OKLAHOMA
State Department
of Health

Delivery via email to: kkellybolner@moradaseniorliving.com

July 10, 2026

License Number: AL1602

Ms. Kristi Kelly-Bolner, Administrator
Morada Lawton
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: CHPL11

Dear Ms. Kelly-Bolner

On **June 25, 2026,** representatives from our agency concluded a complaint investigation at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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

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

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

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

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

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

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: **IDRCoordinator@health.ok.gov**

or mail to:

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

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

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

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

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, Oklahoma, 73501
Provider #: AL1602
Complaint #: OK00091164
Investigation Date(s): 06/18/26 – 06/19/26; 06/22/26-06/25/26

ALLEGATION(S)
The center failed to ensure care and treatment was provided in an effort to prevent accidents with injury.

An unannounced on-site investigation was initiated 06/18/2026 at 8:30 a.m.

A sample of 5 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted on and throughout the survey. Observations were made concerning safety within the facility. Residents were observed receiving personal care. Staff were observed interacting with residents, providing personal care assistance, and conducting care and activities throughout the facility.

Sampled clinical records were reviewed for assessments, care plans, hospital records, physician orders, and treatment administration records. Facility policy and procedures, grievances, incident reports, staff coverage and records regarding qualified staff were reviewed.

Residents were interviewed concerning quality of care, safety in their environment, and adequate staff. Staff were interviewed concerning incident reports, sufficient staff, care plans, and physician orders.

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: 06/29/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, Oklahoma, 73501
Provider #: AL1602
Complaint #: OK00091231
Investigation Date(s): 06/18/26 – 06/19/26; 06/22/26-06/25/26

ALLEGATION(S)
The facility failed to ensure medications were administered as ordered by the physician.
The facility failed to ensure laundry and housekeeping was provided according to the contracted services.

An unannounced on-site investigation was initiated 06/18/2026 at 8:30 a.m.

A sample of 5 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the survey. Resident halls and rooms were observed for cleanliness and odors relating to incontinent care. Residents were observed receiving personal care, participating in activities and interacting with staff.

Records were reviewed regarding orders by the physician, contractual services for laundry and housekeeping, qualified staff, care plans, incident reports and policy and procedures.

Residents were interviewed regarding quality of care, medication administration, and services provided by the facility. Staff were interviewed regarding medication administration, laundry and housekeeping services and adequate staff.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

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of Health

Date report completed: 06/29/2026

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INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, Oklahoma, 73501
Provider #: AL1602
Complaint #: OK00091685
Investigation Date(s): 06/18/26 – 06/19/26; 06/22/26-06/25/26

ALLEGATION(S)
The facility failed to ensure the staff were able to identify a resident's code status in an emergency and/or initiate CPR immediately for a resident who was a full code.
The facility failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 06/18/2026 at 8:30 a.m.

A sample of 5 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted on and throughout the survey. Observations were made concerning safety within the facility. Residents were observed receiving personal care. Staff were observed interacting with residents, providing personal care assistance, and identifiable code status for residents were observed throughout the facility.

Sampled clinical records were reviewed for code status accuracy, assessments, care plans, hospital records, physician orders, and treatment administration records. Facility policy and procedures, grievances, incident reports, staff coverage and records regarding qualified staff were reviewed.

Residents were interviewed concerning quality of care, safety in their environment, and adequate staff. Staff were interviewed concerning incident reports, sufficient staff, care plans, and physician orders.

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
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Date report completed: 06/29/2026

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of Health

INVESTIGATIVE REPORT

Facility: Morada Lawton
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, Oklahoma, 73501
Provider #: AL1602
Complaint #: OK00091715
Investigation Date(s): 06/18/26 – 06/19/26; 06/22/26-06/25/265

ALLEGATION(S)
The facility failed to have adequate staffing to meet the needs of the residents.
The facility failed to ensure medication was administered as ordered by the physician
The facility failed to provide a safe environment

An unannounced on-site investigation was initiated 06/18/2026 at 8:30 a.m.

A sample of 5 residents, including any identified residents, were selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted on and throughout the survey. Observations were made concerning safety within the facility. Residents were observed receiving personal care. Staff were observed interacting with residents, providing personal care assistance, and conducting activities throughout the day.

Records were reviewed regarding qualified staff, staffing schedules, skills assessments, care provided, care plans, and adequate staffing. Records were reviewed for medication administration as ordered by the physician.

Residents were interviewed concerning quality of care, safety in their environment and medication administration.

Staff were interviewed regarding adequate staffing, providing a safe environment and medication administration ordered by the physician.

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: 06/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	R-C 06/25/2026

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 (#OK00091164, OK00091231, OK00091685, and #OK00091715) were conducted from 06//18/26 through 06/19/26 and 06/22/26 through 06/25/26. Deficiencies were cited. Facility Census: 69 Listed below are the abbreviations that will be used throughout this document. ADON - assistant director of nursing CMA - certified medication aide CNA - certified nursing assistant	C 000		
C1505 SS=F	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully	C1505		

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C1505	Continued From page 1 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 center failed to ensure: a. residents had post fall care plan interventions for 3 (#1, 4 and #5) of 3 sampled residents reviewed for care plan interventions; b. assessments were accurate for 1 (#4) of 3 sampled residents reviewed for accurate assessments; and c. ensure staff were educated on fall interventions for 3 (#1, 4 and #5) of 3 sampled residents reviewed for falls. The ADON identified 18 residents at risk for falls. Findings: A policy titled "CL15-Falls," dated 06/07/24, read in part, "All residents are evaluated for fall risk" ..."Plan of Care will be developed/updated." ..."Each resident's Plan of Care and fall risk evaluation (Mores Fall Scale) will be reviewed and updated whenever a resident has: i. a first fall (no prior documented/reported fall). ii. Two or more falls within thirty (30) days. iii. A fall with injury requiring medical intervention/treatment. iv. A change in condition." A policy titled "Resident Assessments," dated 06/07/24, read in part, "Assessments are completed and updated as frequently as necessary to ensure they reflect current residents care needs and preferences. The information	C1505		

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C1505	Continued From page 2	C1505		

from an assessment is used to develop an appropriate plan of care."..."Resident assessments are always completed as accurately as possible, and are never modified to meet financial concerns of the resident or responsible party."

A document titled "Fall Reduction Program," undated, read in part, "Fall Risk Evaluation In addition to those fall reduction risks that are applicable to all residents, such as proper lighting, each resident is to be evaluated for resident specific risk. Based on the results of each residence, fall risk assessment, individualized fall reduction strategies are to be implemented."..."Fall risk, Scoring and Possible Interventions A total score is obtained for each residence fall risk assessment that identifies the residence level of risk as level one, level two, or level three."...
"Level 1: score 0 -24
An annual vision/hearing screening exams
Apartment safety check tool
Offer and encourage fitness classes for balance, stretching, and strengthening.
Level 2: score 25 to 50
Annual vision/hearing screening exam exams.
Apartment safety check tool
Offer and encourage fitness classes for balance, stretching, and strengthening.
Medication review by consulting pharmacist or physician.
Fall risk in interventions must be reflected in the residence service plan."

1. A care plan for Resident #1, dated 10/07/25, read in part, "resident is a Level 2 for the Morse Fall Screen. Level 2 indicates the need to implement standard fall risk reduction interventions." The care plan showed Resident #1

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C1505	Continued From page 3 ambulated with a wheelchair, was dependent to propel, and required two persons assistance with transfers. A six month assessment for Resident #1, dated 04/20/26, showed Resident #1 was forgetful which indicated dementia. The assessment showed Resident #1 was a fall risk level 2 which indicated they had a history of falling. Incident reports for Resident #1 showed the resident had falls on the following dates: a. 12/11/25; b. 01/31/26; and c. 05/09/26. The care plan did not show fall risk reduction interventions had been updated after the falls on 12/11/25, 01/31/26, and 05/09/26. The care plan did not show any fall risk reduction interventions. 2. A care plan for Resident #4, dated 08/27/25, read in part, "resident is a Level 1 for the Morse Fall Screen. Level 1 indicates good basic resident care and coordination of health services." The care plan showed Resident #4 ambulated using a walker and was independent in mobility. Incident reports for Resident #4 showed the resident had falls on the following dates: a. 04/11/26; and b. 06/03/26. A six month assessment assessment for Resident #4, dated 04/20/26, showed Resident #4's cognition was mildly impaired. The assessment showed Resident #4 was a fall risk level 1 and showed the resident did not have a fall prior to the assessment.	C1505		

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C1505	Continued From page 4 The care plan did not show fall risk reduction interventions had been updated after the falls on 04/11/26 and 06/03/26. The care plan did not show any fall risk reduction interventions. 3. A care plan for Resident #5, dated 09/04/25, read in part, "resident is a Level 1 for the Morse Fall Screen. Level 1 indicates good basic resident care and coordination of health services." The care plan showed Resident #5 ambulated with a walker and was independent in mobility. A change in condition assessment for Resident #5, dated 02/18/26, showed Resident #5 had normal cognition. The assessment showed Resident #5 was a fall risk level 2 which indicated they had a history of falling. Incident reports for Resident #5 showed the resident had falls on the following dates: a. 02/09/26; b. 02/10/26; c. 02/14/26; d. 02/26/26; e. 03/08/26; f. 03/16/26; g. 03/17/26; h. 05/07/26; i. 06/14/26; j. 06/17/26; k. 06/20/26; and l. 06/22/26. The care plan did not show fall risk reduction interventions had been updated after fall incidents. The care plan did not show any fall risk reduction interventions. On 06/24/25 at 10:35 a.m., the ADON stated the assessment for Resident #4, dated 04/20/26, was	C1505		

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C1505	Continued From page 5	C1505		

not correct due to Resident #4 had a fall on 04/11/26, before the assessment was completed. The ADON stated the assessment documented no history of falls for Resident #4. The ADON stated Resident #1, Resident #4, and Resident #5 had multiple falls in the facility. The ADON stated the care plans for Resident #1, Resident #4, and Resident #5 did not document any interventions after the falls. The ADON stated they did not know what the standard intervention was for a resident assessed as a morse fall risk scale 2. The ADON stated the facility's fall policy was not followed.

On 06/25/26 at 11:35 a.m., the corporate nurse stated the fall policy was not followed because the care plans for Resident #1, Resident #4, Resident #5, and all other residents at risk for falls in the facility did not have any interventions in their care plans. The corporate nurse stated the care plan interventions for residents at risk for falls had not been implemented, and the care plan interventions had not been updated after the falls for Resident #1, Resident #4, and Resident #5.

On 06/24/26 at 11:40 a.m., CNA #7 stated they had not been educated on what standard fall interventions should have been implemented for a resident who had a morse fall risk level 2. CNA #7 stated Resident #1, Resident #4, and Resident #5 all had a history of falls. CNA #7 stated there were no fall risk reduction interventions in the residents' care plans.

On 06/24/26 at 11:43 a.m., CMA #3 stated they had not beed educated over what standard fall interventions should have been implemented for a resident who had a morse fall scale risk scored at level 2. CMA #3 stated Resident #1, Resident

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C1505	Continued From page 6 #4, and Resident #5 all had a history of falls. CMA #3 stated there were no fall risk reduction interventions in the residents' care plans.	C1505		