

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Mitchell Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>33097</p> <p>Based on record review and interview, the facility failed to complete nurse aide performance reviews at least yearly for 18 of 22 nurse aides employed by the facility.</p> <p>The administrator identified 22 full time nurse aides currently employed by the facility.</p> <p>Findings:</p> <p>An employee list documented 22 staff members currently working as certified nurse aides.</p> <p>On 07/22/24 at 3:17 p.m., the administrator provided documentation regarding a nurse aide skills performance checklist for four certified nurse aides currently working for the facility.</p> <p>On 07/22/24 at 4:00 p.m., the administrator stated only four of the 22 nurse aides currently working had a completed performance review. The administrator stated a previous employee had not completed the required task for all certified nurse aides.</p>

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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