OKLAHOMA
State Department
of Health

Delivery via email to: middleej@yahoo.com

July 8, 2021

License Number: RC6304
Survey Event ID: BIZ811

Ms. Sherry Snider, Administrator
Maud Residential Care
403 W Wanda Jackson Blvd
Maud, OK 74854

Dear Ms. Snider:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care facility on **June 3, 2021**.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
- A reasonable date of correction, which will normally be within 30 days of this notice.

  NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit

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in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 426-8200.

You will be notified you of any enforcement actions being taken. If you have questions or need assistance, please feel free to contact me at (405) 426-8200.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
Date: 2021.07.08 09:52:34 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Maud Residential Care**
Address: **409 W. Wanda Jackson Blvd**
City, State, Zip: **Maud Ok 74854**
Provider #: **RC6304**
Complaint #: **OK00055825**
Investigation Date(s): **06/03/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to ensure residents were allowed to handle their own finances and received private phone calls/visits.	US
2. The home failed to ensure resident funds were not misappropriated.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 3, 2021 at 8:00 a.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the right to handle finances, have phone calls and visitation was conducted.

Residents were observed being given money from their funds.

The administrator stated she was the payee for some of the residents at the home. She stated residents were allowed to have visitors and private phone calls.

Residents stated they were allowed to choose their payee. The residents were able to state the amount of money they received after the rent was paid. They stated they were given money for cigarettes and to spend at the store.

Residents stated they were allowed to have personal phone calls and visitors.

The resident records and personal funds were reviewed.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R158 and R236 for details.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/07/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Maud Residential Care**
Address: **409 W. Wanda Jackson Blvd**
City, State, Zip: **Maud Ok 74854**
Provider #: **RC6304**
Complaint #: **OK00056240**
Investigation Date(s): **06/03/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to provide a safe, clean, comfortable homelike environment.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 3, 2021 at 8:00 a.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

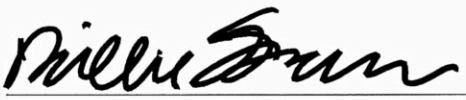
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R309 and R325 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.



Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/07/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Maud Residential Care**
Address: **409 W. Wanda Jackson Blvd**
City, State, Zip: **Maud OK 74854**
Provider #: **RC6304**
Complaint #: **OK00057108**
Investigation Date(s): **06/03/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to provide a safe, homelike environment.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, June 3, 2021 at 8:00 a.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R224, R309, R325 and R813 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman By Jan Anderson

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 06/07/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6304	A. BUILDING: _____ B. WING _____	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUD RESIDENTIAL CARE	403 W WANDA JACKSON BLVD MAUD, OK 74854

(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
R 000	INITIAL COMMENTS An abbreviated survey was conducted on 06/03/21 to investigate complaint #OK00055825, #OK00056240 and complaint #OK00057108. Total residents: 47	R 000		
R 158 SS=D	63 O.S. 1-1918.B.12. RIGHTS-Abuse, Neglect, Seclusion & Restraints Section 1-840. Other provisions applicable to residential care homes Residential care homes subject to the provisions of the Residential Care Act shall comply with the provisions of Sections 1-1909, 1-1910, 1-1914.1, 1-1914.2, 1-1915, 1-1917, 1-1918, 1-1919, 1-1920, 1-1921, 1-1922, 1-1924, 1-1926, 1-1927, 1-1930, 1-1939, 1-1940 and 1-1941 of this title. 63 O.S. 1-1918(B)12. Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	R 158		

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R 158	Continued From page 1 43A-10-103.(A)8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult. 43A-10-103.(A)10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services. This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the home failed to prevent financial exploitation of a vulnerable adult for one (#2) of two sampled residents whose funds were managed by the home. The administrator identified 31 residents whose finances were managed by the home. Findings:	R 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 158	Continued From page 2 Resident #2 had diagnosis which included bipolar disorder. On 06/03/21 at 1:52 p.m., the resident's name and an amount of $1200.00 was written on an envelope. The administrator stated the money was from the resident's stimulus money. The envelope revealed on 07/24/20 an air conditioner (AC) was purchased for $200.00 out of the resident's funds. The administrator stated air conditioning was included in the price of rent. The administrator was asked if the home purchased an AC unit for the common area out of the resident's funds. She stated yes. The window AC unit was observed in an equipment room. At 2:30 p.m., the resident was asked if the home purchased an AC unit out of her personal funds. She stated yes.	R 158		
R 224 SS=D	310:680-3-6 (d) RECORDS AND REPORTS (d) The Department shall be notified of all incidents pertaining to fire, storm damage, death other than natural, residents missing, or utilities failure for more than four (4) hours, and incidents that result in fractures, head injuries or require treatment at a hospital. Notice shall be made no later than the next working day.	R 224		

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R 224	Continued From page 3 This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the home failed to submit an incident report to the Oklahoma State Department of Health (OSDH) for a fall with injury for one (#1) of two sampled residents who had falls in the past year. The home identified two residents who had fallen within the past year. Findings: Resident #1 had diagnosis which included bipolar. On 06/03/21 at 8:00 a.m., the resident was observed in the common area of the home, with a cast on her left arm. The resident was observed ambulating without difficulty. At 9:16 a.m., the administrator stated resident #1 had a cast on her arm because she had a fall outside. The administrator stated she did not submit an incident report to OSDH. At 10:00 a.m., the resident was asked why her arm was in a cast. She stated she fell off the back porch. She stated she went to the doctor and they put the cast on.	R 224		
R 236 SS=D	310:680-3-7 (b)(9) RESIDENT RECORDS/RESIDENT'S FUNDS (b) Every resident record shall be written in ink and include as a minimum, the following information:	R 236		

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R 236	Continued From page 4 (9) An accounting of the resident's funds received and or distributed by the residential care home. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to keep an accurate record of resident funds for one (#2) of two residents whose records were reviewed for funds received and distributed by the home. The administrator identified 31 residents whose finances were managed by the home. Findings: Resident #2 had diagnoses which included bipolar disorder. A financial summary, dated 09/2020, documented the resident received $627.40 from social security. The statement did not document how the funds were distributed. On 06/03/21 at 10:20 a.m., the resident was asked who handled her money. She identified the administrator as her payee. At 1:52 p.m., the administrator stated the home was the payee for resident #2. She was asked why the home was the payee. She stated the resident needed a payee per social security. The administrator was asked if the funds received and distributed were documented on the monthly financial summary for the month of September 2020. She stated, "No."	R 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 309	Continued From page 5	R 309		
R 309 SS=E	310:680-5-1 (9) GENERAL CRITERIA - GOOD REPAIR Residential care homes must meet or exceed the following requirements: (9) Each residential care home shall be maintained in good repair for operation and appearance. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the home was maintained in good repair. This had the potential to affect all 47 residents who resided at the home. Findings: On 06/03/21 at 8:18 a.m., the men's hallway was dim. Two of the fluorescent lights on the hall were completely out and three were partially out and flickering. At 8:07 a.m., a shower room door on the men's hall was closed and locked. A resident stated the shower was not working. At 8:34 a.m., an outside window pane was obsvered to be broken. At 3:04 p.m., maintenance employee #3 stated the shower was leaking and it needed to be repaired. He was asked how long it had not been working. He stated approximately three weeks.	R 309		

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R 309	Continued From page 6 The administrator observed the observations and agreed they needed to be repaired.	R 309		
R 325 SS=E	310:680-5-6 (c) BUILDING ELEMENTS - DOORS/WINDOWS (c) All doors and windows opening to the outside for ventilation shall be screened. Screens shall be well fitted and in good repair. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all windows, opening to the outside for ventilation, had fitted screens in good repair. This had the potential to affect all 47 residents who resided in the home. Findings: On 06/03/21 at 8:00 a.m., a screen was missing over a front common area window. The screen was leaning against the building. At 8:30 a.m., during a tour of the grounds, several windows had either missing or torn screens. The administrator stated the screens needed to be replaced.	R 325		
R 813 SS=G	310:680-19-2 (a)(5) STATEMENT PROVISIONS (a) A statement of rights and responsibilities shall include but not be limited to the following:	R 813		

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R 813	Continued From page 7 (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 shall be fully informed by his attending physician of his medical condition and proposed treatment in terms and language that the resident can understand, unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure cardiopulmonary resuscitation (CPR) was initiated upon finding and unresponsive resident without a pulse for one (#3) of one resident who required CPR. This had the potential to affect all 47 residents who resided at the home. Findings: A facility policy titled, "Emergency Procedures", documented: "...In case of resident injury, staff shall administer appropriate first aid and/or CPR..."	R 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 813	Continued From page 8 Resident #3 had diagnoses which included schizophrenia, hypertension and hyperlipidemia. An Oklahoma State Department of Health (OSDH) incident report, dated 05/02/21, documented the resident was found down and unresponsive and 911 (Emergency Services) was called. The report documented, "They worked on her for about 30 minutes and pronounced her deceased." The police report documented, "...On Sunday 05/02/21 at approximately 1525 hours (3:25 p.m.), I was dispatched to the Maud Residential care...for possible death...I arrived on scene and went into room...where an employee...was standing...I checked on [Resident #3], her hands up to her elbows were cold along with her feet to her kneecaps. I checked her chess [sic] and neck area which seemed to still be warm. Due to CPR not being started I advised [employee #2] she might be too far gone to help but we will see what we can do...Firefighters...arrived on scene...They checked [Resident #3]...and advised they think she could be workable to save...Ambulance services arrived on scene and took over..." A prehospital care report summary from the ambulance company, dated 05/02/21, documented, "Call Information...Initial Patient Acuity: Dead without Resuscitation Efforts..." On 06/03/21 at 9:18 a.m., the administrator stated the resident was last seen by employees at 1:30 p.m., she stated the resident refused her medications at that time. She then stated the evening shift employee went to the women's hall to clean and found the resident unresponsive. The administrator was asked if the resident required CPR. She stated yes. She stated she	R 813		

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R 813	Continued From page 9 did not have any residents who had an order to withhold resuscitation efforts (Do not resuscitate) (DNR). At 9:39 a.m., employee #2 was asked how she found the resident on 05/02/21. She stated the resident was in the bed, unresponsive and cold. She stated she could not get a pulse and the resident was not breathing and she could not get a blood pressure. She was asked if she had started CPR prior to the police arriving. She stated no, she was on the phone with the 911 operator and she told them she could not do mouth to mouth because the resident had drainage coming out of her nose. She stated the operator told her to do chest compressions. She stated when the police arrived she was trying to get CPR going. Employee #2 had training and was certified in CPR. On 06/03/21 at 6:26 p.m., the responding police officer was asked if the employees from the home were administering CPR at the time of his arrival. He stated no. He stated there was an employee standing beside the resident. He stated he did not personally see any CPR being done by the home's employees. He stated the only people he witnessed performing CPR was the Maud Fire Department and the ambulance service. Based on interview and record review, it was determined the home failed to ensure	R 813		

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R 813	Continued From page 10	R 813		

cardiopulmonary resuscitation (CPR) was initiated upon finding and unresponsive resident without a pulse for one (#3) of one resident who required CPR.

This had the potential to affect all 47 residents who resided at the home.

Findings:

A facility policy titled, "Emergency Procedures", documented: "...In case of resident injury, staff shall administer appropriate first aid and/or CPR..."

Resident #3 had diagnoses which included schizophrenia, hypertension and hyperlipidemia.

An Oklahoma State Department of Health (OSDH) incident report, dated 05/02/21, documented the resident was found down and unresponsive and 911 (Emergency Services) was called. The report documented, "They worked on her for about 30 minutes and pronounced her deceased."

The police report documented, "...On Sunday 05/02/21 at approximately 1525 hours (3:25 p.m.), I was dispatched to the Maud Residential care...for possible death...I arrived on scene and went into room...where an employee...was standing...I checked on [Resident #3], her hands up to her elbows were cold along with her feet to her kneecaps. I checked her chess [sic] and neck area which seemed to still be warm. Due to CPR not being started I advised [employee #2] she might be too far gone to help but we will see what we can do...Firefighters...arrived on scene...They checked [Resident #3]...and advised they think she could be workable to save...Ambulance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6304	A. BUILDING: _____ B. WING _____	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUD RESIDENTIAL CARE	403 W WANDA JACKSON BLVD MAUD, OK 74854

(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
R 813	Continued From page 11 services arrived on scene and took over..." A prehospital care report summary from the ambulance company, dated 05/02/21, documented, "Call Information...Initial Patient Acuity: Dead without Resuscitation Efforts..." On 06/03/21 at 9:18 a.m., the administrator stated the resident was last seen by employees at 1:30 p.m., she stated the resident refused her medications at that time. She then stated the evening shift employee went to the women's hall to clean and found the resident unresponsive. The administrator was asked if the resident required CPR. She stated yes. She stated she did not have any residents who had an order to withhold resuscitation efforts (Do not resuscitate) (DNR). At 9:39 a.m., employee #2 was asked how she found the resident on 05/02/21. She stated the resident was in the bed, unresponsive and cold. She stated she could not get a pulse and the resident was not breathing and she could not get a blood pressure. She was asked if she had started CPR prior to the police arriving. She stated no, she was on the phone with the 911 operator and she told them she could not do mouth to mouth because the resident had drainage coming out of her nose. She stated the operator told her to do chest compressions. She stated when the police arrived she was trying to get CPR going. Employee #2 had training and was certified in CPR. On 06/03/21 at 6:26 p.m., the responding police officer was asked if the employees from the home were administering CPR at the time of his arrival.	R 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 813	Continued From page 12 He stated no. He stated there was an employee standing beside the resident. He stated he did not personally see any CPR being done by the home's employees. He stated the only people he witnessed performing CPR was the Maud Fire Department and the ambulance service. Based on interview and record review, it was determined the home failed to ensure cardiopulmonary resuscitation (CPR) was initiated upon finding and unresponsive resident without a pulse for one (#3) of one resident who required CPR. This had the potential to affect all 47 residents who resided at the home. Findings: A facility policy titled, "Emergency Procedures", documented: "...In case of resident injury, staff shall administer appropriate first aid and/or CPR..." Resident #3 had diagnoses which included schizophrenia, hypertension and hyperlipidemia. An Oklahoma State Department of Health (OSDH) incident report, dated 05/02/21, documented the resident was found down and unresponsive and 911 (Emergency Services) was called. The report documented, "They worked on her for about 30 minutes and pronounced her deceased." The police report documented, "...On Sunday	R 813		

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R 813	Continued From page 13 05/02/21 at approximately 1525 hours (3:25 p.m.), I was dispatched to the Maud Residential care...for possible death...I arrived on scene and went into room...where an employee...was standing...I checked on [Resident #3], her hands up to her elbows were cold along with her feet to her kneecaps. I checked her chess [sic] and neck area which seemed to still be warm. Due to CPR not being started I advised [employee #2] she might be too far gone to help but we will see what we can do...Firefighters...arrived on scene...They checked [Resident #3]...and advised they think she could be workable to save...Ambulance services arrived on scene and took over..." A prehospital care report summary from the ambulance company, dated 05/02/21, documented, "Call Information...Initial Patient Acuity: Dead without Resuscitation Efforts..." On 06/03/21 at 9:18 a.m., the administrator stated the resident was last seen by employees at 1:30 p.m., she stated the resident refused her medications at that time. She then stated the evening shift employee went to the women's hall to clean and found the resident unresponsive. The administrator was asked if the resident required CPR. She stated yes. She stated she did not have any residents who had an order to withhold resuscitation efforts (Do not resuscitate) (DNR). At 9:39 a.m., employee #2 was asked how she found the resident on 05/02/21. She stated the resident was in the bed, unresponsive and cold. She stated she could not get a pulse and the resident was not breathing and she could not get a blood pressure. She was asked if she had started CPR prior to the police arriving. She stated no, she was on the phone with the 911	R 813		

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R 813	Continued From page 14 operator and she told them she could not do mouth to mouth because the resident had drainage coming out of her nose. She stated the operator told her to do chest compressions. She stated when the police arrived she was trying to get CPR going. Employee #2 had training and was certified in CPR. On 06/03/21 at 6:26 p.m., the responding police officer was asked if the employees from the home were administering CPR at the time of his arrival. He stated no. He stated there was an employee standing beside the resident. He stated he did not personally see any CPR being done by the home's employees. He stated the only people he witnessed performing CPR was the (local city) Fire and the ambulance service.	R 813		

OKLAHOMA
State Department
of Health

Delivery via email to: middleej@yahoo.com

July 20, 2021

License Number: RC6304
Survey Event ID: BIZ811

Ms. Sherry Snider, Administrator
Maud Residential Care
300 Hwy 39 E
Konawa, OK 74849

Dear Ms. Snider:

On **June 3, 2021**, agents from our office completed a complaint investigation at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **Tag R158 does not address how the deficient pracitce was corrected for resident #2, and does not address how the facility is going to have "clear records."**
- **Tag R309 does not address the actual items needing repair. The plan of correction was to only tell the maintenance man immediately of things which need to be repaired. The facility's plan did not include any documentation of the things which need repair or logging system. Therefore, not likely to prevent further deficienct practice.**
- **The notice of deficiencies was emailed on July 8, 2021. The plan of correction date of August 15, 2021 is greater than 30 calendar days from the date the notice was sent.**
- **Tags R158, R224, R236, R309, and R813 are not accepted due to the POC date being past the 30 day requirement.**
- **Tag R325 is not accepted due to the extension request of September 14, 2021 being greater than 60 days from the letter receipt date of July 8, 2021.**

An amended plan of correction is due within 10 days of receipt of this notice.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.07.20 11:43:20 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement
Oklahoma State Department of Health

Enclosure

Maud Residential

POC for complaint investigation on June 3, 2021

Event #: B12871

R 158 63 O.S. 1-1918.B.12. RIGHTS-Abuse, Neglect, Seclusion & Restraints

Administrator shall ensure that all financial exploitation of all residents is prevented.

Administrator shall ensure this by keeping clear records of all the residents money. That all residents money is just for them and that each just spends their own money on self.

Complete date: 8-15-2021

R 224 310:680-3-6 (d) RECORDS AND REPORTS

Administrator shall ensure that all critical incidents are reported and sent to OSDH.

Administrator shall ensure this by filling out critical incident report within 24 hours of incident and faxing it to OSDH.

Complete date: 8-15-2021

R 236 310:680-3-7 (b)(9) RESIDENT RECORDS/RESIDENTS FUNDS

Administrator shall ensure that all residents funds records are complete and signed by resident.

Administrator shall ensure this by filling in all the blanks of the fund records form and then having resident sign and date.

Complete date: 8-15-2021

R 309 310:680-5-1 (9) GENERAL CRITERIA-GOOD REPAIR

Administrator shall ensure that all repairs are repaired in a timely manner and kept maintained in good repair.

Administrator shall ensure this by immediately telling the maintenance man what needs repaired. If repairs are too much for him, then hire someone to fix repairs.

Complete date: 8-15-2021

R325 310:680-5-6 (c) BUILDING ELEMENTS-DOORS/WINDOWS

Administrator shall ensure that all windows have fitted screens in good repair.

Administrator shall ensure this by repairing or replacing screen on all windows in the facility.

Administrator would request the additional 30 days for this as it is a time consuming job.

Date complete: 9-14-2021

R 318 310:680-19-2 (a)(5) STATEMENT PROVISIONS

Administrator shall ensure that all staff administers the appropriate first aid and/or CPR to any resident requiring it.

Administrator shall ensure this by periodically discussing the procedures in the in-service trainings, such as stay calm, remember training, do what needs to be done. Administrator shall also purchase a rescue mask resuscitation kit to keep in the facility for emergencies. Administrator shall also locate a back board to put under a resident that requires chest compressions.

Complete date: 8-15-2021

Oklahoma State Department of Health

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R 000	INITIAL COMMENTS An abbreviated survey was conducted on 06/03/21 to investigate complaint #OK00055825, #OK00056240 and complaint #OK00057108. Total residents: 47	R 000		
R 158 SS=D	63 O.S. 1-1918.B.12. RIGHTS-Abuse, Neglect, Seclusion & Restraints Section 1-840. Other provisions applicable to residential care homes Residential care homes subject to the provisions of the Residential Care Act shall comply with the provisions of Sections 1-1909, 1-1910, 1-1914.1, 1-1914.2, 1-1915, 1-1917, 1-1918, 1-1919, 1-1920, 1-1921, 1-1922, 1-1924, 1-1926, 1-1927, 1-1930, 1-1939, 1-1940 and 1-1941 of this title. 63 O.S. 1-1918(B)12. Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	R 158		

Oklahoma State Department of Health

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R 158	Continued From page 1 43A-10-103.(A)8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult. 43A-10-103.(A)10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services. This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the home failed to prevent financial exploitation of a vulnerable adult for one (#2) of two sampled residents whose funds were managed by the home. The administrator identified 31 residents whose finances were managed by the home. Findings:	R 158		

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
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R 158	Continued From page 2 Resident #2 had diagnosis which included bipolar disorder. On 06/03/21 at 1:52 p.m., the resident's name and an amount of $1200.00 was written on an envelope. The administrator stated the money was from the resident's stimulus money. The envelope revealed on 07/24/20 an air conditioner (AC) was purchased for $200.00 out of the resident's funds. The administrator stated air conditioning was included in the price of rent. The administrator was asked if the home purchased an AC unit for the common area out of the resident's funds. She stated yes. The window AC unit was observed in an equipment room. At 2:30 p.m., the resident was asked if the home purchased an AC unit out of her personal funds. She stated yes.	R 158		
R 224 SS=D	310:680-3-6 (d) RECORDS AND REPORTS (d) The Department shall be notified of all incidents pertaining to fire, storm damage, death other than natural, residents missing, or utilities failure for more than four (4) hours, and incidents that result in fractures, head injuries or require treatment at a hospital. Notice shall be made no later than the next working day.	R 224		

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R 224	Continued From page 3 This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the home failed to submit an incident report to the Oklahoma State Department of Health (OSDH) for a fall with injury for one (#1) of two sampled residents who had falls in the past year. The home identified two residents who had fallen within the past year. Findings: Resident #1 had diagnosis which included bipolar. On 06/03/21 at 8:00 a.m., the resident was observed in the common area of the home, with a cast on her left arm. The resident was observed ambulating without difficulty. At 9:16 a.m., the administrator stated resident #1 had a cast on her arm because she had a fall outside. The administrator stated she did not submit an incident report to OSDH. At 10:00 a.m., the resident was asked why her arm was in a cast. She stated she fell off the back porch. She stated she went to the doctor and they put the cast on.	R 224		
R 236 SS=D	310:680-3-7 (b)(9) RESIDENT RECORDS/RESIDENT'S FUNDS (b) Every resident record shall be written in ink and include as a minimum, the following information:	R 236		

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R 236	Continued From page 4 (9) An accounting of the resident's funds received and or distributed by the residential care home. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to keep an accurate record of resident funds for one (#2) of two residents whose records were reviewed for funds received and distributed by the home. The administrator identified 31 residents whose finances were managed by the home. Findings: Resident #2 had diagnoses which included bipolar disorder. A financial summary, dated 09/2020, documented the resident received $627.40 from social security. The statement did not document how the funds were distributed. On 06/03/21 at 10:20 a.m., the resident was asked who handled her money. She identified the administrator as her payee. At 1:52 p.m., the administrator stated the home was the payee for resident #2. She was asked why the home was the payee. She stated the resident needed a payee per social security. The administrator was asked if the funds received and distributed were documented on the monthly financial summary for the month of September 2020. She stated, "No."	R 236		

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R 309	Continued From page 5	R 309		
R 309 SS=E	310:680-5-1 (9) GENERAL CRITERIA - GOOD REPAIR	R 309		

Residential care homes must meet or exceed the following requirements:

(9) Each residential care home shall be maintained in good repair for operation and appearance.

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the home was maintained in good repair.

This had the potential to affect all 47 residents who resided at the home.

Findings:

On 06/03/21 at 8:18 a.m., the men's hallway was dim. Two of the fluorescent lights on the hall were completely out and three were partially out and flickering.

At 8:07 a.m., a shower room door on the men's hall was closed and locked. A resident stated the shower was not working.

At 8:34 a.m., an outside window pane was obsvered to be broken.

At 3:04 p.m., maintenance employee #3 stated the shower was leaking and it needed to be repaired. He was asked how long it had not been working. He stated approximately three weeks.

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R 309	Continued From page 6 The administrator observed the observations and agreed they needed to be repaired.	R 309		
R 325 SS=E	310:680-5-6 (c) BUILDING ELEMENTS - DOORS/WINDOWS (c) All doors and windows opening to the outside for ventilation shall be screened. Screens shall be well fitted and in good repair. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all windows, opening to the outside for ventilation, had fitted screens in good repair. This had the potential to affect all 47 residents who resided in the home. Findings: On 06/03/21 at 8:00 a.m., a screen was missing over a front common area window. The screen was leaning against the building. At 8:30 a.m., during a tour of the grounds, several windows had either missing or torn screens. The administrator stated the screens needed to be replaced.	R 325		
R 813 SS=G	310:680-19-2 (a)(5) STATEMENT PROVISIONS (a) A statement of rights and responsibilities shall include but not be limited to the following:	R 813		

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R 813	Continued From page 7 (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 shall be fully informed by his attending physician of his medical condition and proposed treatment in terms and language that the resident can understand, unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure cardiopulmonary resuscitation (CPR) was initiated upon finding and unresponsive resident without a pulse for one (#3) of one resident who required CPR. This had the potential to affect all 47 residents who resided at the home. Findings: A facility policy titled, "Emergency Procedures", documented: "...In case of resident injury, staff shall administer appropriate first aid and/or CPR..."	R 813		

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MAUD RESIDENTIAL CARE	403 W WANDA JACKSON BLVD MAUD, OK 74854

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R 813	Continued From page 8 Resident #3 had diagnoses which included schizophrenia, hypertension and hyperlipidemia. An Oklahoma State Department of Health (OSDH) incident report, dated 05/02/21, documented the resident was found down and unresponsive and 911 (Emergency Services) was called. The report documented, "They worked on her for about 30 minutes and pronounced her deceased." The police report documented, "...On Sunday 05/02/21 at approximately 1525 hours (3:25 p.m.), I was dispatched to the Maud Residential care...for possible death...I arrived on scene and went into room...where an employee...was standing...I checked on [Resident #3], her hands up to her elbows were cold along with her feet to her kneecaps. I checked her chess [sic] and neck area which seemed to still be warm. Due to CPR not being started I advised [employee #2] she might be too far gone to help but we will see what we can do...Firefighters...arrived on scene...They checked [Resident #3]...and advised they think she could be workable to save...Ambulance services arrived on scene and took over..." A prehospital care report summary from the ambulance company, dated 05/02/21, documented, "Call Information...Initial Patient Acuity: Dead without Resuscitation Efforts..." On 06/03/21 at 9:18 a.m., the administrator stated the resident was last seen by employees at 1:30 p.m., she stated the resident refused her medications at that time. She then stated the evening shift employee went to the women's hall to clean and found the resident unresponsive. The administrator was asked if the resident required CPR. She stated yes. She stated she	R 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6304	A. BUILDING: _____ B. WING _____	06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUD RESIDENTIAL CARE	403 W WANDA JACKSON BLVD MAUD, OK 74854

(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
R 813	Continued From page 9 did not have any residents who had an order to withhold resuscitation efforts (Do not resuscitate) (DNR). At 9:39 a.m., employee #2 was asked how she found the resident on 05/02/21. She stated the resident was in the bed, unresponsive and cold. She stated she could not get a pulse and the resident was not breathing and she could not get a blood pressure. She was asked if she had started CPR prior to the police arriving. She stated no, she was on the phone with the 911 operator and she told them she could not do mouth to mouth because the resident had drainage coming out of her nose. She stated the operator told her to do chest compressions. She stated when the police arrived she was trying to get CPR going. Employee #2 had training and was certified in CPR. On 06/03/21 at 6:26 p.m., the responding police officer was asked if the employees from the home were administering CPR at the time of his arrival. He stated no. He stated there was an employee standing beside the resident. He stated he did not personally see any CPR being done by the home's employees. He stated the only people he witnessed performing CPR was the Maud Fire Department and the ambulance service. Based on interview and record review, it was determined the home failed to ensure	R 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6304	A. BUILDING: _____ B. WING _____	06/03/2021

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R 813	Continued From page 10 cardiopulmonary resuscitation (CPR) was initiated upon finding and unresponsive resident without a pulse for one (#3) of one resident who required CPR. This had the potential to affect all 47 residents who resided at the home. Findings: A facility policy titled, "Emergency Procedures", documented: "...In case of resident injury, staff shall administer appropriate first aid and/or CPR..." Resident #3 had diagnoses which included schizophrenia, hypertension and hyperlipidemia. An Oklahoma State Department of Health (OSDH) incident report, dated 05/02/21, documented the resident was found down and unresponsive and 911 (Emergency Services) was called. The report documented, "They worked on her for about 30 minutes and pronounced her deceased." The police report documented, "...On Sunday 05/02/21 at approximately 1525 hours (3:25 p.m.), I was dispatched to the Maud Residential care...for possible death...I arrived on scene and went into room...where an employee...was standing...I checked on [Resident #3], her hands up to her elbows were cold along with her feet to her kneecaps. I checked her chess [sic] and neck area which seemed to still be warm. Due to CPR not being started I advised [employee #2] she might be too far gone to help but we will see what we can do...Firefighters...arrived on scene...They checked [Resident #3]...and advised they think she could be workable to save...Ambulance	R 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6304	A. BUILDING _____ B. WING _____	06/03/2021

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R 813	Continued From page 11 services arrived on scene and took over..." A prehospital care report summary from the ambulance company, dated 05/02/21, documented, "Call Information...Initial Patient Acuity: Dead without Resuscitation Efforts..." On 06/03/21 at 9:18 a.m., the administrator stated the resident was last seen by employees at 1:30 p.m., she stated the resident refused her medications at that time. She then stated the evening shift employee went to the women's hall to clean and found the resident unresponsive. The administrator was asked if the resident required CPR. She stated yes. She stated she did not have any residents who had an order to withhold resuscitation efforts (Do not resuscitate) (DNR). At 9:39 a.m., employee #2 was asked how she found the resident on 05/02/21. She stated the resident was in the bed, unresponsive and cold. She stated she could not get a pulse and the resident was not breathing and she could not get a blood pressure. She was asked if she had started CPR prior to the police arriving. She stated no, she was on the phone with the 911 operator and she told them she could not do mouth to mouth because the resident had drainage coming out of her nose. She stated the operator told her to do chest compressions. She stated when the police arrived she was trying to get CPR going. Employee #2 had training and was certified in CPR. On 06/03/21 at 6:26 p.m., the responding police officer was asked if the employees from the home were administering CPR at the time of his arrival.	R 813		

Oklahoma State Department of Health

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R 813	Continued From page 12 He stated no. He stated there was an employee standing beside the resident. He stated he did not personally see any CPR being done by the home's employees. He stated the only people he witnessed performing CPR was the Maud Fire Department and the ambulance service. Based on interview and record review, it was determined the home failed to ensure cardiopulmonary resuscitation (CPR) was initiated upon finding and unresponsive resident without a pulse for one (#3) of one resident who required CPR. This had the potential to affect all 47 residents who resided at the home. Findings: A facility policy titled, "Emergency Procedures", documented: "...In case of resident injury, staff shall administer appropriate first aid and/or CPR..." Resident #3 had diagnoses which included schizophrenia, hypertension and hyperlipidemia. An Oklahoma State Department of Health (OSDH) incident report, dated 05/02/21, documented the resident was found down and unresponsive and 911 (Emergency Services) was called. The report documented, "They worked on her for about 30 minutes and pronounced her deceased." The police report documented, "...On Sunday	R 813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 813	Continued From page 13 05/02/21 at approximately 1525 hours (3:25 p.m.), I was dispatched to the Maud Residential care...for possible death...I arrived on scene and went into room...where an employee...was standing...I checked on [Resident #3], her hands up to her elbows were cold along with her feet to her kneecaps. I checked her chess [sic] and neck area which seemed to still be warm. Due to CPR not being started I advised [employee #2] she might be too far gone to help but we will see what we can do...Firefighters...arrived on scene...They checked [Resident #3]...and advised they think she could be workable to save...Ambulance services arrived on scene and took over..." A prehospital care report summary from the ambulance company, dated 05/02/21, documented, "Call Information...Initial Patient Acuity: Dead without Resuscitation Efforts..." On 06/03/21 at 9:18 a.m., the administrator stated the resident was last seen by employees at 1:30 p.m., she stated the resident refused her medications at that time. She then stated the evening shift employee went to the women's hall to clean and found the resident unresponsive. The administrator was asked if the resident required CPR. She stated yes. She stated she did not have any residents who had an order to withhold resuscitation efforts (Do not resuscitate) (DNR). At 9:39 a.m., employee #2 was asked how she found the resident on 05/02/21. She stated the resident was in the bed, unresponsive and cold. She stated she could not get a pulse and the resident was not breathing and she could not get a blood pressure. She was asked if she had started CPR prior to the police arriving. She stated no, she was on the phone with the 911	R 813		