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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on interviews and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 6 residents reviewed for resident rights. 1. The facility failed to notify the MD or NP when Resident #1, who has a diagnosis of stage 5 kidney failure, complained of not being able to urinate. 2. The facility failed to notify the MD or NP when Resident #1, with a BIMS score of 15, began exhibiting erratic behaviors, changes in mental status, confusion, and agitation. 3. The facility failed to notify the MD, NP, or abuse coordinator when Resident #1 presented with bruises on her abdomen, back, legs, arms, and forehead . The failures resulted in an identification of an Immediate Jeopardy (IJ) on 11/13/24 at 2:49 PM. While the IJ was removed on 11/14/24 at 7:19 PM, the facility remained at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for delay in medical treatment, decline in health, and death. Findings included: Review of Resident #1's admission MDS assessment dated [DATE], reflected Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including left hemiplegia following cerebral infarct (weakness or paralysis on the left side of the body after a stroke), chronic kidney disease, muscle weakness, seizures, anxiety (intense and excessive worry and fear), and abnormalities of gait. The primary medical condition category was listed as stroke. Section B (Hearing, Speech, and Vision) reflected the resident's speech was clear and she made herself understood. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676440	A. Building B. Wing	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section E (Behavior) reflected no hallucinations (an experience involving the apparent perception of something not present) or delusions (Fixed, false conviction in something that is not real). Section E also reflected no verbal behaviors directed towards others, and no physical behaviors not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Section H (Bladder and Bowel) reflected the resident was continent of bowel and bladder. Section N (Medications) reflected the resident received anticoagulant and antiplatelet medications. Review of Resident #1's comprehensive care plan reflected a focus, initiated 10/30/24, of depressive symptoms with an intervention, Observe and report any changes in mental status, notify MD if any changes in mood, behavior and/or psychosocial status is observed. A focus, initiated 10/25/24, of risk for falls with interventions including, Follow facility fall protocol and, review information on past falls and attempt to determine cause of falls. Record possible root causes . A focus, initiated 10/25/24, reflected potential alteration in nutrition and hydration with interventions including, Monitor/document/report PRN any s/s of dehydration: decreased or no urine output and new onset confusion. A focus, initiated 10/25/24, for antianxiety medication reflected interventions including, Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: .Confusion, impaired thinking and judgement, mania, hostility, rage, aggressive or impulsive behavior, hallucinations. A focus, initiated 10/25/24, for anticoagulant therapy reflected an intervention, Monitor/document/report PRN adverse reactions .sudden changes in mental status. The care plan did not address the resident's kidney disease. A focus initiated 11/04/24 reflected, The resident has a behavior problem of repeatedly putting herself on the floor (purposeful), throwing items on floor and breaking (plates, cups, etc.), yelling out loud, clogging toilet with paper towels. Goals included, Resident will show a decrease in negative behaviors by next review date and Will exhibit socially appropriate behaviors during review period. Interventions included, Approach resident appropriately when resident is hallucinating, delusional or expressing potentially harmful suspicions . Ask resident if these hallucinations/delusions are harmful to themselves in any way .Document resident's inappropriate behaviors when it occurs . If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and or unacceptable to the resident . Intervene as necessary to protect the rights and safety of others . Review of Resident #1's progress note dated 10/31/24 at 4:31 AM, written by LVN D reflected, .resident was sitting on the floor, states she woke up needing to use the restroom and was attempting to get up too quickly; bed was in low position with call light in reach, resident aware to call for help, VS WNL, denies pain, no s/s LE rotation, current anticoag rx [sic] on hold, denies hitting head, on neuro checks. Review of Resident #1's progress note dated 11/1/24 at 1:25 AM, written by LVN D, reflected Guest c/o 'not being able to urinate', bladder scan performed with no residual, noted in 24-hour report for in house NP. (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress note dated 11/1/24 at 9:44 PM reflected, fall f/u day 2/3: resident observed propelling self in hallway on unit, resident observed clogging toilets (toilet in her room and empty rooms) with paper towels, resident redirected multiple times nurse manager notified, maintenance order placed. Review of Resident #1's progress note dated 11/02/24 at 8:00 PM (created 11/03/24 at 1:03 AM), written by LVN K, reflected in part, .resident observed yelling out for help . Review of Resident #1's progress note dated 11/02/24 at 9:35 PM, written by LVN K (created 11/03/24 at 5:37 AM) reflected, Day 3/3 fall f/u bruises noted to abd, lower back, ble, bue, and forehead. The note does not reflect that the provider was notified of the bruises. Review of Resident #1's progress note dated 11/03/24 at 2:59 PM, written by LVN B, reflected in part, Guest noted from previous shift not having a good sleep yelling all night and breaking things and putting herself to the floor many times .the next day the pt continue breaking things and breakfast plates and cup and pulling the call light off the wall and continue throwing herself on the floor and yelling and the NP was called and the pt call 911 by herself and she was sent out for AMS and the pt has scattered bruising all over . Review of Resident #1's progress notes from 11/02/24 through 11/03/24, reflected no documentation that the provider was notified of bruising until the resident was sent out with EMS around 2:51 PM on 11/03/24. Additionally, there was no further information regarding her genitourinary status or that the provider was notified of the change in urinary status. There was no documentation that the provider was notified of the change in mental status or behaviors, or that Resident #1 was yelling out, yelling out all night, clogging toilets, breaking things, putting herself on the floor many times. The notes did not reflect that the provider was notified when the behaviors of throwing things, breaking things, pulling the call light off the wall, and throwing herself to the floor, and yelling continued to the next day. Review of an incident report dated 10/31/24 at 4:31 AM, reflected Resident #1's fall from the same date and time. Immediate actions taken included, Resident aware and reeducated to call for assistance when needing help . Mental Status reflected only the oriented to person box was checked. Predisposing Physiological Factors reflected the boxes for confused and impaired memory were checked. Predisposing Situation Factors reflected the boxes for behavior issues, during transfer and, ambulating without assist were checked. No notifications to the physician or responsible party were documented. Review of Resident #1's shower sheet dated 11/02/24, reflected scattered fading bruises. The time of the note is left blank. Lines on the body diagram indicated bruises on the abdomen, arms, and left leg. The form was signed by a CNA and a nurse. The nurse's signature is illegible. Review of Resident #1's Task: Bladder Continence, the resident was marked as continent five times from 10/26/24 through 10/30/24. On 11/01/24, she was marked as incontinent of bladder. Review of Resident #1's Transfer Form dated 11/03/24 at 2:59 PM reflected the resident was incontinent of bladder. Review of photos of Resident #1 taken in theER on [DATE] between 4:35 PM and 4:39 PM reflected the following: (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Face - two red bruises on her forehead and one on her left eyebrow. Abdomen - one purple/red bruise just below her umbilicus (belly button) and extending down towards the pubic bone, unable to visualize the bottom of the bruise due to positioning. The bruise is about 6 inches wide. A large deep purple hematoma (bruise) on the right abdomen flank is about 14 inches in width Review of the Change in Resident Condition policy revised 06/2022, reflected in part, To provide guidance on notification of the physician when there is a change of condition. 1. Should there be a significant change in the resident's physical, mental or emotional status, the attending physician should be notified. 2. If the attending physician does not respond within 30 minutes, contact the Medical Director. 3. If the Medical Director does not call within 30 minutes, contact the DON. It starts at about the level of the umbilicus, about 5 inches are visible, the bottom edge of the hematoma is covered by clothing. There was a tape measure visible lying across the wound in the in picture. Right upper leg - about 11 purple bruises on lateral (outside)/posterior (back) view. Right lower leg - about 8 purple bruises on posterior view Left lower leg - a purple bruise that starts a few inches below her knee and extends to just above the ankle, about 10 inches on anterior (front) view, tape measure visible in the photo. About 7 purple bruises are visible on the medial (inside) aspect of the leg and the large bruise on the anterior view extends to the medial aspect. Right foot - about 10 purple/red bruises on medial, lateral, dorsal (top), and plantar (bottom) surfaces. Laceration on dorsal surface. Left foot - about 6 purple/red bruises on lateral and dorsal surfaces. Right arm - about 3 purple bruises and one large deep purple/red bruise visible. Review of Resident #1's Emergency Provider Report from the ER, dated 11/03/24 at 5:52 PM, reflected in part, Presentation Chief Complaint - Altered Mental status. Stated complaint Left hip pain/confusion per EMS . presents with altered mental status and scattered bruising . speech nonsensical and unable to communicate effectively . Primary Impression: Altered Mental Status. Secondary Impressions: Anemia, Ecchymosis, History of completed stroke. Review of Resident #1's physician progress notes from the acute hospital dated 11/11/24 at 11:48 AM reflected in part, Patient was agitated on arrival to emergency room , required several doses of sedatives for agitation in emergency room . Per EMS report nursing staff at facility reported patient was hitting her own head against the wall and had frequent falls CT chest abdomen, and pelvis shows significant bladder distention. Markedly enlarged bilateral kidney with innumerable cyst . Hematoma in the subcutaneous fat in the lateral right mid to lower abdomen measuring 8.3 x 3.8 x 7.6 cm. Hemoglobin 6.1 on admission. Patient underwent 2 units of PRBC transfusion from extensive bruising all over the body. No evidence of GI bleed. Eliquis was discontinued, aspirin and Plavix continued. Acute metabolic encephalopathy resolved. Resident has some urinary retention, and a catheter was placed . Urinary tract infection, received Ceftriaxone 1 gram IV every 24 hours. (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's EMR including MDS assessment, progress notes, evaluations, and MARs dated from 10/25/24 through 11/03/26, did not reflect the physician was notified of a change in mental status, changes in mood, behavior and/or psychosocial status. There was no documentation that the physician was notified of hallucinations or delusions. During a telephone interview on 11/06/24 at 8:16 AM, Resident #1's FM stated the resident had called her on 11/02/24 and said she thought she had a UTI because she was not peeing, and she did not feel right. She stated they were on speaker phone and there was a staff member in the room. She stated she asked the other person in the room if the doctor was coming to see the resident and the other person replied, Yes. She stated she did not know if a doctor ever saw the resident about her complaint of not urinating. She stated she saw the resident the next day in the ER. She stated the resident went to the ER for altered mental status and multiple falls. She stated she was never notified of the falls. She stated she noticed, during phone calls and texts, the resident being more confused and irritable for the few days prior to going to the ER. She stated Resident #1 started having trouble writing a coherent text message. She stated the decline went on for days before Resident #1 called 911 to go to the hospital. During an interview on 11/06/24 at 2:28 PM, the VPCO stated the post fall assessment would have the documentation regarding the resident's status. She stated the nurses would document in the progress notes when a bruise was observed or noticed. She stated they would definitely investigate any bruises that could not be explained. She stated if an alert and oriented resident had falls and a change in behavior, her first thought was to get a UA as changes were often a sign of infection. During an interview on 11/07/24 at 10:33 AM, the MD stated she saw Resident #1 on 10/28/24. She stated she did not look under the clothes but there were no bruises on the visible skin. She stated she was not aware of extensive bruising. She stated the resident was on 3 different medications that could have caused her to bruise easily. She stated Resident #1's hemoglobin was 8.8 (hemoglobin, part of the blood, helps carry oxygen to all the vital organs, 12-17 is a normal level) on 10/23/24 at the acute hospital prior to her admission at this facility. She looked but did not see any blood results from the time the resident was in the facility. She stated she was not aware that the resident complained of not being able to urinate. She stated the resident had chronic kidney disease, but she had been urinating, as far as she knew, while at the facility. She stated the resident may not have been drinking enough, or her kidney disease may have worsened. She stated she expected to be notified of changes in condition when they occurred. She stated the resident was a good historian and would have been able to talk about the bruises and any problems with urination. She stated she was not notified of any erratic behavior other than the resident being upset that her daughter did not answer the phone. During an interview on 11/07/24 at 11:11 AM, the NP stated bruising may not occur right away if a resident fell or sustained an injury. The NP stated if a resident were on blood thinners and hit their head, to be safe, the resident would be sent out for evaluation. After viewing the picture of the abdominal bruise, the NP stated that bruise should have been reported immediately as the resident was on blood thinners. The NP stated she was not aware that the resident had complained of not being able to urinate. She stated she was not aware of the facility 24-hour report. She stated the on-call providers kept a report of the calls received. She reviewed the notes and stated she did not see an entry for Resident #1's urinary complaint. The NP stated she was notified of the erratic behavior when the nurse called her at 2:25 PM on 11/03/24. (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/07/24 at 12:33, LVN B stated she had worked at the facility for about three years. She stated she first saw bruises on Resident #1's arm on 10/29/24 but did not work on the resident's hall until 11/01/24. She stated she noticed bruises on Resident #1's abdomen on 11/01/24. She stated because the resident was on blood thinners, she figured the resident was on anticoagulant injections while in the acute hospital and that was the reason for the bruises. She stated because they were old bruises, she did not report them. She stated the resident had scattered bruises all over her body. She stated on Saturday, 11/02/24, the resident was yelling and pulled the call light off the wall. She stated the resident was trying to call her daughter and was yelling about it. LVN B told the resident she would help her call her daughter shortly. When she returned to the room to help, the resident began yelling again and pushed her tray all the way out of her room; the yelling continued. LVN B stated she did not notify the doctor as the resident was just mad about her daughter not answering the phone. She stated on Sunday morning 11/03/24, she was told in report that Resident #1 had yelled all night. She stated the resident continued to yell, kept putting herself on the floor, and hit herself in the head with the phone. She stated it was very different behavior for this resident, but the resident was mad at her daughter. LVN B stated in the afternoon she explained to the resident that she would notify the provider to have her sent out. LVN B stated shortly after she got to the nursing station, the front desk called and asked her if she had called 911. The front desk told her 911 was on the phone about Resident #1 and she told them to come get her. LVN B stated, She heard me say I was going to send her out, so she went ahead and called 911. During an interview on 11/07/24 at 2:00 PM with the VPCO and CNO, the VPCO stated on 10/31/24, she was called to the room after Resident #1 was found sitting on the floor. She stated there was no facial bruising at that time. After seeing the picture of the bruise on Resident #1's abdomen/trunk/back, the CNO stated the bruise was from anticoagulant injections due to its location. The VPCO stated it was a new bruise because it had not changed colors. She stated she could not tell when or where the picture was taken so she could not verify the bruise was present while the resident was at the facility. During a telephone interview on 11/07/24 at 2:38 PM, Resident #1 stated she fell when she was at the facility. She stated, I tried to get help and they said they would be right back, and it was an hour. Resident #1 stated she was crawling around on her butt trying to get help. She stated they took their time to help. She stated one staff member told her they were going to kick her out if she kept acting up. She stated she had bruises on her arms which she sustained during the falls. She said she fell and hit her back. She stated the big bruise hurt and stated an ice pack would have helped. She stated she did not feel right and had trouble urinating, I thought I had a UTI. During an interview on 11/07/24 at 5:05 PM, the GM stated the nursing documentation should reflect the work they were doing. He expected documentation to be accurate and timely. He stated he expected the nurse to contact the MD, NP, or CNO if there was a change in condition or mental status. During an interview on 11/12/24 at 4:17 PM with the ACNO, he stated he had recently provided training on customer service, change of condition, and assessment. After review of Resident #1's abdominal flank bruise, he stated he expected the provider would have been notified of a bruise of that size. He stated if he saw the resident having behaviors, he would not necessarily notify the doctor if those behaviors caused the bruising. He stated if the resident was on blood thinners, he should notify the provider. He stated the provider should be notified if a resident had a change in status. (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/13/24 at 11:49 AM, CNA A stated on 10/31/24, Resident #1 was somewhat confused, so she checked on the resident every 30 minutes. She stated that was a change for the resident. She stated the resident had bruises, but the nurse had already assessed them. She stated there was just a small bruise on the resident's arm that the resident said came from a fall earlier in the day. The CNA stated she reported that bruise to the nurse, but the nurse said it would not show up that fast so it must have been an old bruise. During an interview on 11/13/24 at 1:06 PM, LVN B stated the change in Resident #1's mental status did not occur until Sunday 11/03/24. On Saturday (11/02/24) morning report, which she received from LVN D, she was told the resident was found on the floor. On Sunday morning in report, she was told other residents were mad because Resident #1 was making so much noise all night. She stated the resident had complained of pain the night before and they got a hip x-ray. She stated she did not remember ever being told in report that Resident #1 complained of not being able to urinate. She stated on the morning of 11/03/24 Resident #1 continued to yell and break things and throw herself on the floor. She stated the resident had bruises all over and she notified the provider to send the resident out. She stated she assessed the resident, and it was because her daughter did not answer the phone, that she was mad. Review of the Change in Resident Condition policy revised 06/2022, reflected in part, To provide guidance on notification of the physician when there is a change of condition. 1. Should there be a significant change in the resident's physical, mental or emotional status, the attending physician should be notified. 2. If the attending physician does not respond within 30 minutes, contact the Medical Director. 3. If the Medical Director does not call within 30 minutes, contact the DON. The VPCO was notified on 11/13/24 at 2:49 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 11/14/24 at 4:32 PM: Allegation of Credible Compliance F684 11/13/2024 November 13th, 2024 Immediate Interventions: 1. Notifications made to the Medical Director on 11/13/24 at approximately 4:00pm of the immediate jeopardy citation 2. Emergency meeting conducted with action plan developed. This occurred at 4:30pm on 11/13/24 Attendees: RN, VP of Clinical Operations Administrator (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN, Assistant Director of Nursing Action Plan: Licensed nursing staff, certified medication aides, and certified nursing assistants in-serviced immediately on the facility policy and procedure for notification of change of condition and the abuse and neglect policy and procedure. Resident #1 has discharged from the facility and therefore a plan of correction cannot be accomplished. Current residents were assessed by licensed nursing staff for any changes of condition, including but not limited to their physical (including but not limited to skin integrity), mental and emotional status. No negative outcomes were obtained from these assessments. A root cause analysis was completed by the VP of Clinical Operations and incorporated into staff training and in-servicing, which includes notification of change of condition, and abuse and neglect policies and procedures. 3. Licensed nursing staff, certified medication aides, and certified nursing assistants were in-serviced on the change of condition policy and procedure, including but not limited to: changes in resident behavior, skin integrity changes, increased confusion, and genitourinary changes. The assistant director of nursing and nursing supervisor have provided in-service, education and compliance training with staff. - Changes of condition must be reported to the provider timely (within 30 min) if no response within 30 minutes the Medical Director will be notified. If the Medical Director does not respond within 30 minutes, the Director of Nursing will be contacted. - Documentation of changes of condition will be documented in the medical record within the nurse's shift. - Signs and symptoms of abuse or neglect, the Administrator will be notified immediately. - Allegations of abuse and neglect will be reported to all appropriate state and local entities by the Administrator in accordance with all state and federal regulations. 4. Meeting with the following managers to review Immediate Jeopardy on 11/13/24. We reviewed the notification of changes of condition policy and procedure, as well as the abuse and neglect policy and procedure. - Administrator - VP of Clinical Operations - Director of Rehabilitation - Assistant Director of Nursing - Nursing Supervisor - MDS Coordinator (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Dietary Manager - Social Services Training: 1. RN Director of Nursing, to be in-serviced by RN [NAME] President of Clinical Operations. [Name] will be in-serviced on the notification of changes of condition policy and procedure, and the abuse and neglect policy and procedure. The VP of Clinical Operations ensures in-servicing and training tasks are provided and compliance is achieved. 2. An immediate in-service was initiated on 11/13/2024 by VP of Clinical Operations on change of condition notification and abuse and neglect. 3. Beginning 11/13/24 and on-going: A post-test will be completed by direct care nursing staff to ensure competency on notification of changes of condition and abuse and neglect. Staff must answer all questions correctly before returning to work. 4. New staff will receive in-servicing prior to orientation on the floor. PRN staff will not be allowed to work in the facility until they have completed in-service training and post-test. 5. A payroll report listing current employees will be used to track in-service completion. The VP of Clinical Operations will ensure this task is completed. Monitoring: 1. Nursing Administration (Director of Nursing, Assistant Director of Nursing) will interview and conduct skin assessments at random for residents residing in the facility, as well as review the electronic medical record to ensure compliance with the facility's abuse and neglect and notification of changes of condition policies to ensure compliance. This will occur daily for one week, then twice weekly for four weeks, and monthly thereafter. 2. Administrator, or appointed designee, will review this plan in its entirety in the Clinical Meeting scheduled 5 times per week (Monday through Friday) to monitor for compliance, and to make changes based on the interdisciplinary team's review and decision. This will be on-going. [Facility] requests that the measures we have implemented be reviewed and that our allegation of removal of jeopardy be accepted as of 11/13/24. The investigator monitored the Plan of Removal on 11/14/24 as followed: (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews conducted on 11/14/24 between 4:39 PM and 7:00 PM, 3 CNAs, 2 LVNs, and 2 RNs from both shifts stated they were in-serviced on Abuse and Neglect and Change in Condition. Some staff reported they had the training on 11/13/24, while others reported the training on 11/14/24 prior to starting their shift. All staff stated the abuse coordinator was the GM. Staff stated any abuse had to be reported immediately. Staff reported taking a written test about abuse and neglect. Staff reported in-service and a written test regarding notification of changes. The staff stated the in-service covered reporting any change such as bruises, skin tears, complaints of difficulty urinating, behaviors, or pain. Staff stated the provider needed to be notified immediately. If the provider did not respond within 30 minutes, the medical director was notified. If no response from the medical director within 30 minutes, the CNO was notified. Documentation was to be completed as soon as possible but no later than the end of the shift. The staff stated the test was a multiple-choice test. They stated questions included, Which of the following incidents requires notification to the MD/NP? and, If the resident experiences a significant change, what actions must the nurse take? Review of the facility's Ad Hoc meeting agenda dated 11/13/24, reflected the Medical Director was notified. The VPCO, RN Supervisor, Director of Rehab, MDS Coordinator, DM, SS, and DCE attended the meeting. Review of the post-tests to ensure competency on notification of changes of condition and abuse and neglect was conducted. The test for change of condition contained seven multiple-choice questions. A sample of questions included, A charge nurse must notify the physician of the following: circle all that apply, Which of the following requires notification to the MD/NP? and, If a resident experiences a significant change in their physical, mental, or psychosocial status, which action must the charge nurse take? The Abuse post-test contained 10 True or False questions. A sample of the questions included, Everyone in the facility is responsible for watching for and reporting abuse. Taking away a resident's call light is considered a form of abuse. It is okay to swear in front of a resident if they are swearing too. The tests were taken by direct care nursing staff as well as staff from other departments. The tests reviewed were all passed with no concerns identified. Review of the Abuse in-service given by the VPCO, dated 11/13/24 reflected Notification to Abuse Coordinator (GM). The in-service contained 43 signatures. The Abuse & Neglect policy was attached. Review of the Change of Condition notification in-service given by the VPCO, dated 11/13/24 reflected Assessment and notification must be completed on any physical, mental or emotional changes. The Change of Condition Policy was attached. The sign-in sheet contained 43 signatures. Review of the payroll report listing current employees was reviewed. 18 nursing staff had completed the training. 4 general administrative staff had completed the training. An interview and skin assessment were conducted on all residents in house. A sample of 5 residents medical records reflected the residents were interviewed and a head-to-toe assessment was completed. No significant findings noted. The CNO was out of town but per the VPCO, he was trained verbally during a telephone call and would take the tests when he returned to duty. (continued on next page)

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	11/14/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The VPCO was notified on 11/14/24 at 7:19 PM that the IJ had been removed. While the IJ was removed on 11/14/24 at 7:19 PM, the facility remained at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observations, interviews, and record reviews, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for 1 (Resident #1) of 6 residents reviewed for quality of care. 1. The facility failed to assess the resident or notify the provider when Resident #1, who has a diagnosis of stage 5 kidney failure, complained of not being able to urinate. 2. The facility failed to assess Resident #1, notify the provider or the abuse coordinator when Resident #1, who was taking blood thinners and had a BIMS score of 15, presented with bruises all over her body, and began throwing herself on the floor, hitting herself on the head, yelling, and exhibiting erratic behaviors . 3. The facility failed to follow the care plan and notify the MD of changes in mental status, confusion, and agitation. 4. The facility failed to assist Resident #1 to transfer to the hospital on 11/03/24, before she called 911 and waited 27 minutes on the phone until EMS arrived. The failures resulted in an identification of an Immediate Jeopardy (IJ) on 11/13/24 at 2:49 PM. While the IJ was removed on 11/14/24 at 7:19 PM, the facility remained at a level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for not receiving intervention in a timely manner and a decline in health and hospitalization . Findings included: Review of Resident #1's admission MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including left hemiplegia following cerebral infarct (weakness or paralysis on the left side of the body after a stroke), chronic kidney disease, muscle weakness, seizures, anxiety (intense and excessive worry and fear), and abnormalities of gait. The primary medical condition category was listed as stroke. Section B (Hearing, Speech, and Vision) reflected the resident's speech was clear and she made herself understood. Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Section E (Behavior) reflected no hallucinations or delusions. Section E also reflected no verbal behaviors directed towards others, and no physical behaviors not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Section H (Bladder and Bowel) reflected the resident was continent of bowel and bladder. Section N (Medications) reflected the resident received anticoagulant and antiplatelet medications. Review of Resident #1's comprehensive care plan reflected a focus, initiated 10/30/24, of depressive symptoms with an intervention, Observe and report any changes in mental status, notify MD if any changes in mood, behavior and/or psychosocial status is observed. A focus, initiated 10/25/24, of risk for falls with interventions including, Follow facility fall protocol and, review information on past falls and attempt to determine cause of falls. Record possible root causes . A focus, initiated 10/25/24, reflected potential alteration in nutrition and hydration with interventions including, Monitor/document/report PRN any s/s of dehydration: decreased or no urine output and new onset confusion. A focus, initiated 10/25/24, for antianxiety medication reflected interventions including, Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: .Confusion, impaired thinking and judgement, mania, hostility, rage, aggressive or impulsive behavior, hallucinations. A focus, initiated 10/25/24, for anticoagulant therapy reflected an intervention, Monitor/document/report PRN adverse reactions .sudden changes in mental status. The care plan did not address the resident's kidney disease. A focus initiated 11/04/24 reflected, The resident has a behavior problem of repeatedly putting herself on the floor (purposeful), throwing items on floor and breaking (plates, cups, etc.), yelling out loud, clogging toilet with paper towels. Goals included, Resident will show a decrease in negative behaviors by next review date and Will exhibit socially appropriate behaviors during review period. Interventions included, Approach resident appropriately when resident is hallucinating, delusional or expressing potentially harmful suspicions . Ask resident if these hallucinations/delusions are harmful to themselves in any way .Document resident's inappropriate behaviors when it occurs . If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and or unacceptable to the resident . Intervene as necessary to protect the rights and safety of others . Review of Resident #1's admission Nursing Evaluation, dated 10/25/24 at 7:29 PM, reflected normal skin color on the resident's face, upper extremities, and lower extremities. The assessment note redness on the sacrum but no other skin integrity concerns. Review of Resident #1's physician order dated 10/25/24 reflected, Skin Checks Weekly every day shift every Saturday - Must open and document Skin Evaluation for each assessment (including no new areas found). Review of Resident #1's Medication/Treatment Administration Record for November 2024, reflected LVN B signed the Weekly Skin Evaluation as completed on 11/02/24. Review of Resident #1's Evaluation log from 10/25/24 through 11/03/24 reflected no Weekly Skin Evaluation was completed. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Order Summary Report for active orders as of 11/03/24, reflected the following medication orders: 10/28/24 Apixaban oral tablet 5mg by mouth two times a day for DVT PPX unsupervised self-administration. 10/25/24 Aspirin oral capsule 81mg by mouth on time a day for analgesics. 10/25/24 Clopidogrel Bisulfate oral tablet 75mg by mouth one time a day for hematological agents 10/25/24 Buspirone HCl oral tablet 5mg by mouth two times a day for antianxiety agents. Review of Resident #1's shower sheet dated 11/02/24, reflected scattered fading bruises. The time of the note is left blank. Lines on the body diagram indicated bruises on the abdomen, arms, and left leg. The form was signed by a CNA and a nurse. The nurse's signature is illegible. Review of Resident #1's progress note dated 10/31/24 at 4:31 AM, written by LVN D reflected, .resident was sitting on the floor, states she woke up needing to use the restroom and was attempting to get up too quickly; bed was in low position with call light in reach, resident aware to call for help, VS WNL, denies pain, no s/s LE rotation, current anticoag rx [sic] on hold, denies hitting head, on neuro checks. Review of Resident #1's progress note 10/31/24 at 12:30 PM (created 11/01/24 at 8:35 AM) written by the VPCO, reflected, . Staff member was informed guest called to say she fell in her room, upon entering room guest was observed sitting in an upright position on her buttock . no apparent injuries, no redness, swelling, bruising or abnormalities .denies hitting her head or any other area of her body . educated guest to call for assistance with any further transfers .verbalized understanding. Guest is her own r/p, clinical manager and MD notified as well. Review of Resident #1's progress note dated 11/1/24 at 1:25 AM, written by LVN D, reflected Guest c/o 'not being able to urinate', bladder scan performed with no residual, noted in 24-hour report for in house NP. Review of Resident #1's progress note dated 11/1/24 at 9:44 PM reflected, fall f/u day 2/3: resident observed propelling self in hallway on unit, resident observed clogging toilets (toilet in her room and empty rooms) with paper towels, resident redirected multiple times nurse manager notified, maintenance order placed. Review of Resident #1's progress note dated 11/02/24 at 8:00 PM, written by LVN K, reflected in part, . resident observed yelling out for help . The note did not reflect the provider being notified that the yelling out behavior was a change in mental status from being alert and oriented, with a BIMS score of 15, and able to make her needs known. Review of Resident #1's progress note dated 11/02/24 at 9:35 PM, written by LVN K (created 11/03/24 at 5:37 AM) reflected, Day 3/3 fall f/u bruises noted to abd, lower back, ble, bue, and forehead. The note does not reflect that the provider was notified of the bruises. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress note dated 11/03/24 at 2:59 PM, written by LVN B, reflected in part, Guest noted from previous shift not having a good sleep yelling all night and breaking things and putting herself to the floor many times .the next day the pt continue breaking things and breakfast plates and cup and pulling the call light off the wall and continue throwing herself on the floor and yelling and the NP was called and the pt call 911 by herself and she was sent out for AMS and the pt has scattered bruising all over . Review of Resident #1's progress notes from 11/02/24 through 11/03/24, reflected no documentation that the bruises were assessed, or the provider notified of bruising until the resident was sent out with EMS around 2:51 PM on 11/03/24. Review of the incident report log from 08/01/24 through 11/06/24, reflected Resident #1 had two falls. The throwing herself to the floor was not documented on the incident list. Review of an incident report dated 10/31/24 at 4:31 AM, reflected Resident #1's fall from the same date and time. Immediate actions taken included, Resident aware and reeducated to call for assistance when needing help . Mental Status reflected only the oriented to person box was checked. Predisposing Physiological Factors reflected the boxes for confused and impaired memory were checked. Predisposing Situation Factors reflected the boxes for behavior issues, during transfer and, ambulating without assist were checked. No notifications were documented. Review of an incident report dated 10/31/24 at 12:30 PM, reflected Resident #1's fall from the same date and time. Immediate actions taken included, educated guest to call for assistance with any further transfers to decrease the risk of a fall. Page 1 of the report reflected the guest was alert and oriented x4. Page 2 of the report reflected the mental status as only oriented to person. No Predisposing Environmental or Physiological factors checked. Review of a text message from Resident #1 to a FM sent 11/01/24 at 10:30 PM, the resident texted, In short my pan s, I shit, I'm in sa diaper but, I'm in a dia diaper [sic] Review of Resident #1's Task: Bladder Continence, the resident was marked as continent five times from 10/26/24 through 10/30/24. On 11/01/24, she was marked as incontinent of bladder. Review of an undated document received in an email on 11/15/24 by the VPCO, regarding Resident #1's complaint of not being able to urinate, reflected in part, .The day shift licensed nurse worked with the resident has documented vital signs along with a pain assessment documented in the resident medical record. The resident did not verbally express any further concerns. As such, there was no indication from the residents or the nurse that additional follow-up was necessary at the time. The transfer form, included in the email, reflected the resident required assistance with toileting and was incontinent of bladder. Review of Resident #1's progress notes from 11/01/24 through 11/03/24, reflected no assessment of the cause for the incontinence and no further information regarding her genitourinary status. Review of Resident #1's progress notes dated 11/01/24 through 11/03/24 reflected no documentation that the provider was notified of the change in mental status or behaviors. The notes did not reflect that the nurse manager who was notified, followed up on the resident's change in mental status. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress notes dated 10/31/24 through 11/03/24, up until the final entry, reflected no documentation that the provider was notified of yelling out, yelling out all night, clogging toilets, breaking things, putting herself on the floor many times. The notes do not reflect that the provider was notified when the behaviors of throwing things, breaking things, pulling the call light off the wall, and throwing herself to the floor, and yelling continued to the next day. Review of a screen shot from Resident #1's phone dated 11/03/24, reflected a phone call placed to 911 at 1:59 PM. The call lasted 27 minutes. Review of photos of Resident #1 taken in theER on [DATE] between 4:35 PM and 4:39 PM reflected the following: Face - two red bruises on her forehead and one on her left eyebrow. Abdomen - one purple/red bruise just below her umbilicus (belly button) and extending down towards the pubic bone, unable to visualize the bottom of the bruise due to positioning. The bruise is about 6 inches wide. A large deep purple hematoma (bruise) on the right abdomen flank is about 14 inches in width extending across her low back. It starts at about the level of the umbilicus, about 5 inches are visible, the bottom edge of the hematoma is covered by clothing. There was a tape measure visible lying across the wound in the in picture. Right upper leg - about 11 purple bruises on lateral (outside)/posterior (back) view. Right lower leg - about 8 purple bruises on posterior view Left lower leg - a purple bruise that starts a few inches below her knee and extends to just above the ankle, about 10 inches on anterior (front) view, tape measure visible in the photo. About 7 purple bruises are visible on the medial (inside) aspect of the leg and the large bruise on the anterior view extends to the medial aspect. Right foot - about 10 purple/red bruises on medial, lateral, dorsal (top), and plantar (bottom) surfaces. Laceration on dorsal surface. Left foot - about 6 purple/red bruises on lateral and dorsal surfaces. Right arm - about 3 purple bruises and one large deep purple/red bruise visible. Review of Resident #1's Emergency Provider Report, dated 11/03/24 at 5:52 PM, reflected in part, Presentation Chief Complaint - Altered Mental status. Stated complaint Left hip pain/confusion per EMS . presents with altered mental status and scattered bruising . speech nonsensical and unable to communicate effectively . Primary Impression: Altered Mental Status. Secondary Impressions: Anemia, Ecchymosis, History of completed stroke. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's physician progress notes from the acute hospital dated 11/11/24 at 11:48 AM reflected in part, Patient was agitated on arrival to emergency room , required several doses of sedatives for agitation in emergency room . Per EMS report nursing staff at facility reported patient was hitting her own head against the wall and had frequent falls CT chest abdomen, and pelvis shows significant bladder distention. Markedly enlarged bilateral kidney with innumerable cyst . Hematoma in the subcutaneous fat in the lateral right mid to lower abdomen measuring 8.3 x 3.8 x 7.6 cm. Hemoglobin 6.1 on admission. Patient underwent 2 units of PRBC transfusion from extensive bruising all over the body. No evidence of GI bleed. Eliquis was discontinued, aspirin and Plavix continued. Acute metabolic encephalopathy resolved. Resident has some urinary retention, and a catheter was placed . Urinary tract infection, received Ceftriaxone 1 gram IV every 24 hours. Review of Resident #1's EMR including MDS assessment, progress notes, evaluations, and MARs dated from 10/25/24 through 11/04/26, did not reflect the resident was assessed for a change in mental status, changes in mood, behavior and/or psychosocial status, s/s of dehydration, reactions to anti-anxiety or anticoagulant medications. There was no documentation that the resident was assessed for hallucinations or delusions after the initial MDS assessment, or for possible causes of the altered mental status. During a telephone interview on 11/06/24 at 8:16 AM, Resident #1's FM stated the resident had called her on 11/02/24 and said she thought she had a UTI because she was not peeing, and she did not feel right. She stated they were on speaker phone and there was a staff member in the room. She stated she asked the other person in the room if the doctor was coming to see the resident and the other person replied, Yes. She stated she did not know if a doctor ever saw the resident about her complaint of not urinating. She stated she saw the resident the next day in the ER. She stated the resident went to the ER for altered mental status and multiple falls. She stated she was never notified of the falls. She stated she noticed, during phone calls and texts, the resident being more confused and irritable for the few days prior to going to the ER. She stated Resident #1 started having trouble writing a coherent text message. She stated the decline went on for days before she called 911 to go to the hospital. During an interview on 11/06/24 at 2:28 PM, the VPCO stated the post fall assessment would have the documentation regarding the resident's status. She stated the nurses would document in the progress notes when a bruise was observed or noticed. She stated they would definitely investigate any bruises that could not be explained. She stated if an alert and oriented resident had falls and a change in behavior, her first thought was to get a UA as changes were often a sign of infection. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/07/24 at 10:33 AM, the MD stated she saw Resident #1 on 10/28/24. She stated she did not look under the clothes but there were no bruises on the visible skin. She stated she was not aware of extensive bruising. She stated the resident was on 3 different medications that could have caused her to bruise easily. She stated Resident #1's hemoglobin was 8.8 (hemoglobin, part of the blood, helps carry oxygen to all the vital organs, 12-17 is a normal level) on 10/23/24 at the acute hospital prior to her admission at this facility. She looked but did not see any blood results from the time the resident was in the facility. She stated she was not aware that the resident complained of not being able to urinate. She stated the resident had chronic kidney disease, but she had been urinating, as far as she knew, while at the facility. She stated the resident may not have been drinking enough, or her kidney disease may have worsened. She stated she expected to be notified of changes in condition when they occurred. She stated the resident was a good historian and would have been able to talk about the bruises and any problems with urination. She stated she was not notified of any erratic behavior other than the resident being upset that her daughter did not answer the phone. During an interview on 11/07/24 at 11:11 AM, the NP stated for any unwitnessed fall, she expected the staff to ask the resident if they had hit their head. She stated bruising may not occur right away if a resident fell or sustained an injury. The NP stated if a resident was on blood thinners and hit their head, to be safe, the resident would be sent out for evaluation. After viewing the picture of the abdominal bruise, the NP stated that bruise should have been reported immediately as the resident was on blood thinners. She stated the bruise looked fresh and it may have happened when she threw herself on the floor. The NP stated she was not aware that the resident had complained of not being able to urinate. She stated she was not aware of the facility 24-hour report. She stated the on-call providers kept a report of the calls received. She reviewed the notes and stated she did not see an entry for Resident #1's urinary complaint. The NP stated she was notified of the erratic behavior when the nurse called her at 2:25 PM on 11/03/24. During an interview on 11/07/24 at 12:33, LVN B stated she had worked at the facility for about three years. She stated she first saw bruises on Resident #1's arm on 10/29/24 but did not work on the resident's hall until 11/01/24. She stated she noticed bruises on Resident #1's abdomen on 11/01/24. She stated because the resident was on blood thinners, she figured the resident was on anticoagulant injections while in the acute hospital and that was the reason for the bruises. She stated because they were old bruises, she did not report them. She stated the resident had scattered bruises all over her body. She stated on Saturday, 11/02/24, the resident was yelling and pulled the call light off the wall. She stated the resident was trying to call her daughter and was yelling about it. LVN B told the resident she would help her call her daughter shortly. When she returned to the room to help, the resident began yelling again and pushed her tray all the way out of her room. The yelling continued. LVN B stated she did not notify the doctor as the resident was just mad about her daughter not answering the phone. She stated on Sunday morning 11/03/24, she was told in report that Resident #1 had yelled all night. She stated the resident continued to yell, kept putting herself on the floor, and hit herself in the head with the phone. She stated it was very different behavior for this resident, but the resident was mad at her daughter. LVN B stated in the afternoon she explained to the resident that she would notify the provider to have her sent out. LVN B stated shortly after she got to the nursing station, the front desk called and asked her if she had called 911. The front desk told her 911 was on the phone about Resident #1 and I told them to come get her. LVN B stated, She heard me say I was going to send her out, so she went ahead and called 911. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/07/24 at 2:00 PM with the VPCO and CNO, the VPCO stated on 10/31/24 she was called to the room after Resident #1 was found sitting on the floor. She stated there was no facial bruising at that time. After seeing the picture of the bruise on Resident #1's abdomen/trunk/back, the CNO stated the bruise was from anticoagulant injections due to its location. The VPCO stated it was a new bruise because it had not changed colors. She stated she could not tell when or where the picture was taken so she could not verify the bruise was present while the resident was at the facility. During a telephone interview on 11/07/24 at 2:38 PM, Resident #1 stated she fell when she was at the facility. She stated, I tried to get help and they said they would be right back, and it was an hour. She stated she was crawling around on her butt trying to get help. They took their time to help me. She stated one staff member told her they were going to kick me out if I kept acting up. She stated she had bruises on her arms which she sustained during the falls. She said she fell and hit her back. She stated the big bruise hurt and stated maybe an ice pack would have helped. She stated she did not feel right and had trouble urinating, I thought I had a UTI. During an interview on 11/07/24 at 5:05 PM, the GM stated there were no competencies for the bladder scan . He stated there was a manual for the bladder scan machine itself. He stated nursing documentation varies from person to person. He stated the nursing documentation should reflect the work they were doing. He expected documentation to be accurate and timely. He stated the clinical management team was responsible to monitor documentation. He stated he expected the nurse to contact the provider or CNO if there was a change in condition or mental status. During an interview on 11/12/24 at 4:17 PM with the ACNO, he stated he had recently provided training on customer service, change of condition and assessment. He stated he had not provided any training on bladder scans. He stated if a resident complained of not being able to urinate, the nurse reached out to the provider, performed a straight cath, bladder scan, or whatever the provider ordered. He stated it would be case by case, but voiding should occur at least every 4-8 hours. He stated signs and symptoms of UTI could be itching, burning, frequency, or new onset confusion. He stated if there was a bladder scan with no residual, there was no need for follow up. He stated if it was him, he would have rescanned to ensure the initial reading was correct. He stated skin assessments were done upon admission and he believed the wound care nurse was responsible to complete the skin assessment. He stated the skin assessments were completed, he thought, weekly per the policy. He stated CNAs documented in the electronic record and completed shower sheets. The CNAs were expected to document and report any skin issues such as bruises, skin tears, or red areas. He stated residents could get bruised many ways and they could be self-inflicted if the resident was having behaviors. After review of Resident #1's abdominal flank bruise, he stated she may have sustained the bruise when she fell or threw herself on the floor. He expected the provider to be notified of a bruise of that size. He stated it looked new as he did not see any yellow or other signs of aging. He stated if he saw the resident having behaviors, he would not necessarily notify the doctor if those behaviors caused the bruising. He stated if the resident was on blood thinners, probably, he should notify the provider. During an interview on 11/13/24 at 11:08 AM, LVN C stated she was trained on performing a bladder scan when she worked at a hospital, but she had not had any recent training on the bladder scan. She stated the last time she worked with Resident #1, on 10/31/24, she was alert and oriented, and wheeling herself to the coffee shop in the lobby. She stated she completed a skin assessment that day as she helped the resident get dressed. She did not notice any bruises or skin impairment. She stated she did not document that skin assessment. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/13/24 at 11:49 AM, CNA A stated on 10/31/24, Resident #1 was somewhat confused, so she checked on the resident every 30 minutes. She stated they had the bed in the low position, and she told her several times to call for assistance before getting up, but the resident kept getting up. She stated that was a change for the resident. She stated the resident had bruises, but the nurse had already assessed them. She stated there was just a small bruise on the resident's arm that the resident said came from a fall earlier in the day. The CNA stated she reported that bruise to the nurse but the nurse said it would not show up that fast so it must have been an old bruise. During an interview on 11/13/24 at 1:06 PM, LVN B stated the change in Resident #1's mental status did not occur until Sunday 11/03/24. On Saturday (11/02/24) morning report, which she received from LVN D, she was told the resident was found on the floor. On Sunday morning in report, she was told other residents were mad because Resident #1 was making so much noise all night. She stated the resident had complained of pain the night before and they got a hip x-ray. She stated she did not remember ever being told in report that Resident #1 complained of not being able to urinate. She stated on the morning of 11/03/24 Resident #1 continued to yell and break things and throw herself on the floor. She stated the resident had bruises all over and she notified the provider to send the resident out. She stated she assessed the resident, and it was because her daughter did not answer the phone, that she was mad. Multiple attempts to contact LVN D by telephone were made between 11/07/24 and 11/13/24. No return call was received prior to exit from the facility. Review of the Change in Resident Condition policy revised 06/2022, reflected in part, To provide guidance on notification of the physician when there is a change of condition. 1. Should there be a significant change in the resident's physical, mental or emotional status, the attending physician should be notified. 2. If the attending physician does not respond within 30 minutes, contact the Medical Director. 3. If the Medical Director does not call within 30 minutes, contact the DON. Review of the Post-Fall policy revised 05/2023, reflected in part, The LPN/RN will assess the resident for injury and give care/treatment needed at that time. Evaluating the resident's need for: First aid needs, Assessment will include vital signs, skin assessment, neurological assessment, ROM .pain .The LPN/RN notifies the physician of the fall and findings from his/her assessment. The physician makes the clinical decision to transfer resident to hospital or monitor and treat in facility. The Administrator and DON are notified of fall. Document circumstances, notification of medical doctor, family or responsible party, Administrator and Director of Nursing and findings from the assessment in the clinical record . Review of the Bladder Scan Protocol revised 09/2024 reflected, To ensure bladder scan orders are followed in accordance with physician orders. Policy/ Procedure: 1. Bladder scans may be initiated for residents experiencing signs and symptoms of urinary retention and/or recent catheter removal at the licensed nurse's discretion, provider notification will occur for abnormal results. 2. Post void residuals will be completed via a bladder scan device if available in accordance with physician orders . (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Skin Policy & Procedure dated 03/2020, reflected in part, The nurse will perform a full-body initial skin assessment to identify if the resident is at risk for a pressure ulcer within 24 hours of admission to the facility and weekly .The nurse will conduct a full-body skin assessment for each resident weekly to ensure no risks have developed .Each Direct Care Provider will examine each resident's total body skin with each bathing experience and will report any abnormalities to the nurse using the Skin Sheet. The VPCO was notified on 11/13/24 at 2:49 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 11/14/24 at 4:32 PM: Allegation of Credible Compliance F684 11/13/2024 November 13th, 2024 Immediate Interventions: 1. Notifications made to the Medical Director on 11/13/24 at approximately 4:00pm of the immediate jeopardy citation 2. Emergency meeting conducted with action plan developed. This occurred at 4:30pm on 11/13/24 Attendees: RN, VP of Clinical Operations Administrator RN, Assistant Director of Nursing Action Plan: Licensed nursing staff, certified medication aides, and certified nursing assistants in-serviced immediately on the facility policy and procedure for notification of change of condition and the abuse and neglect policy and procedure. Resident #1 has discharged from the facility and therefore a plan of correction cannot be accomplished. Current residents were assessed by licensed nursing staff for any changes of condition, including but not limited to their physical (including but not limited to skin integrity), mental and emotional status. No negative outcomes were obtained from these assessments. A root cause analysis was completed by the VP of Clinical Operations and incorporated into staff training and in-servicing, which includes notification of change of condition, and abuse and neglect policies and procedures. (continued on next page)

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	11/14/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Licensed nursing staff, certified medication aides, and certified nursing assistants were in-serviced on the change of condition policy and procedure, including but not limited to: changes in resident behavior, skin integrity changes, increased confusion, and genitourinary changes. The assistant director of nursing and nursing supervisor have provided in-service, education and compliance training with staff. - Changes of condition must be reported to the provider timely (within 30 min) if no response within 30 minutes the Medical D [TRUNCATED]

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	11/14/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269 Based on interview, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to prevent development of pressure injuries for 4 (Resident #1, Resident #2, Resident #3, and Resident #4) of 4 residents reviewed for quality of care. 1. The facility did not prevent the development of one facility acquired Stage II pressure injury for Resident #3. 2. The facility failed to complete weekly skin assessments according to their policy for Residents # 1, 2, 3, and 4. These failures could place residents at risk for developing pressure ulcers or wounds. Findings included: Review of Resident #3's face sheet dated 11/12/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] diagnoses included muscle weakness, need for assistance with personal care, other abnormalities of gait and mobility. It reflected Resident # 3 was discharged from the facility on 11/06/2024. Review of Resident #3's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #3's care plan initiated 10/22/2024 reflected Resident #3 had ADL selfcare performance deficits and limitations in physical mobility. The resident was at risk for alteration in skin integrity. The resident had an alteration in musculoskeletal status related to left humerus fracture. It was also reflected Resident #3 was at risk for alteration in skin integrity. Review of Resident #3's initial skin assessment dated [DATE] reflected Resident #3 had no skin breakdown upon admission. The following were also reflected: The resident is at risk for alteration in skin integrity. Goal: The resident will remain free of new skin impairment through the review date Intervention: Apply barrier cream per facility protocol to help protect skin from excess moisture Intervention: Encourage/assist with turning and repositioning every 2-3 hours Intervention: Provide skin/wound treatments as ordered. Review of Resident #3's physician order dated 10/22/2024 reflected: Barrier Cream apply after incontinent episodes as needed. (continued on next page)

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	11/14/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's wound report dated 10/13/2024 to 11/11/2024 reflected Resident #3 had a wound that was identified on 11/05/2024 at her right gluteal fold, classified as trauma/skin stripping . Stage not applicable. Review of Resident #3's physician order dated 11/05/2024 reflected: Apply Hydrocolloid dressing to right gluteal fold skin tear after treatment with collagen. one time a day for wound care. Collagen to right gluteal fold one time a day for wound care. Review of Resident #3's local Home Health clinical records dated 11/08/2024 reflected Resident #3 had pressure ulcer right buttock, stage 2. During an interview on 11/12/2024 at 4:48 PM, Resident #3's family stated staff were leaving Resident # in her soiled brief for long periods and the resident was not being repositioned frequently. Resident #3's family also stated she spoke with facility's staff regarding not being changed frequently and concerns regarding Resident #3 developing pressure ulcers. Family stated a week and a half later Resident #3 was discharged home with a pressure ulcer. During an interview on 11/13/2024 at 10:14 am, CNA G stated skin breakdown was caused from sitting too long or laying too long or not being changed on time . CNA G also stated she worked with Resident #3, and Resident #3 needed assistance with repositioning. During an interview on 11/13/2024 at 11:08 am, LVN C stated Resident #3 had developed redness at Resident #3's buttock and the staff were applying barrier cream to the site. She also stated the area opened at her right-side buttocks just before Resident #3 was discharged from the facility. She stated not moving around, sitting for long, and not being able to reposition could cause skin breakdown. During an interview on 11/13/2024 at about 2:17 PM, the ACNO stated he did not expect a resident to develop skin breakdown. It could be moisture, sitting too long, and a million things. Review of Resident #1's face sheet dated 11/06/2024, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included left hemiplegia following cerebral infarct, chronic kidney disease, muscle weakness, seizures, anxiety, and abnormalities of gait. It reflected the resident discharged [DATE]. Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. MDS also indicated Resident #1 was at risk for skin breakdown. Review of Resident #1's admission Nursing Evaluation, dated 10/25/2024 at 7:29 PM, reflected, redness on the sacrum but no other skin integrity concerns. Review of Resident #1's care plan initiated 10/25/2024 reflected Resident #1 was at risk for alteration in skin integrity, required assistance with ADLs, and had left hemi. Interventions included the following: Apply barrier cream per protocol, encourage good nutrition, encourage/assist with turning every 2-3 hours, monitor skin when providing care, and notify nurse of any changes. (continued on next page)

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	11/14/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's physician order dated 10/25/2024 reflected, Skin Checks Weekly every day shift every Saturday - Must open and document Skin Evaluation for each assessment (including no new areas found). Review of Resident #1's Medication/Treatment Administration Record for November 2024, reflected LVN B signed the Weekly Skin Evaluation as completed on 11/02/2024. Review of Resident #1's Evaluation log from 10/25/24 through 11/03/2024 reflected no Weekly Skin Evaluation was completed. Review of Resident #2's face sheet date 11/06/2024, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hip fracture, pain due to internal orthopedic prosthetic device, unspecified fall, and hypertension. Review of Resident #2's admission MDS assessment, dated 10/28/24 reflected a BIMS score of 15 indicating no cognitive impairment. It was reflected Resident # 2 had surgical incision at left hip. Review of Resident #2's comprehensive care plan initiated 10/25/2024, reflected in part, Focus: The resident is at risk for further alteration in skin integrity, left hip post-surgical. Goal: The resident will remain free of new skin impairment through the review date. Interventions: Apply barrier cream .Avoid scratching .Do not allow linens to be creased/folded .Educate resident/family the importance of changing positions .Encourage and assist with turning and repositioning every 2-3 hours . Provide skin/wound treatments as ordered. Review of the physician order summary for Resident #2 dated 10/25/24 reflected in part, Skin checks Weekly every day shift every Saturday - Must open and document Skin Evaluation for each assessment (including no new areas found). Review of Resident #2's November 2024 MAR/TAR reflected the weekly skin evaluation was signed as completed on 11/02/2024 by RN L. Review of Resident #2's evaluation log reflected no Weekly skin check was completed on 11/02/2024. Review of Resident #3's face sheet dated 11/12/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] diagnoses included muscle weakness, need for assistance with personal care, other abnormalities of gait and mobility. It reflected Resident # 3 was discharged from the facility on 11/06/2024. Review of Resident #3's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #3's initial skin assessment dated [DATE] reflected Resident # 3 had no skin breakdown upon admission. (continued on next page)

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	11/14/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's care plan initiated 10/22/2024 reflected Resident #3 had ADL selfcare performance deficits and limitations in physical mobility, the resident is at risk for alteration in skin integrity, the resident has an alteration in musculoskeletal status related to left humerus fracture (humerus is the long bone in the arm running from the shoulder to the elbow). It reflected Resident # 3 was discharged from the facility on 11/06/2024. Review of Resident #3's evaluation log (skin assessment) reflected no Weekly skin check was completed for Resident # 3 on 10/29/2024 or 11/05/2024. Review of Resident #3's clinical records reflected there was no other skin assessment noted for Resident # 3 on 10/29/2024 and 11/05/2024. Review of Resident #3's October's 2024 MAR/TAR reflected the weekly skin evaluation was signed as completed on 10/29/2024. Review of Resident #3's November 2024 MAR/TAR reflected the weekly skin evaluation was signed as completed on 11/05/2024 by LVN D. Review of Resident #4's face sheet dated 11/12/2024 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of age-related osteoporosis (a condition in which bone strength weakens and is susceptible to fracture), other abnormalities of gait and mobility, muscle weakness. Review of Resident #4's admission MDS assessment dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment. It was reflected MDS had not address Resident #4's skin conditions. Review of Resident #4's care plan initiated 11/05/2024 reflected Resident #4 had ADL self-care performance deficits and limitations in physical mobility, resident was at risk for further alteration in skin integrity, right hip post-surgical incision, right lower leg skin tears, The resident had an alteration in musculoskeletal status related to right femur (the thigh bone) fracture s/p ORIF. Review of Resident #4's skin assessment dated [DATE] reflected right thigh front and right lower leg front, wound vac in place and multiple skin tears. Review of Resident #4's evaluation log reflected no weekly skin check was completed on 11/13/2024 . During an interview on 11/12/2024 at 4:17 PM, the ACNO stated skin assessment were supposed to be done on admission and weekly according to the facility's policy. He also stated all the management team members were responsible to ensure the assessments were completed . During an interview on 11/13/2024 at 11:08 am, LVN C stated skin assessments were done by the nurses and the nurses were prompted weekly on the electronic documentation system to do skin assessments. Review of facility's policy titled Skin Policy and procedure dated March 2020 reflected: [the facility] is committed to ensuring comprehensive skin assessment and treatments are implemented for all residents in accordance with all state and federal regulations. (continued on next page)

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	11/14/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on the comprehensive assessment of the resident, facility clinical staff will ensure that the resident who enters the facility without pressure injury will not develop a pressure injury unless the resident's clinical condition demonstrates that the condition was unavoidable. o The licensed nurse and interdisciplinary team will assess and periodically reassess each resident's risk for developing a pressure ulcer and take action to address any identified risks. o the interdisciplinary team will create a written plan for the identification of risk for and prevention of pressure ulcers. o Identification and evaluation of risk factors of: o the nurse will conduct a full-body skin assessment for each resident weekly to ensure no risks have developed.

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	11/14/2024

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 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** 44317 Based on interviews and record review the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 2 (Resident #1 and Resident #2) of 6 residents who were reviewed for administration. 1. The facility failed to accurately document the administration of Resident #1's anticoagulant medication from 10/28/24 through 11/05/24. 2. The facility failed to transcribe a wound care order 10/30/24 for Resident #2. These failures could place residents at risk of lack of desired effect of medications and treatments, and lack of wound healing. Findings included: 1. Review of Resident #1's admission MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses included left hemiplegia following cerebral infarct, chronic kidney disease, muscle weakness, seizures, anxiety, and abnormalities of gait. The primary medical condition category was listed as stroke. Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Review of Resident #1's face dated 11/06/24 reflected she discharged on [DATE]. Review of Resident #1's comprehensive care plan reflected a focus, initiated 10/25/24, for anticoagulant therapy reflected interventions, Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift and Monitor/document/report PRN adverse reactions .sudden changes in mental status. Review of Resident #1's Order Summary Report for active orders as of 11/03/24, reflected the following medication order: 10/28/24 Apixaban oral tablet 5mg by mouth two times a day for DVT PPX unsupervised self-administration. Review of Resident #1's EMR revealed no assessment or physician's order for self-administration of medications. Review of Resident #1's MAR for October 2024 reflected, U-SA for the two doses due each day on 10/28/24, 10/29/24, 10/30/24, and 10/31/24. The chart codes reflected U=unknown (continued on next page)

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	11/14/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's MAR for November 2024 reflected, U-SA for the two doses due each day on 11/01/24, 11/02/24, 11/03/24, 11/04/24, and 11/05/24. Review of Resident #1's Order Recap Report for orders between 10/25/25 and 11/06/24, did not reveal any orders to hold the anticoagulant medications. Review of Resident #1's progress note dated 10/31/24 at 4:31 AM, written by LVN D reflected, .resident was sitting on the floor, states she woke up needing to use the restroom and was attempting to get up too quickly; bed was in low position with call light in reach, resident aware to call for help, VS WNL, denies pain, no s/s LE rotation, current anticoag rx [sic] on hold, denies hitting head, on neuro checks. 2. Review of Resident #2's admission MDS assessment, dated 10/28/24, Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected her diagnoses included a hip fracture, pain due to internal orthopedic prosthetic device, unspecified fall, and hypertension. Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected she required substantial/maximum assistance for sit to stand, chair to chair, and toilet transfers. Section M (Skin Conditions) reflected the resident had a surgical wound, received surgical wound care, and received applications of ointments/medications, and was at risk for pressure ulcers. Review of Resident #2's comprehensive care plan initiated 10/25/24, reflected in part, Focus: The resident is at risk for further alteration in skin integrity, left hip post-surgical. Goal: The resident will remain free of new skin impairment through the review date. Interventions: Apply barrier cream . Avoid scratching .Do not allow linens to be creased/folded .Educate resident/family the importance of changing positions .Encourage and assist with turning and repositioning every 2-3 hours . Provide skin/wound treatments as ordered. Review of the order summary for Resident #2 reflected in part, [name] hydrocolloid dressing to Right Buttock for denuded skin ordered 10/30/24 with no end date on the order. Review of Resident #2's November 2024 TAR reflected no order for the hydrocolloid dressing to her right buttock. During an observation and interview on 11/06/24 at 7:35 AM, Resident #2 stated she had an incision on her hip. She stated for a while, she had to beg the staff to come put a dressing over the incision because it was draining so much it got her sweater all bloody. She stated she did not recall any other treatments or wound care. (continued on next page)

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	11/14/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/07/24 at 12:33 PM, LVN B reviewed the order for Resident #1's Apixaban then stated, They must have clicked the wrong box when it was ordered because the resident did not give her own meds. She stated by looking at the MAR, she could not tell if the medication had been given . She stated she gave the medication because she remembered reading Eliquis 5mg po bid and it was the right time, so she gave the med. She stated if she saw an order that was not correct, she should have called the doctor for clarification. She stated when she clicked in the box after she administered the medication, the U-SA populated instead of her initials. She stated she did not notice the order was wrong because she quit reading the order after she verified the dose and time. She stated she gave the medication to the resident on 10/29/24, 11/01/24, 11/02/24, and 11/03/24. During an interview on 11/07/24 at 2:00 PM, the VPCO stated they did not have any residents who self-administered medications. She stated she did not know how that order got there. She stated the nurse that discovered an incorrect order was responsible to notify the provider for clarification. She stated she would have to check with the nurses to see if the medication was given to Resident #1. She stated she would look at the order for Resident #2's hydrocolloid dressing because she did not believe the resident had a wound that would require that type of dressing. During an interview on 11/07/24 at 4:56 PM, the VPCO stated she could not get the hydrocolloid dressing to populate on the TAR and was not sure why. She stated she did not know why the treatment was ordered. Review of the facility's Self Administration of Medications and Treatments policy, dated 11/2018, reflected in part, 1. Self administration of medications and treatments is determined by physician order after determining that the resident is able to self administer. 2. Medications and treatments for self administration are kept in a locked drawer in the resident room. 3. All medications and treatments that are self-administered are signed out in the MAR or TAR with the nurses initials . Review of the facility's Physician Orders policy, revised 05/2023, reflected in part, General: To clarify requirements and assure that all physicians' orders are valid and safe for patient care. Policy: 1. Orders may be called, hand-written, faxed, or electronically generated by physician . 3. After the authorized provider has completed the orders, the RN or LPN is responsible to promptly and accurately transcribe all written orders. The RN or LPN must include his/her signature, the date and time of the transcription and credentials . 4. Orders that are unclear must be clarified prior to implementation. Review of the facility's Administration of Medications policy, revised 04/2023, reflected in part, General: All medications are administered safely and appropriately to aid residents to and help in overcome Illness, relieve and prevent symptoms and help in diagnosis. Procedure . 3. Check medication administration record prior to administering medication for the right medication, dose, route, patient and time. 4. Read each order entirely. 5. Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring . 14. Click confirm on the eMAR once the medication is removed from the package . 17. Remain with the resident to ensure that the resident swallows the medication. Once resident takes the medication, hit save on the eMAR. 18. If medication is not administered, record reason on the eMAR and notify physician or nurse practitioner. Observe the resident for medication side effects and inform the physician if any occur .

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	11/14/2024

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 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** 44317 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infection for 1 of 3 residents (Resident #2) reviewed for infection prevention and control. The facility failed to place Resident #2 on Enhanced Barrier Precautions when admitted on [DATE] with a surgical wound. The facility failed to ensure they made PPE available near or outside resident's rooms who were on EBP. These failures could place residents at risk for infections. Findings included: Review of Resident #2's admission MDS assessment, dated 10/28/24, reflected Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected her diagnoses included a hip fracture, pain due to internal orthopedic prosthetic device, unspecified fall, and hypertension. Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected she required substantial/maximum assistance for sit to stand, chair to chair, and toilet transfers. Section M (Skin Conditions) reflected the resident had a surgical wound, received surgical wound care, and received applications of ointments/medications. Review of Resident #2's comprehensive care plan initiated 10/25/24, reflected in part, Focus: The resident is at risk for further alteration in skin integrity, Left hip post-surgical. Goal: The resident will remain free of new skin impairment through the review date. Interventions: Apply barrier cream .Avoid scratching .Do not allow linens to be creased/folded .Educate resident/family the importance of changing positions .Encourage and assist with turning and repositioning every 2-3 hours . Provide skin/wound treatments as ordered. The comprehensive care plan did not address Enhanced Barrier Precautions. Review of Resident #2's Wound Rounds assessment dated [DATE] at 11:53 AM reflected in part, site-right hip, type-surgical, classification-incision, exudate-serosanguineous. Review of Resident #2's Order Summary Report for active orders dated 10/30/24, reflected an order for Bordered Gauze 4x10 and 4x4 to left hip surgical site one time a day on even days. During observations on 11/6/24 between 6:11 AM and 6:58 AM, 9 EBP signs were observed on the doors of rooms 114, 125, 130, 132, 158, 159, 160, 163, and 165 . There was no PPE observed near or at the door of the rooms. After an observation of measuring the distance from the nurses' station to Resident #2's room door on 11/07/24 at 10:15 AM, the meter on the measuring wheel reflected the distance was 110 feet. (continued on next page)

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	11/14/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 11/07/24 at 12:10 PM revealed a blue disposable isolation gown hung on a hook just inside room [ROOM NUMBER]. A sign indicating EBP was observed on the room door. During an observation and interview on 11/06/24 at 7:35 AM, Resident #2 stated she had an incision on her hip. She stated for a while, she had to beg the staff to come put a dressing over the incision because it was draining so much it got her sweater all bloody. She showed the dried blood stains on the sweater she was wearing. The stains lined up with the surgical cite. She stated she did not recall the staff ever wearing gowns when they provided care, Just their regular clothes. She stated the staff always wore gloves but did not always remove them before they left the room. During an interview on 11/6/24 at 6:11 AM, CNA A stated there was no one on her end of the hallway who required PPE during care. Her end of the hall included rooms [ROOM NUMBER]. She stated she wore gloves when providing care to all residents. She stated she had received training on infection control on the computer training system. During an interview on 11/06/24 at 6:13 AM, CNA F stated she had one resident who was on isolation and, You have to gown up when you go in that room but not any of the other rooms. During an interview on 11/06/24 at 6:18 AM, LVN D stated he had worked at the facility, before, as a CNA and returned as an LVN a couple of weeks ago. He stated he did not have the whole orientation training again. When asked about the process for EBP, he stated anyone with wounds or lines such as an IV, would be on EBP. He stated gloves, but not gowns, were required when care was provided to residents on EBP. He stated there were PPE carts in the supply room ready to go for any resident placed on isolation precautions. He stated a possible negative outcome of not wearing the correct PPE could be infection transfer or cross contamination. During an interview on 11/06/24 at 6:35 AM, LVN E stated she recently had training in infection control. She stated the training included hand hygiene and EBP. She stated if the resident had a wound, she had to wear gloves when care was provided. If the resident with the wound had MRSA, she also had to wear a gown. She stated PPE was kept in the supply room. She stated if the resident was on isolation, they kept the PPE in a cart at the room. She stated they re-used the disposable gowns, One gown, one resident, one shift unless the resident had MRSA or C-diff then they used a clean gown each time. She stated there were hooks in the room to hang the gowns. She stated an adverse outcome of not wearing the proper PPE could be the spread of germs. During an interview on 11/06/24 at 9:04 AM, the ACNO stated he was the Infection Preventionist. He stated he had been in the position since he started working at the facility 9 weeks ago. He stated they had one resident on isolation for C-diff and many residents on EBP. He stated everyone with a catheter, peg tube, wound, or IV was on EBP. He stated PPE was kept at the nurse's station and in central supply. He stated he would pull the log to see when infection control training was last done. He stated he was not sure what training rehires received. He stated he had not been using a log or tracking observations of hand hygiene or donning/doffing PPE. He stated they prided themselves on following the EBP protocol, but a negative outcome of not following infection control practices could be cross contamination. He stated residents with stage 3 wounds, or any surgical wound would be on EBP. He stated even if the surgical wound looked closed, it was better to err on the side of caution. (continued on next page)

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	11/14/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/24 at 1:20 PM, CNA H stated he recently had been trained on infection control. When asked to describe EBP, he stated, Some people came in with COVID, so you had to use the extra PPE . He stated a face mask, gown, and face shield were required. He stated PPE was kept in the supply room. During an interview on 11/06/24 at 2:27 PM, the VPCO stated it was her expectation that staff followed EBP. She stated the infection preventionist was responsible for training on infection control. She stated upon hire, EBP was incorporated with Infection Control training. She stated they completed annual skills checks and capability was assessed upon hire. She stated every month they had skill checkoffs on different topics. During an interview on 11/07/24 at 9:42 AM, the ACNO stated management all did rounding and monitored PPE usage. He stated they did not require a physician's order for EBP. He stated the nurse who completed the admission assessment was responsible for initiating the EBP when indicated. He stated it did not meet his expectations that a resident with a draining surgical wound was not on EBP. He stated Resident #2 moved from one hall to another hall and he assumed the EBP sign did not move with her to the new room. He stated it was about 90 feet from the nurse's station where the PPE was kept to Resident #2's door. He stated he considered that to be nearby. During an interview on 11/07/24 at 2:00 PM, the VPCO stated EBP was required for wounds that required a daily dressing. She stated some residents did not require daily dressing changes for their wounds. She stated she would have to look at Resident #2's orders to see if she needed to be on EBP. She stated they did not require an order for EBP because it was just a precaution and not isolation. She stated PPE was kept in the supply room and the nursing station, and it was available. She stated they did not reuse PPE. During an interview on 11/07/24 at 4:24 PM, CNA M stated she had not had much training since working there for three months. She stated when she provided care for residents who required EBP, she had to wear gloves and a gown. She stated she was not sure about reusing a gown but then stated, Well, I guess I would if I was going to be in the room several times, yes, it is okay to use the same gown for the shift. During an interview on 11/07/24 at 5:05 PM, the GM stated he expected staff to follow the infection control policies. He stated on or near the resident door could mean 100 to 150 feet or maybe up to 1000 feet if you looked up the definition of near in the dictionary. They did not put the PPE carts near the rooms in order to provide a more home-like environment. During an interview on 11/12/24 at 5:48 PM, the GM stated the guests in the facility were called guests because they were in the facility for a short period of time. He stated they were not referred to as residents because it was a temporary stay. When asked about the homelike environment he stated they did not have bins of PPE at the rooms because they wanted the facility to look more home-like than hospital-like. (continued on next page)

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	11/14/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 11:08 AM, LVN C stated they used EBP for residents with wound or dressing changes. She stated a gown and gloves were required if providing contact care to residents on EBP. She stated anyone with a line or wound was placed on EBP when they were admitted . She stated Resident #2 was not on EBP when the resident moved to a room on the hall where she worked. She stated the wound was open to air but there was one day when the wound leaked, and it had to be covered with a dressing. She stated the resident should have been put on EBP at that time. She stated, I should have changed her precautions, but I didn't. LVN C stated not wearing proper PPE or following precautions could lead to the spread of infection. During an interview on 11/13/24 at 10:22 AM, CNA G stated she worked with Resident #2 until she moved to another room on the hall. She stated the resident was not on EBP or isolation as far as she knew, she just wore gloves. Review of the facility's Infection Control policy, revised 05/2024, reflected in part, This facility will follow the Enhanced Barrier Precautions Policy for all MDRO infections. Review of the facility's Enhanced Barrier Precautions policy dated, 03/2024, reflected in part, This facility follows recommendations and guidance from the Centers for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI) . EBP: refers to an infection control intervention de signed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities . Wound: refers to any skin opening requiring a dressing such as for chronic wounds such as: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers . Make PPE including gowns and gloves available near or outside resident's room . Staff will not wear the same gown and gloves for care of more than one resident or reuse the gown and gloves for the same resident . Residents will be maintained in EBP throughout the duration of the resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed the resident at higher risk . According to the CDC website, https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html, accessed on 11/18/24, Make PPE, including gowns and gloves, available immediately outside of the resident room; Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.