STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676447	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort San Antonio, LLC	6035 Eckhert Rd San Antonio, TX 78229

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38511 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological's were stored properly in the cart for 1 (100 hallway med aide cart) of 2 medication carts reviewed, in that: The facility failed to ensure Resident #5's Lyrica (pregabalin), a DEA controlled substance, was stored appropriately in a double locked container. This failure could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings included: During an observation of LVN B's medication cart for the 100 hallway on 5/15/2025 at 5:00 p.m., revealed one white capsule marked Z 14 and identified as Lyrica, a schedule V (5) controlled substance, was found in an unmarked medication cup that had been removed from the locked controlled substance box of the medication cart and left in the upper right drawer of the medication cart which did not have a separate locked compartment for controlled substances. During an interview on 5/15/2025 at 5:00 p.m., CNA B stated the white capsule marked Z 14 was a capsule of Lyrica meant for Resident #5. CNA B stated she accidentally popped the medication (removed it from it's original blister pack) earlier and did not want to throw it away. She stated when that happened , she normally just left the medication in a cup to the side. She stated the medication were not labeled. She declined to answer questions on how she was trained and what she should do in this scenario. During an interview on 5/16/2025 at 4:03 p.m., the DON stated her expectation of staff were if they popped medications and were unable to give it, for whatever reason, they should waste the medication . (discard). She stated in the case of Lyrica, since it was a controlled substance, the medication should be wasted with a witness and co-signed. The DON stated controlled substances should be stored in the locked narcotic drawer to prevent drug diversion. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the DEA website at https://www.dea.gov, as viewed on 5/27/2025 revealed: The Controlled Substances ACT (CSA) placed all substances which were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability. Schedule V drugs have the lowest potential for abuse. Pregabalin was listed as a schedule V controlled substance. Record review of thefacility's policy, titled Controlled Medication Storage dated 01/23 revealed: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations.

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(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 - Few	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** 38511 Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 5 residents reviewed for medical records. The facility failed to ensure LVN A documented Resident #1's medication at the correct time the medication was administered. This failure placed resident at risk for delayed or inaccurate medication administration which could result in decline in health and well-being. The findings included: Record review of Resident #1's face sheet, dated 5/15/2025 revealed Resident #1 was a [AGE] year-old female admitted on [DATE] with diagnoses which included: displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing (fracture to left leg bone with surgical repair), benign neoplasm of cerebral meninges (non-cancerous tumor of the lining of the brain and spinal cord) and generalized muscle weakness. Record review of Resident #1's 5-day admission MDS assessment dated [DATE] revealed a BIMS score of 4 which indicated a severe cognitive impairment. The assessment indicated the resident was dependent on staff for care and mobility. Record review of Resident #1's Care Plan dated 4/29/2025 revealed the resident had impaired cognitive function and staff should communicate with the resident/family/caregivers regarding resident's capabilities and needs. Record review of Resident #1's Order Summary for May 2025 revealed she had orders for: -gabapentin 100 mg, give one capsule by mouth three times a day for neuropathy. -cetirizine 10 mg, give one tablet by mouth in the morning for allergy symptoms. -metoprolol tartrate 12.5 mg by mouth two times a day for hypertension -benzonatate capsule 200 mg, give one capsule by mouth three times a day for cough. -ondansetron tablet 4 mg, give one tablet by mouth two times a day for nausea/vomiting. Record review of Resident #1's Medication Administration Audit Report dated 5/16/2025 revealed: -gabapentin 100 mg was scheduled to be administered at 7:00 a.m. on 5/01/2025 and was documented as administered at 12:25 p.m. by LVN A. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-cetirizine 10 mg was scheduled to be administered at 7:00 a.m. on 5/01/2025 and was documented as administered at 12:25 p.m., by LVN A -metoprolol tartrate 12.5 mg was scheduled to be administered at 7:00 a.m. on 5/01/2025 and was documented as administered at 12:25 p.m., by LVN A. -benzonatate 200 mg was scheduled to be administered at 7:00 a.m. on 5/01/2025 and was documented as administered at 12:25 p.m., by LVN A. -ondansetron 4 mg was scheduled to be administered at 7:00 a.m. on 5/01/2025 and was documented as administered at 12:25 p.m., by LVN A. -polyethylene glycol 17 grams was scheduled to be administered at 7:00 a.m. on 5/01/2025 and was documented as administered at 12:25 p.m., by LVN A. During an interview on 5/16/2025 at 4:26 p.m., Resident 1's family members stated they had concerns about the times Resident #1's gabapentin was administered. The family members stated they had asked an unknown staff member when the gabapentin was administered, and the staff member gave them times that seemed too close together. They stated they had not brought their concerns about gabapentin time administration with the administration. The family stated Resident #1 was no longer at the facility. During an interview on 5/16/2025 at 3:27 p.m., LVN A stated on 5/01/2025 she administered Resident #1's medication on time during the administration window. She stated on that day, the computer kept crashing and kicking her out. She stated she was keeping track of the medication administration on a piece of paper, which she stated, she later documented in the electronic medical record. LVN A stated she did not mark the correct time of the medication administration on the medical record. She stated she did not think about changing the entry time when she documented or marking it as a late entry. LVN A stated she was trained to mark medication administration at the time it was given. During an interview on 5/16/2025 at 4:03 p.m., the DON stated her expectation of staff was to notify the ADON on the floor and to notify her (DON) if they were having issues on the floor with the computer or medication administration. She stated the staff should let the management know if a time was documented incorrectly in the medical record so it could be corrected to ensure they know exactly when medication was administered. Record review of the facility's policy titled Medication Administration Schedule undated revealed the facility utilized liberalized med pass times with morning med pass occurring between 7:00 am-10:00 am. The policy did not address documentation. Record review of the facility's policy titled Medication Administration: General Guidelines dated January 2023 revealed: Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 2 of 2 elevators reviewed for essential equipment. The facility failed to ensure elevators #1 and #2 were functioning properly. This failure could place residents at risk of not having functional and safe mode of travel from floor to floor. The findings included: Record review of Elevator #1's Texas Department of Licensing and Regulation revealed last known annual inspection was 7/24/2024 and the hydraulic elevator passed inspection. Record review of Elevator #2's Texas Department of Licensing and Regulation revealed last known annual inspection was 7/24/2024 and the hydraulic elevator passed inspection. Record review of elevator service calls documented [elevator repair company portal] from 5/21/2024 to 5/15/2025 revealed a total of 25 service calls of which 4 were related service calls: -5/15/2025 3:54 pm (after surveyor intervention) elevator 1, Jumping very hard 1 of 2 with resolution documented as checked operation pit/cylinder/packing. -4/30/2025 customer says the elevator in service but it's still bouncing and traveling extremely slow 2 of 2 with resolution documented as checked operational care in-service. -12/13/2024 elevator 2, Bouncing, still in service with resolution documented as reset. -9/26/2024 stuck 1st floor, doors closed, keep on bouncing up and down-reoccurring issue with resolution documented as checked operation. During an observation on 5/15/2025 at 3:00 pm of elevator #2, while riding from the first floor to the second floor with an unknown staff member, the elevator bounced multiple times before coming to a stop on the intended floor. The unknown staff member patted the wall and said, Good old [NAME], and indicated that was normal for the elevator. During an observation on 5/15/2025 at 3:05 p.m., elevator #2 was noted with one minimal bounce upon decent when the elevator car approached the floor. On accent the elevator car bounced 9 times when ascending from floor 1 to 3. The elevator car descended from the 2nd to 3rd car with creaking, groaning, and popping heard but no bounce. On a second run elevator #2 bounced 12 times with very noticeable movement up and down as it approached the 2nd floor from the 1st floor. No inspection was posted in this elevator. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/15/2025 at 3:08 p.m., elevator #1 bounced 6 times when it approached the 2nd floor from the 1st floor and 5 times from the 2nd to 3rd floor. No inspection was posted in this elevator. During an observation on 5/16/2025 at 3:35 p.m. elevator #1 and elevator #2 were utilized to observe for bouncing and noises. Elevator #2 bounced 10-11 times before coming to a rest when going up. Elevator #1 bounced 5-7 times before coming to a rest when going up. No noises were heard during this test. The elevators were taken up and down several times to observe operation. During an interview on 5/15/2025 at 3:19 p.m., the Maintenance Director stated one of the shocks for the elevators was not working and it was a known issue for an unknown period of time. He stated he could not turn elevator #2 off as it would cause the other elevator to get hot. He stated elevator 2 had the worst bounce issue. He stated approximately two-weeks prior, the elevator company had been out to service the elevators. He stated they reset the elevators with their computers, and they were waiting for parts but the reset had not fixed the issue. The Maintenance Director stated he did have the annual inspections in an office and noted the inspections were due next month. He stated he did not document service calls or repairs and did not have any invoices for repairs or parts ordered. During an interview on 5/15/2025 at 3:24 p.m., the elevator repair company declined to give a history of maintenance or service calls/repairs on the elevators for the facility. They stated they would notify the account representative who would get in contact with the facility to provide the information. During an interview on 5/16/2025 at 1:22 p.m., the Maintenance Director stated he had reviewed the ticket history of the elevators. He stated the repair company come out and adjusted both elevators with their computer on 4/23/2025. He stated the adjustment fixed the issue. He stated later he noted the elevators were doing it again. He stated he did not notice the elevators bouncing as much until yesterday (5/15/2025) when the surveyor brought it to his attention. He stated he then notified the repair company again; they came back to the facility (after surveyor intervention) and had them open up the elevators to evaluate and noted that the packing on the elevators hydraulic system needed to be replaced. The Maintenance Director stated replacing the packing on a hydraulic elevator was a lot of work. He stated he was now waiting on a bid to fix the hydraulic lines. He stated the repair company looked at the hydraulics for both elevators but only one, elevator #2 needed to be replaced. He stated the issue was the elevators worked together and when there was an issue with one elevator it affected both. He stated he could not shut off one elevator because it would cause the second elevator to overheat. He stated when they overheat, they stop working. He stated they are too hot if their oil temperature is over 160-170 F. He stated he takes the temperatures of the returns to monitor. The Maintenance Director stated they always have issues with the elevators. He stated one employee with an unknown name notified him of the elevator bounce on an unknown date. He stated he must get approval before any elevator repairs can be authorized by Corporate. The Maintenance Director stated the elevators were needed to transport residents in and out of the facility. He stated he was not aware of any resident injuries related to the elevators. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/2025 at 3:51 p.m., the DON stated both elevators had been bouncing for a couple of months now. She stated the facility had people come out and look on it (unknown date). She stated the residents did utilize the elevators. She stated the risk of the bouncing was someone could fall. She stated they had not had that happen and there were no facility injuries from the elevators. Record review of the facility's policy titled Proper maintenance on Elevators last revised August 2022 revealed: If elevator is deemed inoperable by competent person elevator will be shut down and service ticket will be open with [elevator repair company]. The policy did not address car movement or bouncing.