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	12/03/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation, record review, and interview, the facility failed to appropriately develop and/or implement comprehensive care plans for two (#2 and #3) of three sampled residents identified as exit seeking or confused. The administrator identified 74 residents resided in the facility. Findings: An Elopement Policy, dated November 2018, documented residents identified as having wandering or exit seeking behavior will be assessed and appropriate interventions will be included in the plan of care at the time of identification of the wandering or exit seeking behavior. 1. Resident #2 was admitted to the facility on [DATE] with diagnoses which included nontraumatic intracerbral hemorrhage and hemiplegia. An initial physician history and physical visit for Resident #2, dated 11/20/24, read in part, confused and confabulating [memory loss that effects their higher reasoning] during visit. Nursing reported patient is exit seeking but is easily redirected. The care plan did not indicate the resident was an elopement risk. Resident #2's MDS, dated [DATE], documented their cognition was moderately impaired. A nurse note, dated 11/27/24 at 8:03 p.m., read in part, Guest was found to be missing around [7:00 p.m.]. All staff immediately went to look for guest, two nurses drove through neighborhood and found guest headed towards the [store] across the street from the facility. The care plan did not indicate the resident was an elopement risk. On 12/03/24 the resident's elopement risk was initiated on the care plan. 2. Resident #3 was admitted on [DATE] with a diagnoses which included dementia. A care plan for elopement risk was initiated. The interventions included disguise exits and decorate doors and doorknobs to look like something else. Resident #3's MDS, dated [DATE], documented their cognition was moderately impaired. (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
	375412	A. Building B. Wing	12/03/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 5:15 p.m., the emergency exit door at the end of Resident #3's hall was not decorated or disguised in any way and was clearly marked as an exit. On 12/03/24 at 5:37 p.m., the administrator and CNO stated they were unsure why those interventions were on the care plan and they would look into it.

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	12/03/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation, record review, and interview, the facility failed to adequately supervise and prevent a resident from eloping for one (#2) of three sampled residents identified as exit seeking or confused. The administrator identified 74 residents resided in the facility. Findings: An Elopement Policy, dated November 2018, documented residents identified as having wandering or exit seeking behavior will be assessed and appropriate interventions will be included in the plan of care at the time of identification of the wandering or exit seeking behavior. It documented all exit doors were alarmed with audible alerts. Resident #2 was admitted to the facility on [DATE] with a diagnoses which included nontraumatic intracerbral hemorrhage and hemiplegia. An initial physician history and physical visit for Resident #2, dated 11/20/24, read in part, confused and confabulating [memory loss that effects their higher reasoning] during visit. Nursing reported patient is exit seeking but is easily redirected. Resident #2's MDS, dated [DATE], documented their cognition was moderately impaired. A physician follow-up visit, dated on 11/25/24, documented Resident #2 continued to be confused and confabulating during visit. It documented the resident continued to exit seek. A Combined Initial and Final Incident Report Form, dated 11/27/24, documented at 6:40 p.m. nursing staff noticed Resident #2 was missing. It documented the resident was last seen by nursing staff at 6:00 p.m. It documented the resident was known for wandering and was stationed at the nurses' station prior to going missing. It documented the CNO was notified and management began watching camera footage and found the resident had wheeled themselves through the emergency exit door on hall 200. It documented the resident was found down the road from the facility at 7:10 p.m. It documented a head-to-toe assessment was completed, and no injuries were noted. It documented the resident's family and physician were notified. It documented a one-on-one sitter was put in place that evening and family was asked to come up if possible to assist with close monitoring. It documented social services had already been working on placement in long-term care/memory care. A nurse note, dated 11/27/24 at 8:03 p.m., read in part, Guest was found to be missing around [7:00 p.m.]. All staff immediately went to look for guest, two nurses drove through neighborhood and found guest headed towards the [store] across the street from the facility. On 11/27/24 it was documented the administrator and CNO provided staff with an in-service on elopement. (continued on next page)

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	12/03/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 1:05 p.m., the CNO stated the hall 200 door did not latch and therefore alarm. They stated maintenance was called out and fixed the door immediately. The CNO stated the facility attempted to not bring in confused and exit seeking residents because they are not a memory care facility. On 12/03/24 at 2:26 p.m., LPN #1 was reached via telephone for interview. LPN #1 stated Resident #2 had been exit seeking since about the 20th and they made the physician aware. They stated Resident #2 had been trying that morning so staff placed them at the nurses' station. LPN #1 stated around shift change it was noticed Resident #2 was missing. LPN #1 stated staff were looking for the resident for about 20 minutes before locating them. On 12/03/24 at 4:47 p.m., the administrator stated the exit doors were checked monthly and had last been checked on 11/07/24, but the facility would start checking them weekly for any issues.