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	08/15/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923 Based on interviews and record reviews, the facility failed to deliver the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being for 3 of 30 Residents (Resident # 201, Resident # 67, and Resident # 203 who were reviewed for call light response in that: The facility failed to deliver timely call light response for Resident #201, Resident # 67, and Resident # 203. This deficient practice could affect residents who receive care at the facility and could result in missed or inadequate care. The findings were: Record review of Resident #201's face sheet dated 8/15/24 revealed Resident # 201 was admitted on [DATE] with diagnoses of fusion of spine (a surgical procedure to correct problems with the spine, type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar), and adult T-cell lymphoma (a cancer of the immune system). Record review of Resident # 201's Admission MDS assessment dated [DATE] revealed that Resident # 201's BIMS score was not documented. Record review of Resident # 201's care plan initiated on 8/13/24 revealed Resident # 201 was at risk for falls and incontinence. Record review of Resident #67's face sheet dated 8/15/24 revealed Resident #67 was admitted on [DATE] with diagnoses of pulmonary embolism (a condition in which there is a blood clot in the lungs), acute respiratory failure (a condition in which the lungs are not operating properly, and severe protein-calorie malnutrition (a condition in which the body does not receive enough protein over a period of time) Record review of Resident # 67's 5-day MDS assessment dated [DATE] revealed a BIMS score of 13 (which indicates the cognition is intact). Record review of Resident # 67's care plan initiated on 8/1/24 revealed Resident# 67 was at risk for falls and incontinence. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 203's face sheet dated 8/15/24 revealed Resident # 203 was admitted on [DATE] with diagnoses of anemia (a condition in which the body does not have enough healthy red blood cells), UTI (a condition in which there was an infection in the body's urinary track), and malignant neoplasm of the endocervix(a condition in which there is cancer in the endocervix). Record review of Resident # 203's 5-day MDS assessment dated [DATE] revealed a BIMS score of 13 (which indicates the cognition is intact). Record review of Resident #203's care plan initiated on 8/2/24 revealed Resident #201 was aat risk for falls and incontinence. During an interview on 8/12/24 at 2:00pm with Resident 201 he stated that in the morning on 8/12/24 he put his call light on when he was feeling nauseous and then he had vomited Resident # 201 stated that it took staff 2 hours to respond to his call light and to clean the emesis in his room. Resident #201 stated that waiting for the staff to respond to his call light and clean the emesis in his room was very upsetting and he was considering self-discharge from the facility. During an interview on 8/12/24 at 2:35pm with OT-E she stated that Resident #201 had spoken with her about his frustration with the call light response for his feeling of nauseous and then having vomited. During an interview on 8/12/24 at 3:00pm with CM-F she stated that Resident #201 had spoken with her about his frustration with the call light response for his feeling on nauseous and then having vomited. During an interview on 8/12/24 at 2:20pm with Resident #67 she stated she had an experience with her room call light within the last several days in which she put her light on in the morning for a toileting need and staff did not respond to her call light until after lunch. During a phone interview on 8/14/24 at 10:00am with a family member of Resident # 67, she stated that she visits Resident #67 often and has observed that it took staff over one hour on several occasions to respond to the room call light. The family member stated that the call light response time was very upsetting. During a group interview on 8/13/24 at 2:00pm Resident 203 stated that since her admission to the facility there have been several occasions in which it took staff 45 minutes to respond to her call light. Resident #203 stated that she felt very frustrated that she had to wait so long for her call light to be answered. Record review of the facility's resident council meeting notes for 7/25/24 revealed that a Resident who was discharged had felt that her call light response needed improvement. Record review of the facility's grievance log revealed a resident grievance dated 8/7/24 in which a Resident who was discharged had felt that staff did not respond well to her call lights. During an interview on 8/15/24 at 10:15am with the DON she stated that her expectation is for staff to respond promptly to resident call lights. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/15/24 at 10:40am with the Administrator, she stated that she reviewed resident council notes and grievances and felt that staff response to resident call lights was done in a timely manner and that there was not a problem in this area. Record review of the facility's Admission Agreement that was undated stated under the Statement of Resident Rights the following: ' The right to live in an environment that promotes and supports each resident's dignity and to be treated with consideration and respect.'

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on interview and record review, the facility failed to conduct an accurate comprehensive assessment of each resident's functional capacity including the resident's needs, strengths, goals, life history and preferences for 1 of 5 Residents (Resident #300) reviewed for assessments. Resident #300's Initial MDS Assessment did not reflect his diagnosis of anxiety. This failure could place residents at risk for not receiving the care and services as needed. The findings included : Record review of Resident #300's Face Sheet, dated 8/15/2024, reflected a [AGE] year-old male resident admitted on [DATE] with diagnosis of encounter for other orthopedic aftercare, infection and inflammatory reaction due to other internal joint prosthesis, and type 2 diabetes mellitus. Record review of physician evaluation note, dated 8/10/2024, reflected that Resident #300 had a diagnosis of Anxiety Disorder, Unspecified and orders for hydroxyzine 25mg put in place to help with anxiety. Record review of Resident #300's Care Plan, dated 8/15/2024, reflected no indication of anxiety disorder or interventions for anxiety symptoms. Record review of Resident #300's Initial MDS assessment dated [DATE], reflected under Section I - Active Diagnosis, subsection Psychiatric/Mood Disorder reflected that Resident #300 did not have any psychiatric/mood disorder, to include anxiety. Interview on 8/15/2024 at 10:14 AM, the DON stated that she did not know why Resident #300's diagnosis of anxiety was not included in their MDS assessment and that the risk to residents could include care related to anxiety not being provided as appropriate. The DON stated they use the RAI manual as their policy for MDS Assessments.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923 Based on interviews and record reviews, the facility failed to develop and implement baseline care plans that included the instructions needed to provide effective and person-centered care within 48 hours of admission for 8 of 25 residents (Residents #77, #99, #100, #102, #106, #149, #150, and #199) that were reviewed for baseline care plans in that: The facility failed to complete (Residents #77, #99, #100, #102, #106, #149, #150, and #199) baseline care plans within 48 hours. This deficient practice could affect residents who receive care at the facility and could result in missed or inadequate care. The findings were: Record review of Resident #77's face sheet, dated 08/15/2024, revealed Resident #77 was admitted to the facility on [DATE] with diagnoses which included: acute and chronic respiratory failure with hypoxia, COVID19, pneumonia due to SARS-associated coronavirus, chronic obstructive pulmonary disease, unspecified, acute bronchitis, pulmonary hypertension, unspecified, hypothyroidism, unspecified, depression, unspecified, hypertension, unspecified atrial fibrillation, muscle wasting and atrophy, not elsewhere classified, multiple sites, and scoliosis. Record review of Resident #77's 5-day MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #77's Initial/Baseline Care Plan showed a completion date of 07/29/2024 with a locked date of 07/29/2024. Record review of Resident #99's face sheet, dated 8/14/2024, revealed Resident #99 was admitted to the facility on [DATE] with diagnoses which included: Sepsis-unspecified organism, Bacteremia, MSRA infection-unspecified site, acute pulmonary edema, anemia in chronic kidney disease, hypothyroidism, essential (primary) hypertension, end stage renal disease, repeated falls, and dependence on renal dialysis. Record review of Resident #99's 5-Day MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #99's Initial/Baseline Care Plan showed an initiation date of 08/12/2024 and completion of 08/14/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #100's face sheet, dated 08/15/2024, revealed Resident #100 was admitted to the facility on [DATE], with diagnoses which included: Displaced comminuted fracture (broken bone that has at least two breaks) of right patella (kneecap)-subsequent encounter for closed fracture with routine healing, encounter for other orthopedic aftercare, pain due to internal orthopedic prosthetic devices, implants, grafts, subsequent encounter, psoriatic arthritis mutilans (a severe form of arthritis that causes severe damage to joints), depression - unspecified, essential tremor, essential (primary)hypertension (high blood pressure), and unspecified asthma (condition in which airways narrow and swell and may produce mucus). Record review of Resident #100's 5-Day MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #100's Initial/Baseline Care Plan showed an initiation and completion date of 08/14/2024. Record review of Resident #102's face sheet, dated 08/15/2024, revealed Resident #102 was admitted to the facility on [DATE] with diagnoses which included: Encounter for surgical aftercare following surgery on the genitourinary system, acquired absence of kidney, chronic obstructive pulmonary disease (lung disease that blocks airlfow making it difficult to breathe)-unspecified, depression-unspecified, peripheral vascular disease - unspecified, spinal stenosis (narrowing of spine) - site unspecified, hyperlipidemia (high levels of fat particles in blood) - unspecified, and essential (primary) hypertension (high blood pressure). Record review of Resident #102's 5-Day MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated intact cognitive response. Record review of Resident #102's Initial/Baseline Care Plan showed an initiation and completion date of 8/13/2024. Record review of Resident #106's face sheet, dated 8 /15/2024, revealed Resident #106 was admitted to the facility on [DATE] with diagnoses which included: Fournier Gangrene, acute and subacute infective endocarditis, MRSA infection as the cause of diseases classified elsewhere, severe sepsis with septic shock, Type2 Diabetes Mellitus with hyperglycemia, anemia - unspecified, major depressive disorder - single episode unspecified, epilepsy - not intractable without status epilepticus, essential (primary) hypertension, cardiomyopathy-unspecified, cerebral ischemia, atherosclerotic hear disease of native coronary artery without angina pectoris, and paroxysmal atrial fibrillation. Record review of Resident # 106's 5-day MDS assessment dated [DATE] revealed a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #106's Initial/Baseline Care Plan showed a completion date of 8/14/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #149's face sheet, dated 08/15/2024, revealed Resident #149 was admitted to the facility on [DATE] with diagnoses which included: encounter for surgical aftercare following surgery on the circulatory system, atherosclerosis of native arteries of extremities with intermittent claudication, left leg, pain due to vascular prosthetic devices, implants and grafts, subsequent encounter, unspecified chronic bronchitis, type 2 diabetes mellitus with hyperglycemia, bipolar disorder, current episode mixed, moderate, hyperlipidemia, depression, essential (primary) hypertension, chronic kidney disease, stage 3 unspecified, and post-traumatic stress disorder, chronic. Record review of Resident #149's Admission MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated intact cognition. Record review of Resident #149's Initial/Baseline Care Plan showed a completion date of 08/08/2024 with a locked date of 08/08/2024. Record review of Resident #150's face sheet, dated 08/15/224, revealed Resident #150 was admitted to the facility on [DATE] with diagnoses which included: muscle wasting and atrophy, not elsewhere classified, multiple sites, depression, epilepsy, unspecified, not intractable, without status epilepticus, insomnia, hereditary and idiopathic neuropathy, unspecified, dysphagia following cerebral infarction, peripheral vascular disease, unspecified, personal history of traumatic brain injury, presence of neurostimulator, presence of cerebrospinal fluid drainage device, and hypothyroidism, unspecified. Record review of Resident #150's 5-day MDS assessment dated [DATE], revealed a BIMS score of 99, which indicated unable to participate with BIMS. Record review of Resident #150's Initial/Baseline Care Plan showed a completion date of 08/13/2024 with a locked date of 08/13/2024. Record review of Resident #199's face sheet dated 08/14/24 with recent admitted [DATE] and diagnoses which included: displaced fracture of the left tibia (a left broken shinbone), sepsis (an infection in the blood), and malignant neoplasm of the breast (breast cancer) Record review of Resident #199's 5-day Medicare MDS, completed on 8/14/24, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #199's Baseline Care Plan shows an initiation and completion date of 8/13/24. During an interview with LVN-MDS-C on 08/14/24 at 2:25 p.m., she confirmed that the baseline care plan for Resident # 199 was not done within the required time frame of 48 hours after admission. The MDS Coordinator stated that having the baseline care plan completed within the required time frame was important for resident needs to be met. During an interview with the DON on 8/14/24 at 3:00 p.m., she stated that the time frame for completion of the baseline care plan for Resident # 199 was not met. The DON stated that having the baseline care plan completed within 48 hours of the admitted would help ensure that the resident needs were met. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/2024 @ 10:01a.m., the DON stated the initial/baseline care plans for Residents #99, #100, #102 and #106 were not completed within the required time frame of 48 hours. The DON further stated she was responsible for the completion of the initial/baseline care plans, and with her other job duties, she just couldn't get it all done in time. The DON stated the care plans are important to identify and help ensure residents' needs are met. During an interview on 08/15/2024 at 1:55 p.m. the DON stated regarding the initial/baseline care plans for Resident #77, Resident #149 and Resident #150 she was not sure what had happened, and they were missed. The DON further stated she was responsible for the completion of the initial/baseline care plans, and they are supposed to be done within 48 hours from the admission of the patient. The DON stated the care plans important for the nurses, so they knew how to take care of the patients. Review of the facility policy and procedure titled, Care Plans, revision/reviewed dates November 2018, 11/2019, 11/2020, 09/2021, 10/2022, 04/2023, revealed, Policy: A baseline care plan is developed for each resident upon admission, but not later than 48 hours of admission, to the facility. This care plan includes minimum healthcare information necessary to properly care of the resident. 33866 44020

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44020 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the kitchen. The facility failed to ensure osmolite (a tube feeding formula) was disposed of after its best-by date. The facility failed to ensure staffs facial hair was covered by a hair restraint. The facility failed to ensure trays, insulated plate lids, and insulated plate bases were air dried prior to stacking them with water droplets resulting in being wiped dry with a hand towel during meal prep. The facility failed to ensure dietary staff used proper hand hygiene during meal preparation. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 08/12/2024 at 3:20 PM, revealed 4 8 fl. oz. closeable cartons of Osmolite with a best-by date on the top of the carton of 1FEB2024 in the 3rd floor nutrition fridge. Interview on 8/12/2024 at 5:00 PM, the DON stated that there should be no Osmolite in any nutrition fridge after its best-by date. Observation and interview on 08/14/2024 at 10:15 a.m. revealed the [NAME] was not wearing a facial hair restraint as he crossed the kitchen carrying a bag of fried onions for the green beans he was prepping for lunch. The [NAME] then left the kitchen area and went to the back in which he returned wearing a facial hair restraint over his beard with his mustache exposed. The [NAME] stated he was not wearing a beard guard initially because he had just returned from his break. The [NAME] further stated he did not know his mustache needed to be covered. The [NAME] stated facial hair (beard restraints) restraint were worn so hair did not fall in the food and contaminate it. Observation and interview on 08/14/2024 at 10:25 a.m. revealed Server A was setting up dishes to be washed in the dishwasher and then pulling dishes from the dishwasher while wearing a facial hair restraint only covering his beard but not his mustache. Server A stated he did not believe it was supposed to cover his mustache. Server A further stated the use of the beard restraint was so hair did not fall out onto the dishes when washing or the food when preparing it. Server A stated by not wearing a beard restraint it could cause cross contamination and it could cause the patient to get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/14/2024 at 10:30 a.m. the EXC stated staff when they were around food or dishes should be wearing hair restraints. The EXC further stated hair restraints in general were good hygiene, kept hair away from the face so staff were not tempted to touch their face or hair, kept hair from falling in food or on dishes preventing cross contamination. During an interview on 08/14/2024 at 4:46 p.m. the Dietician stated staff when in the kitchen if they have facial hair should wear beard restraints. The Dietician further stated she had mentioned this to the kitchen staff in the past. The Dietician stated beard guards keep hair from getting in the food which could cause cross contamination. Observation on 08/15/2024 at 11:22 a.m. revealed the EXC drying trays with a hand towel as she was prepping the trays for lunch meal service. The stacked trays, insulated plate lids, and insulated plate bases were observed to have droplets of water on them. Observation on 08/15/2024 at 11:26 a.m. revealed the [NAME] preparing plates for lunch wearing gloves as he prepared crispy chicken patty sandwiches to place on trays. The [NAME] left the kitchen to get salad from the refrigerator upon his return, he moved a bag of buns to the side with gloved hands, pulled the wrap back to cut a cucumber placed it on the salad, then proceeded to get diced tomatoes out of a container with his gloved hand, placed tomatoes on salad, then continued to make the chicken sandwiches, getting bags of buns, taking buns from bags with his gloved hand, prepped another salad which needed boiled eggs, grabbed with his hand the boiled egg slices from another salad and placed on the salad, then grabbed shredded cheese from a bag with his hand and placed on salad, covered the salad, then placed it on a tray. The [NAME] continued to prepare lunch plates by grabbing an insulated plate base which had a droplet of water on it, wiped it dry with a white hand towel which had been sitting on the counter, proceeded to place plate on the insulated plate base, prepped meal, and then wiped off an insulated lid placing it on top of the plate. During this observation the [NAME] did not stop to wash hands and did not change his gloves. During an interview on 08/15/2024 at 11:36 a.m. the [NAME] stated he should have changed gloves due to it was cross contamination by not changing his gloves. During an interview on 08/15/2024 at 11:38 a.m. the EXC stated the cook should have washed his hands and changed gloves due to it was cross contamination by touching other items during the plate prep. The EXC further stated the water droplets on the trays, insulated lids and bases for the plates should have been completely dry and using the rag could cause contamination of the trays, bases, and lids. During an interview on 08/15/2024 at 1:44 p.m. GM stated the cook should have used utensils (tongs). The GM further stated hand washing should have been done and by not changing gloves or washing hands could cause cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility's policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, not dated, read Policy Statement: Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation, 6. Employees must wash their hands: c. whenever entering or re-entering the kitchen: g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. 9. Food service employees will be trained in proper use of utensils such as tongs, gloves, deli paper, and spatulas as tools to prevent foodborne illness. 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-402 Hair Restraints, 2-402.11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 47564

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to establish and 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 infection for 2 of 11 residents (Residents #89 and #204) reviewed for infection control and for residents who eat in their rooms in halls, in that: 1. RN-E did not sanitize glucometer in between uses with Residents #204 and #89, or after leaving Resident's #89 room, who was on droplet precautions. 2. RN-E failed to wash or sanitize his hands between glove changes before administering medications to Resident #204 and Resident #89. RN-E failed to wash or sanitize his hands when entering or exiting Resident #89's room, who was on droplet precautions. 3. Server B during meal pass did not sanitize hands between trays when entering and exiting resident rooms. These deficient practices could place residents at risk for infection due to improper care practices. The findings include: 1. Record review of Resident's #204's face sheet, dated 08/15/2024 revealed an admitted [DATE] with diagnoses which included: Endocarditis (infection of heart valve), valve unspecified; bacteremia (bacterial infection of blood); Type 2 Diabetes Mellitus (problem in way body regulates and uses sugar (glucose) as fuel) and Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone). Record review of Resident #204's physician orders dated 08/15/2024 revealed an order for HumaLOG Solution 100 UNIT/ML (Insulin Lispro (Human)) inject per sliding scale . Record review of Resident #89's face sheet dated 08/15/2024 revealed an admitted [DATE] with diagnoses which included: Arthritis due to other bacteria, right knee (Joint inflammation); acute kidney failure (condition in which the kidneys can't filter waste from the blood); sepsis (serious condition in which the body responds improperly to an infection); morbid obesity (a disorder involving having too much body fat which increases risk of health problems), hypothyroidism-unspecified (condition in which the thyroid gland doesn't produce enough thyroid hormone), and essential (primary) hypertension (high blood pressure). Record review of Resident #89's physician orders dated 08/14/2024 revealed an order for Diabetic: accucheck before meals and at bedtime and Strict one room droplet isolation with all services provided in room alone. (continued on next page)

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	676447	A. Building B. Wing	08/15/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #89's Care Plan dated 07/29/2024 revealed Focus- Covid Positive Date initiated: 08/14/2024 and under interventions for the Focus area: Dedicated equipment will be used whenever possible. When not, thoroughly disinfect equipment between residents, using EPA-registered disinfectant for Use Against SAR-CoV-2. Observation on 08/14/2024 between 12:09pm and 12:19pm revealed RN-E checked the blood glucose reading of Resident #204 and then without sanitizing the glucometer, entered Resident #89's room, which had a Droplet Precautions sign posted on door and PPE supplies just inside the door. After donning PPE, RN-E checked Resident #89's blood glucose reading with that same glucometer. Upon exiting Resident #89's room, RN-E removed his PPE and gloves, then placed the glucometer on the top of his medication cart, entered data into his computer, and without sanitizing the glucometer or medication cart surface, started moving down the hall to continue medication administration. During an interview with RN-E on 8/14/2024 at 12:26PM, RN-E confirmed he used the same glucometer for Residents #204 and Resident #89 to check their blood glucose readings and did not sanitize the glucometer before and after each resident but stated he should have, especially since Resident #89 was on droplet precautions. RN-E stated he should have used the disinfecting wipes to sanitize the glucometer in between uses but had forgotten to stock his medication cart with the container of disinfecting wipes that morning and did not have it available. RN-E stated that his failure to sanitize the glucometer in between uses with residents could spread germs. During an interview on 8/15/2024 at 10:10 am, the DON confirmed RN-E should have sanitized the glucometer with the disinfecting wipes and allowed it to dry 3-5 minutes in between uses with different residents, and before entering and after exiting a room where droplet precautions were in place, to prevent cross-contamination and outbreaks of disease. 2. Observation on 08/14/2024 between 12:09pm and 12:19pm revealed RN-E, while administering medications, did not wash or sanitize his hands before entering Resident #204's room, donned gloves to conduct accu-check, and then after removing gloves did not wash or sanitize his hands upon exit or before entering Resident #89's room. Resident #89's room had a Droplet Precautions sign posted on the door and PPE supplies just inside the door. RN-E was observed to put on gown and gloves at the entrance to room to administer accu-check for Resident #89. Upon exiting Resident #89's room, RN-E removed his PPE and gloves just inside the door but did not wash or sanitize his hands after exiting. During an interview with RN-E on 08/14/2024 at 12:26PM, RN-E confirmed he did not wash or sanitize his hands in between medication administration for Residents #204 and #89, or in between glove changes between the 2 residents. RN-E stated that his failure to sanitize his hands in between residents could spread germs. During an interview on 08/15/2024 at 10:10 am, the DON confirmed RN-E should have washed his hands either manually or with alcohol in between working with each resident and between glove changes to prevent cross-contamination and outbreaks of disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation and interview on 08/14/2024 at 12:54 p.m. revealed Server B passing trays on 100 hall from the meal cart wearing gloves on her hands. Server B while passing lunch trays was observed pushing the cart, opening the door to the cart, pulling trays out, knocking on doors, opening doors to rooms, and closing the room doors by using doorknob. Server B passed approximately 7 trays and entered rooms and exited rooms without changing gloves and without washing hands. Server B stated she was wearing the gloves due to having acrylic nails. Server B further stated she should have sanitized her hands between rooms even though she was wearing gloves. Server B stated hands are supposed to be always sanitized when passing trays whether the person has gloves on or not. Server B stated, it keeps the germs down. During an interview on 08/15/2024 at 1:44 p.m. the GM stated staff don't really need to wear gloves when passing trays. The GM further stated staff should sanitize hands when going in a room and when coming out of the room when passing trays. The GM stated this is part of infection control. Review of facility policy, titled Infection Control Policy, dated July 2020, revealed hand hygiene is to be performed before and after contact with a resident and immediately after removing gloves and that for droplet precautions, wash hands with antimicrobial soap before entering room and after leaving room and remove gloves before leaving resident's environment and wash hands immediately with antimicrobial soap. Further review reveals blood glucose meters will be cleaned and disinfected prior to and after each use . and if use of common equipment or items is unavoidable, adequately clean and disinfect before use for any other resident with chemical agent approved for use on the identified microorganism. Review of facility's policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, not dated, read Policy Statement: Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation, 10. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing. 44020

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923 Based on observations, interviews, and record reviews the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities, for 1 of 30 residents (Resident #79) reviewed for call light accessibility and functionality, in that: On 07/09/2024 at 01:00 PM Resident #79 utilized his call light which did not illuminate the nurse call light directly outside of and above of his room door. This failure could place residents at risk for harm by not receiving care and attention when their nurse call light system malfunctions and or is out of reach. The findings included: A record review of Resident #79's admission record dated 08/15/2024 revealed an admitted [DATE] with diagnoses which included acute kidney failure (the kidney was not functioning correctly), type 2 diabetes mellitus (a condition in which the body's blood sugar is not controlled), and primary hypertension (a condition in which the force of blood against the artery walls is too high). A record review of Resident #79's 5-day Medicare MDS assessment dated [DATE] revealed Resident #79 with a BIMS of 10 (indicating moderate cognitive impairment) A record review of Resident #79's care plan dated 7/18/24 revealed, Resident #79 had care needs of decreased vision, hard of hearing, and fall risk. During an observation and interview on 08/12/24 at 11:00am resident #79 stated that his bathroom call light was not working and he was not sure how long it had been inoperable. Resident #79 stated that he worried about the call light in the bathroom not working as he had recently fallen in his room. Observation revealed the bathroom call light cord when pulled did not activate the room's call light to alert the nurses station. During an interview on 08/12/24 with LVN-D at 11:05am she stated that she had just started working on the resident hallway and was not aware that Resident 79's bathroom call light was not working. During an interview on 08/12/2024 at 11:10 am the maintenance director stated he was not aware the call light for Resident #79's room was not working and had not received a work order request to fix it. The Maintenance Director upon further observation confirmed that the wiring for the bathroom call light had become disconnected from the room's call light device making it inoperable. The Maintenance Director completed the repair of the call light device. He stated that having the call light device working properly was important for resident needs to be met and in the case of an emergency. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A record review of the facility's policy on Preventative Maintenance dated 05/24 stated that preventative maintenance is to be completed in accordance with all state and federal requirements. A record review of the facility's policy on Call Light Outage date 04/23 stated that should a staff member find a call light not to be working, they will immediately notify maintenance to replace the call light.