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	04/03/2026

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. Based on observation, interview, and record review the facility failed to ensure, in accordance withˆstate andˆfederal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 1 treatment carts (TC #1) reviewed for medication storage.ˆ ˆ The facilityˆfailed toˆensure the treatment cart in the public area was locked on 3/25/26.ˆˆ ˆ This failure could place residents at risk of medication misuse and drug diversion.ˆ ˆ Findings included:ˆ ˆ During observation on 3/25/26 at 1:38 pm, TC #1 wasˆobservedˆto beˆunlocked and unattendedˆon the 100 hall by the state investigator. Further observation revealed the resident room the TC was in front of was closed. Observation revealed wound cleanser, iodine, and wound care supplies in the drawers of TC #1. There were 3 staff in black uniforms assisting residents in the hallway and the TC was not within view of the nurses' station. During an interview on 3/25/26 at 1:40 pm RN A said he had only gone inside the resident's room for 2 minutes. RN A further stated he was not supposed to leave TC #1 unlocked because there were treatments and medication in the cart. RN A further stated it was important that unattended carts be locked when unattended because a resident may go in the cart and access the contents. During an interview on 3/26/26 at 1:04 pm PTA C said the facility therapists wore black uniforms. ˆ During an interview on 4/2/26 at 4:12 pm, ADON B said treatment carts were supposed to be locked because there were scissors, and medications in the carts that may be dangerous to guests, staff, and residents. ADON B said the facility had a lot of people walking around, and the treatment cart should be treated just like a medication cart. ADON B further stated whoever was assigned the cart was responsible for ensuring it was locked when unattended, but that any staff can lock medication cart if they were seen unlocked when unattended. The DON was not available during the investigation. ˆ Record review of the facility's policy titled, Medication Storage dated 2007, revealed: .Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.

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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(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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Resident #3 and Resident #5) reviewed for infection control. The facility failed to ensure RN D followed Enhanced Barrier Precautions when providing wound care to Resident # 3 on 3/26/26. The facility failed to ensure RN D followed Enhanced Barrier Precautions when providing wound care to Resident #5 on 3/26/26. The facility failed to ensure RN D followed infection control practices when providing wound care to Resident #3 on 3/26/26. The facility failed to ensure RN D followed infection control practices when providing wound care to Resident #5 on 3/26/26. These failures could affect all residents who require wound care, placing them at risk for infection. Findings included: 1. Record review of Resident #3's admission Record, dated 4/2/26, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Osteomyelitis (serious infection of the bone), muscle weakness, and need for assistance with personal care. Record review of Resident #3's Care Plan, dated 2/17/26, revealed the resident had actual impairment to skin integrity. Further review revealed interventions included Follow facility protocols for treatment of injury. Record review of Resident #3's Order Summary, dated 4/2/26, revealed orders for: Wound care to coccyx area as follows: Cleanse with NS on gauze, pat dry with gauze, apply nickel thick Santyl ointment (a prescription ointment used to remove dead tissue form skin ulcers)and gently pack with hydro [NAME] blue (an antibacterial foam dressing that provides protection against bacteria), cover with foam dressing q daily and PRN, dated 2/17/26. Further review of this document revealed an order for Enhanced Barrier Precautions, dated 2/10/26. Observation of wound care for Resident #3's coccyx area, on 3/26/26 beginning at 11:45 am, revealed RN D entered Resident #3's room without donning a gown and proceeded to perform wound care to the resident's coccyx area. Further observation revealed there was no EBP sign or PPE outside the resident's room. 2. Record review of Resident #5's admission Record, dated 3/31/26, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: surgical aftercare following surgery on the circulatory system, sepsis (life-threatening complication of an infection), muscle weakness, and need for assistance with personal care. Record review of Resident #5's Care Plan, dated 3/11/26, revealed the resident was on Enhanced Barrier Precautions related to wounds. Record review of Resident #5's Order Summary, dated 3/31/26, revealed orders for: Wound care to coccyx area as follows: Cleanse with NS, pat dry with gauze, apply betadine to peri wound, nickel thick Santyl ointment (a prescription ointment used to remove dead tissue form skin ulcers) and calcium alginate (highly absorbent wound dressing) to wound bed, cover with foam dressing q daily and PRN, dated 3/20/26; Wound care to left and right groin surgical incision as follows: Cleanse with Dakins 1/4 solution, pat dry with gauze, apply betadine to peri wound, nickel thick Santyl ointment (a prescription ointment used to remove dead tissue form skin ulcers) nystatin powder (antifungal medication), and calcium alginate (highly absorbent wound dressing) to wound bed, cover with dressing q daily and PRN, dated 3/31/26 Observation of wound care for Resident #5's coccyx area and groin areas, on 3/26/26 beginning at 11:15 am, revealed RN D entered Resident #5's room without donning a gown and proceeded to perform wound care to the resident's coccyx and groin areas. Further observation revealed there was no EBP sign or PPE outside the resident's room. During an interview on 3/26/26 at 12:34 pm, RN D said EBP were required when she provided wound care and would have to wear gown, gloves, mask and perform hand hygiene depending on what the protocols were. RN D further stated she had not been told she had to donn PPE for wound care unless the wound was infected and the resident was on isolation for the wound. RN S said it was important to follow EBP during wound care to prevent the spread of infection into the wounds or have bodily fluids get on the staff and spread to other (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. Observation of wound care for Resident #3's coccyx area, on 3/26/26 beginning at 11:45 am, revealed RN D cleaned Resident #3's wound, applied treatment, packed the wound, and applied foam dressing without performing hand hygiene or changing gloves after cleaning the wound and before applying treatments and dressing. Observation of wound care for Resident #5's groin areas, on 3/26/26 beginning at 11:15 am, revealed RN D cleaned the wound to right groin then the left groin without removing gloves, performing hand hygiene, and donning clean gloves between areas. Further observation revealed RN D applied treatments and dressing to the right groin, without removing gloves, performing hand hygiene and donning clean gloves. RN D then applied treatment and dressing to the wound to the left groin without performing hand hygiene and still wearing the same gloves. During an interview on 3/26/26 at 12:34 pm, RN D said she was required to change gloves and perform hand hygiene when going form dirty to clean, adding she was expected to remove her gloves, perform hand hygiene, and donn clean gloves after cleaning a wound. RN D further stated she was expected to change gloves and perform hand hygiene when going from one wound to another. RN D said she had not realized that she did not change gloves when going from wound to wound during Resident #5's wound care. RN D said this was important to prevent the spread of infection, contamination, and the safety of the residents. RN D further stated all staff were responsible for infection control. During an interview on 4/2/26 at 4:12 pm, ADON B said EBP were required anytime there were tubes extending from outside of the body to the inside and wounds. ADON B further stated it was everyone's responsibility to follow EBP. ADON B said it was important to follow EBP to protect the staff and the residents from any organisms that may cause infections. ADON B said staff were expected to perform hand hygiene anytime gloves have been soiled. ADON B further stated once a wound had been cleaned, staff should remove their gloves and perform hand hygiene, gloves should be removed and hands sanitized before applying treatments and dressings. ADON B said this was important for infection control, to prevent cross contamination. The DON was not available during the investigation. Record review of the facility's policy titled Hand Hygiene, revised April 2023, revealed: .Hand-washing may also be used for routinely decontaminating hands in the following clinical situations.After removing gloves.If hands are not visibly soiled, an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situations.After removing gloves.Change gloves during resident care if moving from a contaminated body site to a clean body site. Decontaminate hands after removing gloves by appropriate hand hygiene. Record review of the facility's policy titled Wound Policy & Procedure last revised 05/2023, revealed: .General infection control practices are maintained during wound care and dressing changes. Record review of the facility's policy titled Enhanced Barrier Precautions dated March 2024, revealed: Policy: This facility follows recommendations and guidance from the Centers for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI).Enhanced Barrier Precautions (EBP) are implemented as one intervention this facility uses to reduce transmission of resistant organisms that employs targeted Personal Protective Equipment (PPE) use during high contact resident care activities.EBP is used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP will be used for any residents in this facility who meet the stated criteria wherever the resident resides in the facility.residents with the following conditions require EBP for all cares and services regardless of MDRO colonization status: Wounds including any skin opening requiring a dressing regardless of MDRO colonization status. Record review of the facility's policy titled Infection Control last revised May 2024, revealed: .Perform hand hygiene.Immediately after touching blood, body fluids, non-intact skin, mucous membranes or contaminated items (even when gloves are worn during contact), immediately after removing gloves, when moving from contaminated body sites to clean body sites during resident care.