STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375583	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Edmond, LLC	1400 East Memorial Road Oklahoma City, OK 73131

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, and interview, the facility failed to provide baseline care plans to the resident and representative for 2 (#76 and #15) of 23 sampled residents reviewed for baseline care plans.The DON identified 68 residents resided in the facility.Findings:1. An undated Baseline Care Plan policy, read in part, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .The baseline care plan will: Be developed within 48 hours of a resident's admission .The supervising nurse, or supervising nurse shall verify within 48 hours that a baseline care plan has been developed. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand .The supervising nurse or MDS nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided by completion of the comprehensive care plan. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record. Review of an undated Baseline Care Preference form, showed questions regarding the preferences of Resident #76 and level of care assistance required for activities of daily living. The form was signed by Resident #76. The form was not signed or dated by a staff member who conducted the interview. The form showed a disclaimer that read in part, By signing this, I agree that the information is filled out to the best of my knowledge. I have reviewed this plan of care and received a copy of the physician orders. An admission MDS assessment, dated 09/07/25, showed Resident #76 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included dementia, restless leg syndrome, hypertension, and respiratory disorders. Section Q showed the overall goal was to discharge to the community. On 10/02/25 at 2:10 p.m., the DON stated baseline care plans were completed by MDS. The DON stated they were working on that. 2. An admission assessment, dated 09/16/25, showed Resident #18 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of depression, and was admitted on [DATE]. An undated 'Baseline Care Preferences' form, showed information regarding Resident #18's preferences had been completed. The form read in part, By signing this, I agree that the information is filled out to the best of my knowledge. I have reviewed this plan of care and received a copy of the (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician orders. The form showed the information had been obtained from Resident #18. Review of the electronic clinical record did not show Resident #18 or the resident's representative had received a copy of the baseline care plan. On 10/01/25 at 4:46 p.m., MDS coordinator #1 stated residents/resident representatives were provided a baseline questionnaire about preferences and they developed baseline care plans off of the information provided. They stated the resident and/or resident representative signed the Baseline Care Preferences form indicating they had received a copy of the form and physician orders. On 10/01/25 at 5:47 p.m., MDS coordinator #1 stated they did not have documentation the residents and/or residents' representatives had been provided a copy of the baseline care plan. On 10/02/25 at 10:20 a.m., Resident #18 stated upon admission they were not able to sign paperwork, so their family member had participated in the admission process and signed required paperwork. On 10/02/25 at 10:55 a.m., family member #1 stated they had not received a copy of Resident #18's baseline care plan. On 10/02/25 at 2:10 p.m., the DON stated the care plan/MDS coordinator was responsible to ensure residents and/or resident representatives received a copy of baseline care plans.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, and interview, the facility failed to ensure a comprehensive care plan focus was developed to address a resident's respiratory needs and a resident's oral care needs for 2 (#3 and #5) of 23 sampled residents reviewed comprehensive care plans. The administrator identified 68 residents resided in the facility. Findings: An undated facility policy titled 'Noninvasive Ventilation (CPAP, BIPAP, AVAPS, Trilogy),' read in part, The facility will obtain an order for the use of CPAP, BIPAP, AVAPS, or Trilogy device and settings from the practitioner.A personal CPAP, BIPAP, AVAPS, or Trilogy device may/may not be brought into the facility for the resident use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. 1.On 10/02/25 at 9:31 a.m., Resident #3 was observed lying in bed alert and oriented. A white BIPAP machine was observed on the bedside dresser. There were a mask and hose observed attached to the BIPAP with visible moisture in the mask laying in the open top drawer of the bed side dresser. The facility's policy titled 'Conducting and Accurate resident Assessment,' undated, read in part, The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. An undated facility policy titled 'Noninvasive Ventilation (CPAP, BIPAP, AVAPS, Trilogy),' read in part, The facility will obtain an order for the use of CPAP, BIPAP, AVAPS, or Trilogy device and settings from the practitioner.A personal CPAP, BIPAP, AVAPS, or Trilogy device may/may not be brought into the facility for the resident use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. Resident #3's admission assessment, dated 09/19/25, showed Resident #3's cognition was intact with a BIMS score of 13. The assessment showed Resident #3 did not use a BIPAP or CPAP. The assessment showed Resident #3 was admitted on [DATE] with diagnoses which included paraplegia and stage 4 pressure ulcers. Resident #3's care plan, revised 09/22/25, did not have a focus for BIPAP or respiratory needs. Resident #3's physician orders were reviewed. The physician orders did not document and order for BIPAP usage. On 10/02/25 at 9:31 a.m., Resident #3 stated they were admitted with the BIPAP machine and used it nightly to help them breathe. On 10/02/25 at 10:17 a.m., CNA #1 was asked about Resident #3's respiratory needs. CNA #1 stated Resident #3 had a BIPAP on their bedside table and the mask was in the top drawer not in a bag. CNA #1 was asked how they knew when to ensure a resident needs BIPAP therapy. CNA #1 stated they would ask the nurse. On 10/02/2025 at 10:50 a.m., the IP sated they observed a BIPAP with a mask and hose attached to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the BIPAP on Resident #3's bed side dresser. The IP stated there was not a physician order or care plan focus in Resident #3's medical record for BIPAP therapy. On 10/02/2025 at 10:58 a.m., MDS Coordinator #2 was asked how they evaluated a resident's respiratory needs upon admission. MDS Coordinator #2 stated they reviewed the residents' notes, review the clinicals, and skilled assessments. MDS Coordinator #2 was asked to review Resident #3 admission assessment dated [DATE] and discuss what was documented for CPAP and BIPAP. MDS coordinator #2 stated they reviewed Resident #3's orders and did not see an order, so they selected, No. MDS coordinator #2 stated they did not interview Resident #3 about the BIPAP use. MDS coordinator #2 stated they looked in progress notes, orders, and assumed nurses on the floor handled it. 2. On 09/29/25 at 10:14 a.m., Resident #5 was observed to not have teeth. An undated, 'Comprehensive Care Plans' policy, read in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. A care plan, revised 09/18/25, showed no concern for dental. An admission assessment, dated 09/20/23, section L showed Resident #5 had no teeth. An MDS admission assessment, dated 09/27/23, section L showed Resident #5 was not edentulous. A significant change assessment, dated 09/18/25, section L showed Resident #5 was not edentulous. The assessment showed Resident #5 had a BIMS of 15 and was cognitively intact for daily decision making. The assessment showed a diagnosis of dementia. On 09/29/25 at 10:14 a.m., Resident #5 stated they had not seen a dentist and did not have teeth but would like to have dentures. On 10/01/25 at 8:44 a.m., Resident #5 stated they had told someone they wanted dentures but did not remember who it was. Resident #5 stated they had not been asked if they wanted to see a dentist and had not seen one since they had been at the facility. On 10/01/25 at 8:44 a.m., CNA #2 stated Resident #5 had no teeth or dentures. CNA #2 stated they did not know if Resident #5 had seen a dentist. On 10/01/25 at 8:47 a.m., MDS coordinator #2 stated they gathered information for an assessment from the progress notes, orders, census, profile, diagnoses, immunizations and orders. They stated they sometimes gathered information in person from the resident. MDS coordinator #2 stated Resident #5 had a cognitive decline, but they were involved in their care plan with their representative. They stated Resident #5 had not said anything to them about wanting dentures. MDS Coordinator #2 stated they did not know why the assessment showed Resident #5 was not edentulous and it might affect the care plan. MDC Coordinator #2 stated they did not see anything on the care plan for oral care for Resident #5.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure care plans were reviewed and revised for 2 (#12 and #61) of 23 sampled residents reviewed for care plan revisions.The DON identified 68 residents resided in the facility.Findings:1. An annual assessment, dated 08/17/25, showed Resident #12 had a BIMS of 14 which indicated they were cognitively intact for daily decision making. The assessment showed a diagnosis of depression. Section N of the assessment showed no antipsychotic or antianxiety medications were administered during the look back period. Section N showed an antidepressant medication was administered during the look back period. A physician's order for Resident #12, dated 09/23/25, showed to administer sertraline HCL (an antidepressant) 50 mg tablet daily related to depression. A care plan, revised 08/17/24, showed a focus for trazodone for insomnia, antiplatelet therapy, refusing medications and pain. The care plan did not show a focus or concern related to antidepressant or psychotropic medications for Resident #12. On 10/01/25 at 3:19 p.m., MDS coordinator #1 stated care plans were revised quarterly, upon significant change, with clinical changes and on admission. They stated the care plan for Resident #12 did not include antidepressants and it was an oversight. 2. On 09/29/25 at 3:35 p.m., Resident #61 was observed to have a leg bag in place with catheter tubing draped along the leg. An admission assessment, dated 09/19/25, showed a BIMS of 13 which indicated Resident #61 was cognitively intact for daily decision making. The assessment showed diagnoses which included cancer, hypertension, benign prostatic hyperplasia, hyponatremia, hyperlipidemia, malnutrition, depression, asthma, wedge compression fracture first lumbar vertebrae. A care plan, revised 09/26/25, did not have a focus for a urinary catheter. A focus for daily care regarding ADLs showed Resident #61 required toileting assistance to include transferring on/off the toilet, adjusting clothing, and cleansing them self with wiping. The focus showed Resident #61 used a urinal at night and preferred it be left at their bedside. Review of physician orders showed no orders for the care of a urinary catheter. On 09/29/25 at 3:35 p.m., Resident #61 stated they had a catheter. On 10/01/25 at 3:22 p.m., MDS coordinator #1 stated the catheter was not on the care plan due to an oversight. MDS Coordinator #1 stated they were made aware of changes during the clinical meeting, by physician orders and a 24-hour report inside the system.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure;a. breathing treatments were monitored during administration for 1 (#18) of 1 sampled resident reviewed for breathing treatments, andb. oxygen tubing, nasal canula, BIPAP mask were labeled with the date they were administered and placed in a bag when not in use for 2 (#3 and #10) sampled residents reviewed for oxygen and BIPAP treatments. The DON identified four residents received breathing treatments, 51 residents required supplemental oxygen, and four residents had BIPAP treatments. Findings:An undated facility's policy titled Noninvasive Ventilation (CPAP, BIPAP, AVAPS, Trilogy), read in part, The facility will obtain an order for the use of CPAP, BIPAP, AVAPS, or Trilogy device and settings from the practitioner.A personal CPAP, BIPAP, AVAPS, or Trilogy device may/may not be brought into the facility for the resident use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. 1.On 10/02/25 at 9:18 a.m., Resident #10 was observed in bed. Oxygen tubing and nasal cannula was observed rolled up and wrapped around the repositioning bar on the bed. The tubing was connected to an oxygen humidifier attached to the wall. There was no date observed on the oxygen tubing, the humidifier, or the nasal cannula indicating when they were administered. There was no date observed on the nasal canula, tubing, or humidifier. The nasal canula and oxygen tubing was not in a bag. Resident #10's admission assessment, dated 09/03/25, showed Resident #10's cognition was moderately impaired with a BIMS score of 9. The assessment showed resident #10 was admitted on [DATE] with diagnoses which included acute respiratory failure and cerebrovascular disease. Resident #10's physician orders, dated 09/08/25, read in part, Administer O2 to relieve shortness of breath and /or to breathe easier. On 10/02/25 at 9:27 a.m., Resident #10 stated they wear oxygen as needed. On 10/02/25 at 10:25 a.m., CNA #1 stated they observed Resident #10's oxygen tubing tied and nasal cannula wrapped around Resident #10"s repositioning bar on their bed. CNA #1 stated the oxygen tubing with the nasal canula was attached to a humidifier bottle at the wall. CNA #1 stated the oxygen tubing, nasal cannula, and humidifier were not labeled with the date they were administered, and the nasal cannula was not bagged to prevent germs. On 10/02/25 at 10:31 a.m., RN #1 was asked what the policy was when administering oxygen tubing, nasal cannulas, and BIPAP treatments. RN #1 stated BIPAP mask and nasal cannulas should be bagged when not in use to protect from germs and cross contamination. RN #1 stated nasal cannulas, oxygen tubing, and the humidifier should be labeled with the date the equipment was administered and changed every 7 days. On 10/02/25 at 10:45 a.m., RN #1 stated they went to Resident #10's room and observed the nasal cannula and oxygen tubing was not labeled with the date they were administered. RN #1 stated they observed the nasal cannula and oxygen tubing not in use, wrapped around the repositioning bar on the residents' bed and it was not bagged to prevent cross contamination. 2. On 10/02/25 at 9:31 a.m., Resident #3 was observed lying in bed alert and oriented. A white BIPAP machine was observed on the bedside dresser. There were a mask and hose observed attached to the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIPAP with visible moisture in the mask laying in the open top drawer of the bed side dresser. Resident #3's admission assessment, dated 09/19/25, showed the residents cognition was intact with a BIMS score of 13. The assessment showed Resident #3 did not use a BIPAP or CPAP. The assessment showed Resident #3 was admitted on [DATE] with diagnoses which included paraplegia and stage 4 pressure ulcers. Resident #3's care plan and physician orders were reviewed. There were no physician orders or focus in Residents #3's medical record for the residents BIPAP usage. On 10/02/25 at 9:31 a.m., Resident #3 stated they were admitted with the BIPAP machine and used it nightly to help them breathe. On 10/02/25 at 10:17 a.m., CNA #1 was asked about Resident #3's respiratory needs. CNA #1 stated Resident #3 had a BIPAP on their bedside table and the mask was in the top drawer not in a bag. On 10/02/25 at 10:50 a.m., the IP was asked to observe Resident #3's room and discuss what they saw. The IP stated they observed a BIPAP with a mask with visible moisture and hose attached to the BIPAP on Resident #3's bed side dresser in an open drawer not in a bag. The IP stated there was not a physician order or care plan focus on Resident #3's medical record for BIPAP therapy. The IP stated the mask should be bagged when not in use to prevent germs and spread of infection. 3. On 09/29/25 at 10:18 a.m., Resident #18 was observed in their bed reclined with a breathing treatment mask on their face. The treatment was empty and not producing any steam. No staff were observed n the room. During the visit the nurse came in and removed the mask, turned off the machine and took the mask into the bathroom. The mask was then placed in a baggie next to the bed. A physician's order, dated 08/19/24, showed to administer the nebulizer treatment as needed. The order showed to assess before during and after the treatment as well as to educate the resident to participate in the medication delivery. A quarterly assessment, dated 09/02/25, showed a BIMS of 15 which indicated Resident #18 was cognitively intact for daily decision making. The assessment showed diagnoses which included heart failure, coronary artery disease, Parkinson's disease and asthma. A care plan, revised 09/02/25, showed a focus for altered respiratory status/difficulty breathing related to my asthma and sleep apnea. The interventions included to administer inhalers and breathing treatments as ordered. Monitor for effectiveness and side effects. A TAR, dated September 2025, showed on 09/29/25 Resident #18 received a breathing treatment, and the lung sounds were documented as clear with vital signs documented. Review of progress notes for 09/29/25, showed no note regarding Resident #8 requiring or receiving a breathing treatment via nebulizer. On 09/29/25 at 10:18 a.m., Resident #18 stated the nurse did not listen to their lungs before or after the treatment. The resident stated the nurse came in, placed the breathing treatment mask on them then left the room. They stated the breathing treatment was routine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/25 at 3:48 p.m., LPN #2 stated Resident #18 had routine breathing treatments. The LPN stated the nurse was to remain in the room with the resident and monitor their respirations during breathing treatments. LPN #2 stated they did not stay the entire time. They stated the treatment would be documented in the progress notes and vital signs were documented on the TAR. On 10/01/25 at 3:55 p.m., the DON stated they expected the nurse to monitor during the breathing treatment for pulse ox, lung sounds, respirations and blood pressure. They stated the nurse was to stay in the room with the resident throughout the breathing treatment.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to complete pre and post assessments of dialysis monitoring for 1 (#7) of 1 sampled resident reviewed for dialysis.The DON identified one resident who received dialysis at the facility.Findings:An undated, Hemodialysis policy, read in part, The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice .The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments .Ongoing assessment and oversight of the resident before during and after dialysis treatments .Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.Review of the assessments tab, showed Dialysis Resident Monitoring assessments were completed up until 07/16/25 when the assessment was discontinued, and the facility began using paper.A quarterly assessment, dated 07/20/25, showed Resident #7 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included end stage renal disease, DMII and arteriovenous fistula.A care plan, revised 07/20/25, showed a focus/concern for renal failure related to chronic kidney disease stage five. Interventions included to monitor for signs of dehydration, fluid overload, signs of infection at dialysis site, monitor lab reports of electrolytes and report to the physician in a timely manner.The care plan for Resident #7 had a focus/concern for chronic kidney disease and dependency on dialysis with a fistula for dialysis. The interventions included to check the site dressing daily that it was still dry and intact, do not draw blood or take blood pressures in the arm with the fistula or graft in it. Resident #7 understands the nurse will check the fistula/graph for bruits and thrills at the dialysis site to monitor that it had blood flow and would report to the doctor if none was felt. Review of dialysis monitoring forms for August 2025, showed the facility had missed six out of 13 opportunities for dialysis monitoring which included 08/01/25, 08/13/25, 08/15/25, 08/18/25, 08/20/25 and 08/29/25. The review showed four out of 13 opportunities were partially incomplete which included 08/04/25, 08/06/25, 08/08/25 and 08/11/25.Review of dialysis monitoring forms for September 2025, showed the facility had missed eight out of 14 opportunities for dialysis monitoring which included 09/08/25, 09/10/25, 09/15/25, 09/17/25, 09/19/25, 09/22/25, 09/24/25 and 09/26/25. A physician's order, dated 09/08/25, showed the dialysis patient monitoring form under the assessment tab must be filled out one time a day every Monday, Wednesday and Friday related to dependence on renal dialysis.A physician's order, dated 09/10/25, showed Resident #7 received outpatient dialysis on Monday, Wednesday and Friday at 8:00 a.m. On 09/30/25 at 3:57 p.m., LPN #1 stated they wrote pre and post dialysis assessments on a dialysis sheet and Resident #7 took it with them to dialysis. They stated the dialysis center wrote on it during the dialysis treatment then the form was returned back with Resident #7, and the facility nurse was to complete the post dialysis assessment. LPN #1 stated the form was given to the DON when the form was completed.On 09/30/25 at 4:04 p.m., the DON stated they reviewed and scanned the dialysis assessment forms into the miscellaneous file in the electronic clinical record. They stated if the facility did not receive the form back from the dialysis center, they called the dialysis center and asked them to fill the form out and fax it back. The DON stated the facility has had trouble with the dialysis center lately. They stated If they did not receive the dialysis form, they were to document and notify the physician. Review of progress notes showed no documentation of notifications made to the physician regarding the dialysis assessment forms.On 09/30/25 at 4:39 p.m., the DON was given a list of missing pre/post assessments to locate for August and September 2025. On 09/30/25 at 4:52 p.m., the DON returned and stated, they did not document on those dates.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to:a. maintain a clean ice machine; b. wash/sanitize hands before handling/storing dishes removed from the clean side of the dish machine; and,c. meet the minimum hot water temperatures for the wash and rinse cycles for the sanitizing of dishes cleaned in the dish machine. The DON identified 72 residents ate meals prepared in the kitchen.Findings:On 09/29/25 at 9:55 a.m., the ice machine in the main kitchen was observed with the dietary manager. The plastic cover was removed to expose the evaporator. The interior of the plastic cover had a black substance along the edges of the molded plastic cover. There was a black substance on the plastic framing the evaporator. The water reservoir tray which sat below the evaporator had a black substance along the sides and edges of the tray. There was a black substance around the pump and other components resting above the reservoir. On 09/29/25 at 10:05 a.m., the dietary manager was observed to load the dish machine with dirty dishes and run it. The dish machine wash temperature was 88 degrees Fahrenheit, and the rinse temperature was 84 degrees Fahrenheit. The dishes were removed on the clean side and another tray of dirty dishes loaded in. The dietary manager did not sanitize their hands after loading dirty dishes into the dish machine, removing clean dishes from the dish machine, and storing clean dishes in their storage area to air dry.On 09/29/25 at 10:08 a.m., cook #1 was observed to load the dish machine with dirty dishes and run it. Without sanitizing their hands, cook #1 moved from the stacking dirty dishes into a tray and loading the tray into the dish machine to unloading the clean dishes from another tray and storing them to dry. The dish machine was observed through several cycles of wash/rinse with water temperatures eventually at 120 degrees Fahrenheit for wash and 116 degrees Fahrenheit for rinse. During the observations, the dietary manager and cook #1 were observed to handle dirty dishes on one side of the dish machine and then clean dishes on the other side of the dish machine without sanitizing their hands. On 09/29/25 at 10:10 a.m., there was a hot water booster observed on the underside of the dish machine which read a water temperature between 80 degrees Fahrenheit and 120 degrees Fahrenheit during observations. There was a 5-gallon bottle of dish detergent with a small diameter hose running from the top of the 5-gallon bottle to the pump residing on top of the dish machine. There was a 5-gallon bottle of rinse aide with a small diameter hose running from the top of the 5-gallon bottle to the pump residing on top of the dish machine. There was a bottle of a chemical sanitizing agent under the clean side of the dish machine, but the bottle of sanitizing agent remained sealed and not connected to the dish machine. On 09/29/25 at 10:30 a.m., the dietary manager was observed to use litmus paper to check the level of chemical sanitizer in the dish machine. The dietary manager checked the well of water located at the bottom of the interior of the dish machine. The litmus paper appeared wet but did not change color. The dietary manager ran dirty dishes through the dish machine and used litmus paper to check the sanitizing agent on the outside of serving containers. The litmus paper appeared wet but did not change color. The dietary manager was observed to look for the container of chemical sanitizer. The dietary manager observed the chemical sanitizer was not connected to the dish machine. On 09/29/25 at 10:45 a.m., the dish machine's front screen showed instructions which declared a minimum wash temperature of 150 degrees Fahrenheit and a minimum rinse temperature of 180 degrees Fahrenheit for hot water sanitization of dishes. The dish machines' front screen showed instructions which declared a minimum water temperature of 120 degrees Fahrenheit for wash and rinse when using a chemical agent to sanitize dishes. On 09/29/25 at 10:00 am., the dietary manager stated the ice machine was dirty and they needed to clean it. The dietary manager stated the kitchen staff tried to clean the ice machine at least monthly.On 09/29/25 at 10:05 a.m., the dietary manager stated the dish machine used hot water to sanitize the dishes. The dietary manager then stepped away from the dish machine and asked the cook if the dish machine used hot water to sanitize the dishes or used a chemical sanitizer. [NAME] #1 stated the dish machine used a chemical sanitizer. (continued on next page)

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	375583	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Edmond, LLC	1400 East Memorial Road Oklahoma City, OK 73131

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dietary manager asked other staff in the kitchen and received mixed answered between chemical sanitization and hot water sanitization for the dish machine. On 09/29/25 at 10:30 a.m., the dietary manager stated the dish machine used a chemical sanitizer to sanitize the dishes. The dietary manager was asked to check the level of chemical sanitizer running through the dish machine. The dietary manager checked the level of chemical sanitizer and stated it was low, and they could not see that the litmus paper changed color. The dietary manager stated they did not know why the sanitizing agent was not connected to the dish machine and did not know how to connect the sanitizing agent. The dietary manager stated they would contact the maintenance man. On 09/29/25 at 11:00 a.m., the dietary manager stated they checked with maintenance and the dish machine used hot water to sanitize dishes. The dietary manager stated everyone should sanitize their hands after handling anything dirty and before touching anything clean.On 09/30/25 at 11:00 a.m., the water temperature of the dish machine was greater than 150 degrees Fahrenheit for wash and greater than 180 degrees Fahrenheit for rinse after the second cycle.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure infection prevention control measures were in place for a. oxygen tubing labeled with the date and stored in a bag when not in use for 1 (#10) of 2 sampled residents reviewed for respiratory care;b. BIPAP mask labeled with the date and stored in a bag when not in use for 1 (#3) of 2 sampled residents reviewed for respiratory care;c. sanitary laundry delivery during 1 of 1 observation;d. legionella surveillance in the water system; ande. the use of enhanced barrier precautions when performing supra-pubic catheter care for 1 (#3) of 1 resident observed for urinary catheter care.The administrator identified 68 residents resided in the facility, 4 residents had BIPAPS, and 51 residents had orders for supplemental oxygen.The DON identified four residents with indwelling urinary catheters. Findings:An undated facility policy titled Noninvasive Ventilation (CPAP, BIPAP, AVAPS, Trilogy), read in part, The facility will obtain an order for the use of CPAP, BIPAP, AVAPS, or Trilogy device and settings from the practitioner.A personal CPAP, BIPAP, AVAPS, or Trilogy device may/may not be brought into the facility for the resident use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. 1. On 10/02/25 at 9:18 a.m., Resident #10 was observed resident in bed. Oxygen tubing and nasal cannula was observed rolled up and wrapped around the repositioning bar on the bed. The tubing was connected to an oxygen humidifier attached to the wall. There was no date observed on the oxygen tubing, the humidifier, or the nasal cannula indicating when they were administered. There was no date observed on the nasal canula, tubing, or humidifier. The nasal canula and oxygen tubing was not in a bag. Resident #10's physician orders, dated 09/08/25, read in part, Administer O2 to relieve shortness of breath and /or to breathe easier. Resident #10's admission assessment, dated 09/03/25, showed Resident #10's cognition was moderately impaired with a BIMS score of 9. The assessment showed Resident #10 was admitted on [DATE] with diagnoses which included acute respiratory failure and cerebrovascular disease. On 10/02/25 at 9:27 a.m., Resident #10 stated they wear oxygen as needed. On 10/02/25 at 10:25 a.m., CNA #1 stated they observed Resident #10's oxygen tubing tied and nasal cannula wrapped around Resident #10"s repositioning bar on their bed. CNA #1 stated the oxygen tubing with the nasal canula was attached to a humidifier bottle at the wall. CNA #1 stated the oxygen tubing, nasal cannula, and humidifier was not labeled with the date they were administered, and the nasal cannula was not bagged to prevent germs. On 10/02/25 at 10:31 a.m., RN #1 was asked what the policy was when administering oxygen tubing, nasal cannulas, and bi-pap treatments. RN #1 stated BIPAP mask and nasal cannulas should be bagged when not in use to protect from germs and cross contamination. RN #1 stated nasal cannulas, oxygen tubing, and the humidifier should be labeled with the date the equipment was administered and changed every 7 days. On 10/02/25 at 10:45 a.m., RN #1 stated they went to Resident #10's room and observed the nasal cannula and oxygen tubing was not labeled with the date they were administered. RN #1 stated they observed the nasal cannula and oxygen tubing not in use, wrapped around the repositioning bar on the residents' bed and it was not bagged to prevent cross contamination. (continued on next page)

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	375583	A. Building B. Wing	11/25/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/25 at 10:50 a.m., the IP was asked to look in Resident #10's room and discuss what they observed. The IP stated the oxygen tubing and nasal canula were not in a bag and open to the air which has the potential for germs and infections. The IP stated the oxygen tubing, nasal cannula, and humidifier did not have the date they were administered. 2.On 10/01/25 at 1:30 p.m., LPN #1 was observed to provide catheter care to Resident #3. The LPN wore gloves but did not wear an isolation gown when they performed catheter care. On 10/02/25 at 9:31 a.m., Resident #3 was observed in lying in bed alert and oriented. A white BIPAP machine was observed on the bedside dresser. A mask and hose were observed attached to the BIPAP with visible moisture in the mask laying in the open top drawer of the bed side dresser. Resident #3's admission assessment, dated 09/19/25, showed Resident #3's cognition was intact with a BIMS score of 13. The assessment showed Resident #3 did not use a BIPAP or CPAP. The assessment showed Resident #3 was admitted on [DATE] with diagnoses which included paraplegia and stage 4 pressure ulcers. A care plan for Resident #3, revised 09/22/25, read in part, I understand that the staff has to wear a gown and gloves while providing care to me as an enhanced barrier protection (EBP) since I have an indwelling catheter to reduce the potential to spread bacteria (organisms) to other sites of my body or to other people. The care plan and physician orders for Resident #3 were reviewed. There were no physician orders, or a care plan focus on Residents #3's medical record for the resident's BIPAP usage. The order summary for Resident #3, dated 10/02/25, showed an order for the staff to perform catheter care every shift and as needed. The order was dated 09/12/25. The order summary for Resident #3, dated 10/02/25, showed an order for the staff to cleanse the resident's supra pubic catheter site with wound cleanser, pat dry, and apply a slit sponge gauze dressing every shift and as needed. The orders were dated 09/15/25. The order summary for Resident #3, dated 10/02/25, showed an order for EBP to be used twice daily and as needed. The orders were dated 09/12/25. On 10/02/25 at 9:30 a.m., Resident #3 stated the nursing staff did not wear an isolation gown when they performed catheter care, changed the slit drain sponge, or drained the catheter bag. On 10/02/25 at 9:31 a.m., Resident #3 stated they were admitted with the BIPAP machine and used it nightly to help them breathe. On 10/02/25 at 10:17 a.m., CNA #1 was asked about Resident #3's respiratory needs. CNA #1 stated Resident #3 had a BIPAP on their bedside table and the mask was in the top drawer not in a bag. On 10/02/25 at 10:50 a.m., the IP stated they observed a BIPAP with a mask with visible moisture and hose attached to the BIPAP on Resident #3's bed side dresser in an open drawer not in a bag. The IP stated there was not a physician order or care plan focus on Resident #3's medical record for BIPAP therapy. The IP stated the mask should be bagged when not in use to prevent germs and spread of infection. (continued on next page)

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	375583	A. Building B. Wing	11/25/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/02/25 at 11:15 a.m., LPN #1 stated they did not recall catheter care required the use of EBP. On 10/02/25 at 11:20 a.m., the DON stated EBP was used with anybody that had a line, wound, or break in their body, to protect the resident from possible infection. The DON agreed when staff performed supra-pubic catheter care, the facility required the staff to use EBP. 3. On 10/01/25 at 8:00 a.m., laundry aide #1 was observed to deliver laundry to resident rooms uncovered. On 10/02/25 at 8:21 a.m., the housekeeping supervisor, stated resident clothes were washed separately and delivered back to their rooms in their own bag. They stated laundry aide #1 did not put the clothes in the bag. They stated they were aware of the incident on 10/01/25 at 8:00 a.m. 4. An undated policy Legionella Surveillance, read in part, It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. An undated policy Water Management Program, read in part, It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens .in the facility's water systems based on nationally accepted standards .A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing .The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder. On 10/02/25 at 9:10 a.m., the maintenance supervisor stated they had no facility map of the water flow in the facility. The maintenance supervisor stated they added sanitizer tablets to the condensation pans in the air conditioning units in the attic to prevent the stopping up of lines and leaks. The maintenance supervisor stated they did not document when they completed that. The maintenance supervisor stated they were not aware of a water management plan or legionella prevention plan.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview the facility failed to provide reasonable accommodation of a bariatric bed for 1 (#3) of 1 sampled resident reviewed for accommodation of needs.The DON identified 73 residents resided in the facility.Findings:On 09/29/25 at 2:33 p.m., Resident #3 was observed on an air mattress. Resident #3 was tall and big built/obese with shoulders that near each side of the bed. Resident #3 was observed to be paraplegic and required assistance to turn hips but did not have room to turn. An admission assessment, dated 09/19/25, showed Resident #3 had a BIMS of 13 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included peripheral vascular disease, diabetes mellitus, paraplegia, depression and pressure ulcers. Section K of the assessment showed Resident #3 had a weight of 295 pounds and a height of 75 inches on admission. A care plan, revised 09/22/25, showed no concern for a bariatric sized bed. A review of physician orders for Resident #3, dated October 2025, showed no order for a bariatric bed. A progress note, dated 10/02/25 at 5:05 p.m., showed nursing spoke with Resident #3 regarding the type of mattress on their bed for pressure relief. The note showed Resident #3 voiced concerns about the air loss mattress feeling like it would force them to fall off the bed then therapy had them sitting up on the side of the bed. The note showed Resident #3 agreed to try using a Roho mattress and the mattress was changed. The note did not mention the need of a bariatric bed. On 09/29/25 at 2:33 p.m., Resident #3 stated the facility was to get them a larger bed on admission, but they had not heard anything more about it. On 10/02/25 at 12:45 p.m., the administrator stated there were several people with the authority to order equipment for residents, including beds. The administrator stated the admissions coordinator usually had any equipment a resident would need delivered before the resident was admitted . They stated the bed frame for Resident #3 was adjustable and large enough to accommodate the resident's needs. The administrator stated the resident needed a larger mattress on the bed and the facility did not have the right size available. The administrator stated any of the staff had the opportunity to notify/request a larger bed for the resident. The administrator stated they were not aware the resident needed a larger mattress until yesterday.

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	375583	A. Building B. Wing	11/25/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to limit a physician's order for a prn anti-anxiety medication to 14 days for 1 (#4) of 5 sampled residents reviewed for unnecessary medications. The DON identified seven residents received anti-anxiety medication. Findings: The medication administration record, dated July 2025, showed Resident #4 received PRN Lorazepam 11 times.The medication administration record, dated August 2025, showed Resident #4 did not receive a PRN dose of lorazepam. The medication administration record, dated September 2025, showed Resident #4 received one PRN dose of lorazepam. The order summary report, dated 09/30/25, showed Resident #4 had diagnoses which included chronic pulmonary embolism, pneumonia, heart failure, atrial fibrillation, and shortness of breath.The order summary report, dated 09/30/25, showed an active order for lorazepam 0.5 mg tablet given orally every six hours PRN for restlessness or agitation was written on 07/13/25.The order summary report, dated 09/30/25, showed an active order for lorazepam 0.5 mg liquid given sublingual every two hours PRN for restlessness or agitation was written on 07/15/25.On 10/02/25 at 10:58 a.m., the DON stated per facility policy, anxiety medication ordered PRN was limited to 14 days. The DON stated the floor nurses knew to write all ordered PRN anxiety medications with a 14 day stop date. The DON stated they reviewed all PRN anxiety medication orders in their morning meeting and likely would have caught any PRN anxiety medication that had extended past the 14-day limit. The DON reviewed the resident's orders for PRN anxiety medications and stated they missed that the PRN anxiety medication order did not have a 14-day limit. The DON stated they would review the resident's clinical record for a physician's documented rationale for extending the ordered as needed anxiety medication past 14 days. By the end of survey, the facility had not provided the documented rationale for the lorazepam.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a physician discharge order was obtained for 1 (#78) of 1 sampled residents reviewed for a planned discharge.The DON identified 162 residents discharged in the past 6 months.Findings: An undated policy titled, Transfer and Discharge, read in part, Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care. A care plan, dated 08/18/25 showed, Resident #78 was admitted to the facility for a short-term stay and would need assistance with discharge planning. An admission assessment, dated 08/21/25, showed Resident #78 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of dementia, their overall goal was to discharge to the community, and active discharge planning was already occurring. A progress note, dated 08/18/25, showed Resident #78 was discharging to an assisted living facility. A progress note, dated 08/21/25, showed a care plan meeting had been held with Resident #78, the resident's power of attorney and the interdisciplinary team and the resident was planning to discharge to an assisted living facility and continue home health services. A progress note, dated 08/28/25, showed Resident #78 was discharged from the facility and was transported by their family member. A Discharge summary, dated [DATE], showed the resident had discharged to an assisted living facility. A discharge return-not anticipated assessment, dated 08/28/25, showed Resident #78 was a planned discharge to the community. An order summary report, dated 10/01/25, which included all active and discontinued orders, did not show a discharge order. On 10/02/25 at 9:16 a.m., the DON stated the social services director coordinated discharges. On 10/02/25 at 9:31 a.m., the social services director stated the clinical team was responsible to obtain a physician order for discharge. On 10/02/25 at 9:34 a.m., the DON stated they had reviewed the electronic clinical record for Resident #78, and it did not show a physician order had been obtained for the resident's discharge. The DON stated they had spoken with the admissions nurse, and they did not know who was responsible to obtain physician orders for planned discharges. On 10/02/25 at 10:38 a.m., the administrator stated they had interdisciplinary team meetings weekly, but they had failed to ensure a physician order had been documented. On 10/02/25 at 3:38 p.m., the DON stated the physician had not provided any documentation related to the discharge for Resident #78.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a bed hold policy and discharge notice to resident representative for 2 (#76 and #9) of 2 sampled residents reviewed for bed hold policies.The DON identified 162 residents had been discharged from the facility in the last six months.Findings:1. An undated Bed Hold Notice policy, read in part, It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave .In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. An admission MDS assessment, dated 09/07/25, showed Resident #76 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included dementia, restless leg syndrome, hypertension, and respiratory disorders. Section Q showed the overall goal was to discharge to the community. A progress note, dated 09/07/25, showed Resident #76 was sent to the hospital per representative request due to the resident sleeping a lot and very lethargic. A discharge assessment, dated 09/07/25, showed Resident #76 was anticipated to return. On 10/02/25 at 11:24 a.m., the DON stated they had not seen a nurse give report to the emergency medical service technicians at this facility. They stated the bed hold policy was an administrative task to provide to the resident and representative. On 10/02/25 at 11:26 a.m., the administrator stated the nurse who was transferring the resident out gave report to the emergency medical technician and gave the bed hold policy in writing to the resident and representative upon transfer. They stated once the bed hold policy form was signed it should be uploaded into the electronic clinical record. The administrator stated they did not see one in the record for Resident #76. They stated the bed hold policy was not issued. The administrator stated the discharge notice was not in the record for Resident #76 and should have been sent by a nursing representative. 2.An admission assessment, dated 07/20/25, showed Resident #9's cognition was intact with a BIMS score of 15. The assessment showed Resident #9 was admitted on [DATE] with diagnoses which included acute diastolic heart failure and acute kidney failure. Section Q showed the overall goal was to discharge to the community. A nurses note, dated 09/28/25, showed Resident #9 was sent to the hospital per the request of the physician due to the resident vomiting blood. The resident did not return to the facility. A discharge assessment, dated 09/28/25, showed Resident #9 anticipated to return to the facility. On 10/02/25 at 2:01 p.m., the DON stated there was no documentation in Resident #9s health record Resident #9 or the family representative received a bed hold policy on 09/28/25 when the resident was sent to the hospital. The DON stated they were aware bed hold policies being documented was an issue. The DON stated the facility was non-compliant on the bed hold regulations.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure MDS assessments were accurately coded to reflect the resident's status for 2 (#3 and #5) of 23 sampled residents reviewed for accurate MDS assessments.The administrator identified 68 residents resided in the facility. Findings: 1.On 10/02/25 at 9:31 a.m., Resident #3 was observed lying in bed alert and oriented. A white bi-pap machine was observed on the bedside dresser. There were a mask and hose observed attached to the BIPAP with visible moisture in the mask laying in the open top drawer of the bed side dresser. An undated facility's policy titled Conducting an Accurate Resident Assessment, read in part, The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. An undated facility's policy titled 'Noninvasive Ventilation (CPAP, BIPAP, AVAPS, Trilogy)', read in part, The facility will obtain an order for the use of CPAP, BIPAP, AVAPS, or Trilogy device and settings from the practitioner.A personal CPAP, BIPAP, AVAPS, or Trilogy device may/may not be brought into the facility for the resident use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. Resident #3's admission assessment, dated 09/19/25, showed Resident #3's cognition was intact with a BIMS score of 13. The assessment showed Resident #3 did not use a BIPAP or CPAP. The assessment showed Resident #3 was admitted on [DATE] with diagnoses which included paraplegia and stage 4 pressure ulcers. Resident #3's care plan and physician orders were reviewed. There were no physician orders or focus in Residents #3's medical record for the resident BIPAP usage. On 10/02/25 at 9:31 a.m., Resident #3 stated they were admitted with the BIPAP machine and used it nightly to help them breathe. On 10/02/25 at 10:17 a.m., CNA #1 was asked about Resident #3's respiratory needs. CNA #1 stated Resident #3 had a BIPAP on their bedside table and the mask was in the top drawer not in a bag. CNA #1 was asked how they knew when to ensure a resident needed BIPAP therapy. CNA #1 stated they would ask the nurse. On 10/02/25 at 10:50 a.m., the IP stated they observed a BIPAP with a mask and hose attached to the BIPAP on Resident #3's bed side dresser. The IP stated there was not a physician order or care plan focus in Resident #3's medical record for BIPAP therapy. On 10/02/25 at 10:58 a.m., the MDS coordinator #2 was asked how they assessed a resident's respiratory needs upon admission. MDS Coordinator #2 stated they reviewed the residents' notes, reviewed the clinical records, and skilled assessments. MDS Coordinator #2 was asked to review Resident #3's admission assessment, dated 09/19/25, and discuss what was documented for CPAP and BIPAP. The MDS coordinator stated they reviewed Resident #3's orders and did not see an order, so they selected, No. MDS Coordinator #2 stated they did not interview Resident #3 about the BIPAP use. MDS Coordinator #2 stated they looked in the progress notes, orders, and assumed nurses on the (continued on next page)

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	375583	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Edmond, LLC	1400 East Memorial Road Oklahoma City, OK 73131

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor handled it. 2. On 09/29/25 at 10:14 a.m., Resident #5 was observed to not have teeth. An admission assessment, dated 09/20/23, section L showed Resident #5 had no teeth. An admission assessment, dated 09/27/23, showed section L showed Resident #5 was not edentulous. A significant change assessment, dated 09/18/25, section L showed Resident #5 was not edentulous. The assessment showed a BIMS of 13 which indicated Resident #5 was cognitively intact for daily decision making. The assessment showed a diagnosis of dementia. A care plan, revised 09/18/25, showed no concern for dental. On 09/29/25 at 10:14 a.m., Resident #5 stated they had not seen a dentist and did not have teeth but would like to have dentures. On 10/01/25 at 8:44 a.m., Resident #5 stated they had told someone they wanted teeth but did not remember who it was. They stated they had never been asked if they wanted to see a dentist and had not seen one since they had been at the facility. On 10/01/25 at 8:44 a.m., CNA #2 stated Resident #5 did not have teeth. They stated they did not know if Resident #5 had seen a dentist. On 10/01/25 at 8:47 a.m., MDS Coordinator #2 stated they gathered information for assessments sometimes in person from the resident, from the electronic clinical record which included assessments, vital signs, physician orders, diagnoses, immunizations and progress notes. They stated Resident #5 had a cognitive decline but was involved in their care plan along with their representative. MDS coordinator #2 stated Resident #5 had not said anything to them about wanting dentures. MDS Coordinator #2 stated they did not know why the assessment showed Resident #5 was not edentulous and it might affect their care plan. MDS Coordinator #2 stated they did not see anything on the care plan for oral care.

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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. Based on record review and interview, the facility failed to ensure showers were provided for dependent residents for 1 (#15) of 2 sampled residents who were reviewed for activities of daily living.The DON identified 10 residents who were dependent on staff for showers/bathing.Findings: On 10/01/25 at 9:45 a.m., Resident #15 was observed in bed watching television. The resident was observed to be well-groomed and free from odors. An undated policy, titled Resident Showers, read in part, Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. An admission assessment, dated 09/16/25, showed Resident #15 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of depression, and was dependent on staff for showering/bathing. A care plan, dated 09/16/25, showed Resident #15 required staff assistance with showering/bathing. Review of the electronic clinical record and shower sheets, dated 09/09/25 - 09/30/25, showed Resident #15 had received a shower/bath six out of eight opportunities. The electronic clinical record and shower sheets did not show the resident had received a shower/bath on 09/16/25 or 09/20/25. On 10/01/25 at 9:45 a.m., Resident #15 stated they had asked for a shower in the past, but the staff never assisted them. They stated they had received a shower on 09/30/25. On 10/01/25 at 11:23 a.m., CNA #4 stated they documented showers in the electronic clinical record and on shower sheets. On 10/01/25 at 11:24 a.m., RN #1 stated they reviewed completed shower sheets and put them in a box to be filed. On 10/02/25 at 9:20 a.m., the DON stated the electronic clinical record sent alerts, they reviewed daily, if residents had not received a shower or bath in 72 hours. The DON stated they did not know why Resident #15 had not received their scheduled shower/bath on 09/16/25 or 09/20/25.

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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. Based on observation, record review, and interview, the facility failed to ensure a safe smoking assessment was completed to prevent accidents and hazards for 1 (#10) of 1 sampled resident reviewed for safe smoking assessments to prevent accidents and hazards.The administrator identified no residents who smoke, and the facility was a non-smoking facility.Findings: On 10/02/25 at 10:49 a.m., Resident #10 was observed ambulating with a walker. Resident #10 was observed putting in the door code on the east exit and went outside. Resident #10 sat in a chair outside the door, less than 15 feet from the door. Resident #10 was observed with a lighter and cigarette in their possession. Resident #10 lit a cigarette and sat and smoked less than 15 feet from the entrance unsupervised. Resident #10's admission assessment, dated 09/03/25, showed Resident #10's cognition was moderately impaired with a BIMS score of 9. The assessment showed Resident #10 was a tobacco user.Resident #10's care plan, revised 09/09/25, read in part, I have behaviors of smoking outside and refusing my lactulose, Interventions in the care plan for smoking focus read in part, I have been educated on the non-smoking policy and the health risk involved with smoking.A review of Resident #10's medical record did not document a safe smoking assessment was completed. On 10/02/25 at 9:27 a.m., Resident #10 was asked about their smoking. Resident #10 stated they had a lighter and cigarettes in their possession. Resident #10 stated they went outside to smoke whenever they wanted. Resident #10 was asked about the designated smoking area. Resident #10 stated they went outside, and the facility has never spoke to them about it. On 10/02/25 at 10:17 a.m., CNA #1 stated the facility is a non-smoking facility. CNA #1 stated they have seen Resident #10 smoke outside of the facility. On 10/02/25 at 10:31 a.m., RN #1 stated Resident #10 was a smoker. RN #1 stated the facility was a non-smoking facility. RN #2 stated Resident #10 could open the door and went outside to the parking area to smoke. On 10/02/25 at 10:50 a.m., the IP stated they observed Resident #10 smoking with a lighter and cigarettes in the resident's possession. The IP stated the facility was a non-smoking facility and they did not usually allow residents to smoke. The IP stated they observed Resident #10 was smoking within 10 feet of the facility entrance and exit. The IP stated the resident was smoking unsupervised and should be assessed for safe smoking because they had their cigarettes and lighter in their possession. The IP stated the facility was a non-smoking facility and the resident was not evaluated for safe smoking.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure indwelling urinary catheters were secured for 1 (#1) of 4 sampled residents reviewed for urinary catheters.The DON identified four residents had indwelling urinary catheters.Findings: On 10/01/25 at 10:23 a.m., CNA #1 and CNA #3 were observed to provide catheter care for Resident #1. The catheter was not observed to be secured before or after the care had been provided. A care plan, updated 07/23/25, showed Resident #1 had an indwelling urinary catheter for urinary retention. A quarterly assessment, dated 07/23/25, showed Resident #1 had a BIMS score of four, which indicated the resident was severely impaired in cognition for daily decision making, and had an indwelling urinary catheter. On 10/02/25 at 11:50 a.m., CNA #3 stated they typically utilized a device to secure indwelling urinary catheters. CNA #3 observed Resident #1's catheter and stated they did not know why Resident #1's urinary catheter was not secured. CNA #3 stated they did not know why it had not been secured after catheter care on 10/01/25. On 10/02/25 at 11:52 a.m., Resident #1 stated if they or the staff were not careful the catheter would pull against them at the insertion site. On 10/02/25 at 11:54 a.m., LPN #3 stated indwelling urinary catheters were to be secured but they had not yet assessed Resident #1's catheter or secured it. On 10/02/25 at 12:00 p.m., the DON observed Resident #1's indwelling urinary catheter and stated indwelling urinary catheter was supposed to be secured. The DON stated they did not know why it was not secured.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure a clinical rationale had been documented for a declined gradual dose reduction for 2 (#11 and #5) of 5 sampled residents reviewed for unnecessary medications.The DON identified seven residents who received psychotropic medications.Findings: 1.A physician order, dated 08/24/25, showed Resident #11 had been ordered fluoxetine (an antidepressant medication) 40mg daily. A Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction, dated 03/22/25, showed a gradual dose reduction was recommended for fluoxetine 40mg daily. The physician check marked a box which indicated the minimal effective dose. The Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction, read in part, Continue current use of above stated medication. My Clinical Rationale for continuance is as follows. The section for the clinical rationale from the physician was left blank. An annual assessment, dated 08/24/25, showed Resident #11 had a BIMS score of 14, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of depression, and had received an antidepressant during the look back period. A care plan, updated 08/28/25, showed Resident #11 was ordered fluoxetine for a diagnosis of depression, to monitor for effectiveness and continued need, and if need continued to maintain on the lowest possible effective dose. On 10/02/25 at 1:06 p.m., the DON stated they were responsible to ensure a clinical rationale had been documented by the physician if a gradual dose reduction was declined. The DON stated they had assumed by check marking the minimal effective dose that was the physician's clinical rationale. 2. A Letter to the Physician dated 04/19/25, showed a request for GDR (gradual dose reduction) for Abilify 5 mg HS Hydroxyzine 50 mg every 8 hours as needed for anxiety. The letter showed an as needed medication should be limited to 14 days then reassessed. The letter requested to ensure behavior and side effect monitoring was in place for venlafaxine 75 mg twice a day. The letter was sent from the pharmacist in email to the DON. The administrator printed the letter. The document was not signed by the physician. A physician's order, dated 05/16/25, showed to administer velafaxine HCL (an antidepressant) 37.5 mg 1 tab via PEG twice a day. A significant change assessment, dated 09/18/25, showed Resident #5 had a BIMS of 11 which indicated they had moderate cognitive impairment for daily decision making. The assessment showed diagnoses which included dementia, diabetes, depression and psychotic disorder with delusions.Section N of the assessment showed Resident #5 did not receive antipsychotic or antianxiety medications but did receive antidepressant medication. A care plan, revised 09/18/25, showed a focus/concern for depression. Review of the med regimen reviews and gradual dose reductions from August 2024 to August 2025 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed no GDRs were requested by the pharmacist. On 10/02/25 at 1:05 p.m., the DON stated the pharmacist completed the medication review monthly. The DON stated they ensured a clinical rationale was provided when a gradual dose reduction was denied. The DON stated if the physician marked the box which indicated the minimal effective dose, then that was the lowest possible dose. The DON stated they assumed that was the physician's rationale even though a gradual dose reduction had not been attempted. The DON stated Resident #5 had a GDR letter dated for 04/19/25. They stated they did not know where the signed letter to the physician would be for Resident #5. The DON stated they began working at the facility June 1st 2025.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure monitoring for anticoagulants for 1 (#11) of 5 sampled residents reviewed for unnecessary medications.The DON identified 22 residents received an anticoagulant medication.Findings: An undated policy titled, Medication Monitoring, read in part, Interventions shall be identified on the resident's comprehensive plan of care for the systematic monitoring of high risk medications to facilitate early identification of adverse consequences. A physician order, dated 08/23/24, showed Resident #11 was ordered Xarelto (an anticoagulant medication) 10mg daily for quadriplegia. An annual assessment, dated 08/24/25, showed Resident #11 had a BIMS score of 14, which indicated the resident was cognitively intact for daily decision making, had a diagnosis of multiple sclerosis, and had received an anticoagulant medication during the look back period.A care plan, dated 08/24/25, showed the resident received Xarelto and staff were to monitor, document, and report to the physician signs or symptoms of anticoagulant complications.On 10/02/25 at 1:25 p.m., LPN #3 reviewed the electronic clinical record, stated Resident #11 received Xarleto daily but would refer the surveyor to the admissions nurse when asked what side effects they monitored for when residents received anticoagulant medications.On 10/02/25 at 1:58 p.m., the DON stated Resident #11 had not been monitored for side effects related to anticoagulant medication. They stated anticoagulant side effect monitoring should have populated onto the treatment record for Resident #11.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure treatment carts were secured for 1 (400 hall) of 4 treatment carts observed.The DON identified four treatment carts in the facility. Findings:On 10/01/25 at 1:55 p.m., the 400-hall treatment cart was observed to be unlocked and unattended by room [ROOM NUMBER]. The cart was observed to contain insulin, heparin, medicated ointments, and wound cleanser/wound care supplies.On 10/01/25 at 1:57 p.m., RN #1 was observed to lock the 400-hall treatment cart.An undated policy titled Medication Storage, read in part, During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.On 10/01/25 at 1:57 p.m., RN #1 stated the treatment cart was to be locked when unattended.On 10/01/25 at 2:06 p.m., the DON stated treatment carts were to be kept locked when unattended to ensure medications were secured.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure radiology services were provided for 1 (#2) of 1 sampled resident reviewed for radiology services.The DON identified 68 residents resided in the facility.Findings: An undated policy titled Diagnostic Testing Services, read in part, The facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines. A care plan, updated 01/13/25, showed Resident #2 had pain related to osteoarthritis and chronic pain, and to administer pain medication per physician orders. A physician visit note, dated 06/05/25, read in part, Assessments 1. Pain in left upper arm.Treatment 1. Pain in left upper arm. Notes: order x-ray of the left humerus and elbow then escalate to MRI evaluation. A physician visit note, dated 06/30/25, read in part, Assessments 1. Pain in left upper arm.Treatment 1. Pain in left upper arm. Notes: order x-ray of the left humerus and elbow then escalate to MRI evaluation. A quarterly assessment, dated 07/04/25, showed Resident #2 had a BIMS score of five, which indicated the resident was severely impaired in cognition for daily decision making, had pain occasionally, and received scheduled and as needed pain medications, had a diagnosis of osteoporosis and osteoarthritis. On 10/01/25 at 3:09 p.m., the ADON stated after physician visits were conducted, they faxed the notes to the facility, and they uploaded them into the electronic clinical record. They stated if the physician wrote orders during the visit, they left them with the charge nurses, and they reviewed to ensure the orders had been placed into the electronic clinical record. The ADON stated they would look for the x-ray results for Resident #2. On 10/01/25 at 3:20 p.m., Resident #2 stated they had chronic pain in their bilateral shoulders from years of playing golf. They stated the pain was managed with their current medication regimen. Resident #2 stated they had not had any radiologic/diagnostic testing while a resident at the facility. On 10/01/25 at 3:35 p.m., the ADON stated they had missed the physician visit note on 06/05/25 and 06/30/25 which indicated an x-ray for Resident #2. They stated the physician had not left a separate written order and the notes had not been reviewed after they had been provided to the facility. On 10/02/25 at 9:37 a.m., the DON stated when the physician visits, they write orders while in the facility and provide them to the charge nurse. The DON stated the notes for physician visit conducted on 06/05/25 was sent to the facility on [DATE]. They stated the notes for the physician visit conducted on 06/30/25 was sent to the facility on [DATE]. They stated the x-ray indicated in the physician visit notes had not been completed.