STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375549	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Adams Parc	6006 SE Adams Blvd Bartlesville, OK 74006

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records review and interview, the facility failed to:a. report an incident of elopement to the OSDH within 24 hours for 1 (#21) of 4 sampled residents reviewed for accidents; andb. report an allegation of physical abuse to the OSDH and a local law enforcement agency within two hours of the allegation for 1 (#17) of 3 sampled residents reviewed for abuse. The general manager stated two allegations of abuse in the past 12 months and three residents that wandered in the facility.Findings:1. A policy titled Elopement Policy, dated 11/2018, read in part, Upon discovering an unaccountable absence of a resident by a staff member, the staff member will immediately contact a nurse. Record the time that the resident was discovered missing and when and where resident was last seen.The administrator will notify the State Agency to report an unusual occurrence and activation of the facility's Emergency Operations Plan.A behavior narrative note, dated 10/18/25 at 7:04 p.m., showed Res #21 had eloped from the facility and walked to their apartment located approximately 600 feet to the west on an adjoining property. The note showed Res #21 knocked on the door of their apartment and their family told them to go back to the facility. The note showed facility staff located Res #21 next to their apartment and walked the resident back to the facility. The note showed Res #21 was missing from the facility for 15 minutes or less.An incident report, dated 10/19/25, showed Res #21 had eloped from the facility. The incident report showed the elopement was reported to the OSDH on 10/20/25.On 06/10/26 at 3:46 p.m., LPN #5 stated they had observed a person leaving the facility on 10/18/26 when they were coming to work but did not recognize the person. They stated when they went to shift report, they heard Res #21 had been missing and told the staff about the person they had seen leaving. LPN #5 stated when they had completed the incident report for Res #21's elopement, they had written the wrong incident date of 10/19/26 instead of the actual date of 10/18/26. LPN #5 stated they did not recall why they had faxed the incident report to the OSDH on 10/20/25. They stated they knew the incident report was supposed to have been faxed within 24 hours.On 06/10/26 at 4:17 p.m., the general manager stated they had been informed by LPN #5 the date Res #21 had eloped was 10/18/25 and not 10/19/25 which had been indicated on the incident report sent to the OSDH. They stated the incident report should have been sent to the OSDH within 24 hours of the elopement.2. A policy titled Abuse Policy, dated 11/2025, read in part, If an allegation of abuse is made the facility employee who becomes made (sic) aware of the allegation is required to immediately report the allegation to the facility Administrator.The facility Administrator or designee shall report the initial notification to the Department of Health and Senior Services immediately (within 2 hours of being made aware).The Administrator or designee will also inform any responsible party of the allegation and that an investigation is being conducted. If reasonable suspicion of a crime has occurred, local law enforcement shall be notified immediately.A health status note, dated 06/02/26 at 7:45 p.m., showed Res #17 had reported to LPN #7 that LPN #6 had been rude and abused them on 06/01/26. An incident report, dated 06/03/26, showed Res #17 had reported to LPN #7 that LPN #6 had pushed them and yelled at them on 06/01/26. The incident report showed the local law enforcement agency was contacted about the allegation of abuse on 06/03/26. A fax sheet attached to the incident report showed the report was faxed to the OSDH on 06/03/26 at 11:05 a.m.On (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/10/26 at 10:05 a.m. the general manager stated their staff should have reported the allegation of abuse to the OSDH and local law enforcement within two hours of hearing of the allegation on 06/02/26.

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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 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** Based on record review and interview, the facility failed to ensure a resident did not elope from the facility for 1 (#21) of 4 sampled residents reviewed for accident hazards.The general manager stated three residents wandered in the facility.Findings:A Wander/Elopement Risk Evaluation for Res #21, dated 10/17/25, showed the resident had scored 5 on the evaluation. A score of five indicated the resident was not a risk for wandering or elopement. The evaluation showed a score of 6 would have indicated a resident would be at risk for wandering or elopement.A behavior narrative note, dated 10/18/25 at 7:04 p.m., showed Res #21 had eloped from the facility and walked to their apartment located approximately 600 feet to the west on an adjoining property. The note showed Res #21 knocked on the door of their apartment and their family told them to go back to the facility. The note showed facility staff located Res #21 next to their apartment and walked the resident back to the facility. The note showed Res #21 was missing from the facility for 15 minutes or less.An incident report, dated 10/19/25, showed Res #21 had eloped from the facilityA five-day assessment, dated 10/24/25, showed Res #21 had a BIMS score of 12 (a BIMS score of 12 indicated the resident's cognition was moderately impaired). The assessment showed Res #21 was admitted to the facility on [DATE].On 06/10/26 at 3:46 p.m., LPN #5 stated they had observed a person leaving the facility on 10/18/26 when they were coming to work but did not recognize the person. They stated when they went to shift report, they heard Res #21 had been missing and told the staff about the person they had seen leaving. LPN #5 stated they did not see any staff member following the resident when they left the building. LPN #5 stated they had written the wrong date of 10/19/26 as the incident date instead of the actual date of 10/18/26 when they completed the incident report. They stated they did not recall why they had faxed the incident report to OSDH on 10/20/25. LPN #5 stated they knew the incident report was supposed to have been faxed within 24 hours.On 06/10/26 at 4:17 p.m., the general manager stated they had been informed by LPN #5 the date Res #21 had eloped was 10/18/25 and not 10/19/25 as indicated on the incident report sent to the OSDH.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to:a. ensure a resident was not administered medications that were not prescribed to them; andb. ensure medication prescribed to a resident was administered as ordered for 1 (#18) of 3 sampled residents reviewed for medication administration. The general manager stated 47 residents were administered medication at the facility.Findings:A policy titled Administration of Medication,dated 10/2025, 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.Procedure Check medication administration record prior to administering medication for the right medication, dose, route, patient and time.Identify resident by reading wrist band or checking the picture in the MAR.A medication administration record for Res #18, dated 02/01/26 through 02/28/26, showed on 02/22/26 the resident did not receive their prescribed medications scheduled for 8:00 p.m. The missed medications were:a. amlodipine besylate 5 mg for hypertension;b. Aricept 5 mg for dementia;c. atorvastatin calcium 20 mg for high cholesterol;d. citalopram hydrobromide 20 mg for depression;e. montelukast sodium 10 mg for allergies;f. doxycycline hyclate 100 mg for bullous pemphigoid (an autoimmune disorder causing itchy blisters on the skin);g. folic acid 1 mg for a supplement;h. lacosamide 50 mg for seizure prevention; [NAME]. methylphenidate 5m g for CNS stimulation (a medication that increases activity in the brain and spinal cord).A medication administration record for Res #23, dated 02/01/26 through 02/28/26, showed on 02/22/26 the resident was ordered to receive the following prescribed medications at 8:00 p.m.:a. lovastatin 40 mg for high cholesterol;b. apixaban 5 mg for deep vein thrombosis (a blood thinner medication);c. clindamycin HCL 300 mg for cellulitis (an antibiotic medication);d. hydralazine HCL 25 mg for hypertension; ande. metronidazole 500 mg for cellulitis (an antibiotic medication).A progress note for Res #18, dated 02/22/26 at 7:15 p.m., showed LPN #8 had administered Res #23's 8:00 p.m. medications to Res #18.An electronic medication administration record note for Res #18, dated 02/22/26 at 8:01 p.m., showed Res #18's prescribed 8:00 p.m. medications were withheld from the resident because they had erroneously received Res #23's 8:00 p.m. medications.A progress note for Res #18, dated 02/23/26 at 10:32 a.m., showed Res #18 had become unresponsive and was speaking in a nonsensical manner during morning medication administration. The note showed the resident was assessed by a nurse practitioner and sent to a local acute care hospital for evaluation.An acute care hospital discharge document, dated 02/23/26, showed the resident was evaluated for seizure activity and altered level of conciseness. The document showed Res #18 was discharged the same day they arrived at the hospital. On 06/08/26 at 2:15 p.m., RN #2 stated on 02/22/26, Res #18 had mistakenly been administered Res #23's evening medications. RN #2 stated because Res #18 had been given the wrong medication, they had to hold Res #18's own prescribed evening medications.