL1602

Complaint #: OK00086930

Investigation Date(s): 10/09/25 and 10/13/25 through 10/15/25

ALLEGATION(S)

The facility failed to ensure medications were administered as per physicians' orders.
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The facility failed to provide adequate supervision and a safe environment to prevent elopements.

The center failed to provide palatable meals.

The facility failed to provide a clean environment.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 Centers for Medicare and Medicaid Services (CMS) 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 during meals, during medication administration, while participating in activities, and while receiving assistance with activities of daily living. The facility housekeepers were observed to be cleaning residents' rooms and common areas. Other staff members were observed about the facility assisting residents and interacting with them.

Two separate sample lunch trays, containing two different meals, were obtained and tested for taste and appropriate temperatures by surveyors. The meals were at the appropriate temperatures, and the taste was palatable. The daily menu included meal choices the residents could choose from.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and medication administration records. Incident reports and grievance logs were reviewed. The facility sign-in book was reviewed. Facility policies and procedures were reviewed. Staff in-service training was reviewed.

Residents and family were interviewed regarding meals, medications, and a safe and clean environment.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2025

INVESTIGATIVE REPORT

Facility: Morada Lawton

Address: 3610 Southeast Huntington Circle

City, State, Zip: Lawton, Ok. 73501

Provider #: AL1602

Complaint #: OK00087019

Investigation Date(s): 10/09/25 and 10/13/25 through 10/15/25

ALLEGATION(S)

The facility failed to ensure facility had trained staff in the kitchen and was providing food to residents that was edible.
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The facility failed to ensure that the facility was free from tobacco products.

An unannounced on-site investigation was initiated 10/09/2025 at 8:30 a.m.

A sample of 12 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 Centers for Medicare and Medicaid Services (CMS) 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 kitchen was conducted upon entrance and throughout the investigation. Kitchen staff were observed to utilize sanitary measures preparing and handling food. No facility staff was observed to be using tobacco products, including dip.

Two separate sample lunch trays, containing two different meals, were obtained and tested for taste and appropriate temperatures by surveyors. The meals were at the appropriate temperatures, and the taste was palatable. The daily menu included meal choices the residents could choose from.

Facility policies and procedures were reviewed. Staff in-service training was reviewed.

Residents were interviewed regarding tobacco use by employees and about the quality and taste of the food served by the facility. Staff members were interviewed about the use of tobacco products by employees.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2025

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER MORADA LAWTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
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C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00075515, OK00079402, OK00079487, OK00079655, OK00081101, OK00082828, OK00082907, OK00083111, OK00085140, OK00086721, OK00086861, OK00086930, and #OK00087019 was conducted from 10/09/25 and 10/13/25 through 10/15/25. Deficiencies were cited as a result of the survey. Facility Census: 80 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide CMA - certified medication aide CNA - certified nursing assistant DON - director of nursing MAR - medication administration record MAT - medication aide in training mg - milligram ml - milliliter	C 000		
C 322 SS=D	310:663-3-3(a)2 DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (2) nursing supervision during nursing intervention;	C 322		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 322	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents were signing in and out at the front desk when leaving the facility per the facility agreement for 1 (#9) of 1 sampled resident reviewed for leaving and returning to the facility. The administrator reported 80 residents resided in the facility. Findings: Resident #9's agreement upon admittance, signed on 07/22/24, read in part, "Your Rights and Responsibilities"... "part S"... "You have the right to come and go as you please. When leaving and returning, residents must sign in and out at the front desk." Resident #9's six-month assessment, dated 07/16/25, showed they had diagnoses which included Lewy body dementia and cerebrovascular disease and was alert and oriented to person, place and time. The resident could communicate independently and was independent in life enrichment and socialization activities. The sign-in book at the front desk was reviewed and showed no signatures from Resident #9. On 10/13/25 at 10:30 a.m., the DON reported Resident #9 had been discharged from the facility on 10/03/25. The DON reported while living at the facility the resident walked outside of the facility every morning. On 10/13/25 at 2:30 p.m., the DON reported	C 322		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

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C 521	Continued From page 3 Findings: A "Resident Pre-Admission Appraisal" policy, dated 06/07/24, showed preadmission assessments would be completed within 30 days prior to admission. A "Recommended Assisted Living Resident Assessment" form, dated 01/13/25, was provided by the facility for the Resident #1's admission assessment. The assessment showed Resident #1 was admitted to the facility on 12/30/24 with diagnosis which included dementia. On 10/14/25 at 9:40 a.m., the DON reported the admission assessment was completed late.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a comprehensive assessment within 14 days after admission for 2 (#7 and #6)	C 522		

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C 522	Continued From page 4 of 10 residents reviewed for assessments. The administrator reported 80 residents resided in the facility. Findings: A "Resident Assessments" policy, dated 04/01/25, showed the comprehensive assessment will be completed within 14 days after admission of the resident. 1. A 14-day assessment for Resident #7, dated 06/18/25, showed the resident was admitted to the facility on 05/15/25. The assessment was not completed within 14 days after admission. 2. A-14 day comprehensive assessment, dated 07/16/25, showed Resident #6 admitted to the facility on 06/18/25. On 10/14/25 at 9:40 a.m., the DON reported the 14-day comprehensive assessment for Resident #6 and #7 were completed late. The DON reported not being aware of the reason the assessments were completed late.	C 522		
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	C1505		

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C1505	Continued From page 5 medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have qualified staff scheduled to administer injections for 1 (#12) of 3 sampled residents reviewed for insulin injections. The administrator reported 80 residents resided in the facility. Findings:	C1505		

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C1505	Continued From page 6 A "Certified Medication Aides" policy, dated 06/07/25, showed CMAs were not allowed to perform blood glucose testing or administer insulin unless the CMA had successfully completed an advanced training program. A medical provider report/order, dated 12/19/24, showed for Resident #12's medication management staff would assist/administer medications. A 14-day comprehensive assessment, dated 01/27/25, showed Resident #12 was admitted to the facility with diagnoses which included diabetes mellitus and dementia. A physician order, dated 02/27/25, showed Toujeo Solo injection (insulin) 300 units/ml inject 50 units subcutaneously at bedtime, scheduled at 8:00 p.m. The order showed to hold the insulin if the blood glucose level was less than 90. Resident #12's May 2025 medication administration record for Toujeo Solo injection showed: a. on 05/07/25 the insulin scheduled at 8:00 p.m. could not be given due to medication aide not being an ACMA. The medication administration record showed no blood glucose level; b. on 05/20/25 the insulin scheduled at 8:00 p.m. was not given due to no ACMA on shift. The medication administration record showed no blood glucose level; and c. on 05/24/25 the insulin scheduled at 8:00 p.m. was not given due to no ACMA available. The medication administration record showed no blood glucose level. A medication administration record, dated 06/13/25, showed Resident #12's insulin	C1505		

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C1505	Continued From page 7 scheduled at 8:00 p.m. was not given due to no ACMA. The medication administration record showed no blood glucose level. Resident #12's service plan, dated 09/18/25, showed staff assistance with blood glucose monitoring and insulin administration was required. On 10/15/25 at 12:35 p.m., CMA #1 reported they were not qualified to give insulin. CMA #1 reported only nurses or an ACMA were qualified to give insulin injections. CMA #1 reported it happened on and off that no ACMA or nurse was working on their shift to give routine insulin. CMA #1 reported they documented no ACMA available when no one was available to give insulin. On 10/15/25 at 12:55 p.m., MAT #1 reported they were not able to administer insulin to residents. MAT #1 reported that a few times no ACMA or nurse was available on their shift to give residents their routine insulin. MAT #1 reported they were told if a staff member qualified to give injections was not working, they were to document no ACMA was available. On 10/15/25 at 2:13 p.m., the DON reported an ACMA or a licensed nurse could administer insulin to residents. The DON reported a MAT or CMA were not allowed to give injections. The DON reported not being previously aware Resident #12 had missed any doses of insulin due to a qualified staff member not being available.	C1505			
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION	C1921			

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C1921	Continued From page 8 (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered per physician orders for 2 (#9 and #12) of 3 sampled residents reviewed for receiving medications as prescribed. The administrator reported 80 residents resided in the facility. Findings: A facility "Assisted Living Residency" agreement, dated 06/01/23, showed the facility would assist the residents with the storage and administration of medications. 1. Resident #9's six-month assessment, dated 07/16/25, showed they had diagnoses which included Lewy body dementia and cerebrovascular disease Resident #9's physician's monthly order summary, dated July 2025, showed the resident was to receive zaleplon (a sedative) 5 mg, one tablet by mouth at bedtime. Resident #9's MAR, dated July 2025, showed no initials by the facility staff to indicate the zaleplon was given on 07/26/25, 07/28/25, and 07/31/25. Resident #9's physician's monthly order	C1921		

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C1921	Continued From page 9 summary, dated August 2025, showed the resident was to receive: a. zaleplon 5 mg, one tablet by mouth at bedtime; b. memantine (used to slow the progression of dementia) 10 mg by mouth for dementia, one tablet twice a day; and c. donepezol (treatment of dementia) 10 mg by mouth every day for dementia. Resident #9's MAR, dated August 2025, had no initials by the facility staff to indicate: a. zaleplon was given on 08/17/25; b. memantine was given for the morning doses on 08/04/25, 08/05/25, 08/08/25, 08/13/25, 08/14/25, 08/22/25, 08/25/25, 08/27/25 and, 08/29/25; and for the evening dose on 08/17/25; and c. donepezol was given on 08/04/25, 08/05/25, 08/08/25, 08/13/25, 08/14/25, 08/22/25, 08/25/25, 08/27/25, and 08/29/25. Resident #9's physician's monthly order summary, dated September 2025, showed the resident was to receive: a. memantine 10 mg twice a day for dementia; and b. zaleplon 5 mg, one tablet by mouth at bedtime. Resident #9's MAR, dated September 2025, showed no initials by facility staff to indicate: a. memantine was given on 09/08/25; and b. zalephlon was given on 09/08/25 and 09/29/25. On 10/15/25 at 2:30 p.m., the DON reported they could not confirm the medications with blanks, not initialed by facility staff, on Resident #9's MARs had been given as ordered. 2. A medical provider report/order, dated 12/19/24, showed for Resident #12's medication management staff would assist/administer	C1921		

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C1921	Continued From page 10 medications. A 14-day comprehensive assessment, dated 01/27/25, showed Resident #12 was admitted to the facility with diagnoses which included diabetes mellitus and dementia. A physician order, dated 02/27/25, showed Toujeo Solo injection (insulin) 300 units/ml inject 50 units subcutaneously at bedtime, scheduled at 8:00 p.m. Resident #12's May 2025 medication administration record for Toujeo Solo injection showed: a. on 05/07/25 the insulin scheduled at 8:00 p.m. could not be given due to medication aide not being an ACMA. The medication administration record showed no blood glucose level; b. on 05/20/25 the insulin scheduled at 8:00 p.m. was not given due to no ACMA on shift. The medication administration record showed no blood glucose level; and c. on 05/24/25 the insulin scheduled at 8:00 p.m. was not given due to no ACMA available. The medication administration record showed no blood glucose level. A medication administration record, dated 06/13/25, showed Resident #12's insulin scheduled at 8:00 p.m. was not given due to no ACMA. The medication administration record showed no blood glucose level. On 10/15/25 at 12:35 p.m., CMA #1 reported they were not qualified to give insulin. CMA #1 reported only nurses or an ACMA were qualified to give insulin injections. CMA #1 reported it happened on and off that no ACMA or nurse was working on their shift to give routine insulin. CMA	C1921		

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C1921	Continued From page 11 #1 reported they documented no ACMA available when no one was available to give insulin. On 10/15/25 at 12:55 p.m., MAT #1 reported they were not able to administer insulin to residents. MAT #1 reported that a few times no ACMA or nurse was available on their shift to give residents their routine insulin. MAT #1 reported they were told if a staff member qualified to give injections was not working, they were to document no ACMA was available. On 10/15/25 at 2:13 p.m., the DON reported an ACMA or a licensed nurse could administer insulin to residents. The DON reported a MAT or CMA were not allowed to give injections. The DON reported not being previously aware Resident #12 had missed any doses of insulin due to a qualified staff member not being available.	C1921		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were educated on abuse	C1972		