
Delivery via email to: middleej@yahoo.com

February 28, 2023

License Number: RC6304

Survey Event ID: YUPR11

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

Dear Ms. Snider:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **February 21, 2023**.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

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

In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 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 or conducted in a face-to-face 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.

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC6304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/21/2023
NAME OF PROVIDER OR SUPPLIER MAUD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A re-licensure survey was conducted on 02/21/23. Current census was 45. The following deficiencies were cited.	R 000		
R 322 SS=F	310:680-5-5 FIRE SAFETY Each residential care home shall provide documentation that the State Fire Marshal or the State Fire Marshal's representative has inspected and approved the home prior to issuance of an initial license. Each residential care home with more than six beds shall provide documentation of annual inspection and approval prior to issuance of a license renewal. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to provide documentation that the State Fire Marshal or their representative completed an annual inspection with approval. This failed practice had the widespread potential for more than minimal harm for all 45 residents. Findings: On 02/21/23 at 2:30 p.m., the most current documentation found of a fire marshal inspection of the home was expired. No other fire inspection documentation could be located in the submitted manuals. The owner/administrator was asked if the home had a fire marshal inspection in the past year. She stated she knows it is expired and has been trying to get an inspection scheduled. She stated she would schedule an inspection as soon as possible.	R 322		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC6304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/21/2023
NAME OF PROVIDER OR SUPPLIER MAUD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 1	R 510		
R 510 SS=F	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements. (A) All employees shall be currently certified in first-aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure current first-aid and CPR (cardiopulmonary resuscitation) certification documentation was on file in the home for 3 (cook/employee #7, cook/employee #8, maintenance/employee #9) of 9 direct care employees. This failed practice had the widespread potential for more than minimal harm	R 510		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC6304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/21/2023
NAME OF PROVIDER OR SUPPLIER MAUD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 510	Continued From page 2 for all 45 residents. Findings: The employee record for cook/employee #7, did not contain documentation of current first-aid or CPR certification. The employee record for cook/employee #8, did not contain documentation of current first-aid or CPR certification. The employee record for maintenance/employee #9, did not contain documentation of current first-aid or CPR certification. On 02/21/23 at 3:15 p.m., the administrator was asked about the missing current first-aid and CPR certifications. She stated she would schedule classes to get the employees current first-aid and CPR certification.	R 510		

Delivery via email to: middleej@yahoo.com

March 9, 2023

License Number: RC6304
Survey Event ID: YUPR11

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

Dear Ms. Snider:

On **February 21, 2023**, a State Licensure survey was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 4, 2023**.

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,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2023.03.09 15:26:19 -06'00'

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

enc

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC6304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/21/2023
NAME OF PROVIDER OR SUPPLIER MAUD RESIDENTIAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 A re-licensure survey was conducted on 02/21/23. Current census was 45. The following deficiencies were cited.	R 000			
R 322 SS=F	310:680-5-5 FIRE SAFETY Each residential care home shall provide documentation that the State Fire Marshal or the State Fire Marshal's representative has inspected and approved the home prior to issuance of an initial license. Each residential care home with more than six beds shall provide documentation of annual inspection and approval prior to issuance of a license renewal. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to provide documentation that the State Fire Marshal or their representative completed an annual inspection with approval. This failed practice had the widespread potential for more than minimal harm for all 45 residents. Findings: On 02/21/23 at 2:30 p.m., the most current documentation found of a fire marshal inspection of the home was expired. No other fire inspection documentation could be located in the submitted manuals. The owner/administrator was asked if the home had a fire marshal inspection in the past year. She stated she knows it is expired and has been trying to get an inspection scheduled. She stated she would schedule an inspection as soon as possible.	R 322			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE FORM

6899

YUPR11

If continuation sheet 1 of 3

[Signature]

Administrator

3-7-23

R322 310:680-5-5 FIRE SAFETY

Administrator shall ensure that the residential home provides documentation that the State Fire Marshall has inspected and approved the home to issue license renewal.

Administrator shall ensure this by contacting the State Fire Marshall to come and conduct an inspection. Administrator shall also check files and keep all inspections current and up to date.

Complete date: 4-4-2023

R510 310:680-11-1 (3)(A) STAFF TRAINING – FIRST AID/CPR

Administrator shall ensure that all staff employed at Maud Residential have CPR/FIRST AID training.

Administrator shall ensure this by contacting qualified person to conduct the training on all employees. Administrator shall also check files and keep all the trainings current.

Complete date: 4-4-2023

Delivery via email to: middleej@yahoo.com

March 24, 2023

License Number: RC6304
Survey Event ID: YUPR12

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

Dear Ms. Snider:

On **March 23, 2023**, a revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **February 21, 2023**, have now been corrected and your facility is in compliance with licensure standards effective **March 22, 2023**.

If you have any questions concerning the information in this letter, please contact this office at (405) 426-8200.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC6304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/23/2023
NAME OF PROVIDER OR SUPPLIER MAUD RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A follow-up survey was conducted on 03/23/23. All deficiencies were cleared.	{R 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE