STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375412	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Okc, LLC	6312 North Portland Oklahoma City, OK 73112

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45583 Based on record review and interview, the facility failed to ensure a medication error did not occur for one (#2) of three sampled residents whose medication regime was reviewed. The assistant general manager identified 74 residents resided in the facility. Findings: An Administration of Medications policy, dated 05/2024, read in part, GENERAL All medications are administered safely and appropriately to aid residents to and help in overcome illness, relieve and prevent symptoms and help in diagnosis. The policy also read, A physician or nurse practitioner order is required for administration of all medications. The policy also read, Check medication administration record prior to administering medication for the right medication, dose, route, patient and time. Read each order entirely. Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring .Identify resident by reading wrist band or checking the picture in the MAR. Resident #2 had diagnoses which included acute kidney failure, seizure, sepsis, and acute cystitis. An incident report, dated 07/24/24 at 9:37 a.m., read in part, This nurse was notified by charge nurse on the 100 hall that guest stated [they] got a shot this morning and someone got blood from [their] finger and [they] didn't know what is was for. Guest is not diabetic and has no orders for any shots to be given. Guest is in stable condition at this time. After investigation, it was found that guest was given 25 units of Insulin Glargine. Stable, vs wnl, blood sugar normal. A Health Status Note, dated 07/24/24 at 5:24 p.m., read in part, This nurse was informed by therapy that the night nurse did a fingerstick and gave [them] insulin. Guest is not diabetic and has not taken insulin or had a FSBS since admission. CNO and [provider PA] notified. N/O from [provider PA] to check FSBS TID today. Guest has been monitored today by this nurse and no adverse reactions noted. [Family member] was notified by this nurse. Guest in bed at this time and call light in within reach. An All staff inservice 1 hour, dated 07/24/24, documented the topic was five rights of medication administration. It was documented to verify the label on the medication for the patient the medication was being administered to. It was documented there was no sharing medication amongst patients. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 07/24/24, documented FSBS TID for 1 day. The July 2024 TAR documented the midday FSBS reading on 07/24/24 was 105 and the evening reading was 96. It was documented the morning FSBS reading on 07/25/24 was 97. A Corrective Action Form dated 07/31/24, documented LPN #1 was suspended for two shifts for the insulin error. It was documented there was a med pass observation on 07/31/24. A QAPI data sheet, dated 08/01/24, documented notes for the medication error for Resident #2. On 10/07/24 at 3:31 p.m., the CNO stated they did speak to LPN#1 and did corrective action. They stated LPN #1 was suspended for two shifts, did QAPI, inserviced all staff, and observed a med pass for LPN #1.