

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2024
NAME OF PROVIDER OR SUPPLIER Thunder Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 North Broadway Moore, OK 73160	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>43023</p> <p>Based on record review and interview, the facility failed to ensure resident's were treated with dignity and respect for one (#1) of three sampled residents.</p> <p>The ADON reported 98 residents resided in the facility.</p> <p>Findings:</p> <p>Res #1 admitted to the facility with diagnoses of intellectual disability disorders, bipolar, and anxiety.</p> <p>An admission assessment, dated 07/19/23, documented the resident's was severely impaired with cognition.</p> <p>A state incident report, dated 01/23/24, documented a staff member grabbed the resident and took her back to her room and sat her down on the bed because she was trying to hit them.</p> <p>A care plan, dated 01/25/24, documented the resident had the potential to demonstrate physical and verbal behaviors.</p> <p>On 01/30/24, the administrator reported the staff member had been terminated and an in-service was held regarding how to respond to resident behaviors.</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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