OKLAHOMA
State Department
of Health

Delivery via email to: albaggs@moradalakehefner.com

April 10, 2025

License Number: AL5507

Mr. Alex Baggs, Administrator
Morada Lake Hefner
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event ID: KZVB11

Dear Mr. Baggs:

On **March 6, 2025**, agents from our office concluded a State Licensure survey 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 **March 6, 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAKE HEFNER	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted on 03/04/25 through 03/06/25. Facility Census: 32 Listed below are abbreviations that will be used in this document. Admin - administration RN - registered nurse	C 000		
C 324 SS=D	310:663-3-3(a)(4) 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: (4) medication administration; This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure safe medication administration services for 1 (#2) of 8 sampled residents reviewed for safe, self administration of medication practices and assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 03/04/25, showed 32 residents resided in the center. Findings:	C 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 324	Continued From page 1 On 03/05/25 at 1:12 p.m., a medication planner filled with medications was observed on Resident #2's table beside their recliner. The container was not secured with any type of locking mechanism. Resident #2 was admitted to the center on 08/31/24 with diagnoses which included hypertension, renal disease, and a stage 2 pressure ulcer on right buttocks. Resident #2's service contract, dated 08/31/24, showed in Addendum E, they could be allowed to self administer their medications and store medications in their unit. The contract, read in part, "The community using a self-medication screening"..."and ongoing assessments verify the same"..."Must have a signed statement from your primary physician, that you are capable of self administering medications"..."you agree at all times to keep medications in a locked container." A "Service Description-Full" for Resident #2, dated 01/02/25, read in part, "Resident is completely independent with self medication administration with accompanying physicians orders, Self Admin"..."Assessment and Self Medication Admin Results." There was no documentation in the resident's health record a self medication screening by the center to determine if the resident was physically and cognitively able to store and self administer medications. On 03/05/25 at 3:30 p.m., the director of wellness was asked if there are any residents who self administered their own medications and how often were assessments completed. The director of wellness stated the medication assessments were done quarterly on the three residents who	C 324		

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C 324	Continued From page 2 self administered their own medications. When asked to see the assessments, the director of wellness reported none were completed.	C 324		
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to complete an admission assessment within 30 days before or at the time of admission for 5 (#2, 4, 5, 6, and #8) of 8 sampled residents reviewed for admission assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 03/04/25, showed 32 residents residing in the center. Findings: 1. Resident #2 was admitted to the center on 08/31/24 with diagnoses which included hypertension, renal disease, and a stage 2 pressure ulcer on right buttocks. There was no documentation in the resident's	C 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING: _____ B. WING _____	03/06/2025

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C 521	Continued From page 3 health record an admission assessment was completed within 30 days before or at the time of admission. 2. Resident #4 was admitted to the center on 01/28/25 with diagnoses which included hypertension, clotridoides difficile colitis, irritable bowel syndrome, femur fracture, venous embolism, and arthritis. There was no documentation in the resident's health record an admission assessment was completed. 3. Resident #5 was admitted to the center on 09/24/24 with diagnoses which included chest pain, tachycardia, hypertension, hypotension, malnutrition, chronic pain, and chronic obstructive pulmonary disease, and dysphagia. There was no documentation in the resident's health record an admission assessment was completed. 4. Resident #6 was admitted to center on 11/30/24 with diagnoses which included dyspnea, dementia, and hypertension. There was no documentation in the resident's health record an admission assessment was completed. 5. Resident #8 was admitted to the center on 08/22/24 with diagnoses of stroke, hyperlipidemia, dementia, and dysphagia. There was no documentation in the resident's health record an admission assessment was completed.	C 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 521	Continued From page 4 On 03/05/25 at 3:30 p.m., the director of wellness was asked if there were any assessments for Residents #2, 4, 5, 6, and #8 located somewhere else besides their health record. The director of wellness stated they were not completed. On 03/06/25 at 10:30 a.m., the regional RN was shown the list of missing assessments for the residents listed above and was unable to produce any additional assessments. The regional RN stated there were not any other assessments.	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 center failed to ensure comprehensive assessments were completed 14 days after admission for 6 (#2, 4, 5, 6, 7, and #8) of 8 sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 03/04/25 showed 32 residents resided in the center. Findings:	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAKE HEFNER	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(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 522	Continued From page 5 1. Resident #2 was admitted to the center on 08/31/24 with diagnoses which included hypertension, renal disease, and a stage 2 pressure ulcer on right buttocks. There was no documentation in the resident's health record a 14 day (comprehensive) assessment was completed. 2. Resident #4 was admitted to the center on 01/28/25 with diagnoses which included hypertension, C-Difficile Colitis, irritable bowel syndrome, femur fracture, venous embolism, and arthritis. There was no documentation in the resident's health record a 14 day (comprehensive)assessment was completed. 3. Resident #5 was admitted to the center on 09/24/24 with diagnoses which included chest pain, tachycardia, hypertension, hypotension, malnutrition, chronic pain, and chronic obstructive pulmonary disease, and dysphagia. There was no documentation in the resident's health record a 14 day (comprehensive) assessment was completed. 4. Resident #6 was admitted to center on 11/30/24 with diagnoses which included dyspnea, dementia, and hypertension. There was no documentation in the resident's health record a 14 day (comprehensive) assessment was completed. 5. Resident #7 was admitted to the center on 01/24/25 with diagnoses which included	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAKE HEFNER	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(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 522	Continued From page 6 congestive heart failure, asthma, and fibromyalgia syndrome. There was no documentation in the resident's health record a 14 day (comprehensive) assessment was completed. 6. Resident #8 was admitted to the center on 08/22/24 with diagnoses which included stroke, hyperlipidemia, dementia, and dysphagia. There was no documentation in the resident's health record a 14 day (comprehensive) assessment was completed. On 03/05/25 at 3:30 p.m., the director of wellness was asked if there were any assessments for Residents #2, 4, 5, 6, 7, and #8 located somewhere else besides their health record. The director of wellness stated no other assessments were completed. On 03/06/25 at 10:30 a.m., the regional RN was shown the list of missing assessments for the residents listed above and was unable to produce any additional assessments. They stated there were not any other assessments.	C 522		

OKLAHOMA
State Department of Health

Delivery via email to: albaggs@moradalakehefner.com

April 23, 2025

License Number: AL5507

Alex Baggs, Administrator
Morada Lake Hefner
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event KZVB11

Dear Mr. Baggs:

On **March 6, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **May 1, 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: 4/15/2025** **Facility Name:** Morada Lake Hefner **License Number:** AL5507 **Survey Event ID:** KZVB11 **Date Survey Completed: 3/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C324	Based on: Based on record review and interview, the center failed to ensure safe medication administration services for 1 (#2) of 8 sampled residents reviewed for safe, self administration of medication practices and assessments.

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?	Director of Health and Wellness or Designee will conduct Self-medication Assessments monthly and will be reviewed at Quarterly Audit Review by the ED and the DHW. Residents who self-medicate will have lockboxes for all medications. This will be checked by either the ED and/or the DHW on a weekly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Director of Health and Wellness or Designee will conduct Self-medication Assessments monthly and will be reviewed at Quarterly Audit Review by the ED and the DHW. Residents who self-medicate will have lockboxes for all medications. This will be checked by either the ED and/or the DHW on a weekly basis.
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?	Through weekly review the Executive Director and the DHW will review all new and upcoming self-medication assessments. All assessments will be reviewed at Quarterly Audit and Reviewed by the ED and DHW.
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.	Through ongoing weekly review weekly by ED and DHW, then at Quarterly Audit and Review. Through weekly review, and Quarterly Audit review. Through weekly review, and Quarterly Audit review. Through weekly review, and Quarterly Audit Review.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		5/1/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 4/17/2025**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/15/2025** **Facility Name:** Morada Lake Hefner **License Number:** AL5507 **Survey Event ID:** KZVB11 **Date Survey Completed: 3/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C521	Based on: Based on record review and interview, the centerfailed to complete an admission assessment within 30 days before or at the time of admissionfor 5 (#2, 4, 5, 6, and #8) of 8 sampled residentsreviewed for admission assessments.

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, who is a Registered Nurse for Morada Senior Living, will review, monitor, and sign all assessments upon completion and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Through weekly review the Executive Director and the DHW will review all new and upcoming assessments and will send to the Director of Resident Care, who is a Registered Nurse for Morada Senior Living, who will review, monitor, and sign all assessments upon completion and ongoing. All assessments will be reviewed at Quarterly Audit and Review by the ED and DHW.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	h weekly review the Executive Director and the DHW will review all new and upcoming assessments and will send to the Director of Resident Care, who is a Registered Nurse for Morada Senior Living, who will review, monitor, and sign all assessments upon completion and ongoing. All assessments will be reviewed at Quarterly Audit and Review by the ED and DHW.
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.	Through ongoing review by Director of Resident Care, who is a Registered Nurse for Morada Senior Living, weekly review by ED and DHW, then at Quarterly Audit and Review. Through Quarterly Audit and Review. Through Quarterly Audit and Review. Through ongoing Quarterly Audit and Review.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/7/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 4/17/2025**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/15/2025** **Facility Name:** Morada Lake Hefner **License Number:** AL5507 **Survey Event ID:** KZVB11 **Date Survey Completed: 3/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Based on record review and interview, the center failed to complete an admission assessment within 30 days before or at the time of admissionfor 5 (#2, 4, 5, 6, and #8) of 8 sampled residents reviewed for admission assessments.

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, who is a Registered Nurse for Morada Senior Living, will review, monitor, and sign all assessments upon completion and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Through weekly review the Executive Director and the DHW will review all new and upcoming assessments and will send to the Director of Resident Care, who is a Registered Nurse for Morada Senior Living, who will review, monitor, and sign all assessments upon completion and ongoing. All assessments will be reviewed at Quarterly Audit and Review by the ED and DHW.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	h weekly review the Executive Director and the DHW will review all new and upcoming assessments and will send to the Director of Resident Care, who is a Registered Nurse for Morada Senior Living, who will review, monitor, and sign all assessments upon completion and ongoing. All assessments will be reviewed at Quarterly Audit and Review by the ED and DHW.
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.	Through ongoing review by Director of Resident Care, who is a Registered Nurse for Morada Senior Living, weekly review by ED and DHW, then at Quarterly Audit and Review. Through Quarterly Audit and Review. Through Quarterly Audit and Review. Through ongoing Quarterly Audit and Review.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	3/7/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date 4/17/2025**	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

Delivery via email to: Pashen Bennett <pabennett@moradalakehefner.com>; Alex Baggs <albaggs@moradalakehefner.com>

May 7, 2025

License Number: AL5507

Alex Baggs, Administrator
Morada Lake Hefner
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event KZVB12

Dear Mr. Baggs:

On **May 6, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 6, 2025,** have now been corrected effective **May 1, 2025.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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
	AL5507	A. BUILDING: _____ B. WING _____	R 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORADA LAKE HEFNER	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(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 05/06/25. 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