STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375512	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell Care & Rehab Center	315 West Electric Avenue McAlester, OK 74501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45462 Based on record review and interview, the facility failed to ensure a residents were free from abuse for two (#3 and #4) of four sampled residents reviewed for abuse. The DON identified 52 residents resided in the facility. Findings: An Abuse Prevention policy, revised 10/21/22, read in part, The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff .Mental Abuse: The use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame 1. Resident #3 had diagnoses which included major depressive disorder and morbid obesity. A 5-day resident assessment, dated 09/09/24, documented Resident #3's cognition was moderately impaired. It documented the resident made themselves understood and was able to understand others. On 11/05/24 at 2:35 p.m., Resident #3 was asked how they were treated by staff. They reported CNA #1 would talk mean to them and called them disgusting. Resident #3 stated it made them feel bad and they were glad CNA #1 was no longer at the facility. 2. Resident #4 had diagnoses which included severe vascular dementia and other impulse disorders. A quarterly resident assessment, dated 10/16/24, documented Resident #4's cognition was severly impaired. On 11/05/24 at 2:08 p.m., an interview was attempted with Resident #4. The resident would smile, but did not respond to any of the questions which were asked. An initial incident report form, incident date 08/20/24, documented CNA #1 was overheard telling Resident #4 if they did not stop misbehaving they were not getting another cigarette. The report documented CNA #1 was later overheard telling Resident #3 several times that they were a disgrace. A facsimile transmission report documented the incident report was faxed to the OSDH on 08/21/24 at 4:33 p.m. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A final incident report form, with a facsimile transmission date of 08/23/24 at 6:03 p.m., documented the above allegations of abuse were substantiated and CNA #1 was terminated. On 11/05/24 at 4:30 p.m., the administrator stated CNA #1 was terminated on 08/21/24 for being verbally abusive towards Resident #3 and #4. They reported the facility had six in-services within the last year on abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to report an allegation of abuse to the proper authorities for one (#2) of four sampled residents reviewed for abuse. The administrator reported there were 52 residents residing in the facility. Findings: An Abuse Prevention policy, revised 10/21/24, read in parts, The Administrator, or designee, shall report any allegations of abuse .to the Department of Health as required. Resident #2 had diagnoses that included muscle weakness, lack of coordination, and chronic respiratory failure. A MDS, dated [DATE], documented Resident #2 required one person assistance for hygiene and dressing, experienced shortness of breath with exertion, was oxygen dependent, and was currently using a wheelchair for mobility. A formal complaint submitted to the OSDH on 08/15/24 alleged that LPN #1 had been abusive towards Resident #2. The report documented Resident #2 had asked LPN #1 to get them a cup of coffee. It documented LPN #1 went and got a wheelchair, put it in the resident's doorway, and told the resident if they wanted a cup of coffee they would have to get it themselves. It documented LPN #1's response was considered abusive. On 11/05/24 at 2:35 p.m., LPN #1 reported they had taken Resident #2 to the DON to report the incident when it happened. There was no documentation the alleged allegation of abuse had been reported to the OSDH. On 11/05/24 at 4:13 p.m., the DON acknowledged Resident #2 had reported the above incident to them and had expressed they felt the staff had been abusive. The DON was asked if Resident #2's reporting of the incident would be considered an allegation of abuse by a staff member. They stated, Yes. They were asked if the incident had been reported to the proper authorities and they stated, No, we did not do a State Reportable.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45462 Based on record review and interview, the facility failed to investigate an allegation of abuse for one (#2) of four sampled residents reviewed for abuse. The administrator reported there were 52 residents residing in the facility. Findings: An Abuse Prevention policy, revised 10/21/22, read in part, The facility will initiate at the time of any finding of potential abuse or neglect an investigation .and provide protection to any alleged victims to prevent harm during the continuance of the investigation. Resident #2 had diagnoses which included muscle weakness, lack of coordination, and chronic respiratory failure. A formal complaint submitted to the OSDH on 08/15/24 alleged that LPN #1 had been abusive towards Resident #2. The report documented Resident #2 had asked LPN #1 to get them a cup of coffee. It documented LPN #1 went and got a wheelchair, put it in the resident's doorway, and told the resident if they wanted a cup of coffee they would have to get it themselves. It documented LPN #1's response was considered abusive. On 11/05/24 at 2:35 p.m., LPN #1 reported they had taken Resident #2 to the DON to report the incident when it happened. LPN #1 denied being asked to write a statement describing their account of the incident or being removed from their work assignment while an investigation of the incident was completed. On 11/05/24 at 4:13 p.m., the DON acknowledged Resident #2 had reported the above incident to them and expressed they felt the staff had been abusive. When asked if there had been a formal investigation conducted the DON stated, No. They agreed facility policy had not been followed.