STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375331	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thunder Care and Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43023 Based on record review and interview, the facility failed to ensure a resident's representative was notified of a medication change for one (#1) of three sampled residents reviewed for notification. The administrator identified 109 residents resided in the facility. Findings: Resident #1 was admitted to the facility with diagnoses which included cerebral palsy, autistic disorder, and spastic quadriplegic cerebral palsy. A physician's order, dated 08/01/24, documented permethrin external cream 5%, apply to entire body topically, leave on and wash off after 8 hours. The resident's record was reviewed and contained no documentation the resident's representative was notified of the new order. On 10/08/24 at 12:27 p.m., licensed practical nurse #1 stated they did not remember if they notified the resident's representative of the new order.

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