OKLAHOMA
State Department of Health

Delivery via email to: maudresidential@gmail.com

June 11, 2025

License Number: RC6304
Survey Event ID: **UOFU11**

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

Dear Ms. Snider:

Enclosed is a report of the inspection with complaint investigation conducted at your Residential Care facility on **June 3, 2025**. No deficiencies were cited. Oklahoma Statutes 63, Section 1-840 requires that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: MAUD RESIDENTIAL CARE
Address: 403 W WANDA JACKSON BLVD
City, State, Zip: MAUD, OK 74854
Provider #: RC6304
Complaint #: OK00064117
Investigation Date(s): 06/03/25

ALLEGATION(S)
THE CENTER FAILED TO ENSURE RESIDENTS' BELONGINGS WERE RETURNED UPON DISCHARGE.
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An unannounced on-site investigation was initiated 06/03/2025 at 11:30 A.M.

A sample of 8 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:

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: 06/03/2025

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
	RC6304	A. BUILDING: _____ B. WING _____	C 06/03/2025

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 A relicensure and complaint survey (#OK00064117) was conducted on 06/03/25. No deficiencies were cited. Facility Census: 45	R 000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE