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	09/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure a homelike environment for 1 (#16) of 5 sampled resident rooms reviewed for cleanliness.The MDS coordinator identified 72 residents resided in the facility.Findings: On 09/09/25 at 9:50 a.m., Resident #16's floor of their room was observed to have a substance throughout the room. The substance was clear to white in appearance and there were footprints in the substance in several different places. There were small pieces of paper and white tape scattered on the floor. There were two large pieces of black cardboard on the floor by Resident #16's bed. On 09/09/25 at 10:59 a.m., Resident #16's floor was observed to still have the sticky substance, pieces of paper, tape, and black cardboard on the floor of their room. On 09/10/25 at 5:22 p.m., Resident #16's floor was observed to still have the sticky substance, pieces of paper, tape, and black cardboard on the floor of their room. An undated policy Room Cleaning for Residents, read in part, The resident's room daily cleaning steps daily cleaning steps and recommended procedures are as follows: Pick up all paper, trash, etc. Dust the floor thoroughly. After mopping the floor, place a wet floor sign. On 09/09/25 at 9:51 a.m., Resident #16 was asked how comfortable their room was for them. They stated, It's dirty. My [family member] told them to clean it and they still haven't. On 09/09/25 at 11:00 a.m., Resident #16's family member stated they had asked multiple staff members to have Resident #16's room cleaned since their admission, but it still had not been done. On 09/11/25 at 8:56 a.m., housekeeper #1 was asked how often they cleaned resident rooms. They stated, Every day. They were asked if Resident #16's room was cleaned on 09/10/25. Housekeeper #1 stated, Yeah, every day. They were asked if the floor had been swept and mopped. They stated, Yeah. On 09/11/25 at 9:00 a.m., housekeeper #1 was shown Resident #16's floor and asked when the last time the floor was mopped. They stated, Yesterday. Housekeeper #1 was advised the floor had been sticky with footprints on it and the paper, tape, and black cardboard had been present since at least 09/09/25. They stated, Oh. Housekeeper #1 was asked if Resident #16's floor was dirty. They stated, Yes. On 09/11/25 at 10:37 a.m., the maintenance director was asked how often the housekeepers were supposed to mop the resident rooms. They stated, Every day. The maintenance director was asked what their expectation of the housekeepers was for mopping resident rooms. They stated, A quick sweep or dust mop first, then mop every day.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 1 (#62) of 18 sampled residents were reviewed for baseline care plans.The MDS coordinator identified 72 residents resided in the facility.Findings:Resident #62's Care Plan Report, dated 08/28/25, showed Resident #62 admitted on [DATE].Review of the electronic health record did not show a baseline care plan had been completed for Resident #62.A Care Plan policy, revised 04/2025, read in part, A baseline care plan is developed for each resident upon admission, but no later than 48 hours of admission to the facility. The care plan includes minimum health care information necessarily to properly care for the resident.On 09/10/25 at 3:03 p.m., the MDS coordinator stated the facility had 48 hours to complete a baseline care plan. They stated it was to be completed by the admitting nurse. The MDS coordinator stated the baseline care plan had been started but not completed within the required 48 hours.

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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** Based on record review and interview, the facility failed to ensure a comprehensive care plan was completed for 1 (#62) of 18 sampled residents reviewed for care plans.The MDS coordinator identified 72 residents resided in the facility.Findings:Resident #62's Care Plan Report, dated 08/28/25, showed Resident #62 admitted on [DATE].Review of the electronic health record showed 1 activity entry in the care plan; no other entries had been documented.A Care Plan policy, revised 04/2025, read in part, The comprehensive care plan is developed within 7 days of CAA completion . The care plans are developed by the members of the interdisciplinary team based on their assessments and interaction with the resident and/or resident's significant others.On 09/10/25 at 3:04 p.m., the MDS coordinator stated the comprehensive care plan had not been completed by all departments and should have been completed on 09/03/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to assess, monitor, and intervene for no bowel elimination from 09/02/25 to 09/07/25 for 1 (#48) of 3 sampled residents reviewed for bowel elimination.The MDS coordinator identified 72 residents resided in the facility.Findings:On 09/10/25 at 1:20 p.m., Resident #48 was lying in bed watching television. The resident was clean and without foul odor. The resident was pleasant and denied pain or discomfort at the time. A private sitter was in the room at the time of the observation.A facility policy titled Bowel Monitoring, revised/reviewed 07/2025, read in part, Licensed nursing staff will complete a review daily to ensure there are no abdominal abnormalities present. Abnormal findings may include but aren't limited to:.Infrequent bowel patterns and/or consistency of stool.An undated face sheet showed the Resident #48 had disease of spinal cord, quadriplegia C5-C7 incomplete, cognitive communication deficit, and need for assistance with personal care.A care plan, dated 08/16/25, did not show a care plan for constipation. A physician order, dated 08/22/25, showed Resident #48 was to have bowel and bladder training every two hours. The order showed the resident was to be offered the bedpan and urinal every two hours. A physician order, dated 08/22/25, showed Resident #48 was to receive Colace (a stool softener) 100mg two times a day for constipation.A physician order, dated 08/23/25, showed Resident #48 was to receive MiraLAX (an osmotic laxative) 17 GM every 24 hours as needed for constipation. An admission assessment, dated 08/28/25, showed Resident #48 had a BIMS of 10 which indicated they were moderately impaired for daily decision making. The assessment showed Resident #48 was incontinent of bowel. The task area of Resident #48's medical record showed the history of bowel elimination. The record showed Resident #48 had not had a bowel movement from 09/02/25 to 09/07/25.On 09/11/25 at 12:43 p.m., RN #1 stated if a resident had not had a bowel movement within two days, they would notify the physician and see if the resident had a physician order for as needed medication for constipation available. On 09/11/25 at 1:03 p.m., the DON stated if a resident had not had a bowel movement within three days, they would expect the nurse to notify the physician.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview, the facility failed to ensure a resident with limited mobility was provided with the appropriate padding for a cervical collar for 1 (#48) of 1 sampled resident reviewed for the use of a cervical collar. The MDS coordinator identified 72 residents resided in the facility.Findings:On 09/10/25 at 1:20 p.m., Resident #48 was lying in bed watching television. The resident was wearing a Miami J cervical collar. On 09/11/25 at 8:57 a.m., Resident #48 was sitting in their wheelchair eating breakfast with assistance from the private sitter. The resident's cervical collar was lying on the bed and the padding was soiled. An undated face sheet showed Resident #48 had diagnoses which included disease of the spinal cord, quadriplegia C5- C7 incomplete, and falls. The care plan, dated 08/16/25, showed Resident #48 had an ADL self-care performance deficit and limitations in physical mobility. A physician order, dated 08/25/25, showed Resident #48 was to always wear the Miami J cervical collar except during meals and showers until follow up in six weeks.An admission assessment, dated 08/28/25, showed Resident #48 had a BIMS of 10, which indicated the resident was moderately impaired for daily decision making. The assessment showed Resident #48 was dependent with bathing and required assistance with eating. On 09/10/25 at 1:34 p.m., LPN #1 stated the Resident #48 had a Miami J cervical collar and the facility only had padding to fit an Aspen cervical collar. On 09/10/25 at 2:40 p.m., the DON stated the padding the facility had was not for a Miami J cervical collar. The DON stated the facility did not have padding for the cervical collar. On 09/10/25 at 2:57 p.m., the DON stated the facility did not have the correct padding for Resident #48's cervical collar. The DON stated there was a miscommunication regarding the availability of the correct cervical collar padding. The DON stated the padding should be changed when soiled, at least after showers, or maybe daily with sweating.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight for 1 (#48) of 3 sampled residents reviewed for weight loss. The MDS coordinator identified 72 residents resided in the facility.Findings:On 09/11/25 at 8:57 a.m., Resident #48 was sitting in their wheelchair eating breakfast. The resident was assisted with the meal by the private sitter. An undated face sheet showed Resident #48 had diagnoses which included quadriplegia, muscle weakness, the need for assistance with personal care, gastroesophageal reflux disease, and a body mass index (BMI) 19.9 or less. A care plan, dated 08/16/25, showed Resident #48 had the potential for alterations in nutrition and hydration. Interventions were to evaluate any weight changes and follow facility protocol for weight change. A physician order, dated 08/22/25, showed Resident #48 was to receive a regular diet and Ensure one can with meals for a supplement. A physician order, dated 08/22/25, showed Resident #48 was to be offered assist with every meal. A physician order, dated 08/28/25, showed Resident #48 was to be weighed weekly for four weeks and then monthly.An admission assessment, dated 08/28/25, showed Resident #48 had a BIMS of 10. The assessment showed the resident had not had weight loss.Resident #48's weight record, dated 09/04/25, showed the resident weighed 137.5 pounds and had a 5.4% weight loss from the weight on 08/16/25 of 145.4 pounds.Resident #48's electronic record for the task amount eaten of meals, showed the resident ate 76% to 100% of meals. On 09/10/25 at 1:20 p.m., the private sitter stated they assisted the staff with Resident #48's personal care. On 09/10/25 at 4:17 p.m., the DM stated the dietitian was in the facility twice a week. The DM stated the dietitian was responsible for monitoring resident weights. On 09/11/25 at 8:38 a.m., the physician stated the facility had weekly QA meetings and weight loss was one of the topics. The physician stated they did not have a QA meeting last week. The physician stated the dietician monitored the resident weights and should be aware. On 09/11/25 at 9:21 a.m., the dietician stated they were not in the facility last week and the weekly QA meeting was cancelled. The dietician stated they would have been aware of the resident's weight loss this week.On 09/11/25 at 10:00 a.m., the DON stated the dietician was responsible for monitoring resident weights and notifying the physician. The DON stated the resident's weight loss had flagged in the computer last week. The DON stated no new intervention had been implemented since the identified weight loss on 09/04/25.

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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. Based on record review and interview, the facility failed to ensure medications were administered according to physicians' orders for 2 (#2 and #69) of 4 sampled residents reviewed or medication administration.The MDS coordinator identified 72 residents resided in the facility.Findings:A Medication Orders policy, dated 01/2023, read in part, If medication is ordered but not available, check to see if it was misplaced and then call the pharmacy to obtain the medication. 1. Resident #32's Order Summary Report, dated 09/2025, showed they had diagnoses which included atherosclerosis of coronary artery bypass graft without angina pectoris, major depressive disorder, and overactive bladder. Resident #32's Order Summary Report, dated 09/2025, showed clopidogrel bisulfate (antiplatelet) 75 mg, lamotrigine (anti-epileptic) 25 mg, oxybutynin (anticholinergic/antimuscarinic) 15 mg. On 09/11/25 a number 9 (other/see nurses note) was documented on the MAR on the following medications:a. clopidogrel bisulfate 75 mgb. lamotrigine 25 mgc. oxybutynin 15 mg2. Resident #69's Order Summary Report, dated 09/2025, showed they had diagnosis which included major depressive disorder. and an order for escitalopram oxalate (antidepressant) 20 mg.On 09/11/25 a number 9 (other/see nurses note) was documented on the MAR on the above medication. There was no other documentation found in the resident's health record for this medication.On 09/11/25 at 1:01 p.m., CMA #1 stated a number 9 on the MAR meant see other/ notes. She stated she had marked them because they were waiting on the pharmacy for the medication. They stated the medication was unavailable.On 09/11/25 at 1:02 p.m., CMA #1 stated the policy for ordering medications was to order before it ran out.On 09/11/25 at 2:11 p.m., the DON stated their expectation for reordering medications was to order when down to about three days' worth and if medications were in within 24 hours they should be notified.On 09/11/25 at 2:14 p.m., the DON stated there should not have been a break in days on those medications. They stated those are important medications.

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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. Based on observation, record review, and interview, the facility failed to ensure proper hand hygiene was performed during medication administration observation for 4 (#32, 53, 69, and #69) of 6 sampled residents reviewed for medication administration.The MDS coordinator identified 72 residents resided in the facility.Findings:On 09/11/25 at 8:32 a.m., CMA #1 was observed to prepare and administer Resident #81's medications without proper hand hygiene performed. CMA #1 was not observed to wash their hands before, during, and throughout the medication administration process.On 09/11/25 at 8:40 a.m., CMA #1 was observed to prepare and administer Resident #53's medications without proper hand hygiene, CMA #1 was not observed to wash their hands before, during, and throughout the medication administration process.On 09/11/25 at 9:25 a.m., CMA #1 was observed to prepare and administer Resident #32's medications without proper hand hygiene, CMA #1 was not observed to wash their hands before, during, and throughout the medication administration process.On 09/11/25 at 9:40 a.m., CMA #1 was observed to prepare and administer Resident #69's medications without proper hand hygiene, CMA #1 was not observed to wash their hands before, during, and throughout the medication administration process.A Hand Hygiene policy, revised 04/2025, read in part, All staff members will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of healthcare-associated infections (HAIs) .Indications for Hand-washing .Before and after medication administration .If hands are not visibly soiled, an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situation .before and after medication administration.On 09/11/25 at 9:53 a.m., CMA #1 stated the policy for hand hygiene during medication administration was to either wash or sanitize their hands before and after each resident. They stated they had not sanitized during the observed medication administration observation at all.