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	03/13/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on record review and interview, the facility failed to provide bathing for 1 (#3) of 3 sampled residents reviewed for bathing. The director of MDS identified 69 residents resided in the facility. Findings: A BATHING policy, revised 04/2023, read in part, All residents are given a bath or shower in accordance with preferences. If no preference on a bath is voiced, a bath or shower will be offered twice per week. Resident #3 was admitted on [DATE] and discharged on [DATE]. Resident #3 had diagnoses which included need for assistance with personal care, muscle weakness, and unsteadiness on feet. Resident #3's admission resident assessment, dated 01/02/25, showed the resident required substantial to maximum assistance with bathing. A shower schedule showed Resident #3's weekly shower schedule was Tuesday and Friday. There was no documentation Resident #3 received a bath on 12/27/24, 12/31/24, and 01/07/25 during their admission stay at the facility. On 03/13/25 at 3:19 p.m., certified nurse aide #1 stated resident showers were set to two days a week based on room numbers. They stated they go through the shower book daily to see which residents were scheduled for the day. They stated if a resident refused, they would document on the shower sheet and inform the nurse. On 3/13/25 at 4:52 p.m., the DON stated they could not locate documentation Resident #3 received a bath on 12/27/24, 12/31/24, and 01/07/25.

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to ensure: a. medication allergy adherence; b. a medication was accurately transcribed; and c. medications were administered as ordered for 1 (#2) of 3 sampled residents reviewed for medication administration. The director of MDS identified 69 residents resided in the facility. Findings: An Administration of Medication policy, dated 04/2024, read in part, All medications are administered safely and appropriately to aid residents to and help in overcome [sic] illness, relieve and prevent symptoms and help in diagnosis. Resident #2 had diagnoses which included polyosteoarthritis, essential hypertension, and venous insufficiency. Resident #2's admission record showed they admitted to the facility on [DATE] and had allergies which included acetaminophen. A physician order, dated 01/04/25, showed Tylenol/acetaminophen (a pain reliever and fever reducer) eight hour oral tablet 650 mg, give one tablet every six hours as needed for pain not to exceed 3000 mg in 24 hours. The medication was discontinued on 01/06/25. Resident #2's medication administration record did not document the Tylenol was ever administered. A provider visit note, dated 01/06/25, showed the assessment and plan for Resident #2's bilateral leg edema included adding metolazone daily for a few days. The note was signed by physician #1. A physician order, dated 01/06/25, showed metaxalone (a muscle relaxant) oral tablet give 5 mg orally one time a day for edema for five days. A discontinue order for the above metaxalone was dated 01/08/25. The reason for the discontinue showed entered wrongly. Resident #2's medication administration record did not document the metaxalone was ever administered. A physician order, dated 01/08/25, showed metolazone (a diuretic) oral tablet 5 mg, give one tablet by mouth one time a day for fluid retention for five days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's medication administration record did not document the metolazone was ever administered. On 03/11/25 at 9:24 a.m. family member #1 stated they were concerned with medical negligence. They stated while at the facility, Resident #2 had an order for Tylenol. They stated the resident was allergic to the medication and regardless of the outcome, should not have been ordered when the resident was allergic to it. They stated Resident #2 had experienced swelling in their legs and the physician had ordered medication for it that was not started for two days. On 03/12/25 at 9:25 a.m., CMA #1 stated if a medication was not available to be administered, staff would call the pharmacy and check on the status. They stated they would ensure a resident was not allergic to the medication before administering it. They stated if the resident had an allergy to the medication, they would notify the nurse who would notify the physician. They stated the medication would be held until clarification was obtained. On 03/12/25 at 9:26 a.m., CMA #1 stated the charge nurse was responsible for handling new medication orders from the provider. They stated they would fax new orders over to the pharmacy. They stated new medications that were not ordered stat (urgently) should be received within four hours of ordering. On 03/12/25 at 9:28 a.m., CMA #1 stated Resident #2 had allergies which included Tylenol. They stated they did not know the resident's reaction to the medication. On 03/12/25 at 9:30 a.m., CMA #1 stated Resident #2 had an order for Tylenol eight hour as needed that was dated 01/04/25. They stated they did not know who put the order in. They stated Resident #2 had an order for metolazone dated 01/08/25 and metaxalone 5 mg one time daily for edema which was ordered on 01/06/25. They stated they were unable to view previous administration records and were unable to determine if the resident received either of these medications. On 03/12/25 at 9:44 a.m., LPN #4 stated they would confirm pharmacy received the medication orders to ensure they were available for administration in the facility. They stated they would put new orders into the system and ensure the order was faxed to the pharmacy and the family was aware of the new order. They stated they would check with pharmacy to see how soon the medication would be filled. On 03/12/25 at 10:13 a.m. a.m., LPN #4 stated when staff received new medication orders, if they had any questions, they would send a message to the provider to confirm the medication, dosage, and time. They stated sometimes the handwriting was not the best. They stated staff needed to have a clear understanding of the order before putting it in the system. On 03/12/25 at 10:15 a.m., LPN #4 stated new medications were usually received within four to six hours. They stated if a resident was allergic to the medication, they would determine the reaction, and let the provider know. They stated sometimes the need for the medication outweighs the risk and the provider would still want it given. On 03/12/25 at 10:16 a.m., LPN #4 stated Resident #2 had allergies which included acetaminophen. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/25 at 10:18 a.m., LPN #4 stated they did not know the resident's reaction to the medication. They stated Resident #2 did have a Tylenol order that was discontinued. They stated they did not know the reason it was prescribed with their allergy. On 03/12/25 at 10:23 a.m., LPN #4 stated they did not see a note the medication was ever administered. On 03/12/25 at 10:28 a.m., LPN #4 stated Resident #2's metolazone was ordered 01/08/25. They stated the metaxalone 5 mg one time a day was ordered on 01/06/25. They stated they were not sure who put the order in. On 03/12/25 at 10:30 a.m., LPN #4 stated metaxalone was a muscle relaxer. They stated metolazone was a diuretic. They stated the provider visit note dated 01/06/25 documented they were adding metolazone to treat Resident #2's edema. They stated they could not see where metaxalone was given, just that it was discontinued. They stated they were unable to see if either one was given. On 03/12/25 at 10:44 a.m., the DON stated anytime medications ran out, the CMA would push reorder in the computer. They stated the facility also had an emergency kit for ensuring medications were available to administer. They stated staff ordered three days in advance before running out. On 03/12/25 at 10:45 a.m., the DON stated for new orders, staff let the resident know, entered it in the electronic record, and notified family. On 03/12/25 at 10:46 a.m., the DON stated both the DON and assistant director of nursing ran an audit of orders on Mondays to ensure orders were put in correctly. They stated pharmacy usually got new medications to the facility within six hours. On 03/12/25 at 10:48 a.m., the DON stated if a resident was allergic to a medication ordered, staff would notify the doctor and make sure they okayed the medication. They stated the resident would be informed as well. On 03/12/25 at 10:52 a.m., the DON stated Resident #2 had allergies which included acetaminophen. They stated they were unsure of the resident's reaction to the medication. They DON stated they were the person who put in the Tylenol order. They stated the resident's orders were reviewed by physician #1 on admit and they placed a check next to Tylenol. They stated it was difficult to remember the reason. On 03/12/25 at 11:00 a.m., the DON stated Resident #2 did not receive the Tylenol before it was discontinued. On 03/12/25 at 11:01 a.m., the DON stated the metolazone was ordered for Resident #2 on 01/09/25 and the medication was used to treat fluid retention. They stated Resident #2 had an order for metaxolone 5 mg give one time a day for edema for five days ordered 01/07/25. They stated the order was put in wrong. They stated metaxolone was used for a muscle relaxant. The DON reviewed the provider visit note dated 01/06/25 and stated metolazone was supposed to be ordered. They stated neither medication was ever administered to Resident #2.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. 35389 Based on record review and interview, the facility failed to ensure physician ordered labs were obtained for 1 (#2) of 3 sampled residents reviewed for assess monitor and intervene. The director of MDS identified 69 residents resided in the facility. Findings: A facility lab policy, dated 05/2024, read in part, A physician or nurse practitioner order is necessary for any lab specimen collection .Label container with pertinent information .place specimen in designated area . Document in the nursing notes that a specimen was collected and a description of the specimen. Resident #2 had diagnoses which included diverticulitis of the intestine. A physician order, dated 01/04/25, read in part, STOOL SAMPLE NEEDED (CDIFF?) [clotridoides difficile colitis] LEAVE ORDER UNTIL COLLECTED. ONCE COLLECTED CALL LAB TO PICK UP .PRINT ORDER OUT AND PUT IN PURPLE BOOK. A physician progress note, dated 01/06/25, showed Resident #2 had experienced diarrhea since before Thanksgiving. The note showed stool studies collected 01/05/25 and the results were pending. The note was signed by physician #1. There were no stool specimen results located in Resident #2's clinical record for the 01/04/25 physician ordered stool sample. On 03/11/25 at 9:24 a.m., family member #1 stated Resident #2 had experienced diarrhea for an extended period of time (months) and they were concerned a stool specimen wasn't collected. On 03/11/25 at 2:13 p.m., the DON stated they did not believe Resident #2's stool specimen was ever collected. They stated the family had complained about the lab. They stated the facility had changed lab services during the time and had difficulty getting it integrated into their electronic system. The DON stated the facility completed a follow up on the issue, educated staff, and completed a QA. On 03/12/25 at 9:43 a.m. LPN #4 stated when providers ordered labs, they would put it in the electronic system on the treatment administration record. They stated once the specimen was collected, they would label it and notify the lab company it was collected so they could pick it up. On 03/12/25 at 10:43 a.m., the DON stated when providers ordered labs, they would notify the family and put the lab order in the system. They stated staff would collect the labs such as stool specimens, date, sign and label the specimen container, and call the lab to pick it up. (continued on next page)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/25 at 3:15 p.m., LPN #1 stated staff would collect stool, urine, and blood specimens and call the lab for pickup. On 03/13/25 at 3:16 p.m., LPN #1 stated the facility had switched lab services not long ago and received an inservice related to labs. On 03/13/25 at 3:41 p.m., LPN #2 stated when they received an order for labs, they would put it into the electronic system and the lab system. They stated after the lab was collected, they would call the lab to pick it up and mark it off once it was picked up. They stated they had received a recent inservice on labs. On 03/13/25 at 3:47 p.m., LPN #3 stated when they received a lab order they would let the resident know, put it into the computer system, collect the specimen, and click it off the system after it was collected. They stated they had received inservice training recently related to labs. The facility initiated a QA plan of improvement with monitoring on 01/08/25. The facility provided ongoing monitoring related to lab services. A review of the in-service documentation related to the investigation of labs being completed as ordered documented the facility completed an all staff training on 01/22/25. A review of the employee list and signatures indicated all employees had been in-serviced. Interviews with staff during the survey indicated they had knowledge of the in-service education provided regarding the laboratory policy. Staff demonstrated knowledge of the process of obtaining physician ordered labs. The deficiency was determined to be a past noncompliance. The record review and interviews support a past noncompliance.