STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375461	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, record review, and interview, the facility failed to provide pain medication to a resident as ordered for 1 (#1) of 3 sampled residents reviewed for medication as ordered. The general manager identified 36 residents resided in the facility. Findings:On 07/09/25 at 12:01 p.m., CNA #1 and CNA #2 were providing incontinent care on Resident #1. The resident informed CNA #1 and CNA #2 they were in pain. Resident #1 was groaning holding their left hip. On 07/09/25 at 12:10 p.m., Resident #1 groaned in pain as they were turned to their left side. On 07/9/25 at 12:22 p.m., CNA #2 was observed speaking with CMA #3. A physician's order, dated 04/15/25, showed Tylenol (pain medication) 325 mg give two tablets by mouth every six hours as needed for pain.A Pain Management policy, dated 04/17/25, read in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.Physician's orders, dated 05/01/25, showed oxycodone HCl (pain medication) 5 mg give one tablet by mouth every six hours as needed for pain level three to six and oxycodone HCl 5 mg give two tablets by mouth every six hours as needed for pain level seven to 10. Resident #1's significant change status resident assessment, dated 05/10/25, showed the resident's cognition was intact with a brief interview for mental status of 14. The assessment showed the resident received pain medication as needed and was frequently in pain. A July 2025 MAR showed oxycodone 5 mg was administered on 07/09/25 at 5:06 a.m.A July 2025 MAR showed oxycodone 5 mg was administered on 07/09/25 at 1:07 p.m.Tylenol 325 mg was not administered on 07/09/25 during the time of investigation. On 07/09/25 at 12:04 p.m., CNA #1 informed Resident #1 they could take a break, but they had to clean them. On 07/09/25 at 12:07 p.m., CNA #1 asked Resident #1 if they received their pain medication this morning. Resident #1 responded, Yes.On 07/09/25 at 12:14 p.m., CNA #1 and CNA #2 completed incontinent care. CNA #1 informed the Resident #1 they would inform the nurse about their pain. On 07/09/25 at 12:36 p.m., CNA #2 stated they informed CMA #3 the res complained of pain. They stated CMA #3 stated Resident #1 had pain medication, but it was not time to administer. On 07/09/25 at 12:37 p.m., CNA #2 stated if a resident complained of pain, they were to inform the CMA. On 07/09/25 at 12:40 p.m., CMA #3 stated they were informed the resident complained of pain around 12:25 p.m. to 12:30 p.m. but it was too early for administration. They stated the Resident #1 already had everything they could for pain.On 07/09/25 at 12:41 p.m., CMA #3 stated the resident took oxycodone 5 mg 2 tablets every six hours as needed, and Tylenol 325 mg two tablets every six hours as needed for pain. On 07/09/25 at 12:42 p.m., CMA #3 stated the last time Resident #1 received their pain medication prior to incontinent care observation was on 07/09/25 at 5:17 a.m. On 07/09/25 at 12:43 p.m., CMA #3 stated they administered the pain medication at 1:07 p.m. on 07/09/25. They stated the Resident #1 rated their pain at 8/10 on a numerical scale.On 07/09/25 at 12:46 p.m., CMA #3 stated the resident should have received their pain medication when they complained of pain. They stated it was a miscalculation on their part. On 07/10/25 at 6:30 a.m., LPN #3 stated CMA #3 had informed them Resident #1 complained of pain, and it was too soon to administer. On 07/10/25 at 8:30 a.m., the DON stated CMA #3 did not follow Resident #1's order for pain.

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
	375461	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375461	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 07/11/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to prevent a significant medication error by administering the wrong dose of morphine (an opioid) to Resident #3.On 07/11/25 at 12:34 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 07/11/25 at 2:23 p.m., the administrator and the general manager were notified of the IJ situation and the IJ template was provided.On 07/14/25 at 2:00 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,IJ removal Plan - Ignite Medical Resort [NAME].Ignite Medical Resort [NAME] is committed to ensuring the safety and well-being of all residents and operates in substantial compliance with Federal and State laws and regulations. This removal plan constitutes Ignite Medical Resort [NAME]'s written credible allegation of compliance for the immediate jeopardy noted. Facility will be in compliance on 7/14/2025.1. On 07/02/25, Resident #3 was transferred to the emergency room for evaluation and treatment of altered mental status related to receiving morphine 15 mg ER instead of prescribed morphine 5 mg IR. The facility immediately:Removed all morphine 15 mg ER from Resident #3's medication supply.Ensured Narcan [opioid antagonist] was obtained and available in the emergency medication supply.Narcan to be available at all times and present on each nurse cart.Conducted medication reconciliation for all of Resident #3's medications.2. On 07/03/25, the facility:Identified 25 additional residents receiving opioid medications; audit completed on 7/11/2025 and all were receiving correct medications as ordered.Verified correct medication strength/formulation for all current residents in house against physician orders.Confirmed Narcan availability for all residents on opioid therapy.Reviewed all medication changes from the past 7 days to ensure proper receipt and reconciliation.3. Effective 07/04/25:Medication manifest will be checked with all delivered medications.Re-educated all medication administration staff on proper medication verification procedures (5 rights). Included but not limited to the policy and procedures on ordering, receiving, reconciliation, administration, and discrepancy process (completed on 7/11/2025).4. The Director of Nursing reported monitoring plan and results to the Quality Assurance and Performance Improvement (QAPI) committee on 7/11/2025.The IJ was lifted, effective 07/14/25, when all components of the plan of removal had been completed. Multiple staff on different shifts were interviewed regarding the in-service they received, availability of Narcan, medication carts, pharmacy manifest, and all audits were reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to have a system in place to ensure medications received were reconciled for accuracy and to ensure medications were available to be administered as ordered for 1 (#3) of 3 sampled residents reviewed for medication administration. The general manager identified 36 residents resided in the facility.Findings:A Medication Ordering and Receiving From Pharmacy Provider policy, revised 01/2025, read in part, Receives medications delivered to the nursing care center from the pharmacy and documents delivery on the medication delivery receipt/manifest. Verifies medications received with the prescriber orders. An admission Record with an admit date of 06/30/25, showed Resident #3 had a diagnosis of other chronic pain.Resident #3 had a physician's order, dated 06/30/25, for morphine tablet soluble, give 5 mg IR by mouth three times a day for pain. A physician's order, dated 06/30/25, showed Narcan nasal liquid 4 mg /0.1 milliliter. Administer one spray in nostril as needed for opioid reversal. Spray contents of one nasal spray as a single dose in one nostril. Administer additional doses if required in alternating nostril.A pharmacy Delivery Manifest Report Details, showed morphine 15 mg tablet was delivered to the facility on [DATE] at 10:24 p.m. for Resident #3.There was no documentation the facility received Resident #3's Narcan from the pharmacy. There was no documentation the pharmacy received the order for morphine 5 mg IR three times a day.A Nursing Evaluation note, dated 06/30/25 at 5:25 p.m., showed Resident #3 was alert, oriented to person, place, and situation. It showed the resident had clear speech.A Medication Error report, dated 07/02/25 at 3:45 p.m., showed CMA #1 administered 15 mg ER instead of 5mg IR. The report showed the Resident #3 was more difficult to arouse than normal. The report showed the resident continued to become more obtunded and less responsive to painful stimuli. EMSA was called to administer Narcan. The report showed family was worried about a possible stroke and wanted the resident taken to the emergency room.A nursing note, dated 07/02/25 at 5:36 p.m., showed Resident #3 was sent to the emergency room for altered mental status. An EMS report, dated 07/02/25, showed Resident #3 was picked up for possible overdose.A hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375461	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375461	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 07/11/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to prevent a significant medication error for Resident #3. On 07/11/25 at 12:34 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 07/11/25 at 2:23 p.m., the administrator and the general manager were notified of the IJ situation and the IJ template was provided.On 07/14/25 at 2:00 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,IJ removal Plan - Ignite Medical Resort [NAME].Ignite Medical Resort [NAME] is committed to ensuring the safety and well-being of all residents and operates in substantial compliance with Federal and State laws and regulations. This removal plan constitutes Ignite Medical Resort [NAME]'s written credible allegation of compliance for the immediate jeopardy noted. It is the facility's policy to ensure that residents are free of any significant medication errors. Facility will be in compliance on 7/14/2025.On 07/02/25, the following immediate actions were taken for Resident #3:Emergency medical services were contacted when resident showed signs of altered mental status and decreased responsiveness.Resident was transferred to the emergency department for evaluation and treatment.Narcan (an opioid antagonist) was administered to reverse opioid effects.Physician was notified of the medication error.Morphine (an opioid) 15 mg ER tablets were immediately removed from the medication cart.Correct medication (morphine 5mg IR) was verified and placed on the medication cart.On 07/02/25 and 07/03/25, the facility:Conducted 100% audit of all residents receiving medications to verify correct medication, dose, and formulation. Reviewed all medication carts to identify any other instances where incorrect medications were stocked. Verified all medications match current physician orders.Identified 25 additional residents receiving opioid medications; audit completed on 7/11/2025 and all were receiving correct medications as ordered.Effective 07/03/25, the facility implemented:Mandatory in-service training for all medication administration staff on high-alert medications and proper verification procedures. To include but not limited to policy and procedure on ordering, receiving, reconciliation, administration, and discrepancy process (completed 07/11/25 for all staff).Narcotics placed on nurse cart and to be administered by licensed nurses only.The Director of Nursing reported monitoring plan and results to the Quality Assurance and Performance Improvement (QAPI) committee on 7/11/2025.The IJ was lifted, effective 07/14/25, when all components of the plan of removal had been verified as completed. Multiple staff on different shifts were interviewed regarding the in-service they received, medication carts, and all audits were reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.Based on record review and interview, the facility failed to prevent a significant medication error for 1 (#3) of 3 sampled residents reviewed for medication administration. The general manager identified 36 residents resided in the facility. Findings: An ADMINISTRATION OF MEDICATIONS policy, revised 07/2025, read in part, All medications are administered safely and appropriately to aid residents to and help in overcome illness, relieve and prevent symptoms and help in diagnosis.An admission Record with an admit date of 06/30/25, showed Resident #3 had a diagnosis of other chronic pain.Resident #3 had a physician's order, dated 06/30/25, for morphine tablet soluble, give 5 mg IR by mouth three times a day for pain. A nursing evaluation note, dated 06/30/25 at 5:25 p.m., showed Resident #3 was alert, oriented to person, place, and situation. The note showed the resident had clear speech.A narcotic record, dated 06/30/25, showed morphine 15 mg ER, give one tablet by mouth daily. The record showed Resident #3 received morphine 15 mg ER three times on 07/01/25 and one time on 07/02/25. A July 2025 MAR, showed Resident #3 received the wrong morphine on:a. 07/01/25 at 9:59 a.m.,b. 07/01/25 at 1:04 p.m.,c. 07/01/25 at 7:05 p.m., andd. 07/02/25 at 8:00 a.m.A Medication Error report, dated 07/02/25 at 3:45p.m., showed CMA #1 administered 15 mg ER instead of 5 mg IR. The report showed Resident #3 was more difficult to arouse than normal. The report showed the resident continued to become more obtunded and less responsive to painful stimuli. EMSA was called to administer Narcan. The report showed family was worried about a possible stroke and wanted the resident taken to the emergency room.A nursing note, dated 07/02/25 at 5:36 p.m., showed Resident #3 was sent to the emergency room for altered mental status. An EMS report, dated 07/02/25, showed Resident #3 was picked up for possible overdose.A hospital record, dated 07/02/25, showed chief complaint of altered mental status.On 07/10/25 at 12:08 p.m., CMA #2 stated they administered morphine15mg ER that was on the cart instead of the 5 mg IR as ordered. They stated they administered the medication twice on 07/01/25 around 8:00 a.m. and 2:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375461	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure dirty linens were handled in a manner to prevent cross contamination during:a. incontinent care for 1 (#1) of 3 sampled residents observed for incontinent care; and b. a hall observation. The general manager identified 36 residents resided in the facility. Findings:On 07/09/25 at 12:01 p.m., CNA #1 and CNA #2 was observed to provide incontinent care on Resident #1. Both CNAs had on gloves and provided privacy. On 07/09/25 at 12:05 p.m., Resident #1's brief was observed soiled. CNA #2 wiped the resident's genitalia.On 07/09/25 at 12:10 p.m., Resident #1 was observed rolled to their left side. CNA #1 removed the resident's soiled pad and placed on the floor next to a white sheet. On 07/09/25 at 12:12 p.m., CNA #1 was observed to wipe the Resident #1's buttocks and anal area. CNA #1 changed their gloves and put a new brief on the resident. On 07/09/25 at 12:14 p.m., CNA #1 and CNA #2 completed incontinent care on Resident #1. They adjusted the resident in bed.On 07/09/25 at 12:18 p.m., CNA #2 was observed to remove the resident's pillowcase and place it on the floor next to the pad and white sheet. They retrieved a plastic bag and put the dirty linens in the bag. On 07/09/25 at 12:20 p.m., CNA #1 and CNA #2 were observed to take out the trash and the bag of dirty linens.On 07/10/25 at 4:50 a.m., CNA #3 was observed to pick up linen and a pad from room [ROOM NUMBER]'s floor by the door. The door was open. They had no gloves. CNA #3 held the linen and pad close to their upper body and transported to a room identified as environment. On 07/09/25 at 12:30 p.m., CNA #1 stated dirty linens should be put in a bag. They stated they did not follow the facility's process on handling dirty linens during the incontinent care observation. On 07/09/25 at 12:34 p.m., CNA #2 stated dirty linens should be placed in a plastic and taken to the designated laundry. They stated they did not follow the process during incontinent care observation. On 07/10/25 at 6:07 a.m., CNA #3 stated the linen they transported was a top blanket, flat sheet and a bed pad. They stated the linen was dirty. CNA #3 stated the facility's process was to put dirty linen in a bag and put them in a hamper in the environment room. They stated they did not follow the process. On 07/10/25 at 8:30 a.m., the DON stated staff should put dirty linens in bags during care and transportation.