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	01/15/2025

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** 42949 Based on interview and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for three (Resident #1, Resident #2, and Resident #3) of five residents reviewed for pressure injuries. The facility failed to: 1.) Ensure Resident #1 had wound care treatments until four days after being admitted . She missed seven wound care treatments in December 2024 and January 2025. 2.) Ensure Residents #2 and #3 had orders for the monitoring of their wound vacs (a negative pressure wound therapy) every shift. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain. Findings included: 1.) Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type II diabetes, need for assistance with personal care, and chronic kidney disease. Review of Resident #1's admission MDS assessment, dated 12/30/24, reflected a BIMS was not conducted due to her rarely/never being understood. Section M (Skin Conditions) reflected she had one or more pressure ulcers/injuries. Review of Resident #1's admission care plan, dated 12/31/24, reflected she was at risk for further alteration in skin integrity, admitted with pressure ulcers, health conditions, and poor oral intake with an intervention of providing skin/wound treatments as ordered. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's admission skin assessment, dated 12/23/24, reflected she had skin integrity issues on her RUE midline, discoloration to her bilateral buttocks, discoloration to her bilateral heels, discoloration to both feet and ankles, wound to her LUE, multiple wounds to her toes, and multiple pressure injuries to her sacral/coccyx (tailbone). Review of Resident #1's physician orders, undated with no start date, reflected to cleanse the L 2nd toe, L 3rd toe, L 4th toe, L 5th toe, and L great toe with NS or wound cleanser, pat dry, apply betadine and cover with dry dressing and PRN when soiled - one time a day for wound to toes. Review of Resident #1's physician orders, undated with no start date, reflected to cleanse the R and L heel with NS or wound cleanser, pat dry, apply betadine to site, and leave open to air one time a day for wounds to heels. Review of Resident #1's physician orders, undated with no start date, reflected to cleanse sacrum with NS or wound cleanser, pat dry, apply skin prep to peri wound, apply Medihoney to wound bed, cover with dressing and PRN when soiled one time a day for sacral wound. Review of Resident #1's December 2024 TAR reflected treatments for all of her wounds her wounds were provided on 12/27/24, 12/29/24, 12/30/24, and 12/31/24. Resident #1 was admitted to the facility with the wounds on 12/23/24. Review of Resident #1's December 2024 and January 2025 TARs reflected she missed wound care treatments for all of her wounds from 12/23/24 - 12/26/24, on 12/28/24, 01/02/25, and 01/05/25. 2.) Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of the legs and lower body), chronic pain syndrome, and stage IV pressure ulcers to the sacral region and right and left buttock. Review of Resident #2's admission MDS assessment, dated 01/08/25, reflected a BIMS score of 15, indicating no cognitive impairment. Section M (Skin Conditions) reflected he had one or more pressure ulcers/injuries. Review of Resident #2's admission care plan, dated 01/03/25, reflected he was at risk for alterations in skin integrity with an intervention of encouraging/assisting with turning and repositioning every 2-3 hours. Review of Resident #2's physician orders, dated 01/14/25, reflected wound vacs to his right and left buttock - suction setting 125 mmHG, change (T/Th/S), Cleanse with wound cleanser; pat dry; skin prep peri wound; cut granufoam to fit wound bed. Apply transparent drape. Cut a small hole in the drape near the center for granufoam and place connecter pad directly over hole, connect tubing to vac canaster and turn on device. Ensure seal is patent and no leaks, patch if necessary - one time a day every Tuesday, Thursday, and Saturday. There was no order to monitor every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/15/25 at 12:58 PM revealed Resident #2's wound vac to be connected and running appropriately. He stated he had it put on on 01/13/25 and the staff would be replacing it the following day, 01/16/25. He stated the staff were tending to his wound and he had no concerns. Review of Resident #3's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including paraplegia, chronic pain syndrome, and unspecified staged pressure ulcers of his sacral region and left buttock. Review of Resident #3's EMR, on 01/15/25, reflected his 5-day MDS assessment had not been completed. Review of Resident #3's EMR, on 01/15/25, reflected his baseline care plan had not been completed. Review of Resident #3's physician orders, dated 01/14/25, reflected wound vac to his left ischium (bone of the lower back) - suction setting 155 mmHG, change (Monday and Thursday), Cleanse with wound cleanser; pat dry; skin prep peri wound; cut granufoam to fit wound bed. Apply transparent drape. Cut a small hole in the drape near the center for granufoam and place connecter pad directly over hole, connect tubing to vac canaster and turn on device. Ensure seal is patent and no leaks, patch if necessary - one time a day every Monday and Thursday. There was no order to monitor every shift. During an interview on 01/15/25 at 11:14 AM, the CNO stated a head-to-toe assessment should be completed by the admitting nurse upon admission and wound treatment orders should be implemented within 24 hours at the latest. He stated if a resident went four days without treatment orders after being admitted , that would not meet his expectations. He stated that could cause the wounds to possibly worsen. He stated residents with a wound vac should have orders to monitor it every shift. During an interview on 01/15/25 at 1:11 PM, the WCN stated the admitting nurse should ensure wound treatment orders were put in place within 24 hours of a residents' admission. She stated it would not meet her expectations for a resident to go 4-5 days without treatment orders. She stated that could be bad/detrimental and wounds could worsen. She stated residents with wound vacs should have orders to monitor every shift. She stated the nurses needed to monitor to make sure the machine was actually suctioning, making sure it still had a seal, and that there was no seepage or drainage. She stated that would be to ensure wounds were not worsening and also for infection control prevention. Review of an in-service conducted by the CNO, dated 11/27/24, reflected the nursing staff were in-serviced on skin assessments and their Skin Policy and Procedure. Review of the facility's Skin Policy and Procedure Policy, dated 03/2020, reflected the following: If the resident has, on admission, or develops pressure sore(s), he/she will receive necessary and appropriate treatment and services to promote healing, prevent infection and prevent further development of additional impaired skin integrity. A request for a policy on wound vacs was requested but not received prior to exiting.