

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>35474</p> <p>On 02/11/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect Resident #1 from sexual abuse. Resident #1 was observed in Resident #2's bed. Resident #2 was observed by staff to have their hand down Resident #1's pants and was observed to suck on Resident #1's breast. Resident #1 was severely cognitively impaired for daily decision making and had not been evaluated for the capacity to consent to a sexual relationship. Resident #2 was cognitively intact for daily decision making. Resident #1 was known to wander in the facility and enter other resident rooms, as well as, seek out Resident #2.</p> <p>A progress note, dated 12/03/24, showed Resident #2 was laying in bed with Resident #1 and they were redirected.</p> <p>A progress note, dated 12/11/24, showed another resident informed a CNA Resident #2 had Resident #1 on their bed, in their room, Resident #1's shirt was up, and Resident #2's hand was down their pants. The incident was not identified as sexual abuse by the facility.</p> <p>A progress note, dated 01/27/25 at 3:46 p.m., showed Resident #1 entered another resident's room unwelcomed and was redirected.</p> <p>On 02/10/25 at 4:42 p.m., Resident #1 was observed entering another resident's room.</p> <p>On 02/11/25 at 11:39 a.m., CNA #1 stated they observed Resident #2 on top of Resident #1 in Resident #2's bed on 12/11/24. CNA #1 stated they observed Resident #2's hand down Resident #1's pants and Resident #2 was sucking on Resident #1's breast.</p> <p>A progress note, dated 02/11/25 at 12:00 p.m., showed Resident #1 was attempting to grab at and touch male residents in the dining room. The note showed Resident #1 attempted to sit on the lap of a resident of the opposite sex.</p> <p>On 02/11/25 1:23 p.m., Resident #1 was observed entering another resident's room.</p> <p>On 02/11/25 at 1:35 p.m., Resident #1 was observed entering another resident's room.</p> <p>(continued on next page)</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
---	-------	-----------

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 02/11/25 at 2:56 p.m., CNA #2 stated they observed Resident #2 attempting to coerce Resident #1 into sexual activity on 12/11/24. CNA #2 stated they observed Resident #2 touching Resident #1's breast.</p> <p>On 02/11/25 at 3:38 p.m., the administrator stated Resident #1 wandered and routinely sought out Resident #2.</p> <p>On 02/11/25 at 4:00 p.m., the DON stated they were not aware of Resident #1 and Resident #2 laying in bed together on 12/03/24. They stated Resident #1 wandered and required redirection from staff. The DON stated since the incident on 12/11/24, Resident #2 was discharged from the facility and staff were to keep a watch on Resident #1 and redirect as needed.</p> <p>On 02/11/25 at 4:22 p.m., the administrator stated since 12/03/24 when Resident #1 and Resident #2 were laying in bed together they were redirecting Resident #1 from wandering.</p> <p>On 02/11/25 at 5:51 p.m., the administrator stated the facility had not evaluated or assessed Resident #1 for consent to enter into a sexual relationship. The administrator stated due to Resident #1's impaired cognition they were unable to have a conversation regarding consent for a sexual relationship.</p> <p>On 02/11/25 at 9:08 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 02/11/25 at 9:19 p.m., the administrator, COO, and the corporate MDS coordinator were notified of the presence of an immediate jeopardy situation related to Resident #1 not being free from sexual abuse. The IJ template was provided to the administrator and the COO.</p> <p>On 02/13/25 at 1:50 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Thunder Care and Rehab [address withheld] Survey Date/IJ date 2/11/2025 9:19 p.m. Completion Date of Removal 2/12/25 Immediate Plan of Removal Noncompliance</p> <p>Resident #1 has been placed on 1 on 1 staffing due to continuous wandering throughout the facility to ensure [they] is not in threat of abuse or neglect. Team is currently evaluating further needs to ensure steps to be taken long term for [their] individual needs and placement in a facility that can meet [their] needs.</p> <p>Until such a facility can be found or further options explored by team to ensure no abuse and neglect can occur due to [their] wandering and searching out the opposite sex, [they] will remain on 1 on 1 staffing.</p> <p>All current residents have been reviewed for any wandering issues that may place them at risk for Abuse and Neglect and steps taken to ensure each individual based on their needs are protected.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>After a review of the state reportable completed 12-12-2024, an amended follow up report has been completed on 2-11-25 to include further information that was reported to the state surveyor by a CNA stating that Resident #2 was witnessed laying on top of Resident #1 in [their] bed, while on top of [them] it was reported that [they] were witnessed sucking on [their] breast with [their] hand down [their] pants. This information was not all reported to the Administrator/Abuse Coordinator at the time of the incident, [they were] not informed of all this information until the State Surveyor relayed this information to [them]. All staff are being in-serviced over Abuse and Neglect Procedure. All information has been updated and updated to OSDH, APS, Police, PCP, and Family notified. We are currently interviewing all parties that were working at the time of the incident to determine why new information has arisen that was not reported at time of incident. We will report further information from all parties involved. Resident #2 was placed on 1 on 1 staffing at time of incident and placed in [hospital name withheld] hospital on 12-12-2024 and returned on 01-14-2025 and discharged to another facility on January 15th, 2025.</p> <p>All staff on the shift as of 11:17 p.m. on 2/11/2025 were in-services at that time over the abuse and neglect policy and reporting all abuse and neglect to the administrator/Abuse coordinator immediately for investigation and steps to be taken to immediately address the situation to protect the patients.</p> <p>ALL facility employees have been in-serviced over the abuse and neglect policy, reporting abuse and neglect to the administrator/Abuse coordinator immediately for investigation and steps to be taken to immediately address the situation to protect the patients. Completion of in-service was 2-12-25 at 3:30pm</p> <p>All employees on the shift at 11:17 p.m. on 2/11/2025 were interviewed at that time to ensure no other abuse and neglect had been observed and not reported as stated in the facility abuse and neglect policy.</p> <p>ALL facility employees have been interviewed to ensure no other abuse and neglect situations had been observed and not reported at [sic] stated in the facility abuse and neglect policy. Completion of the interviews were done on 2-12-25 at 5:30pm</p> <p>All residents were interviewed to ensure no other abuse and neglect had been observed and not reported as stated in the facility abuse and neglect policy. Completion of the interviews were done on 2-12-25 at 5:30pm</p> <p>Administrator/Abuse Coordinator was in-serviced by COO over facility abuse and neglect policy and implementing the policy as written in order to identify an allegation of sexual abuse and documenting such on the OSDH 283 form on 2-11-25. This will ensure all allegations of abuse are investigated as such and the abuse protocols are followed.</p> <p>On 02/14/25 at 2:35 p.m., the IJ was lifted when all components of the plan of removal were completed. The deficient practice remained at a level of potential for more than minimal harm.</p> <p>Based on observation, record review, and interview, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 (#1) of 3 sampled residents who were reviewed for abuse.</p> <p>(continued on next page)</p>

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The administrator identified 118 residents who resided in the facility.</p> <p>Findings:</p> <p>1. On 02/10/25 at 4:42 p.m., Resident #1 was observed walking into another resident's room, on the 200 hall, then exited less than one minute later.</p> <p>On 02/11/25 at 1:23 p.m., Resident #1 was observed entering another resident's room, on the 100 hall, exited less than a minute later and walked to the 200 hall, then the 300 hall.</p> <p>Resident #1 had diagnoses which included mild intellectual disabilities.</p> <p>An Abuse policy, dated 08/12/22, read in part, It is the policy of this facility to maintain an abuse free environment. SEXUAL ABUSE - including any gesture, verbal or physical that is threatening, degrading, lewd or lascivious in nature.</p> <p>A progress note, dated 11/09/24 at 9:40 p.m., showed Resident #1 was observed walking and pacing around the facility, and entering other residents' rooms.</p> <p>A quarterly MDS assessment, dated 11/23/24, showed the resident was severely impaired in cognition for daily decision making and wandered daily.</p> <p>A progress note, signed by the administrator, dated 12/01/24 at 12:04 p.m. and documented as a late entry on 12/12/24 at 12:05 p.m., showed Resident #1 walked around the facility.</p> <p>A progress note, signed by the administrator, dated 12/02/24 at 2:05 p.m. and documented as a late entry on 12/12/24 at 12:05 p.m., showed Resident #1 walked around the facility and entered other residents' rooms.</p> <p>A progress note, signed by the administrator, dated 12/03/24 at 1:06 p.m. and documented as a late entry on 12/12/24 at 12:09 p.m., showed Resident #1 walked around the facility.</p> <p>A progress note, dated 12/03/24 at 2:25 p.m., showed Resident #1 seemed to be seeking out to be around another resident of the opposite sex and kept going to that resident's room. The note showed Resident #1 and Resident #2 laid in Resident #2's bed together and neither resident was engaged in any type of sexual activity.</p> <p>A progress note, dated 12/03/24 at 9:03 p.m., showed Resident #1 was ambulating in the hallways.</p> <p>A progress note, dated 12/11/24 at 10:50 p.m., showed Resident #1 continued to seek out another resident of the opposite sex and was found in resident room again. The note showed Resident #1 was redirected out of the other resident's bed/room.</p> <p>A physician's order, dated 12/12/24, showed staff were to monitor the location, behavior, and general mood for Resident #1 in progress notes every hour.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The ODH form 283 incident report, showed an incident dated 12/12/24, and identified Resident #1 and Resident #2. The incident report was identified as Inappropriate Behaviors. The incident report showed on 12/11/24 another resident alerted two CNAs and a RN that Resident #1 and Resident #2 had gone into Resident #2's room. The incident report showed Resident #1 and Resident #2 were in Resident #2's bed when staff arrived and Resident #2 was attempting to possibly stroke [Resident #1's] breasts, nothing down [their] pants or on any other areas of [Resident #1] nor [Resident #2's] body. The incident report showed staff guided Resident #1 out of Resident #2's room and due to the difference in cognition the facility preferred to keep the two residents separated and 15 minute checks were implemented.</p> <p>A care plan, showed it was created on 12/13/24 and showed Resident #1 wandered aimlessly and staff were monitoring Resident #1 to ensure the separation between the resident and another resident of the opposite sex.</p> <p>A progress note, dated 01/27/25 at 3:46 p.m., showed Resident #1 entered another resident's room unwelcomed and was redirected.</p> <p>2. Resident #2 had diagnoses which included unspecified psychosis.</p> <p>A care plan, updated 06/10/24, showed Resident #2 was witnessed going in other residents' rooms and was observed by the DON and ADON to peek into another resident's room from the courtyard.</p> <p>A progress note, dated 12/03/24 at 2:25 p.m., showed a resident of the opposite sex seemed to be seeking out to be around Resident #2 and kept going to Resident #2's room. The note showed Resident #2 and a resident of the opposite sex had laid in Resident #2's bed together and staff redirected them.</p> <p>An annual MDS assessment, dated 12/07/24, showed Resident #2 was cognitively intact for daily decision making and did not exhibit behaviors.</p> <p>A progress note, signed by the DON, dated 12/11/24 at 11:00 p.m., showed another resident alerted two CNAs and a RN that Resident #1 and Resident #2 had gone into Resident #2's room. The note showed Resident #1 and Resident #2 were in Resident #2's bed when staff arrived and Resident #2 was attempting to possibly stroke [Resident #1's] breasts, nothing down [their] pants or on any other areas of [Resident #1] nor [Resident #2's] body. The note showed staff guided Resident #1 out of Resident #2's room and due to the difference in cognition the facility preferred to keep the two residents separated and 15 minute checks were implemented.</p> <p>A progress note, signed by LPN #1, dated 12/11/24 at 11:06 p.m., showed another resident had notified a CNA Resident #2 had a resident of the opposite sex on Resident #2's bed with the other resident's shirt up and Resident #2's hand down the other resident's pants. The note showed the CNA removed Resident #2 away from the other resident and called for the nurse. The note showed the nurse then moved Resident #2 into a room closer to the nurses station and placed Resident #2 on 15 minute checks. The note showed the DON was contacted.</p> <p>A care plan, dated as initiated on 12/12/24, showed the resident had a behavior problem and was found in bed with a resident of the opposite sex. The interventions, read in part, Intervene as necessary to protect the rights and safety of others.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A progress note, dated 12/12/24 at 4:41 p.m., showed Resident #2 was discharged from the facility.</p> <p>A progress note, dated 01/14/25 at 3:25 p.m., showed Resident #2 was readmitted to the facility.</p> <p>A progress note, dated 01/15/25 at 11:31 a.m., showed Resident #2 was discharged to another long term care facility.</p> <p>On 02/11/25 at 11:39 a.m., CNA #1 stated on 12/11/24 another resident had approached the nurses station and informed RN#1, CNA #2 and themselves Resident #2 had led Resident #1 to Resident #2's room. CNA #1 stated they immediately went to Resident #2's room and they observed Resident #2 in their bed, on top of Resident #1. CNA #1 stated Resident #1's legs were apart, Resident #2 had their hand down Resident #1's pants, and Resident #2 was sucking on Resident #1's breast. CNA #1 stated they were the first staff member to enter Resident #2's room and they removed Resident #2 from Resident #1 and CNA #2 and RN #1 were right behind them. CNA #1 stated they guided Resident #1 out of Resident #2's room. CNA #1 stated they reported what they had observed to RN #1. CNA #1 stated no one from the facility had interviewed them about the incident. They stated RN #1 stated they would notify the administrator. CNA #1 stated after the incident on 12/11/24, Resident #2 was placed in a room closer to the nurses station so staff could watch them. They stated Resident #1 used to wander all day and all night, but had recently been wandering less at night, and the staff had to keep a good eye on them.</p> <p>On 02/11/25 at 1:36 p.m., CMA #1 stated Resident #1 wandered all the time, would go into other residents' rooms, and required redirection. During the interview, CMA #1 stated, just like that and redirected Resident #1 from another resident's room on the 200 hall.</p> <p>On 02/11/25 at 1:39 p.m., CNA #3 stated Resident #1 wandered and they had to redirect them from other residents' rooms frequently.</p> <p>On 02/11/25 at 1:47 p.m., RN #1 stated on 12/11/24 they were at the nurses station and another resident notified them they had seen Resident #1 enter Resident #2's room. RN #1 stated they were the third person to enter Resident #2's room. RN #1 stated the first staff member to enter the room was CNA #1. They stated CNA #1 reported to them Resident #2 was on top of Resident #1 in Resident #2's bed, but Resident #2 had their pants on. RN #1 stated that was all they remembered and the surveyor needed to review the incident report and progress note they had completed for further details. RN #1 stated they moved Resident #2 to a room closer to the nurses station and notified the administrator immediately.</p> <p>On 02/11/25 at 2:56 p.m., CNA #2 stated another resident had notified CNA #1, RN #1, and themselves Resident #1 was in Resident #2's room. CNA #2 stated the three staff members went to Resident #2's room. CNA #2 stated they observed Resident #2 attempting to coerce Resident #1 into sexual activity. CNA #2 stated they observed Resident #2 touching Resident #1's breast and reported the observation to RN #1. CNA #2 stated the staff were notified to monitor Resident #1 due to their wandering and wandering into other residents' rooms.</p> <p>On 02/11/25 at 3:16 p.m., RN #1 stated they had not documented the incident between Resident #1 and Resident #2. They stated LPN #1 had documented a progress note.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 02/11/25 at 3:17 p.m., LPN #1 stated they were on the East hall doing treatments on 12/11/24, and when they returned to the nurses station, RN #1 had notified them of the incident between Resident #1 and Resident #2. LPN #1 stated they notified the administrator of the incident. They stated they informed the administrator of what the CNAs had observed. LPN #1 stated they reported to the administrator Resident #1 was in Resident #2's room and Resident #2 basically was about to get on top of [Resident #1]. LPN #1 stated they did not know exactly what had happened, but the CNAs had reported Resident #2 was on top of Resident #1 in Resident #2's bed and they had heard Resident #2 may have had their hands down Resident #1's pants, but they had not gotten the full story. LPN #1 stated they had documented what was reported to them and what they had reported to the administrator.</p> <p>On 02/11/25 at 3:28 p.m., the DON stated they were made aware of the incident on 12/11/24, between Resident #1 and Resident #2, the following morning when they had arrived to work. The DON stated they had determined what had happened between Resident #1 and Resident #2 from the incident report documented by the administrator and what RN #1 had reported to them. They stated RN #1 had reported Resident #1 and Resident #2 were laying in bed together. The DON stated they thought the administrator had investigated the incident.</p> <p>On 02/11/25 at 3:38 p.m., the administrator stated on 12/11/24 staff had reported they observed Resident #1 walk into Resident #2's room with them. The administrator stated they were told three staff walked into Resident #2's room and found Resident #1 laying in Resident #2's bed. They stated staff had taken Resident #1 to their own room and moved Resident #2 closer to the nurses station. The administrator stated they had determined what had happened between Resident #1 and Resident #2 by what RN #1 had reported to them. The administrator stated RN #1 reported to them they had entered Resident #2's room first, followed by CNA #2, then CNA #1 had arrived last. The administrator was asked how they differentiated between inappropriate behavior and an allegation of abuse. They stated Resident #1 would seek out Resident #2 and due to Resident #1 having impaired cognition for daily decision making it was inappropriate behavior. The administrator stated Resident #1 had not been assessed for the ability to consent to a sexual relationship because Resident #1 was unable to have conversation with the staff. The administrator stated their investigation of the incident on 12/11/24 consisted of what RN #1 had reported to them. The administrator stated Resident #1 still wandered into other residents' rooms and staff were to redirect them.</p> <p>On 02/11/24 at 4:22 p.m., the administrator stated staff were notified to redirect Resident #1 after they were found in bed with Resident #2 on 12/03/24.</p> <p>On 02/11/25 at 5:17 p.m., Resident #1's POA stated the administrator had reported to them a resident of the opposite sex was going after Resident #1 in a sexual manner approximately three weeks ago. The POA stated the administrator had reported to them a resident of the opposite sex had grabbed Resident #1's breasts, but they had transferred that resident from the facility.</p> <p>On 02/11/25 at 6:56 p.m., the DON stated the resident of the opposite sex referenced in Resident #1's care plan was related to Resident #2.</p> <p>On 02/11/25 at 8:21 p.m., the administrator stated they were the abuse coordinator for the facility.</p>		

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>35474</p> <p>On 02/11/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to implement the abuse policy and procedure to identify an incident of sexual abuse. Resident #1 was observed in Resident #2's bed. Resident #2 was observed by staff to have their hand down Resident #1's pants and was observed to suck on Resident #1's breast. Resident #1 was severely cognitively impaired for daily decision making and had not been evaluated for the capacity to consent to a sexual relationship. Resident #2 was cognitively intact for daily decision making. Resident #1 was known to wander in the facility and enter other resident rooms, as well as, seek out Resident #2. The abuse protocol was not implemented by the facility and was not identified or investigated as an allegation of sexual abuse.</p> <p>A progress note, dated 12/03/24, showed Resident #2 was laying in bed with Resident #1 and they were redirected.</p> <p>A progress note, dated 12/11/24, showed another resident informed a CNA Resident #2 had Resident #1 on their bed, in their room, Resident #1's shirt was up, and Resident #2's hand was down their pants. The incident was not identified as sexual abuse by the facility.</p> <p>The ODH form 283 incident report, showed an incident dated 12/12/24, and identified Resident #1 and Resident #2. The incident report was identified as Inappropriate Behaviors. The incident report showed that on 12/11/24 another resident alerted two CNAs and a RN that Resident #1 and Resident #2 had gone into Resident #2's room. The incident report showed Resident #1 and Resident #2 were in Resident #2's bed when staff arrived and Resident #2 was attempting to possibly stroke [Resident #1's] breasts, nothing down [their] pants or on any other areas of [Resident #1] nor [Resident #2's] body. The incident report showed staff guided Resident #1 out of Resident #2's room and due to the difference in cognition the facility preferred to keep the two residents separated and 15 minute checks were implemented.</p> <p>A progress note, dated 01/27/25 at 3:46 p.m., showed Resident #1 entered another resident's room unwelcomed and was redirected.</p> <p>On 02/10/25 at 4:42 p.m., Resident #1 was observed entering another resident's room.</p> <p>On 02/11/25 at 11:39 a.m., CNA #1 stated they observed Resident #2 on top of Resident #1 in Resident #2's bed on 12/11/24. CNA #1 stated the observed Resident #2's hand down Resident #1's pants and Resident #2 was sucking on Resident #1's breast.</p> <p>A progress note, dated 02/11/25 at 12:00 p.m., showed Resident #1 was attempting to grab at and touch male residents in the dining room. The note showed Resident #1 attempted to sit on the lap of a resident of the opposite sex.</p> <p>On 02/11/25 1:23 p.m., Resident #1 was observed entering another resident's room.</p> <p>On 02/11/25 at 1:35 p.m., Resident #1 was observed entering another resident's room.</p> <p>(continued on next page)</p>

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 02/11/25 at 2:56 p.m., CNA #2 stated they observed Resident #2 attempting to coerce Resident #1 into sexual activity on 12/11/24. CNA #2 stated they observed Resident #2 touching Resident #1's breast.</p> <p>On 02/11/25 at 3:38 p.m., the administrator stated Resident #1 wandered and routinely sought out Resident #2.</p> <p>On 02/11/25 at 4:00 p.m., the DON stated they were not aware of Resident #1 and Resident #2 laying in bed together on 12/03/24. They stated Resident #1 wandered and required redirection from staff. The DON stated that since the incident on 12/11/24, Resident #2 was discharged from the facility and staff were to keep a watch on Resident #1 and redirect as needed.</p> <p>On 02/11/25 at 4:22 p.m., the administrator stated since 12/03/24 when Resident #1 and Resident #2 were laying in bed together they were redirecting Resident #1 from wandering.</p> <p>On 02/11/25 at 5:51 p.m., the administrator stated the facility had not evaluated or assessed Resident #1 for consent to enter into a sexual relationship. The administrator stated due to Resident #1's impaired cognition they were unable to have conversation regarding consent for a sexual relationship.</p> <p>On 02/11/25 at 9:08 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 02/11/25 at 9:19 p.m., the administrator, COO, and the corporate MDS coordinator were notified of the presence of an immediate jeopardy situation related to not implementing the abuse policy and procedure for Resident #1. The IJ template was provided to the administrator and the COO.</p> <p>On 02/13/25 at 1:50 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in parts, Thunder Care and Rehab [address withheld] Survey Date/IJ date 2/11/2025 9:19 p.m. Completion Date of Removal 2/12/25 Immediate Plan of Removal Noncompliance</p> <p>After a review of the state reportable completed 12-12-2024, an amended follow up report has been completed on 2-11-25 to include further information that was reported to the state surveyor by a CNA stating that resident #2 was witnessed laying on top of resident #1 in [their] bed, while on top of [them] it was reported that [they] were witnessed sucking on [their] breast with [their] hand down [their] pants. This information was not all reported to the Administrator/Abuse Coordinator at the time of the incident, [they were] not informed of all this information until the State Surveyor relayed this information to [them]. All staff are being in-serviced over Abuse and Neglect Procedure. All information has been updated and updated to OSDH, APS, Police, PCP, and Family notified. We are currently interviewing all parties that were working at the time of the incident to determine why new information has arisen that was not reported at time of incident. We will report further information from all parties involved.</p> <p>Resident #2 was placed on 1 on 1 staffing at time of incident and placed in [hospital name withheld] hospital on 12-12-2024 and returned on 01-14-2025 and discharged to another facility on January 15th, 2025.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>All staff on the shift as of 11:17 p.m. on 2/11/2025 were in-services at that time over the abuse and neglect policy and reporting all abuse and neglect to the administrator/Abuse coordinator immediately for investigation and steps to be taken to immediately address the situation to protect the patients.</p> <p>ALL facility employees have been in-serviced over the abuse and neglect policy, reporting abuse and neglect to the administrator/Abuse coordinator immediately for investigation and steps to be taken to immediately address the situation to protect the patients. Completion of in-service was 2-12-25 at 3:30pm</p> <p>All employees on the shift at 11:17 p.m. on 2/11/2025 were interviewed at that time to ensure no other abuse and neglect had been observed and not reported as stated in the facility abuse and neglect policy.</p> <p>ALL facility employees have been interviewed to ensure no other abuse and neglect situations had been observed and not reported at [sic] stated in the facility abuse and neglect policy. Completion of the interviews were done on 2-12-25 at 5:30pm</p> <p>All residents were interviewed to ensure no other abuse and neglect had been observed and not reported as stated in the facility abuse and neglect policy. Completion of the interviews were done on 2-12-25 at 5:30pm</p> <p>Administrator/Abuse Coordinator was in-serviced by COO over facility abuse and neglect policy and implementing the policy as written in order to identify an allegation of sexual abuse and documenting such on the OSDH 283 form on 2-11-25. This will ensure all allegations of abuse are investigated as such and the abuse protocols are followed. Resident #1 has been placed on 1 on 1 staffing due to continuous wandering throughout the facility to ensure she is not in threat of abuse or neglect. Team is currently evaluating further needs to ensure steps to be taken long term for [their] individual needs and placement in a facility that can meet [their] needs.</p> <p>Until such a facility can be found or further options explored by team to ensure no abuse and neglect can occur due to [their] wandering and searching out the opposite sex, [they] will remain on 1 on 1 staffing.</p> <p>All current residents have been reviewed for any wandering issues that may place them at risk for Abuse and Neglect and steps taken to ensure each individual based on their needs are protected.</p> <p>On 02/14/25 at 2:35 p.m., the IJ was lifted when all components of the plan of removal were completed. The deficient practice remained at a level of potential for more than minimal harm.</p> <p>Based on observation, record review and interview, the facility failed to ensure the abuse policy and procedure was implemented for 1 (#1) of 3 sampled residents who were reviewed for abuse.</p> <p>The administrator identified 118 residents who resided in the facility.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. On 02/10/25 at 4:42 p.m., Resident #1 was observed walking into another resident's room, on the 200 hall, then exited less than one minute later.</p> <p>On 02/11/25 at 1:23 p.m., Resident #1 was observed entering another resident's room, on the 100 hall, exited less than a minute later and walked to the 200 hall, then the 300 hall.</p> <p>Resident #1 had diagnoses which included mild intellectual disabilities.</p> <p>An Abuse policy, dated 08/12/22, read in parts, SEXUAL ABUSE - including any gesture, verbal or physical that is threatening, degrading, lewd or lascivious in nature. IDENTIFICATION: Staff will be trained to identify potential signs of abuse and to report same to the charge nurse. INVESTIGATION: Any allegation of abuse will be investigated by the Administrator and the Director of Nursing. The Administrator and Director of Nursing will, as a minimum: a. Review the resident medical record looking for events leading up to the incident. b. Interview the person(s) reporting the incident. c. Interview any witnesses to the incident. d. Interview the resident (if cognitive ability permits); e. Interview staff members (on all shifts) who had contact with the resident during the period of the alleged incident if necessary. All forms of Abuse, including resident to resident abuse, resident to family/visitor, or staff must be reported to the charge nurse who then must report to the Director of Nursing and the Administrator.</p> <p>A progress note, dated 11/09/24 at 9:40 p.m., showed Resident #1 was observed walking and pacing around the facility, and entering other residents' rooms.</p> <p>A quarterly MDS assessment, dated 11/23/24, showed the resident was severely impaired in cognition for daily decision making and wandered daily.</p> <p>A progress note, signed by the administrator, dated 12/01/24 at 12:04 p.m. and documented as a late entry on 12/12/24 at 12:05 p.m., showed Resident #1 walked around the facility.</p> <p>A progress note, signed by the administrator, dated 12/02/24 at 2:05 p.m. and documented as a late entry on 12/12/24 at 12:05 p.m., showed Resident #1 walked around the facility and entered other residents' rooms.</p> <p>A progress note, signed by the administrator, dated 12/03/24 at 1:06 p.m. and documented as a late entry on 12/12/24 at 12:09 p.m., showed Resident #1 walked around the facility.</p> <p>A progress note, dated 12/03/24 at 2:25 p.m., showed Resident #1 seemed to be seeking out to be around another resident of the opposite sex and kept going to that resident's room. The note showed Resident #1 and Resident #2 laid in Resident #2's bed together. The note showed neither resident was engaged in any type of sexual activity.</p> <p>A progress note, dated 12/03/24 at 9:03 p.m., showed Resident #1 was ambulating in the hallways.</p> <p>A progress note, dated 12/11/24 at 10:50 p.m., showed Resident #1 continued to seek out another resident of the opposite sex and found in resident room again. The note showed Resident #1 was redirected out of the other resident's bed/room.</p> <p>(continued on next page)</p>

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The ODH form 283 incident report, showed an incident dated 12/12/24, and identified Resident #1 and Resident #2. The incident report was identified as Inappropriate Behaviors. The incident report showed that on 12/11/24 another resident alerted two CNAs and a RN that Resident #1 and Resident #2 had gone into Resident #2's room. The incident report showed Resident #1 and Resident #2 were in Resident #2's bed when staff arrived and Resident #2 was attempting to possibly stroke [Resident #1's] breasts, nothing down [their] pants or on any other areas of [Resident #1] nor [Resident #2's] body. The incident report showed staff guided Resident #1 out of Resident #2's room and due to the difference in cognition the facility preferred to keep the two residents separated and 15 minute checks were implemented. The ODH form 283 showed the administrator was the person who completed the incident report.</p> <p>A care plan, showed it was created on 12/13/24 and showed Resident #1 wandered aimlessly and staff were monitoring Resident #1 to ensure the separation between resident and another resident of the opposite sex.</p> <p>A progress note, dated 01/27/25 at 3:46 p.m., showed Resident #1 entered another resident's room unwelcomed and was redirected.</p> <p>2. Resident #2 had diagnoses which included unspecified psychosis.</p> <p>A care plan, updated 06/10/24, showed Resident #2 was witnessed going in other residents' rooms and was observed by the DON and ADON to peek into another resident's room from the courtyard.</p> <p>A progress note, dated 12/3/24 at 2:25 p.m., showed a resident of the opposite sex seemed to be seeking out to be around Resident #2 and kept going to Resident #2's room. The note showed Resident #2 and a resident of the opposite sex had laid in Resident #2's bed together and staff redirected them.</p> <p>An annual MDS assessment, dated 12/07/24, showed Resident #2 was cognitively intact for daily decision making and did not exhibit behaviors.</p> <p>A progress note, signed by the DON, dated 12/11/24 at 11:00 p.m., showed another resident alerted two CNAs and a RN that Resident #1 and Resident #2 had gone into Resident #2's room. The note showed Resident #1 and Resident #2 were in Resident #2's bed when staff arrived and Resident #2 was attempting to possibly stroke [Resident #1's] breasts, nothing down [their] pants or on any other areas of [Resident #1] nor [Resident #2's] body. The note showed staff guided Resident #1 out of Resident #2's room and due to the difference in cognition the facility preferred to keep the two residents separated and 15 minute checks were implemented.</p> <p>A progress note, signed by LPN #1, dated 12/11/24 at 11:06 p.m., showed another resident had notified a CNA that Resident #2 had a resident of the opposite sex on Resident #2's bed with the other resident's shirt up and Resident #2's hand down the other resident's pants. The note showed the CNA removed Resident #2 away from the other resident, called for the nurse, Resident #2 was moved into a room closer to the nurses station, and placed Resident #2 on 15 minute checks. The note showed the DON was contacted.</p> <p>A care plan, dated as initiated on 12/12/24, showed the resident had a behavior problem and was found in bed with a resident of the opposite sex. The interventions, read in part, Intervene as necessary to protect the rights and safety of others.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A progress note, dated 12/12/24 at 4:41 p.m., showed Resident #2 was discharged from the facility.</p> <p>A progress note, dated 01/14/25 at 3:25 p.m., showed Resident #2 was readmitted to the facility.</p> <p>A progress note, dated 01/15/25 at 11:31 a.m., showed Resident #2 was discharged to another long term care facility.</p> <p>On 02/11/25 at 11:39 a.m., CNA #1 stated on 12/11/24 another resident had approached the nurses station and informed RN #1, CNA #2, and themselves Resident #2 had led Resident #1 to Resident #2's room. CNA #1 stated they immediately went to Resident #2's room and they observed Resident #2 in their bed, on top of Resident #1. CNA #1 stated Resident #1's legs were apart, Resident #2 had their hand down Resident #1's pants, and Resident #2 was sucking on Resident #1's breast. CNA #1 stated they were the first staff member to enter Resident #2's room and they removed Resident #2 from Resident #1 and CNA #2 and RN #1 were right behind them. CNA #1 stated they guided Resident #1 out of Resident #2's room. CNA #1 stated they reported what they had observed to RN #1. CNA #1 stated no one from the facility had interviewed them about the incident. They stated RN #1 stated they would notify the administrator. CNA #1 stated after the incident on 12/11/24, Resident #2 was placed in a room closer to the nurses station so staff could watch them. They stated Resident #1 used to wander all day and all night, but had recently been wandering less at night, and the staff had to keep a good eye on them.</p> <p>On 02/11/25 at 1:36 p.m., CMA #1 stated Resident #1 wandered all the time, would go into other resident's rooms, and required redirection. During the interview, CMA #1 stated, just like that and redirected Resident #1 from another resident's room on the 200 hall.</p> <p>On 02/11/25 at 1:39 p.m., CNA #3 stated Resident #1 wandered and they had to redirect them from other resident's rooms frequently.</p> <p>On 02/11/25 at 1:47 p.m., RN #1 stated on 12/11/24 they were at the nurses station and another resident notified them they had seen Resident #1 enter Resident #2's room. RN #1 stated they were the third person to enter Resident #2's room. RN #1 stated the first staff member to enter the room was CNA #1. They stated CNA #1 reported to them Resident #2 was on top of Resident #1 in Resident #2's bed, but Resident #2 had their pants on. RN #1 stated that was all they remembered and the surveyor needed to review the incident report and progress note they had completed for further details. RN #1 stated they moved Resident #2 to a room closer to the nurses station and notified the administrator immediately.</p> <p>On 02/11/25 at 2:56 p.m., CNA #2 stated another resident had notified CNA #1, RN #1, and themselves that Resident #1 was in Resident #2's room. CNA #2 stated the three staff members went to Resident #2's room. CNA #2 stated they observed Resident #2 attempting to coerce Resident #1 into sexual activity. CNA #2 stated they observed Resident #2 touching Resident #1's breast and reported the observation to RN #1. CNA #2 stated the staff were notified to monitor Resident #1 due to their wandering and wandering into other residents' rooms.</p> <p>On 02/11/25 at 3:16 p.m., RN #1 stated they had not documented the incident between Resident #1 and Resident #2. They stated LPN #1 had documented a progress note.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 02/11/25 at 3:17 p.m., LPN #1 stated they were on the East hall doing treatments on 12/11/24, and when they returned to the nurses station, RN #1 had notified them of the incident between Resident #1 and Resident #2. LPN #1 stated they notified the administrator of the incident. They stated they informed the administrator of what the CNAs had observed. LPN #1 stated they reported to the administrator that Resident #1 was in Resident #2's room and that Resident #2 basically was about to get on top of [Resident #1]. LPN #1 stated they did not know exactly what had happened but the CNAs had reported that Resident #2 was on top of Resident #1 in Resident #2's bed and they had heard Resident #2 may have had their hands down Resident #1's pants but they had not gotten the full story. LPN #1 stated they had documented what was reported to them and what they had reported to the administrator.</p> <p>On 02/11/25 at 3:28 p.m., the DON stated they were made aware of the incident on 12/11/24, between Resident #1 and Resident #2, the following morning when they had arrived to work. The DON stated they had determined what had happened between Resident #1 and Resident #2 from the incident report documented by the administrator and what RN #1 had reported to them. They stated RN #1 had reported Resident #1 and Resident #2 were laying in bed together. The DON stated they thought the administrator had investigated the incident.</p> <p>On 02/11/25 at 3:38 p.m., the administrator stated on 12/11/24 staff had reported they observed Resident #1 walk into Resident #2's room with them. The administrator stated they were told three staff walked into Resident #2's room and found Resident #1 laying in Resident #2's bed. They stated staff had taken Resident #1 to their own room and moved Resident #2 closer to the nurses station. The administrator stated they had determined what had happened between Resident #1 and Resident #2 by what RN #1 had reported to them. The administrator stated RN #1 reported to them they had entered Resident #2's room first, followed by CNA #2, then CNA #1 had arrived last. The administrator was asked how they differentiated between inappropriate behavior and an allegation of abuse. They stated Resident #1 would seek out Resident #2 and due to Resident #1 having impaired cognition for daily decision making they addressed the incident as inappropriate behavior. The administrator stated Resident #1 had not been assessed for the ability to consent to a sexual relationship because Resident #1 was unable to have conversation with the staff. The administrator stated their investigation of the incident on 12/11/24 consisted of what RN #1 had reported to them and no other staff or resident interviews were conducted. The administrator stated Resident #1 still wandered into other residents' rooms and staff were to redirect them. The administrator reviewed the ODH form 283 and was asked why the abuse policy had not been implemented. The administrator stated they had not implemented the abuse policy because Resident #1 willingly sought out Resident #2.</p> <p>On 02/11/24 at 4:22 p.m., the administrator stated staff were notified to redirect Resident #1 after they were found in bed with Resident #2 on 12/03/24.</p> <p>On 02/11/25 at 5:17 p.m., Resident #1's POA stated approximately 3 weeks ago, the administrator had reported to them a resident of the opposite sex was going after Resident #1 in a sexual manner. The POA stated the administrator had reported to them a resident of the opposite sex had grabbed Resident #1's breasts, but they had transferred that resident from the facility.</p> <p>On 02/11/25 at 6:56 p.m., the DON stated the resident of the opposite sex referenced in Resident #1's care plan was related to Resident #2.</p> <p>(continued on next page)</p>		

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 02/14/2025
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 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 02/11/25 at 8:21 p.m., the administrator stated they were the abuse coordinator for the facility.</p>