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	04/24/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46582 Based on observation, record review, and interview, the facility failed to ensure: a. a resident had a physician order for an indwelling urinary catheter; and b. a resident with an indwelling urinary catheter received services to help prevent urinary tract infections for 1 (#101) of 1 sampled resident reviewed for urinary catheters. The administrator identified three residents with an indwelling urinary catheter. Findings: On 04/21/25 at 11:25 a.m., Res #101 was observed lying in bed with eyes closed. An indwelling urinary catheter with medium yellow urine was observed hooked to the bedframe. On 04/23/25 at 9:09 a.m., Res #101 was observed sitting in a reclined geriatric chair. An indwelling urinary catheter was observed hooked to the chair. A diagnoses report, dated 08/08/24, showed Res #101 had a diagnosis of benign prostatic hyperplasia without lower urinary tract symptoms. A care plan, dated 08/09/24, showed Res #101 used disposable briefs due to urinary incontinence. The care plan showed to monitor and change the brief every two hours and as needed. There was no documentation of an indwelling catheter on the care plan. A quarterly assessment, dated 02/16/25, showed Res #101 had a BIMS score of 11 and was moderately cognitively impaired. The assessment showed Res #101 required partial to moderate assistance with toileting and was always incontinent of urine. A nurse note, dated 03/24/25, showed Res #101 returned to the facility from the hospital with an indwelling catheter in place. There was no physician order for an indwelling urinary catheter found in the medical record. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation related to urinary catheter maintenance or infection prevention interventions documented in the medical record or the care plan. On 04/21/25 at 11:30 a.m., Res #101 stated they did not know why they needed a catheter. They stated they did not know if the staff cared for the catheter regularly. On 04/23/25 at 9:12 a.m., LPN #1 stated Res #101 returned to the facility from the hospital with the catheter. They stated they were not sure why the catheter was still in place. LPN #1 was asked what care was provided to ensure prevention of urinary tract infections. They stated catheter care was generally performed every shift by a nurse when a resident had a catheter. LPN #1 stated a physician order and care interventions should have been documented in the medical record. They stated there was no way to know if Res #101 had received regular care and maintenance of the catheter since nothing had been documented. On 04/23/25 at 10:55 a.m., the DON stated any resident with an indwelling urinary catheter should have a physician order which specified a medical diagnosis, catheter size, and catheter care interventions every shift and as needed. They stated Res #101 returned from the hospital with the catheter, but they were not sure why they still required the catheter. The DON stated a physician order and care interventions should have been documented in Res #101's plan of care. They stated the resident had not been assessed for removal of the catheter.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46703 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed for the use of bed rails prior to installation for 1 (#79) of 1 sampled resident reviewed for bed rails. The administrator identified six residents used bed rails. Findings: On 04/21/25 at 11:22 a.m., bed rails were observed to be up on both sides of Resident #79's bed. On 04/23/25 at 10:00 a.m., bed rails were observed to be up on both sides of Resident #79's bed. An undated policy titled Bed Safety and Bed Rails reads in part, 3. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. 6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. Use of Bed Rails: 6. The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight; c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. condition; j. communication; k. mobility (in and out of bed); and l. risk of falling. An admission assessment, dated 02/24/25, showed Resident #79 had a BIMS summary score of three, which indicated the resident was severly impaired in cognition for daily decision making. On 04/23/25 at 1:46 p.m., the administrator stated the resident did not have an assessment done prior to having bed rails, but should have.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43023 Based on observation and interview, the facility failed to ensure all components of the daily staffing information was posted for 2 of 2 observations. The administrator reported 127 residents resided in the facility. Findings: On 04/22/25 at 8:50 a.m., a daily staffing schedule was observed in a glass case on the North hall. The schedule was dated 04/22/25 and did not contain the census or the actual hours worked. On 04/23/25 at 8:42 a.m., a daily staffing schedule was observed in a glass case on the North hall. The schedule was dated 04/23/25 and did not contain the census or the actual hours worked. On 04/24/25 at 12:05 p.m., the administrator reported they did not know the census and actual hours worked had to be on the schedule.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46216 Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 1 (#124) of 6 residents sampled for timely administration of medications. The administrator identified 127 residents resided in the facility. Findings: An undated administration time document showed the morning medication pass was from 7:00 a.m. to 11:00 a.m. A policy titled Administering Medications, revised 04/2019, read in part, Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescribe orders, including any required time frame. Physician orders for Resident #124, dated 04/20/25, showed to administer the following: a. pristiq (an antidepressant) 50 mg in the morning for depression, b. clozapine (an antipsychotic) 200 mg two times a day for schizophrenia, c. rilutek (benzothiazole drug) 50 mg two times a day for bipolar disorder, d. naltrexone (opioid antagonist) 50 mg in the morning for opioid abuse. An April 2025 Medication Administration Audit Report, showed: a. clozapine was given on 04/21/25 at 12:28 p.m., b. pristiq and naltrexone were given on 04/21/25 at 12:31 p.m., and c. rilutex was given on 04/21/25 at 12:32 p.m. On 04/23/25 at 2:36 p.m., the DON stated the last time these medications were scheduled to be given was 11:00 a.m. On 04/23/25 at 2:37 p.m., the DON stated the 04/21/25 a.m. medications were given late. The DON stated they should have been given by 11:00 a.m.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46703 Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were utilized for a resident with a wound for 1 (#79) of 1 sampled resident reviewed for wound care. The DON identified 18 residents received wound care. Findings: On 04/23/25 at 9:52 a.m., RN #1 was observed to provide wound care for Resident #79. RN #1 was not observed to utilize a gown during wound care. Signage was not observed near the resident's room. A policy titled Enhanced Barrier Precautions, dated April 2024, read in part, EBP's employs targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following .wounds. An admission assessment, dated 02/24/25, showed Resident #79 had a stage four pressure ulcer and a BIMS summary score of three, which indicated the resident was severly impaired in cognition for daily decision making. On 04/23/25 at 10:15 a.m., RN #1 stated EBP included a gown and gloves. RN #1 stated they should have worn a gown for wound care. On 04/23/25 at 10:44 a.m., the DON stated a gown and gloves should be worn for wound care.