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	01/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interview and record review, the facility failed to ensure all residents were free from physical abuse for one (Resident #1) of seven residents reviewed for abuse in that: CNA B forced Resident #1 to have his vitals taken after he refused and used force to push Resident #1 on his back on 01/27/2025. Noncompliance existed from 01/27/2025 to 01/28/2025, but the facility corrected the noncompliance through re-training and assessment of staff, reviews of clinical information, and the immediate suspension of CNA B. Therefore, the findings are of past noncompliance. This deficient practice could place residents at risk of fear, physical injury and psychosocial harm. Findings included: Review of Resident #1's face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnosis of pressure ulcer of sacral region (above tailbone), paraplegia (a condition that causes paralysis or loss of mobility in both legs), muscle weakness, and chronic pain (syndrome a condition characterized by persistent pain that lasts for at least three to six months and significantly impacts a person's life). Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 15 which indicated no cognitive impairment. Review of MDS functional abilities section reflected Resident #1 was dependent for toilet transfers, tub/shower transfers, going from lying to sitting on side of bed and for chair-to-bed/bed-to-chair transfers. Further review reflected Resident #1 required substantial/maximal assistance to go from sitting to lying. Review of Resident #1's care plan dated 01/09/2025 reflected that Resident #1 had an ADL self-care perform deficit and limitations in physical mobility. Interventions reflected Resident #1 was dependent and/or substantial/maximal assistance for siting to lying. (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

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	01/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's nursing progress notes dated 01/27/2025 by LVN A reflected Resident #1 was upset and wanted nurse to his room and complained of alleged abuse. LVN A stated she called the ED, spoke with HD and CNO was notified. Resident #1 was assessed head to toe and no bruising or marks were noted on Resident #1. Review of Resident #1's nursing progress note dated 01/29/2028 by ACNO reflected Resident was doing fine and received pain medication. Review of Resident #1's nursing progress note dated 01/28/2025 by CNO reflected ED, CNO, ACO interviewed Resident #1 regarding allegation of abuse and that Resident #1 felt safe at the facility. Review of Resident #1's MAR/TAR pain evaluation reflected no increased pain and appeared consistent with Resident #1's normal level of pain on 01/27/2025, 01/28/2025 and 01/29/2025. During an interview on 01/29/2025 at 10:31 AM, Resident #1 stated that there was an incident with CNA B on 01/27/2025 in the evening around 7:00 PM. Resident #1 stated that he asked CNA B to bring him coffee and when CNA B returned with his coffee, CNA B told Resident #1 she was going to take his vital signs. Resident #1 stated he was sitting in his bed watching television when CNA B returned and stated he did not want to have his vitals taken. Resident #1 stated CNA B told him you're going to give me the vitals and took his coffee and put it in the bathroom away from his reach. Resident #1 stated CNA B told him, he was not going to get the coffee until Resident #1 gave CNA B his vital signs. Resident #1 stated he again declined and stated he did not want his vital signs taken and asked CNA B for his coffee back. Resident #1 stated CNA B then snatched his call light, and television remote and threw his television remote across the room into his wheelchair. Resident #1 stated CNA B stated to Resident #1 that he was going to watch television without his coffee until Resident #1 let CNA B take his vital signs. Resident #1 stated that he had tucked his hands under his legs and then CNA B then grabbed his left arm and put the blood pressure cuff on his arm, crossed his arms over his chest and made an x with his arms and laid him on his back on his bed. Resident #1 stated he yelled at CNA B, and she stated if you want to act like a n*****, I'll show you how one acts. Resident #1 stated that CNA B then left the room and he called his nurse in and asked to speak with administration. Resident #1 stated CNO then called him and Resident #1 explained what happened and CNO stated it would be taken care of. Resident #1 stated the next morning, administration (ED, CNO, ACNO) talked to him about the incident. Resident #1 stated CNO told him that CNA B would no longer be working with him, and he had not seen her again since immediately after the incident. Resident #1 stated he felt CNA B's actions were abusive. Resident #1 stated he felt safe at the facility at the time of the interview. Resident #1 stated that he was unsure if anyone heard or was around but stated it was pretty loud between him and CNA B. (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	01/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview via telephone on 01/29/2025 at 2:40 PM, CNA B stated that on 01/27/2028 she was required to take residents' vitals. CNA B stated she and Resident #1 had been messing around, playing throughout the week. CNA B stated on that day (01/27/2025) she and Resident #1 asked her to get him coffee. CNA B stated she returned to Resident #1's room and said she was going to give him his drink but asked that he give her vitals. CNA B stated she thought Resident #1 and her were messing around in a friendly manner. CNA B stated she put Resident #1's drink in the bathroom and she pretended she was going to walk out of the room. CNA B stated she got the blood pressure cuff around Resident #1's arm and believed Resident #1 allowed it. CNA B stated Resident #1 told her you know I am stronger than you and pushed his arms up. CNA B stated Resident #1 then frowned. CNA B stated she thought Resident #1 was getting serious and she took the blood pressure cuff and left his room. She stated that after thinking about it, she thought it was unprofessional but believed she and Resident #1 had a rapport. CNA B stated her hands were on Resident #1's arms but she was not applying pressure. CNA B stated when she took residents' blood pressure, she usually did not have her hands on the residents. She stated when she did that, Resident #1 was still smiling and then he leaned back and pushed his hands up and CNA B realized Resident #1 was no longer playing around. CNA B stated she was currently suspended and was sent home on 01/27/2025 CNA B stated she took Resident #1's call light and television remote, but she believed they were playing. CNA B stated she had to review policies when she started and it included abuse and neglect, and resident rights. CNA B stated Resident #1 could not walk or get out of bed. CNA B stated an example of physical abuse included hitting a resident, restraining a resident, and placing a call light out of their reach. CNA B stated she gave Resident #1 his call light back. Interview was attempted via phone call and text message with LVN A on 01/29/2025 at 11:22 AM and 12:12 PM. Requested CNO assistance with getting in touch with LVN A on 01/29/2025 at 12:20 PM. Phone call has not been returned as of 01/31/2025. During an interview on 01/29/2025 at 11:59 AM, LVN C stated that she worked with Resident #1 on 01/28/2025, the morning after the incident. LVN C stated that Resident #1 did not appear emotionally distressed, and he was up and ready for therapy. She stated that he had general pain and that his was normal for Resident #1. LVN C stated that residents had the right to refuse care. LVN C stated that she received training on abuse and neglect, and it included who to report allegations to, and when to report it. LVN C stated if she received a report of abuse, she would remove the staff from the resident, and report to the ED immediately. She stated that she would do a head-to-toe assessment and assess for any potential emotional changes. She stated that she was assigned to work with Resident #1 the morning after the incident and that the ED and CNO checked in with Resident #1 as well. LVN C stated that when she asked Resident #1 how he was doing, he told her he was doing okay and appeared normal. LVN C stated that Resident #1 is unable to walk and required a mechanical lift to get in and out of bed. (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	01/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 12:20 PM, CNO stated that he received a phone call Monday (01/27/2025) night from HD and LVN A. CNO stated that he received report from the HD that when CNA B returned with Resident #1's coffee, she asked to take his vitals and he declined. CNA B then placed his coffee in the restroom and asked Resident #1 again to take his vitals and Resident #1 again declined and asked for his coffee. CNA B then took his remotes and said if he did not allow his vitals to be taken, he was not going to get his coffee. Resident #1 had his hands under his legs and CNA B grabbed his arms and attempted to take his vitals and was able to get the blood pressure cuff on him. Resident #1 had reported he was tensing and said he was not going to let CNA B get his vitals and held his arms together and Resident #1 attempted to show CNA B he was stronger. It was then reported to CNO that CNA B said if Resident #1 did not give her his vitals, she was not going to care for him. CNO stated that CNA B was immediately suspended, and she was asked to leave the facility. CNO stated he informed LVN A that CNA B was suspended. CNO stated he instructed LVN A to ensure the resident had an assessment completed, pain medication in the event he needed them, and notify the on-call physician of the allegation and ensure there were no new injuries. CNO stated that Resident #1 stated CNA B was out of line and not being playful. CNO stated he spoke with CNA B and the first thing she told him was I'm sorry and CNA B stated she tried to get Resident #1 to take his vital signs and CNA B started to cry on the phone and again stated I'm sorry. CNO stated that CNA B told him she straightened Resident #1's arm to get his vitals. CNO stated on 01/28/2025, the ACNO, CNO and ED went to Resident 1's room to follow up with him. CNO stated Resident #1 told him, he felt safe. CNO stated there were no adverse reactions noted during this follow up. CNO stated that CNA B was still suspended and pending her statement. CNO stated CNA B did not come to the facility as scheduled on 01/29/2025 at 10:00 AM to provide her written statement for the facility's ongoing investigation. During an interview on 01/29/2025 at 12:56 PM, NP stated that he saw Resident #1 on 01/28/2025 and that the Resident #1 reported his pain was controlled, nothing unusual and there were no significant new complaints. NP stated that Resident #1 did not appear emotionally distressed. During an interview on 01/29/2025 at 1:50 PM, HD stated she was made aware of the concerns on 01/27/2025 in the evening, and she was asked to get a statement from Resident #1 by CNO. She stated that during the statement, Resident #1 was matter of fact and was not overly expressive. She stated he did not appear emotionally distressed. She stated she visited all residents the next morning (01/28/2025) and asked how they were treated and if there were any concerns. HD stated that all residents denied any issues with staff or care. During an interview on 01/29/2025 at 1:55 PM, ACNO stated that he completed in-servicing with each department regarding abuse and neglect. ACNO stated that he followed up with Resident #1 yesterday morning (01/28/2025) and no issues were noted. ACNO stated he checked in with residents around Resident #1's room and all denied issues or concerns. ACNO stated that Resident #1 appeared to be within his normal demeanor. (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	01/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 2:06 PM, the ED stated that she reported the incident to HHSC and also reported to police department. ED stated she was familiar with Resident #1 and worked with him at a previous facility. ED stated that she checked in on him after the incident and completed a psychosocial evaluation and he appeared fine and had no changed in appetite and mood was elevated. ED stated Resident #1 reported he was fine and thought it was a weird and strange the way CNA B interacted with him. ED stated Resident #1 felt safe and denied any injuries. ED stated Resident #1 was in wheelchair smiling, talking, and laughing. ED stated CNA B was currently suspended and was not taking the facility's phone calls. ED stated that CNA B had only been working two weeks and she was usually engaging with residents so the incident was surprising. ED stated that CNO spoke with CNA B regarding the incident on 01/27/2025. ED stated that Resident #1 could not reach his coffee because he was paralyzed. ED stated CNA B admitted to CNO that she moved Resident #1's coffee and tv remote and Resident #1 stated CNA B laid her body on him. ED stated that she believed Resident #1 and stated he was alert and orientated. During an interview on 01/29/2025 at 2:27 PM, CNA D stated she received training on abuse and neglect yesterday or the day before. CNA D stated that if any abuse was witnessed it should be reported immediately to the ED. She stated an example of physical abuse could be roughly handling a resident or leaving them on the toilet for too long. CNA D stated taking a resident's call light or remote was considered abuse, especially if they could not reach it. During an interview on 01/29/2025 at 4:29 PM, CNO stated that in-servicing was completed over abuse and neglect, regular check-ins were initiated with all residents and stated HD continued to check-in with all residents every day to ensure they are getting the care. CNO stated the investigation regarding CNA B was ongoing. CNO stated he expected staff to report all allegations immediately to ED, and if unable to reach her, they can reach out to him. He stated the nurse or CNO will complete an initial head-to-toe assessment, assess pain and if there is an alleged identified AP, CNO would assist with suspension. During an interview on 01/29/2025 at 4:29 PM, ED stated there were no other incidents or warning regarding concerns with CNA B. ED stated they rounded frequently on residents and there were guardian angel rounds with leadership staff. ED stated HD completed daily rounds and reports anything big or small. Review of CNA B employee filed revealed hire date of 01/14/2025 reflected abuse and resident rights policy was included. Abuse competency post test was completed by CNA B on 01/15/2025. Further review of posttest reflected that taking a resident's call light was considered a form of abuse. Review of facility in-service dated 01/28/2025 titled Abuse and Neglect reflected in-servicing was completed with each department (management, clinical, dietary, therapy) and included 40 staff members. In-servicing included abuse policy acknowledgement/post-test. Review of the facility's policy titled Abuse & Neglect with revision date of April 2024 revealed it is the policy of this facility to prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property . Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse included deprivation of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being by caretaker or individual.