

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 08/07/2025
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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This CMS-2567 was amended following an administrative review conducted on 09/05/2025. ER on [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect residents from Res #1's sexual abuse. Res #1 had a known history of sexually inappropriate behaviors and there was no evidence the facility had assessed or investigated to identify the potential risk to other residents related to Res #1's behaviors. On 08/05/25 at 2:49 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 08/05/25 at 3:07 p.m., the COO and the corporate nurse consultant were notified of the presence of an IJ situation related to residents not being free from Res #1's sexual abuse. The IJ template was provided to the COO. On 08/06/25 at 2:49 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The facility plan of removal, read in part, Thunder Care and Rehab [address withheld] Survey Date/IJ Date 08/05/25. Completion Date of Removal 08/06/25. Time of Completion 3:00 p.m. Immediate Plan of Removal Noncompliance. Due to sexual and physical abuse toward another resident and staff members, [Res] #1 was placed on one on one staffing on 8-4-2025 and placed in a private room on 8-5-2025. [They] will remain on 1 on 1 staffing and in a private room until placement in a psych facility or a facility suited to meet [their] needs can be found. ALL facility employees were 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 on 8-5-25 at 1730 hrs [5:30 p.m.]. Administrator/Abuse Coordinator and Director of Nursing were in-serviced by COO over facility abuse and neglect policy and implementing the policy as written to identify an allegation of abuse and documenting such on the OSDH 283 form. This will ensure all allegations of abuse are investigated as such and the abuse protocols are followed immediately in order to protect patients. In-service completed on 8-5-2025 at 1730 hrs [5:30 p.m.]. Facility will develop and implement a PIP plan that requires daily review of all incidents and progress notes to ensure all allegations of abuse and neglect have been reported as required by state, federal regulations and appropriate actions taken to protect patients from further concerns. Pip Plan will also require Care Plans to be reviewed and updated to include all changes implemented due to a behavior and/or allegation of abuse. Will be implemented by 8-6-2025, by 2:30 p.m. All PIP plan audits will be reviewed at QA meeting on 8-6-2025 by 3:00 p.m. PIP plan Audits will continue weekly and presented at QA meeting weekly until further determination of any changes needed. All cognitive residents were interviewed on 8-6-2025 to ensure no other abuse and neglect had been observed and not reported as stated in the facility abuse and neglect policy. All interviews have been completed as of 8-6-2025 at 12:30 p.m. No further allegations of physical or sexual abuse was identified in interviews. If any allegations are made proper steps to follow facility abuse and neglect policy will be taken and interventions put in place. Care plans will be reviewed and updated. All residents had skin assessments to assess for any injuries completed as 8-6-2025 by 1:00 p.m. No injuries of unknown origin were found. On 08/07/25 at 12:33 p.m., after all staff members had been in-serviced, resident interviews and skin assessments were reviewed, care plans and performance improvement projects were initiated with ongoing auditing, the immediacy was lifted, effective 08/06/25 at 3:00 p.m. The deficient practice remained at an isolated level with the potential for more than minimum harm. Based on record review and interview the facility failed to ensure residents were free from sexual abuse for 2 (#2 ad #3) of 3 sampled residents reviewed for abuse. Residents #2 and #3 were touched inappropriately by Resident #1 and the facility had no interventions to protect them and all residents from the sexual abuse. The DON identified 118 residents resided in the facility. Findings: A policy titled Abuse, 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. A behavior progress note, dated 06/05/25, showed Res #3 was in the dining room and reported Res #1 grabbed Res #3's hand and placed it in their pants. The note showed Res #1 said they only wanted to play and attempted to grab the nurse's breast voicing they wanted to play. Res #1's care plan, updated 06/06/25, had no interventions in place to address Res #1's behavior. A behavior note, dated 06/08/25, showed Res #1 stating to a certified nurse aide I'm going to fill you up with cum. You want some? The note showed Res #1 stated in dining room You hungry? then started pointing towards their genital area. A behavior note, dated 06/08/25, showed Res #1 asked a nurse Can I [explicit] you. The note showed the nurse intervened and told the resident that was</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review and interview, the facility failed to implement their abuse policy by reporting within two hours an allegation of abuse for 1 (#3) of 3 sampled residents reviewed for abuse. The DON reported 118 residents resided in the facility. Findings: A facility Abuse Policy, dated 08/12/22, read in part, All incidents and allegations involving abuse or results in serious bodily injury is required to be reported within 2 hours. A behavior note, dated 06/05/25, showed it was reported by Res #6 that Res #1 grabbed Res #3's hand and placed the resident's hand in Res #1's pants. Res #1 was informed their behavior was inappropriate in the dining room and Res #3 was married. Res #1 voiced they did not know the resident was married and they only wanted to play. Res #1 was redirected and when a staff member of the opposite sex was feeding them. Res #1 reached up and grabbed at the staff member voicing, they wanted to play. The resident was taken back to their room. An order summary report, dated 08/04/25, showed Res #1 had diagnoses which included bipolar disorder and anxiety. On 08/04/25 at 3:06 p.m., the DON reported they were notified of the incident. The DON reported the administrator told staff to take Res #1 back to their room and the DON instructed staff to put in a note and to continue to monitor behaviors. The DON reported a facility related Incident form should have been completed within two hours and OSDH should have been notified.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse to the OSDH within two hours for 1 (#1) of 3 sampled residents reviewed for abuse. The DON reported 118 residents resided in the facility. Findings: A facility Abuse Policy, dated 08/12/22, read in part, All incidents and allegations involving abuse or results in serious bodily injury is required to be reported within 2 hours. An order summary report, dated 08/04/25, showed Res #1 had diagnoses which included bipolar disorder and anxiety. A behavior note, dated 06/05/25, showed that it was reported by Res #6 that Res #1 grabbed Res #3's hand and placed the resident's hand in Res 1's pants. Res #1 was informed their behavior was inappropriate in the dining room and Res #3 was married. Res #1 voiced they did not know the resident was married and they only wanted to play. Res #1 was redirected and when a staff member of the opposite sex was feeding them, Res #1 reached up and grabbed at the staff member voicing they wanted to play. Res #1 was taken back to their room. On 08/04/25 at 3:06 p.m., the DON reported an incident report should have been completed and OSDH should have been notified within two hours.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interview, the facility failed to conduct a thorough investigation after a allegation of abuse for 1 (#1) of 3 sampled residents reviewed for abuse. The DON reported 118 residents resided in the facility. Findings: An Abuse Policy, dated 08/12/22, read in part, Any allegation of abuse will be investigated by the Administrator and the Director of Nursing. A behavior note, dated 06/05/25, showed it was reported by Res #6 that Res #1 grabbed Res #3's hand and placed Res #3's hand in Res #1's pants. Res #1 was informed their behavior was inappropriate in the dining room and Res #3 was married. Res #1 voiced they did not know Res #3 was married and they only wanted to play. Res #1 was redirected and when a staff member was feeding them. Res #1 reached up and grabbed at the staff member voicing they wanted to play. Res #1 was taken back to their room. An order summary, dated 08/04/25, showed Res #1 had diagnoses which included bipolar disorder and anxiety. On 08/04/25 at 3:06 p.m., the DON reported they did not investigate the incident.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interview, the facility failed to ensure the care plan was revised for 1 (#1) of 6 sampled residents reviewed for care plans. The DON reported 118 residents resided in the facility. Findings: A behavior note, dated 06/05/25, showed that it was reported by Res #6 that Res #1 grabbed Res #3's hand and placed their hand in Res #1's pants. Res #1 was informed their behavior was inappropriate in the dining room and Res #3 was married. Res #1 voiced they did not know Res #3 was married and they only wanted to play. Res #1 was redirected and when a staff member was feeding them. Res #1 reached up and grabbed at the staff member and voiced, they wanted to play. Res #1 was taken back to their room. A care plan, revised on 06/06/25, showed the incident on 06/05/25 with no intervention put in place. An order summary report, dated 08/04/25, showed Res #1 had diagnoses of bipolar disorder and anxiety. On 08/04/25 at 2:34 p. m., minimum data set #1 reported the care plan should have been revised with an intervention.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on record review and interview, the facility failed to ensure residents were bathed as scheduled for 2 (#4 and #5) of 5 sampled residents reviewed for assistance with activities of daily living. The DON reported 118 residents resided in the facility. Findings: 1.An annual assessment, dated 05/15/25, showed Res #4's cognition was intact.Res #4's bath sheets showed the resident missed three of three opportunities for a shower from 08/01/25 to 08/06/25.A diagnoses report, dated 08/06/25, showed Res #4 had diagnoses which included epilepsy and morbid obesity.On 08/06/25 at 1:41 p.m., Res #4 reported they had problems getting their showers like they should. The resident reported they were supposed to be on Monday, Wednesday, and Friday and they had not had a shower this month. On 08/06/25 at 2:35 p.m., ADON #2 stated they were unable to locate bath sheets for the month of August. 2.Res #5's bath sheets showed the resident missed three of three opportunities for a shower from 08/01/25 to 08/06/25.A diagnoses report, dated 08/06/25, showed Res #5 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction.On 08/06/25 1:41 p.m., Res #5 reported they had problems getting their showers like they should. The resident reported they were supposed to be on Monday, Wednesday, and Friday and had not had a shower this month. On 08/06/25 at 2:35 p.m., ADON #2 stated they were unable to locate bath sheets for the month of August.</p>