

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Tulsa, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 South 101st Avenue Tulsa, OK 74133	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interview, the facility failed to ensure a medical appointment was attended for 1 (#3) of 3 sampled residents reviewed for medical appointments. The administrator identified 88 residents resided in the facility. Findings: A review of hospital discharge orders, dated 03/14/25, read in part, Discharge instructions Patient needs to follow-up with podiatry 2 weeks after surgery. 3/21/25. An admission assessment, dated 03/20/25, showed a BIMS of 12 which indicated Resident #3 was moderately impaired for daily decision making. The assessment showed diagnoses which included amputation, peripheral vascular disease, and end stage renal disease. A Medication Administration Note, dated 03/21/25, read in part, Remove sutures/staples from amputation sites to L [left] toes unless contraindicated. Contact [the physician] with any concerns. One time only for 1 [one] day Appt [appointment] Monday [03/24/25]. Pt [patient] wanted surgeon to remove sutures. A physician encounter note, dated 03/24/25, read in part, Date of Service: 03/24/25 Visit Type: Follow up Transition of Care: No transition occurred. Details: This is a copy of a signed encounter note documented in GEHRIMED. Progress Note .Plan: Continue current medical regimen. No changes. Patient has follow-up appointment today. On 10/14/25 at 1:03 p.m., the resident representative for Resident #3 stated the delay in therapy was caused due to a missed appointment that would have provided orders for weight bearing as tolerated, and Resident #3 could have gotten more therapy before discharging home. On 10/17/25 at 10:29 a.m., the social services director stated the appointment on 03/24/25 was cancelled due to the staff did not see on the dashboard, Resident #3 had an appointment that day. On 10/17/25 at 11:20 a.m., the DON stated the appointment was scheduled and transportation was set up, but the staff missed the appointment on the dashboard. They stated the physician was notified and provided instruction and orders to remove the sutures and re-schedule an appointment. The DON stated the appointment was rescheduled for 04/09/25, but Resident #3 discharged on 04/08/25.</p>

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
---	-------	-----------