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	01/28/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident has the right to secure and confidential personal and clinical records for 2 of 23 residents (Resident #1 and Resident #2) on Kindle Unit of the facility reviewed for Privacy and Confidentiality. The facility failed to ensure Resident #2's clinical records were protected from being viewed by unauthorized persons when the CNA left Resident #2's personal information visible on the computer's screen at unattended charting station on Kindle Unit. The facility failed to ensure Resident #1's clinical records were protected from being viewed by unauthorized persons when the RN left Resident #1's personal information visible on the computer's screen on unattended NC on Kindle Unit. This failure could result in residents' personal information being exposed to unauthorized individuals. The findings included: Observation on 1/28/2026 at 9:09 a.m. revealed that the computer screen on the CNA's charting station on Kindle Unit was opened and unlocked with Resident #2's personal (plan of care) information displayed and visible to unauthorized individuals, including visitors or other residents. Unauthorized individuals were not present near the charting station at that time. During an interview on 1/28/2026 at 12:15 p.m. with the CNA, she stated that she had an in-service on HIPAA a few months ago and it included instructions not discussing residents' private clinical information with unauthorized individuals and to lock the computer screen when stepping away from the charting station. She stated that everybody who works with charting computers was responsible for closing it and locking it when not in attendance. She stated that she was called by another staff member to help with resident care, and she forgot to close the computer's screen. She stated that she was responsible for shutting down and locking the charting computer's screen when stepping away. She stated that leaving the screen unlocked with clinical information displayed on it could be harmful for residents as anybody can see it. Observation on 1/28/2026 at 10:00 a.m. revealed that the computer screen on the RN's NC on Kindle Unit was open and unlocked, with Resident #1's personal medical information (medication administration record) displayed and visible to unauthorized individuals, including visitors or other residents. Unauthorized individuals were not present near the RN's NC at that time. During an interview on 1/28/2026 at 10:05 a.m. with the RN, he stated that staff who worked with residents' personal information was responsible for shutting down the charting computers' screen when needed to leave. He stated that he received HIPAA training several months ago. RN stated that leaving a computer screen without locking the screen could lead to exposing residents' private medical information to unauthorized people and residents' privacy could be violated. During an interview on 1/28/2026 at 12:34 p.m. with the ADM, she stated that she had the HIPAA annual training which covered the importance of maintaining the residents' private information. She stated that whoever used the computer was responsible for shutting it down to ensure the residents' information was not visible. She stated that the potential risk for not shutting down charting computers could be a breach of residents' privacy. She stated that all staff complete HIPAA (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	01/28/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-service at hire and annually through computer modules. She stated that the RN and the CNA completed their annual training. During an interview on 1/28/2026 at 1:02 p.m. with the VPCO, she stated that the facility's policy was to minimize the charting computers' screens when stepping away. She stated that if the screen was not minimized, someone could have unauthorized access to the private clinical information displayed on the screen. She stated that HIPAA in-service was provided to all employees at hire and annually through computer modules which include instructions on locking the computer screens. She stated that the person who works with residents' private clinical information should lock the screen before walking away. She stated that the potential negative effect was unauthorized disclosure of residents' private information. Record review of Resident #2's face sheet, dated 1/28/2026, revealed, a 95-years-old male originally admitted on [DATE] and readmitted on [DATE]. Resident's #1's diagnoses included acute posthemorrhagic anemia (a critical condition caused by rapid, significant blood loss), acute kidney failure the sudden, rapid loss of kidney function) and type 2 diabetes mellitus (a chronic condition characterized by insulin resistance, where body cells fail to use insulin properly, resulting in high blood sugar). Record review of Resident #1's face sheet, dated 1/28/2026, revealed, a 66-years-old female admitted on [DATE]. Resident's #1's diagnoses included type 2 diabetes mellitus (a chronic condition characterized by insulin resistance, where body cells fail to use insulin properly, resulting in high blood sugar), myopathy (muscle diseases characterized by structural or functional impairment, primarily causing weakness, fatigue, stiffness, and cramps) and polyneuropathy (a condition characterized by damage to multiple peripheral nerves, often causing symmetric numbness, tingling, weakness, and pain). Record review did not reveal HIPAA in-services completed and documented by the CNA and the RN before this incident. Record review of facility's Notice of Privacy Practices, dated 01/2026, revealed, This facility is required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of each of our elder's medical information. Protecting the confidentiality of each elder's personal information has been, and always will be, a top priority for this facility. All staff members are trained to protect all health information and keep the information confidential at the time of employment prior to performing any/all assigned duties, at least annually and at any time a supervisors feel the staff member may need additional training.

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	01/28/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (Resident #3) reviewed for medication errors. The facility failed to ensure nursing staff administered Resident #3's medication at the scheduled time. These failures could place all 3 residents at risk of their medications not being administered according to Physician's orders, getting their medications late, or not receiving the intended therapeutic benefits of their medications.Findings included: Record review of Resident #3's order summary report indicated Resident #3 had an order for Carbidopa-Levodopa Oral Tablet Disintegrating 25-100 MG. Give 1.5 tablet by mouth every 8 hours for Parkinson's. Please give at scheduled time. Notify provider if unable to give at scheduled time with start date 01/06/2026. Record review of Resident #3's Medication Administration Record, dated 01/01/2026-01/31/2026, indicated the following scheduled time for administration of Carbidopa-Levodopa Oral tablet 25-100 MG, give 1.5 tablet at 6:00 a.m., 2:00 p.m., and 10 p.m. Resident #3's MAR indicated all scheduled doses of Carbidopa-Levodopa Oral tablet 25-100 MG were administered to Resident #3 without specific time of administration indicated. Record review of facility's Medication Administration Audit Report for schedule dates 01/01/2026-01/28/2026 revealed Carbidopa-Levodopa Oral tablet 25-100 MG. Give 1.5 tablet by mouth three times a day for Parkinson's. One dose scheduled time at 0600 a.m. on 01/07/2025 was administered at 08:33 a.m.One dose schedule time at 2:00 p.m. on 01/08/2026 was administered at 3:15 p.m.One dose schedule time at 2:00 p.m. on 01/10/2026 was administered at 3:05 p.m.One dose schedule time at 2:00 p.m. on 01/19/2026 was administered at 4:00 p.m.One dose schedule time at 2:00 p.m. on 01/22/2026 was administered at 3:04 p.m. Record review of the NP's progress note for Resident #3, dated 01/06/2026, revealed that Resident #3's Family voices concerns of timing of carbidopa-levodopa, patient has been receiving his medication later than scheduled and has increased tremors. Discussed with nursing and will adjust order to reflect every 8 hours on specific times. Record review of Resident #3's face sheet, dated from 01/28/2026, indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with fluctuations (progressive neurodegenerative disorder caused by the loss of dopamine-producing brain cells, leading to movement issues like muscle tremors and stiffness), hypertension (a chronic condition with high blood pressure), and traumatic subarachnoid hemorrhage (bleeding into the space around the brain, most commonly caused by head injuries from accidents or falls). Record review of Resident #3's admission MDS assessment, dated 01/09/2026, revealed Resident #3's BIMS score of 15, indicating intact cognition. Record review of Resident #3's comprehensive care plan, revised 01/15/2026, indicated Resident #3 was on anti-Parkinsonian therapy for Parkinson's disease with interventions in place to administer anti-Parkinson's medications as ordered by physician. Monitor/document side effects and effectiveness every shift. During an interview on 1/28/2026 at 12:34 p.m. with the ADM, she stated that she did not have medication administration training as she was not a medical professional. She stated that nurses and medication aides were responsible for proper medication administration including administration scheduled medications according to physician's orders. She stated that the potential risk for not administering medications according to the physician's orders could be not treating residents' diagnoses properly. She stated that nursing leadership was responsible for monitoring proper medication administration at the facility. During an interview on 01/28/2026 at 1:02 p.m. with the VPCO, she stated that she had medication administration training annually. She was aware of right time as one of the significant characteristics of medication administration. She stated that medication aides and charge nurses were responsible for timely medication administration. She stated that most of the (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	01/28/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications at the facility administered on the liberalized schedule: 07:00-10:00 a.m. (AM pass), 1:00-3:00 p.m. (mid-day pass), and 7:00 - 10:00 p.m. (PM pass). But certain medications, like seizure and Parkinson's medications, if ordered for specific times, should be administered according to physician's orders with following one hour before and one hour after scheduled time rule. She stated if medication was not administered to residents as ordered or administered late, it could affect residents' health conditions these medications were intended to treat. She stated that late administration of Carbidopa-Levodopa for Resident #3 could affect his Parkinson's disease. Interview with the DON was not attempted secondary to the DON was only two days in this role. During an interview on 01/23/2026 at 12:05 p.m. with the NP, she stated that Resident #3's health condition improved while he stayed at the facility, he was able to get up with therapy and walk in the hallway. She stated that she communicated with Resident #3 and his family, and they expressed the concern with medication administration timing specifically for his Parkinson's medication. She stated that she adjusted the administration time to specific three times a day times, and after that she did not hear any concerns from Resident #3 or his family during her weekly rounds. Record review of the facility's Medication Pass Policy and Procedure, undated, revealed Purpose: to ensure that all medications in the facility are administered safely, accurately, and in compliance with Texas law and regulatory requirements.3. Resident rights to timely and appropriate medication administration.Right Time: Administer the medication at the correct time and frequency, as ordered. Record review of facility's Medication Pass Policy and Procedure, undated, revealed that Med Pass: Scheduled administration of medications to residents. Medication Administration: Right Time - Administer the medication at the correct time and frequency, as ordered.