STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676440	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Round Rock, LLC	16219 Ranch Road 620 North Austin, TX 78717

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 0690 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #1) of three residents reviewed for foley catheter care. The facility failed to monitor/document Resident #1's (who has a history of urine retention) urine output for three days (09/11/24 - 09/13/24). On 09/14/24 an I/O catheter removed 700 CCs of urine and he was sent out to the hospital the following day due to swelling to his groin, the foley not draining, and his urine being cloudy with clots of pus. This failure could place residents at risk of UTIs, urine retention, bladder rupture, or hospitalization . Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including urinary tract infection, severe sepsis (a serious condition in which the body responds improperly to an infection), acute kidney failure, type II diabetes, and neuromuscular dysfunction of the bladder (what happens when the relationship between the nervous system and bladder function is disrupted by injury or disease). As of 09/24/24, Resident #1 was still in the hospital. Review of Resident #1's admission MDS Assessment, dated 09/12/24, reflected a BIMs of 8, indicating a moderate cognitive impairment. Section H (Bladder and Bowel) reflected he had an indwelling catheter and required intermittent catheterization. Review of Resident #1's admission care plan, dated 09/12/24, reflected he had a urinary catheter and was at risk of complications associated with F/C placement with an intervention of monitoring/recording/reporting to MD for s/sx of UTI: pain, burning, blood-tinged urine, cloudiness, no output . It further reflected he had the potential for alterations in nutrition and hydration with an intervention of monitoring/documenting/reporting PRN and any s/sx of dehydration: decreased or no urine output . Review of Resident #1's hospital medical records, dated 08/25/24, reflected the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Actual harm Residents Affected - Few	.CT Abd showed urinary distention . Bilateral hydronephrosis (excess urine accumulation in the kidneys) secondary to large urinary bladder distention . Review of Resident #1's NP A assessment, dated 09/10/24, reflected the following: . On exam today, [Resident #1] is seen lying down in bed, [FM B] at bedside. [Resident #1] is sleepy, HOH, forgetful-on-RA-noted tenderness to suprapubic area with palpation and has abdominal distension on exam-as per [FM B] the Foley was discontinued from the hospital since he was pulling on it-will order bladder scan with orders for I/O cath . Review of Resident #1's NP A assessment, dated 09/12/24, reflected the following: . [Resident #1] is more alert today, HOH, forgetful-on RA-[Resident #1] was retaining urine and Foley has been placed . GU: Foley CDI to bedside drainage with dark yellow urine Review of Resident #1's physician order, dated 09/12/24, reflected Foley Catheter Care to include anchoring tubing and checking skin integrity every shift and PRN. There were no orders for the reason for the catheter, size of catheter, or monitoring the input/output of urine. Review of Resident #1's progress note, dated 09/14/24 and documented by LVN C , reflected the following: This nurse reported to on call Dr [sic] that [Resident #1]'s urine output was cloudy with flakes and pus in urine bag. Foley was removed due to leakage and I&O cath was completed for 700 and reported to on call physician. N/O for Rocephin (antibiotic) 1 gm q24hrs x7 days . Review of Resident #1's progress note, dated 09/15/24 and documented by LVN C, reflected the following: This nurse noticed swelling in [Resident #1]'s groin area, attempted to I&O due to leakage with foley and not draining, was able to drain 100 cc from [Resident #1] but very cloudy and clots of pus draining out. Dr was notified of swelling and unable to drain, order to send out to hospital (hospital name) . During an interview on 09/24/24 at 11:08 AM, NP D stated she was not Resident #1's NP while he was at the facility . She stated if a resident had a foley catheter, there should be separate orders for foley care, emptying the bag every 6-8 hours, stat lock placement, and recording the output of urine. She stated if a resident had a history of urine retention it was even more important to have orders for monitoring output to show that the foley was working properly and that output was getting charted. She stated the importance of the orders was to ensure care was getting done and monitoring input/output. She stated a possible negative outcome of not having these orders could be reoccurring UTIs. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 09/24/24 at 12:56 PM, NP A stated she had been Resident #1's NP while he was at the facility. She stated he had a catheter in the hospital but he kept trying to pull it out so the hospital removed it and he was admitted to the facility without one. She stated she first saw him on 09/10/24 and she could tell he was retaining urine so she gave orders for a foley to be placed. She stated once a resident has a foley catheter in place, the staff are no longer expected to conduct bladder scans because they should be monitoring and documenting urine output to ensure the resident was not retaining urine. She stated it was particularly important to monitor Resident #1's urine output because urine retention was one of his problems when he was in the hospital. She stated a negative outcome of not monitoring/documenting urine output/input could lead to complications such as a UTI, bladder rupture, and higher risk for infection. She stated Resident #1 already had a history of sepsis from UTIs in the past. She stated it was her expectation that urine output be monitored every shift . During a telephone interview on 09/24/24 at 2:09 PM, the MD stated when a resident had a foley catheter they should have orders for routine foley care, assessing that the bag is situated below the bladder, and more medical stuff. He stated monitoring urine output was important because it could help determine if a resident is going into renal failure or if their kidneys are shutting down. He stated if the bladder did not feel full and the resident was not producing a lot of urine, they could also be dehydrated. He stated a negative outcome of not monitoring urine output depended on what the underlying issue was. He stated urine retention could lead to UTIs, damaged kidneys, and distention of the bladder. During an interview on 09/24/24 at 3:50 PM, the VPCS stated the nurses were responsible for ensuring all orders (for catheter care) were in the residents' EMR. She stated orders for a foley catheter would include care every shift, what type of foley, and fluid restrictions. She stated a negative outcome of not monitoring urine output could not be determined because foley catheters were not meant to be a long-term intervention. Review of the facility's Catheterization of Urinary Bladder Policy, dated November 2018, reflected the following: A catheter is placed in the bladder when it is needed to prevent urinary retention . . 19. Output should be recorded every shift only with a physician order, 20. Make sure the physician order sheet contains an order for the catheter specifying reason, size of catheter and balloon and to change the bag PRN.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure that medical records were accurately documented for three (Resident #2, Resident #3, and Resident #4) of six residents reviewed for accurate medical records. The facility failed to document nursing notes in Residents #2's, #3's, and #4's EMRs when they were discharged from the facility. This deficient practice could result in errors in care and treatment. Findings included: Review of Resident #2's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including adult failure to thrive , type II diabetes, urinary tract infection, hypertension (high blood pressure), and a history of falling. Review of Resident #2's discharge MDS assessment, dated 09/13/24, reflected a BIMS of 12, indicating a moderate cognitive impairment. Section Q (Participation in Assessment and Goal Setting) reflected he was in active discharge planning already occurring for him to return to the community. Review of Resident #2's admission care plan, dated 08/19/24, reflected he wished to return/be discharged to his previous home situation with an intervention of making arrangements with required community resources to support independence post-discharge. Review of Resident #2's progress notes in his EMR, on 09/24/24, reflected the last note documented was from 09/12/24 and did not mention anything about being discharged . Review of Resident #3's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including muscle weakness, depression, anxiety disorder, and fusion of the spine . Review of Resident #3's discharge MDS assessment, dated 09/16/24, reflected a BIMS had not been conducted. Section Q (Participation in Assessment and Goal Setting) reflected she was in active discharge planning already occurring for her to return to the community. Review of Resident #3's admission care plan, dated 09/12/24, reflected she wished to return/be discharged to her previous home situation with an intervention of making arrangements with required community resources to support independence post-discharge. Review of Resident #3's progress notes in her EMR, on 09/24/24, reflected the last note documented was from 09/16/24 and did not mention anything about being discharged . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including type II diabetes, urinary tract infection, fibromyalgia (a disorder that affects muscle and soft tissue), and generalized muscle weakness. Review of Resident #4's admission MDS assessment, dated 09/12/24, reflected a BIMS of 15, indicating no cognitive impairment. Section Q (Participation and Goal Setting) reflected her overall goal was to be discharged to the community. Review of Resident #4's admission care plan, dated 09/08/24, reflected she wished to return/be discharged to her previous home situation with an intervention of making arrangements with required community resources to support independence post-discharge. Review of Resident #4's progress notes in her EMR, on 09/24/24, reflected the last note documented was from 09/20/24 and did not mention anything about being discharged . During an interview on 09/24/24 at 3:50 PM with the VPCS, she stated nurses were expected to document in resident progress notes anytime there was a change in condition, a new order, if a resident was being sent to the hospital, or being discharged . The importance was to ensure that all nursing staff were on the same page. Review of the facility's Discharge Policy, dated November 2018, reflected the following: . Document on the nursing notes the condition of the patient, who was notified of the transfer, where the resident is going, mode of transportation, disposition of resident belongings and medications, notification to all parties of the discharge.