

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort San Antonio, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for 1 of 1 facility reviewed for competent staffing. The facility failed to complete annual performance reviews for CNAs employed by the facility for 1/1/2025 through 9/1/2025. This failure could lead to incompetent staff and improper care to residents. Findings included: Record review of the facility staff roster provided by the HR Dir on 9/23/2025 reflected 35 CNA staff members. Of the 25 CNAs, 25 were eligible for an annual performance review in that they had been employed by the facility for over one year and had a month of hire occurring from January through September. In an interview with HR Dir. on 9/24/2025 at 8:35 AM, she stated the facility did not have a formal process for annual reviews. She said informal, periodic performance evaluations were completed by the nursing managers and issues were addressed as they occurred. She said the performance evaluations were not documented. In an interview with CNA C on 9/24/2025 at 9:03 AM, she said she had worked at the facility for 6 years. She said she had not participated in an annual performance review with the nursing leadership. In an interview with the DON on 9/24/2025 at 9:20 AM, she said there is not a formal, annual performance review process. She said the ADONs will meet with staff members and take notes on any concerns, and they use the notes to determine any training needs. She said the notes taken during any meetings with staff about performance were not documented in the employment records. Record review of the facility policy titled Performance Evaluation (undated, received 9/24/2025) revealed the following: In order to satisfactorily complete your duties and responsibilities, communication and constructive feedback are key parts in doing so. Employees of [facility] will be evaluated on their anniversary date. Between scheduled evaluations, informal performance discussions may be held between you and your supervisor to discuss your performance.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the resident environment remained free of accident hazards as is possible for 1 of 1 laundry departments (2 of the 3 dryers) reviewed for fire hazards. The facility failed to clean out the lint from the 2 commercial dryer's interiors for a year. This failure could place residents at risk for a potential fire. The findings included: During an observation on 9/23/2025 at 2:41 PM revealed the facility's laundry department had 2, natural gas fueled, commercial dryers. The mechanical back of the dryers were housed in an enclosed room accessed by a wood frame door. Observation of the room revealed the back of the dryers which included electrical connections, natural gas connections, and electrical motors with pulleys and rubber belts. Further observation revealed the dryers were operating and the flames from the burners used to heat the air could be visualized inside the machines. Further observation revealed a layer of dust / lint lining the interior of the machines, the exterior of the machines, and covered the electrical motors which drove the machines clothing tumblers. During an interview on 9/23/2025 at PM Laundry Aide P stated she cleaned the lint from the front side of the commercial dryers everyday but had not been assigned to clean out the back of the machines. During an observation and interview on 9/24/2025 at 9:10 AM the Maintenance Director toured the laundry department and stated he was also the laundry department supervisor. The Maintenance Director stated the commercial dryers had their mechanical rears enclosed in a room accessed by a door directly behind the dryers. The Maintenance Director demonstrated the door and reviewed the room which housed the dryers. The Maintenance Director stated the machines were covered with a layer of lint / dust throughout the interior and exterior of the machines. The Maintenance Director stated the machines had not been cleaned out from their rear in the past year. The Maintenance Director stated the machines needed to be cleaned out immediately and suspended their use. During an interview on 9/24/2025 at 1:00 PM the Maintenance Director stated he had dismantled the dryers and cleaned them of their lint dust and had placed them back in service. The Maintenance Director stated he would add the task of cleaning the dryers to the facility's monthly tasks and keep documents of their cleaning. The Maintenance Director stated the lint dust build up could possibly contribute to a fire. A policy was requested on 9/24/2024 from the Administrator and as of 9/29/2025 a policy was not provided. A record review of the commercial dryers undated manufactures maintenance manual revealed, Quarterly1. Use a vacuum to clean air vents on drive motors.5. Clean the machine's top panel with mild detergent. Rinse with clean water.6. Models equipped with a fire suppression system: Perform the fire suppression system maintenance test by pressing the test button in the control box. Bi-Annually2. Check gas connections for leakage.6. Remove all front panels and vacuum, .9. Clean burner tubes and orifice area of any lint buildup. Annually1. Remove burner tubes.2. Clean burner tubes using water and a brush. Fire Suppression System (Optional Equipment) Maintenance Test NOTE: Fire suppression system only available on gas and steam models. To ensure proper operation, the fire suppression system must be tested every three months. If the system test does not perform as indicated: 1. Discontinue use of the tumble dryer. 2. Refer to Troubleshooting Manual or contact a qualified service person. 3. Restore the fire suppression system to proper working order before using tumble dryer. Create a maintenance record with a check box for pass, the date and a signature. Store this record in an area where it will not be damaged but is easily accessible to person performing tests. NOTE: Failure to maintain the fire suppression system will void the tumble dryer warranty. NOTE: The auxiliary output is activated during the fire suppression system maintenance test sequence. Confirm [NAME] this fact prior to testing the system every three months. (Example - If the external system uses the auxiliary output to call the fire department, inform the fire department before and after the fire suppression system maintenance test.)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs for 3 of 3 LVNs (ADON A, LVN F, and LVN G) reviewed for staff competency. The facility failed to ensure ADON A, LVN F, and LVN G were competent and trained to provide care for Resident #108's PleurX [a catheter placed in the chest cavity for long-term drainage]. This failure could lead to improper care and complications of Residents' medical care. Findings included: Record review of Resident #108's face sheet, dated 9/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included resistance to vancomycin related antibiotics, malignant pleural effusion [a fluid collection in the space surrounding the lung], and secondary malignant neoplasm of unspecified lung [lung cancer]. Record review of Resident #108's admission MDS, dated [DATE], reflected a BIMS score of 14, indicating intact cognition. Section I0100 indicated Resident #108 had an active diagnosis of cancer, and section OD. of the MDS reflected 0 minutes of respiratory therapy treatments were administered to Resident #108 in the last 7 days. Record review of Resident #108's Order Summary Report dated 9/22/2025 reflected the following active orders: Drain pleurx drain [a catheter inserted into the chest to allow for repeated drainage of fluid] to R-front quad (R-lung) one time a day on even days for drain every other day [sic] (date ordered 9/20/2025, start date 9/22/2025) Record review of Resident #108's care plan report printed 9/22/2025 did not reflect care planning for the PleurX draining procedure. Record review of Resident #108's progress notes reflected nursing documentation indicating Resident #108 was transferred to the emergency department on 9/12/2025 at 12:00 PM for abnormal laboratory results. An additional progress note documented on 9/18/2025 at 6:44 PM reflected Resident #108 returned to the facility and that Resident #108 refused a full skin assessment and weight after arrival. Record review of Resident #108's hospital discharge paperwork dated 9/17/2025 reflected the PleurX catheter had been accessed and drained by hospital staff on 9/16/2025. Record review of a physician's progress note dated 9/19/2025 at 12:00 PM reflected the following: ASSESSMENT AND PLAN:,,,# Lung cancer with mets to throat# squamous cell carcinoma [a type of skin cancer]# recurrent malignant right plural effusion-Plurex drain management by nursing staff, drain as ordered, and PRN, continue lasix, nebs, monitor weights-Follow up oncology and pulmonology [sic] Further record review of Resident #108's progress notes did not reveal documentation from nursing staff accessing and draining the PleurX from 9/18/2025 through 9/22/2025. Record review of Resident #108's September 2025 TAR, dated 9/23/2025, reflected the following:Right pulmonary drain: drain every other day one time a day every other day for pulmonary drain/ edema drain every other day [sic] (order date 9/03/2025 2:46 AM, D/C date 9/15/2025 5:19 PM)9/4/2025 8:00 AM: treatment performed, output documented as XmL (ADON J)9/6/2025 8:00 AM: treatment performed, output 50mL (ADON J)9/8/2025 8:00 AM: treatment performed, output NA (LVN F)9/10/2025 8:00 AM: treatment performed, output 50mL (LVN F)9/12/2025 8:00 AM: treatment performed, output 50mL (LVN F)9/14/2025 8:00 AM: other/see nurse's notes (LVN F)Record review of Resident #108's September 2025 NMAR, dated 9/23/2025, reflected the following:9/18/2025: no order to drain the PleurX9/20/2025: no order to drain the PleurXDrain pleurx drain to R-front quad (R-lung) one time a day on even days for drain every other day (order start 9/22/2025) 9/22/2025 12:00 PM: drug refusedRecord review of Resident #108's documented vital signs for 9/18/2025 through 9/22/2025 reflected no abnormalities in oxygen saturations or respiratory rates. In an observation and interview on 9/21/2025 at 12:34 PM, a coiled catheter was observed to Resident #108's right, lower chest area with a clean, intact dressing dated 9/16/2025. Resident #108 said the catheter had not been accessed since she returned to the facility from the hospital on 9/18/2025. She stated she had been told by multiple unknown nursing staff that (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they could not drain the catheter because they did not know how. She said an unknown staff member had told her yesterday (9/20/2025), that the catheter would be drained today (9/21/2025). Resident #108 said she asked the staff about the draining procedure because she was aware of the physician's order to drain the catheter every other day, and she was aware the schedule was not being followed. She said she did not feel any increase in symptoms even though the catheter had not been drained since before 9/18/2025. Resident #108 denied shortness of breath, chest pain/pressure, or difficulty breathing during the interview. In an interview on 9/23/2025 at 8:31 AM, LVN G said he was the primary nurse for Resident #108, and he was informed during change of shift report that Resident #108 had a PleurX with scheduled draining procedures occurring every five days. He said the next scheduled procedure was on 9/22/2025. LVN G was unaware the physician's order for the PleurX catheter directed nursing staff to perform the procedure every other day, and he stated he would clarify with the physician. He was unsure when the PleurX was last drained. LVN G stated he was hired at the facility approximately 1 month before and did not receive training from the facility on PleurX catheters. He said he felt comfortable accessing Resident #108's PleurX, if needed, because he had prior experience at a different facility. In an interview with ADON A on 9/23/2025 at 12:30 PM, she said she was the primary nurse for Resident #108 on 9/22/2025. She said Resident #108 informed her on 9/22/2025 that the PleurX had been drained on 9/21/2025, but ADON A did not verify this information with the medical record. She said Resident #108 then told her she would prefer to have the PleurX drained every 5 days and did not want the procedure done that day. ADON A said she had forgotten to contact the provider to discuss the request and obtain a modified order for the new frequency. ADON A said she felt comfortable providing care for a PleurX catheter, and she had previously received training for PleurX catheters from the facility. She said training was provided to nursing staff only as needed, but the facility did not document the training. She said she expected that facility would not perform the PleurX procedure if they did not have adequate training, but she was unsure how the facility would ensure the treatment had been performed correctly if not all staff had received training. ADON A then said there was no potential harm to Resident #108's chest tube [an alternative descriptor of the device] because the catheter was inserted into Resident #108's abdomen. ADON A clarified that a chest tube is inserted into a person's chest, but Resident #108 had a catheter in her abdomen. ADON A was unable to recall Resident #108's diagnosis that led to the need for a long-term drainage device. In an interview on 9/23/2025 at 3:23 PM, LVN F stated she had accessed and drained Resident #108's PleurX catheter several times in September. She said she had not received training from the facility for PleurX catheters, and she was shown how to perform the procedure by another nurse who was working that day. She said this was the only nurse in the building who knew how to access the PleurX. She was not aware the procedure was to be performed using sterile technique and had not utilized sterile technique on any of the procedures she performed for Resident #108. In an interview with the DON on 9/24/2025 at 8:05 AM, she said the training and skills validation for nursing staff caring for a PleurX was not included on the new hire or annual curriculum. She stated any staff who had not been trained on PleurX catheters are expected to reach out to herself or the nursing leader on call in order to receive training before accessing a PleurX. She said she had not been contacted by any staff for PleurX training since Resident #108 had admitted to the facility. She was unaware that the PleurX draining procedure was not included in Resident #108's care plan, and she felt the task should have been included. She said she was jointly responsible for the care plan with the ADONs and MDS nurse. She was unaware that Resident #108 did not have an order to drain the PleurX on 9/18/2025 or 9/20/2025, and she was unaware Resident #108 had been allegedly refusing the procedure. Record review of the facility document titled Licensed/Registered Nurse Competency Validation Checklist (undated, received 9/23/2025) did not reveal PleurX or chest tubes as a training topic. Record review of the facility policy titled PleurX Drain Care [sic] revised 9/2024, revealed the following: All procedures must follow aseptic technique and manufacturer guidelines . Review resident's comprehensive care plan for instructions All staff must complete initial and annual competency validation .		

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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** Number of residents sampled: Number of residents cited: Based on the interview and record review, the facility failed to ensure that 1 of 8 residents (Resident # 87) reviewed for medication errors was free of any significant medication errors. The facility failed to administer the prescribed medication (Potassium & Sodium Phosphates Oral Packet 280-160-250 MG) for low potassium and sodium to Resident #87. This deficient practice could place residents at risk of inadequate therapeutic outcomes, increased adverse side effects, and a decline in health. The findings included: Record review of admission face sheet, dated 9/22/2025, revealed Resident # 87 was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included Type two diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and Anxiety Disorder (excessive fear of or apprehension about real or perceived threats, leading to altered behavior) and Hypertension (is a chronic medical condition characterized by persistently elevated blood pressure). Record review of the quarterly MDS assessment, dated 9/22/2025, revealed Resident # 87 had a BIMS score of 15, which indicated intact cognition. Record review of physician orders for September 2025 revealed that Resident # 87 had the following order: Phosphates Oral Packet 280-160-250 MG, give one packet by mouth with meals 7:30 a.m., 11:30 a.m., and 1:30 p.m. Review of the medication administration record for Resident # 87 from 9/16/25 to 9/23/25 revealed 18 missed doses of Phosphates Oral Packet 280-160-250 MG, which were documented as medication unavailable. Record review of Labs for Resident # 87, dated 9/23/25, drawn on 9/21/25, revealed potassium and sodium levels to be within range. Record review of Resident #87's physician's orders for 9/16/25 -9/23/25 did not reveal any orders to hold Phosphates Oral Packet 280-160-250 MG; however, the order was discontinued on 9/23/25 at 10:55 a.m., after surveyor intervention. Interview on 9/23/2025 at 11:35 A.M., Resident # 87 stated she had not received the Phosphates Oral Packet 280-160-250 MG since admission on [DATE] but felt she did not need it . Interview with MA (I) on 9/23/25 at 9:18 AM stated she did not know the medication was not available until the surveyor's intervention, as this was her first day back after being off for five days and had not worked the side Resident # 87 was on since prior to her admission . MA (I) confirmed that she was aware that if a medication is missing, she is to inform the charge nurse, who then calls the pharmacy and notifies the DON. Interview with LVN (G) on 9/23/25 at 9:40 AM stated he was unaware that Resident #87 was missing doses of medication Phosphates Oral Packet 280-160-250 MG, until MA (I) brought it to his attention earlier today. LVN (G) stated he called the physician and informed him of the missing doses for Resident #87, including labs being within range, and the physician discontinued the order for Phosphates Oral Packet 280-160-250 MG. LVN (G) stated Resident # 87 risked labs being out of normal limits if medication was missed; however, this was not the case this time. Interview with the DON on September 24, 2025, at 8:45 A.M. revealed that the pharmacy did not send the medication for Resident #87 because it was considered over-the-counter on 9/16/25 and required authorization from the DON (she was never informed). The DON stated that she was unaware that Resident #87 was missing Phosphates Oral Packet (280-160-250 mg) until LVN (G) notified her on September 23, 2025. Had she known earlier, she would have authorized the delivery of the supplement. The DON explained that licensed nurses are responsible for informing her and the pharmacy if any medication is missing, so she can follow up on why the pharmacy did not send it. While she noted she did not have a policy to address this because it was considered a process, she mentioned that she would randomly monitor all MAs in the facility to ensure compliance regarding missing medications.		

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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** Based on observation, interview, and record review, 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 5 of 5 residents (Residents #52, #53, #87, #108, and #121) reviewed for infection control. The facility failed to ensure enhanced-barrier precautions were initiated for Residents #52, #53, #87, and #121. The facility failed to ensure contact isolation precautions were initiated for Resident #108 when she admitted to the facility on antibiotic therapy for blood culture results positive for VRE (a contagious bacterial infection that is resistant to multiple antibiotics). These failures could lead to the spread of infection and illness. Findings included: 1. Record review of Resident #52's face sheet dated 9/22/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included encounter for surgical aftercare following surgery on the circulatory system and burn of unspecified degree of right thigh, subsequent encounter. Record review of Resident #52's Order Summary Report dated 9/22/2025 reflected an order dated 9/11/2025 for enhanced barrier precautions. Record review of Resident #52's care plan report, printed 9/22/2025, reflected the following:[Resident #52] is on Enhanced Barrier Precautions [a type of isolation precaution requiring special protection to staff when caring for a resident] related to chronic wounds (pressure ulcers, diabetic ulcers), colonization or infection with MDRO(s), ostomy [a surgically created opening in the skin], IV therapy, dialysis and or presence of an indwelling device(s) such as central venous catheter, indwelling urinary catheter, tracheostomy, feeding tube [sic] . date initiated 9/14/2025 Record review of Resident #52's MDs assessments revealed no submissions of a BIMS score assessment as of 9/22/2025. In an observation and interview on 9/21/2025 at 1:03 PM, Resident #52's room was observed without posted signage indicating Resident #52 required EBP. No PPE cart was present in the hallway in front of the door. Resident #52 said she was admitted to the facility for care after her heart surgery, and a surgical wound was observed on Resident #52's chest. Resident #52 also said she had a wound to her right thigh, and a wound was observed on the back of her leg, above the knee. Record review of Resident #53's face sheet, dated 9/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included sepsis [an infection that has spread into the bloodstream], unspecified organism and urinary tract infection, site not specified. Record review of Resident #53's Order Summary Report dated 9/21/2025 reflected an order dated 9/11/2025 for enhanced barrier precautions. Record review of Resident #53's care plan report, printed 9/21/2025, did not reveal care planning for enhanced barrier precautions. Record review of Resident #53's MDs assessments revealed no submissions of a BIMS score assessment as of 9/21/2025. In an observation and interview on 9/21/2025 at 11:18 AM, Resident #53's room was observed without posted signage indicating Resident #53 required EBP. No PPE cart was present in the hallway in front of the door. Resident #53 exhibited confusion during the interview and was not able to provide reliable information regarding the clinical care provided by the facility. Record review of Resident #87's face sheet, dated 9/22/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included encounter for surgical aftercare following surgery on the circulatory system and dependence on renal dialysis [a procedure that filters the blood due to kidney disease]. Record review of Resident #87's Order Summary Report dated 9/22/2025 reflected an order dated 9/15/2025 for enhanced barrier precautions. Record review of Resident #87's care plan report, printed 9/22/2025, reflected the following:[Resident #87] is on Enhanced Barrier Precautions related to chronic wounds (pressure ulcers, diabetic ulcers), colonization or infection with MDRO(s), ostomy, IV therapy, dialysis and or presence of an indwelling device(s) such as central venous catheter, indwelling urinary catheter, tracheostomy, feeding tube . date initiated 9/16/2025 Record review of Resident #87's MDs assessments revealed no submissions of a BIMS score assessment as of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/21/2025. In an observation and interview on 9/22/2025 at 9:33 AM, Resident #87's room was observed without posted signage indicating Resident #53 required EBP. No PPE cart was present in the hallway in front of the door. Resident #87 said she received dialysis treatments from the facility five days a week via catheter. A dialysis catheter was observed to Resident #87's right chest with a clean, intact dressing dated 9/22/2025 covering the insertion site. In an interview on 9/24/2025 at 6:59 AM, CNA C stated Resident #87 did not require any TBP precautions. CNA C said that when she worked, she knew which residents required TBP based on the signs posted outside of their rooms and from report given by other staff at shift change, and since Resident #87 did not have a sign, she knew the resident was not on TBP. Also, she was not told by the overnight CNA during shift change about TBP for Resident #87. Record review of Resident #121's face sheet, dated 9/22/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included urinary tract infection, site not specified and cognitive communication deficit. Record review of Resident #121's Order Summary Report dated 9/22/2025 reflected an order dated 9/10/2025 for enhanced barrier precautions. Record review of Resident #121's care plan report, printed 9/22/2025, reflected the following:[Resident #121] is on Enhanced Barrier Precautions related to chronic wounds (pressure ulcers, diabetic ulcers), colonization or infection with MDRO(s), ostomy, IV therapy, dialysis and or presence of an indwelling device(s) such as central venous catheter, indwelling urinary catheter, tracheostomy, feeding tube . date initiated 9/21/2025 Record review of Resident #121's MDs assessments revealed no submissions of a BIMS score assessment as of 9/22/2025. In an observation on 9/21/2025 at 3:35 PM, Resident #121's room was observed without posted signage indicating Resident #53 required EBP. No PPE cart was present in the hallway in front of the door. 2. Record review of Resident #108's face sheet, dated 9/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included resistance to vancomycin related antibiotics, malignant pleural effusion [a fluid collection in the space surrounding the lung], and secondary malignant neoplasm of unspecified lung [lung cancer]. Record review of Resident #108's Order Summary Report dated 9/22/2025 reflected an order dated 9/22/2025 that read as follows:Drain pleurx drain [a catheter inserted into the chest to allow for repeated drainage of fluid] to R-front quad (R-lung) one time a day on even days for drain every other day [sic] Resident #108's Order Summary Report did not reflect an order for EBP. Record review of Resident #108's care plan report, printed 9/22/2025, reflected the following:[Resident #52] is on Enhanced Barrier Precautions related to chronic wounds (pressure ulcers, diabetic ulcers), colonization or infection with MDRO(s), ostomy, IV therapy, dialysis and or presence of an indwelling device(s) such as central venous catheter, indwelling urinary catheter, tracheostomy, feeding tube [sic] . date initiated 9/04/2025 Record review of Resident #108's hospital discharge paperwork dated 9/17/2025 revealed a discharge report from a hospitalist 9/17/2025 that indicated Resident #121's blood samples were cultured and grew VRE sensitive to linezolid (an antibiotic), and she was subsequently evaluated while in the hospital for VRE bacteremia. In an observation and interview on 9/21/2025 at 12:34 PM, Resident #108's room was observed without posted signage indicating Resident #53 required TBP. No PPE cart was present in the hallway in front of the door. A coiled catheter was observed to Resident #108's right, lower chest area with a clean, intact dressing dated 9/16/2025. Resident #108 said the catheter had not been accessed since she returned to the facility from the hospital on 9/18/2025. In an observation and interview on 9/23/2025 at 8:31 AM, a sign was observed on Resident #108's door frame indicating Resident #108 required EBP precautions. LVN G said Resident #108 should be on contact precautions due to the opening in her skin. He was unaware of Resident #108's diagnosis of VRE. LVN G also said any resident requiring TBP should have a posted sign and PPE cart in front of the room door. He said the potential harm to residents from not having TBP signage posted, or proper PPE was infection. In an interview with the DON on 9/24/2025 at 8:05 AM, she identified herself as the staff member serving as the Infection Preventionist for the facility. She said the facility uses a tracking device to monitor ordered TBP precautions, and it is the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort San Antonio, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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	responsibility of the ADONs to monitor their respective floors on a daily basis for compliance with the orders. She was unaware of Resident #108's diagnoses of VRE, and said Resident #108 should have been on contact isolation precautions based on the diagnosis. The DON also said she was unaware of the missing TBP signage and PPE carts for Residents #52, #53, #87, and #121. She said the signage and PPE carts should have been implemented as soon as staff became aware of the need for TBP. She said the need for TBP was identified during the admission assessment by the nursing staff or orders from the referral source. She reported the potential harm to residents from not having properly implemented TBP was infection. Record review of the facility policy titled Infection Control Policy dated 9/2022 revealed the following: The resident's clinical record and door will display the appropriate isolation notification by nursing staff. When a resident is placed on transmission-based precautions, facility's Infection Preventionist [sic] will implement the following but is not limited to: .Make PPE readily available near the entrance to the resident's room .Contact precautions are implemented most often for residents who have an infection due to an epidemiologically important organism such as multi-drug resistant organism .		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure at the time each resident is admitted , the facility must have physician orders for the resident's immediate care for 2 of 2 residents (Residents #108 and #148) reviewed for new admissions.The facility failed to ensure Resident #108 had an order in place to drain the PleurX device [a catheter inserted into the chest cavity for long-term drainage of fluid accumulation] after readmission on [DATE]. The facility admitted Resident #148 with the need for a thoracolumbar spine orthosis (TSLO) back brace and did not support the Resident with a physician's order for the TSLO brace.These failures could lead to residents not receiving necessary care. Findings included: 1. Record review of Resident #108's face sheet, dated 9/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included resistance to vancomycin related antibiotics, malignant pleural effusion [a fluid collection in the space surrounding the lung], and secondary malignant neoplasm of unspecified lung [lung cancer]. Record review of Resident #108's admission MDS, dated [DATE], reflected a BIMS score of 14, indicating intact cognition. Section I0100 indicated Resident #108 had an active diagnosis of cancer, and section OD of the MDS reflected 0 minutes of respiratory therapy treatments were administered to Resident #108 in the last 7 days. Record review of Resident #108's care plan report printed 9/22/2025 did not reflect care planning for the PleurX draining procedure. Record review of Resident #108's Order Summary Report dated 9/22/2025 reflected the following active orders: Drain pleurx drain [a catheter inserted into the chest to allow for repeated drainage of fluid] to R-front quad (R-lung) one time a day on even days for drain every other day [sic] (date ordered 9/20/2025, start date 9/22/2025) Record review of Resident #108's progress notes reflected nursing documentation indicating Resident #108 was transferred to the emergency department on 9/12/2025 at 12:00 PM for abnormal laboratory results. An additional progress note documented on 9/18/2025 at 6:44 PM reflected Resident #108 returned to the facility and that Resident #108 refused a full skin assessment and weight after arrival. Record review of a physician's progress note dated 9/19/2025 at 12:00 PM reflected the following: ASSESSMENT AND PLAN: ...# Lung cancer with mets to throat # squamous cell carcinoma [a type of skin cancer] # recurrent malignant right plural effusion (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Plurex drain management by nursing staff, drain as ordered, and PRN, continue lasix, nebs, monitor weights -Follow up oncology and pulmonology [sic] Further record review of Resident #108's progress notes did not reveal documentation from 9/18/2025 through 9/22/2025 by nursing staff related to accessing and draining the PleurX. Record review of Resident #108's hospital discharge paperwork dated 9/17/2025 reflected the PleurX catheter had been accessed and drained by hospital staff on 9/16/2025. Record review of Resident #108's September 2025 TAR, dated 9/23/2025, reflected the following: Right pulmonary drain: drain every other day one time a day every other day for pulmonary drain/ edema drain every other day [sic] (order date 9/03/2025 2:46 AM, D/C date 9/15/2025 5:19 PM) 9/4/2025 8:00 AM: treatment performed, output documented as X mL (ADON J) 9/6/2025 8:00 AM: treatment performed, output 50mL (ADON J) 9/8/2025 8:00 AM: treatment performed, output NA (LVN F) 9/10/2025 8:00 AM: treatment performed, output 50mL (LVN F) 9/12/2025 8:00 AM: treatment performed, output 50mL (LVN F) 9/14/2025 8:00 AM: other/see nurse's notes (LVN F) Record review of Resident #108's September 2025 NMAR, dated 9/23/2025, reflected the following: 9/18/2025: no order to drain the PleurX 9/20/2025: no order to drain the PleurX Drain pleurx drain to R-front quad (R-lung) one time a day on even days for drain every other day (order start 9/22/2025) 9/22/2025 12:00 PM: drug refused In an observation and interview on 9/21/2025 at 12:34 PM, a coiled catheter was observed to Resident #108's right, lower chest area with a clean, intact dressing dated 9/16/2025. Resident #108 said the catheter had not been accessed since she returned to the facility from the hospital on 9/18/2025. She stated she had been told by multiple unknown nursing staff that they could not drain the catheter because they did not know how. She said an unknown staff member had told her yesterday (9/20/2025), that the catheter would be drained today (9/21/2025). Resident #108 said she asked the staff about the draining procedure because she was aware of the physician's order to drain the catheter every other day, and she was aware the schedule was not being followed. She said she did not feel any increase in symptoms even though the catheter had not been drained since before 9/18/2025. Resident #108 denied shortness of breath, chest pain/pressure, or difficulty breathing (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during the interview. In an interview on 9/23/2025 at 8:31 AM, LVN G said he was the primary nurse for Resident #108, and he was informed during change of shift report that Resident #108 had a PleurX with scheduled draining procedures occurring every five days. He said the next scheduled procedure was on 9/22/2025. LVN G was unaware the physician's order for the PleurX catheter directed nursing staff to perform the procedure every other day, and he stated he would clarify with the physician. He was unsure when the PleurX was last drained. LVN G stated he was hired at the facility approximately 1 month before and did not receive training from the facility on PleurX catheters. He said he felt comfortable accessing Resident #108's PleurX, if needed, because he had prior experience at a different facility. In an interview with ADON A on 9/23/2025 at 12:30 PM, she said she was the primary nurse for Resident #108 on 9/22/2025. She said Resident #108 informed her on 9/22/2025 that the PleurX had been drained on 9/21/2025, but ADON A did not verify this information with the medical record. She said Resident #108 then told her she would prefer to have the PleurX drained every 5 days and did not want the procedure done that day. ADON A said she had forgotten to contact the provider to discuss the request and obtain a modified order for the new frequency. In an interview with the DON on 9/24/2025 at 8:05 AM, she said she was unaware that Resident #108 did not have an order after readmission to drain the PleurX on 9/18/2025 or 9/20/2025, and she was unaware Resident #108 had been allegedly refusing the procedure. She said residents should have all orders implemented upon admission that are required to provide necessary care. 2. A record review of Resident #148's admission record dated 9/24/2025 revealed an admission date of 9/18/2025 with diagnoses which included fracture of T11-T12 vertebra without healing (the T11 and T12 vertebrae are part of the mid-back spine, which consists of 12 vertebrae labeled from T1 to T12.) further review revealed Resident ##148 was an [AGE] year-old female. A record review of Resident #148's physicians orders dated 9/24/2025 revealed no orders for a TSLO. A record review of Resident #148's care plan dated 9/23/2024 revealed no plan for interventions and or supports for a TSLO back brace. A record review of Resident #148's nursing progress notes revealed on 9/18/2025 at 4:52 PM LVN K documented, (Resident #148) admitted here from (name of hospital) hospital for nausea vomiting, AMS (altered mental status), T12-L1 fracture (fracture). Allergy to sulfa abt (antibiotic), full code, on amoxicillin abt for colitis (painful inflammation of the colon). TSLO brace when out of bed. During an observation and interview on 9/24/2025 at 10:00 AM revealed Resident #148 seated in her chair in her room, Resident #148 was observed to wear her TSLO back brace. Resident #148 stated she had a broken back, and the brace helped her with movement and minimized some of the pain. Resident #148 stated she was admitted to the facility from the hospital with the back brace. Resident #148 could not recall if she wore the brace daily but did recall a CNA applied the brace this morning. During an interview on 9/24/2025 at 10:04 AM LVN N stated her work schedule was from 6:00 AM to 6:00 PM and Resident #148 resided in the 300-hall. LVN N stated she received a report from LVN O for the 300-hall which did not include Resident #148's need for a TSLO back brace. LVN N stated she (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unaware Resident #148 had a need for a back brace. LVN N performed a record review of Resident #148's medical record which included Resident #148's physicians orders, care plan, and progress notes. LVN N stated there were no orders for a TSLO brace and no care plan for a TSLO back brace. LVN N stated she reviewed Resident #148's progress notes and recognized the 1st nursing note dated 9/18/2025 which mentioned Resident #148's need for a back brace. LVN N stated she would report the discrepancies to the DON. LVN N stated the failure for an order and care plan could have a negative outcome for Resident #148 without her back brace. During an interview on 9/24/2025 at 10:11 AM CNA M stated he worked Friday 9/19/2025 through Sunday 9/21/2025 and again on 9/24/2025 from 6:00 AM to 6:00 PM and had provided care for Resident #148. LVN M stated on Saturday 9/20/2024 the therapy department staff trained him on applying Resident #148's back brace daily. CNA M stated he had not reported the training to anyone. CNA M stated he was unaware if any other CNA's were aware of Resident #148's need for a back brace and Resident #148 would be in bed after 6:00 PM and her need for the brace was when she was out of bed. During an interview on 9/24/2025 at 10:50 AM the Director of Rehabilitation (DOR) stated Resident #148 was admitted from the hospital on 9/18/2025 in the early evening. The DOR stated her staff reviewed the hospital nurse to facility nurse notes and the hospital discharge documents and recognized the hospital physician had ordered Resident #148 a TSLO brace related to her spine fracture at the T11-T12 vertebra. The DOR stated the therapy department supported Resident #148's needs for physical and occupational therapy which included the use of her TSLO brace while out of bed. The DOR stated the nursing department had access to the therapy departments notes which included the information regarding Resident #148's TSLO brace. The DOR stated she was a member of the facility's Interdisciplinary Team and had attended morning IDT meetings and recalled the review of newly admitted residents but could not directly recall Resident #148's new admission review. The DOR stated the potential negative outcome for residents who did not have orders or care plans for prosthetic devices could be a decline in health status with range of motion, pain, and or skin breakdown. During an interview on 9/24/2025 at 4:00 PM the Administrator and the DON stated Resident #148 had a need for a TSLO brace and was supported with the need for her back brace even though she had no order or care plan for the back brace. The DON stated the potential negative outcome for residents who did not have admission orders and or care plans for their admission needs could be not receiving care as prescribed by a physician. The DON stated she was responsible for the oversight for new admissions. A record review of the facility's Transcription Orders policy dated July 2025 revealed, Orders will be verified only by a Licensed Nurse or designee. If orders are transcribed by other than a licensed nurse, a licensed nurse will verify the order transcription and will sign off the orders per policy and procedure to ensure the order has been correctly transcribed and/or implemented including reviewing actions completed for scheduling or ordering medications, laboratory testing, radiology orders, referrals, diets, etc. An RN/LPN must verify the transcriptions' accuracy and completeness prior to the end of the RN/LPN's shift and PRIOR TO administration of the orders including medication administration . A record review of the facility's policy Physicians' Orders, dated May 2023, revealed, POLICY: 1. New orders and order changes may be called, hand-written, faxed, or electronically generated by a physician. (continued on next page)		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The physician's order must be documented completely with sufficient content to clearly convey the provider's intent. Indications for PRN orders should be included in the order. 3. After the authorized provider has completed the orders, the RN or LPN is responsible to promptly and accurately transcribe all written orders. The RN or LPN must include his/her signature, the date and time of the transcription and credentials. 4. Orders that are unclear must be clarified prior to implementation.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, interviews, and record reviews the facility failed to develop and implemented a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the residents that met professional standards of quality care. The baseline care plan was not developed within 48 hours of a resident's admission and did not include the minimum healthcare information necessary to properly care for a resident including for 1 of 8 residents (Resident #148) [TT1] reviewed for a baseline care plan. Resident #148 was admitted on [DATE] at 5:00 PM with the need for a thoracolumbar spine orthosis (TSLO) back brace, the TSLO brace was not addressed in the baseline care plan. This failure could place residents at risk for not receiving care and services. The findings included: A record review of Resident #148's admission record dated 9/24/2025 revealed an admission date of 9/18/2025 with diagnoses which included fracture of T11-T12 vertebra without healing (the T11 and T12 vertebrae are part of the mid-back spine, which consists of 12 vertebrae labeled from T1 to T12.) further review revealed Resident ##148 was an [AGE] year-old female. A record review of Resident #148's physicians orders dated 9/24/2025 revealed no orders for a TSLO. A record review of Resident #148's care plan dated 9/23/2024 revealed no plan for interventions and or supports for a TSLO back brace. A record review of Resident #148's nursing progress notes revealed on 9/18/2025 at 4:52 PM LVN K documented, (Resident #148) admitted here from (name of hospital) hospital for nausea vomiting, AMS (altered mental status), T12-L1 fracture (fracture). Allergy to sulfa abt (antibiotic), full code, on amoxicillin abt for colitis (painful inflammation of the colon). TSLO brace when out of bed. During an observation and interview on 9/24/2025 at 10:00 AM revealed Resident #148 seated in her chair in her room, Resident #148 was observed wearing her TSLO back brace. Resident #148 stated she had a broken back, and the brace helped her with movement and minimized some of the pain. Resident #148 stated she was admitted to the facility from the hospital with the back brace. Resident #148 could not recall if she wore the brace daily but did recall a CNA applied the brace this morning. During an interview on 9/24/2025 at 10:04 AM LVN N stated her work schedule was from 6:00 AM to 6:00 PM and Resident #148 resided in the 300-hall. LVN N stated she received a report from LVN O for the 300-hall which did not include Resident #148's need for a TSLO back brace. LVN N stated she was unaware Resident #148 had a need for a back brace. LVN N performed a record review of Resident #148's medical record which included Resident #148's physicians orders, care plan, and progress notes. LVN N stated there were no orders for a TSLO brace and no care plan for a TSLO back brace. LVN N stated she reviewed Resident #148's progress notes and recognized the 1st nursing note dated 9/18/2025 which mentioned Resident #148's need for a back brace. LVN N stated she would report the discrepancies to the DON. LVN N stated the failure for an order and care plan could have a negative outcome for Resident #148 without her back brace. During an interview on 9/24/2025 at 10:11 AM CNA M stated he worked Friday 9/19/2025 through Sunday 9/21/2025 and again on 9/24/2025 from 6:00 AM to 6:00 PM and had provided care for Resident #148. LVN M stated on Saturday 9/20/2024 the therapy department staff trained him on applying Resident #148's back brace daily. CNA M stated he had not reported the training to anyone. CNA M stated he was unaware if any other CNA's were aware of Resident #148's need for a back brace and Resident #148 would be in bed after 6:00 PM and her need for the brace was when she was out of bed. During an interview on 9/24/2025 at 10:50 AM the Director of Rehabilitation (DOR) stated Resident #148 was admitted from the hospital on 9/18/2025 in the early evening. The DOR stated her staff reviewed the hospital nurse to facility nurse notes and the hospital discharge documents and recognized the hospital physician had ordered Resident #148 a TSLO brace related to her spine fracture at the T11-T12 vertebra. The DOR stated the therapy department supported Resident #148's needs for physical and occupational therapy which included (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the use of her TSLO brace while out of bed. The DOR stated the nursing department had access to the therapy departments notes which included the information regarding Resident #148's TSLO brace. The DOR stated she was a member of the facility's Interdisciplinary Team and had attended morning IDT meetings and recalled the review of newly admitted residents but could not directly recall Resident #148's new admission review. The DOR stated the potential negative outcome for residents who did not have orders or care plans for prosthetic devices could be a decline in health status with range of motion, pain, and or skin breakdown.uring an interview on 9/24/2025 at 4:00 PM the Administrator and the DON stated Resident #148 had a need for a TSLO brace and was supported with the need for her back brace even though she had no order or care plan for the back brace. The DON stated the potential negative outcome for residents who did not have admission orders and or care plans for their admission needs could be not receiving care as prescribed by a physician. The DON stated she was responsible for the oversight for new admissions. A record review of the facility's Care Plan policy dated April 2024, revealed, Each resident will have a care plan that is current, individualized and consistent with their medical regimen. Care Plan/MOS Coordinator, Social Services, Activities, Rehab, Dietary, Nursing and other members of the Interdisciplinary Team . POLICY: A baseline care plan is developed for each resident upon admission, but no later than 48 hours of admission, to the facility. This care plan includes minimum health care information necessarily to properly care for the resident. Therapy services		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene for 1 of 1 residents (Resident #87) reviewed for ADLs. The facility failed to ensure Resident #87 received routine bathing assistance after admitting to the facility in September 2025. These failures could lead to skin breakdown, infection, or psychosocial harm. Findings included: Record review of Resident #87's face sheet, dated 9/22/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included encounter for surgical aftercare following surgery on the circulatory system and dependence on renal dialysis [a procedure that filters the blood due to kidney disease]. Record review of Resident #87's MDs assessments revealed no submissions of a BIMS score assessment as of 9/21/2025. Record review of Resident #87's care plan report, printed 9/22/2025, reflected the following: resident has ADL self-care performance deficits and limitations in physical mobility (date initiated 9/16/2025) shower/bathe self: substantial maximal assistance Record review of the scheduled tasks in Resident #108's electronic medical record revealed Resident #108 was scheduled for bathing assistance during night shifts on Mondays, Wednesdays, and Fridays of every week. Further review revealed since admission on [DATE], staff had checked no for the bathing task on 9/16/2025 (CNA B), 9/17/2025 (CNA L), and 9/20/2025 (CNA B). 9/22/2025 was marked as not applicable by CNA L. In an observation and interview on 9/22/2025 at 9:33 AM, Resident #87's was observed resting in bed wearing a hospital gown. Resident #87 said she had not been offered assistance with bathing since her arrival at the facility. She said she had not declined a bath, and she had not thought to ask for one because her experience at previous facilities was that bathing was offered to her when someone was available to provide assistance. She denied skin issues related to not bathing. In a subsequent interview on 9/23/2025 at 12:20 PM, Resident #108 stated she was not offered assistance bathing by the previous overnight staff. In an interview with CNA D on 9/23/2025 at 12:50 PM, she stated that if residents prefer to bathe at a time that is different than the scheduled bathing time, the staff will pass the information to the incoming shift. She was not informed by the overnight staff that Resident #108 had refused bathing assistance the night prior and wanted to bathe that day. In an interview with LVN G on 9/23/2025 at 12:56, he stated he was the primary nurse for resident #108. He was unaware that Resident #108 needed assistance with bathing during the day, and he said she had not asked him for assistance that day. CNA L did not respond to a phone call and voicemail requesting interview on 9/23/2025 at 2:20 PM. CNA B was interviewed on 9/23/2025 at 2:21 PM. She said she had taken care of Resident #108 several times over the previous two weeks, and that Resident #108 consistently refused to bathe at night because she liked to shower during the day. She stated she informed the day shift staff of the need to assist Resident #108 with bathing. She was unsure of the process to change a resident's scheduled bathing time. She said she had not notified the primary nurse of Resident #108's consistent bathing refusal or that Resident #108 had not bathed since arrival. The DON was interviewed on 9/24/2025 at 8:08 AM. She stated residents are assigned bathing times based on their room number- even room numbers bathe during the day and odd room numbers bathe at night. She stated residents could request a bathing schedule change, and that staff should communicate the requests to the primary nurse or the ADON for the floor. She said that if a resident was continuously refusing bathing assistance, the staff should alert the primary nurse, and the primary nurse could escalate the situation to the ADON so that a conversation could be held with a resident's family, if able, to intervene. She was unaware that Resident #108 had not received bathing assistance since arrival. She was also unaware that Resident #108 had allegedly been refusing bathing assistance. She stated the potential harm to residents of not receiving consistent bathing assistance was skin breakdown. Record review of the facility policy titled ADL Policy revised 04/2023, revealed the following: This facility will provide each resident with (continued on next page)		

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Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort San Antonio, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6035 Eckhert Rd San Antonio, TX 78229	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care, treatment, and services according to the resident's individualized care plan . including: bathing, dressing, grooming .		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review the facility failed to ensure for a resident who enters the facility with an indwelling catheter or subsequently receives one had a clinical condition that demonstrates catheterization is necessary for 1 of 3 residents (Resident # 50) reviewed for indwelling urinary catheterization necessity, in that: Resident #50 did not have a physician's order for an indwelling catheter. This deficient practice could affect residents in the facility who have an indwelling or external catheter and place them at risk for infection and improper care. The findings were: Record review of Resident #50 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnosis that included: Urinary retention (refers to the inability to empty the bladder), Congestive heart failure (a condition where the heart muscle is weakened or stiffened), and Hypertension (is a condition where the force of blood against the artery walls is consistently too high). Record review of Resident # 50's quarterly MDS assessment dated [DATE] revealed a BIMS score 14, suggesting intact cognition, and the resident had an indwelling catheter. Record review of Resident #50's physician's orders for September 2025, dated 09/22/2025, revealed there was no order for the resident's indwelling urinary catheter. Record review of Resident # 50's Hospital discharge orders dated 9/15/2025 revealed an order for an indwelling urinary catheter 16 fr. Observation on 09/22/25 at 10:40 a.m., revealed Resident # 50's catheter was present in the peri area, and a urinary bag was covered, hanging on the movable part of the bed frame. Interview with Resident # 50 on 09/22/2025 at 11:00 AM revealed she has had a urinary catheter since admission. Staff have always emptied the urinary bag and provided care for the appliance. Interview on 09/22/25 at 11:05 a.m. LVN H stated Resident #50 had an indwelling urinary catheter. LVN H reported that Resident #50 was admitted with an indwelling urinary catheter and verified that Resident #50 had no physician's order for the catheter. Later, she stated that she emptied the catheter each shift and checked it for signs and symptoms of infection. Interview with LVN Q (admission nurse) was attempted via telephone on 9/22/2025 at 11:25 am and did not return call . Interview on 9/22/25 at 3:00 p.m., the DON stated Resident #50's physician's orders did not include an indwelling urinary catheter order. The DON stated this was because the physicians' orders were entered as an order set by the admission nurse. However care was provided to the indwelling catheter by all nursing staff evident in Resident # 50's urinary bag had been emptied each shift . The DON stated Resident #50 risked possible improper care to the catheter site if the nurses did not know the resident had a urinary catheter. Record review of facility policy, Transcription of Orders, dated July 2020, revised July 2021, revealed, Transcribing and verifying orders are a responsibility of a licensed nurse .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 residents (Resident #108) reviewed for respiratory care. The facility failed to ensure Resident #108's long-term indwelling chest catheter, known by the brand name PleurX, was drained per physician order and by competent staff. These failures could result in infection and/or complications to a resident's respiratory or cardiovascular systems. Findings included: Record review of Resident #108's face sheet, dated 9/21/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included resistance to vancomycin related antibiotics, malignant pleural effusion [a fluid collection in the space surrounding the lung], and secondary malignant neoplasm of unspecified lung [lung cancer]. Record review of Resident #108's admission MDS, dated [DATE], reflected a BIMS score of 14, indicating intact cognition. Section I0100 indicated Resident #108 had an active diagnosis of cancer, and section OD. of the MDS reflected 0 minutes of respiratory therapy treatments were administered to Resident #108 in the last 7 days. Record review of Resident #108's Order Summary Report dated 9/22/2025 reflected the following active orders: Drain pleurx drain [a catheter inserted into the chest to allow for repeated drainage of fluid] to R-front quad (R-lung) one time a day on even days for drain every other day [sic] (date ordered 9/20/2025, start date 9/22/2025) Record review of Resident #108's care plan report printed 9/22/2025 did not reflect care planning for the PleurX draining procedure. Record review of Resident #108's progress notes reflected nursing documentation indicating Resident #108 was transferred to the emergency department on 9/12/2025 at 12:00 PM for abnormal laboratory results. An additional progress note documented on 9/18/2025 at 6:44 PM reflected Resident #108 returned to the facility and that Resident #108 refused a full skin assessment and weight after arrival. Record review of Resident #108's scanned hospital discharge paperwork dated 9/17/2025 reflected the PleurX catheter had been accessed and drained by hospital staff on 9/16/2025. Record review of a physician's progress note dated 9/19/2025 at 12:00 PM reflected the following: ASSESSMENT AND PLAN:,,,# Lung cancer with mets to throat# squamous cell carcinoma [a type of skin cancer]# recurrent malignant right plural effusion-Plurex drain management by nursing staff, drain as ordered, and PRN, continue lasix, nebs, monitor weights-Follow up oncology and pulmonology [sic] Further record review of Resident #108's progress notes did not reveal documentation from nursing staff accessing and draining the PleurX from 9/18/2025 through 9/22/2025. Record review of Resident #108's September 2025 TAR, dated 9/23/2025, reflected the following:Right pulmonary drain: drain every other day one time a day every other day for pulmonary drain/ edema drain every other day [sic] (order date 9/03/2025 2:46 AM, D/C date 9/15/2025 5:19 PM)9/4/2025 8:00 AM: treatment performed, output documented as XmL (ADON J)9/6/2025 8:00 AM: treatment performed, output 50mL (ADON J)9/8/2025 8:00 AM: treatment performed, output NA (LVN F)9/10/2025 8:00 AM: treatment performed, output 50mL (LVN F)9/12/2025 8:00 AM: treatment performed, output 50mL (LVN F)9/14/2025 8:00 AM: other/see nurse's notes (LVN F)Record review of Resident #108's September 2025 NMAR, dated 9/23/2025, reflected the following:9/18/2025: no order to drain the PleurX9/20/2025: no order to drain the PleurXDrain pleurx drain to R-front quad (R-lung) one time a day on even days for drain every other day (order start 9/22/2025) 9/22/2025 12:00 PM: drug refusedIn an observation and interview on 9/21/2025 at 12:34 PM, a coiled catheter was observed to Resident #108's right, lower chest area with a clean, intact dressing dated 9/16/2025. Resident #108 said the catheter had not been accessed since she returned to the facility from the hospital on 9/18/2025. She stated she had been told by multiple unknown nursing staff that they could not drain the catheter because they did not know how. She said an unknown staff member had told her (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yesterday (9/20/2025), that the catheter would be drained today (9/21/2025). Resident #108 said she asked the staff about the draining procedure because she was aware of the physician's order to drain the catheter every other day, and she was aware the schedule was not being followed. She said she did not feel any increase in symptoms even though the catheter had not been drained since before 9/18/2025. Resident #108 denied shortness of breath, chest pain/pressure, or difficulty breathing during the interview. In an interview on 9/23/2025 at 8:31 AM, LVN G said he was the primary nurse for Resident #108, and he was informed during change of shift report that Resident #108 had a PleurX with scheduled draining procedures occurring every five days. He said the next scheduled procedure was on 9/22/2025. LVN G was unaware the physician's order for the PleurX catheter directed nursing staff to perform the procedure every other day, and he stated he would clarify with the physician. He was unsure when the PleurX was last drained. LVN G stated he was hired at the facility approximately 1 month before and did not receive training from the facility on PleurX catheters. He said he felt comfortable accessing Resident #108's PleurX, if needed, because he had prior experience at a different facility. In an interview with ADON A on 9/23/2025 at 12:30 PM, she said she was the primary nurse for Resident #108 on 9/22/2025. She said Resident #108 informed her on 9/22/2025 that the PleurX had been drained on 9/21/2025, but ADON A did not verify this information with the medical record. She said Resident #108 then told her she would prefer to have the PleurX drained every 5 days and did not want the procedure done that day. ADON A said she had forgotten to contact the provider to discuss the request and obtain a modified order for the new frequency. ADON A said she felt comfortable providing care for a PleurX catheter and that training was provided to nursing staff only as needed, but the facility did not document the training. ADON A then said there was no potential harm to Resident #108's chest tube [an alternative descriptor of the device] because the catheter was inserted into Resident #108's abdomen. ADON A clarified that a chest tube is inserted into a person's chest, but Resident #108 had a catheter in her abdomen. ADON A was unable to recall Resident #108's diagnosis that led to the need for a long-term drainage device. In an interview on 9/23/2025 at 3:23 PM, LVN F stated she had accessed and drained Resident #108's PleurX catheter several times in September. She said she had not received training from the facility for PleurX catheters, and she was shown how to perform the procedure by another nurse who was working that day. She said this was the only nurse in the building who knew how to access the PleurX. She was not aware the procedure was to be performed using sterile technique and had not utilized sterile technique on any of the procedures she performed for Resident #108. In an interview with the DON on 9/24/2025 at 8:05 AM, she said the training and skills validation for nursing staff caring for a PleurX was not included on the new hire or annual curriculum. She stated any staff who had not been trained on PleurX catheters are expected to reach out to herself or the nursing leader on call in order to receive training before accessing a PleurX. She said she had not been contacted by any staff for PleurX training since Resident #108 had admitted to the facility. She was unaware that the PleurX draining procedure was not included in Resident #108's care plan, and she felt the task should have been included. She said she was jointly responsible for the care plan with the ADONs and MDS nurse. She was unaware that Resident #108 did not have an order to drain the PleurX on 9/18/2025 or 9/20/2025, and she was unaware Resident #108 had been allegedly refusing the procedure. Record review of the facility document titled Licensed/Registered Nurse Competency Validation Checklist (undated, received 9/23/2025) did not reveal PleurX or chest tubes as a training topic. Record review of the facility policy titled Pleurx Drain Care [sic] revised 9/2024, revealed the following: All procedures must follow aseptic technique and manufacturer guidelines . Review resident's comprehensive care plan for instructions All staff must complete initial and annual competency validation .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5%, for 25 medication administration opportunities with 2 errors resulting in a 8% medication error rate, for 2 of 8 residents (Resident #25 and Resident #126) reviewed for medication administration. 1. LVN K administered to Resident #126 his prescribed insulin aspart after breakfast contrary to the physician's orders. 2. ADON LVN A attempted to administer Resident #25 his prescribed insulin aspart after breakfast contrary to the physician's orders. These failures could place residents at risk for not receiving the therapeutic effects of their medications. The findings included: 1 A record review of Resident #126's admission record dated 9/24/2025 revealed an admission date of 9/15/2025 with diagnoses which included type II diabetes with hyperglycemia (a disease where excess sugar accumulates in the bloodstream and could contribute to infections) and infection of right knee prosthetic (artificial knee). Further review revealed Resident #126 was a [AGE] year-old male. A record review of Resident #126's care plan dated 9/24/2025 revealed, the resident is receiving insulin . blood glucose monitoring as per physician order. A record review of Resident #126's physicians orders dated 9/24/2025 revealed the physician prescribed for Resident #126 to have his blood sugar checked before meals and if needed to receive an injection of insulin according to his blood sugar level, Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML[Jm2] (Insulin Aspart) Inject as per sliding scale: if 151 - 200 = 2 units ; 201 - 250 = 4 units; 251 - 300 = 6 units ; 301 - 350 = 8 units ; 351 - 400 = 10 units ; 401+ = 12 units Call MD/NP for BS greater than 400, subcutaneously before meals and at bedtime for DM Notify MD/NP if over 400 or under 70. During an observation and interview on 9/23/2025 at 8:46 AM revealed Resident #126 in his bed with his bedside table across his lap. The bedside table presented with the remains of his breakfast. Resident #126 stated he had eaten breakfast about 20 minutes ago and he had not yet had his blood sugar checked. Resident #126 stated he would receive an injection of insulin if his blood sugar was high. Resident #126 stated he was supposed to have his blood sugar checked before breakfast and if needed he would receive his insulin before breakfast. During an observation and interview on 9/23/2025 at 8:48 AM revealed LVN K assessed Resident #126's blood sugar level as 155. LVN K prepared and administered 2 units of insulin aspart subcutaneously, LVN K stated she had administered Resident #126's insulin after breakfast because she did not want to administer his insulin to far ahead of his breakfast for fear he would crash regarding the insulin aspart was fast acting and would lower his blood sugar with possible negative outcomes. LVN K stated I wait to see if the meal carts were on the hall and then I administer the insulins. 2 record review of Resident #25's admission record dated 9/24/2025 revealed an admission date of 9/8/2025 with diagnoses which included diabetes type II, cerebral palsy (neurological disorders that affect movement, posture, and muscle coordination, typically caused by damage to the developing brain), and chronic kidney disease (kidney failure). Further review revealed Resident #25 was a [AGE] year-old male. A record review of Resident #25's care plan dated 9/24/2025 revealed, the resident is receiving insulin . blood glucose monitoring as per physician order. A record review of Resident #25's physicians orders dated 9/24/2025 revealed the physician prescribed for Resident #25 to have his blood sugar checked before meals and if needed to receive an injection of insulin according to his blood sugar level, Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 151 - 200 = 2 units ; 201 - 250 = 4 units; 251 - 300 = 6 units ; 301 - 350 = 8 units ; 351 - 400 = 10 units ; 401+ = 12 units Call MD/NP for BS greater than 400, subcutaneously before meals and at bedtime for DM Notify MD/NP if over 400 or under 70. A record review of the American Diabetes Association's website https://diabetes.org/health-wellness/medication/insulin-routines accessed 9/30/2025, titled When to Take Insulin for Diabetes revealed, Insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	example, regular insulin works best if you take it 30 minutes before you eat. During an observation and interview on 9/23/2025 at 8:39 AM revealed ADON A prepared to administer Resident #25's insulin by first assessing his blood sugar. ADON A assessed Resident #1's blood sugar as 138. ADON A stated per the physicians' orders he would not receive an insulin injection. ADON A stated the physicians orders stated to administer the insulin prior to meals but she waited to administer Resident #25's insulin until after breakfast because she was concerned he may drop in blood sugar with potential negative outcomes. ADON A stated she would wait until the breakfast trays were out on the floor and then administer the insulin injections. ADON A stated Resident #25 was assessed with a blood sugar level of 138 after breakfast. During an observation and interview on 9/23/2025 at 8:40 AM revealed Resident #25 in his bed with his bedside table across his lap. The bedside table presented with the remains of his breakfast. Resident #25 stated he had eaten breakfast about 20 minutes ago which included sausage, eggs, toast, and oatmeal. Resident #25 stated he had just had his blood sugar checked after breakfast. During an interview on 9/24/2025 at 4:00 pm the administrator and the DON stated the expectation for insulin orders was for the nursing staff to follow physician's orders and check residents blood sugar levels before breakfast and then administer any insulins as needed before meals. The DON stated potential negative outcomes for residents could be not receiving the therapeutic effects of their medications as prescribed by their physicians. A record review of the facility's policy Medication Errors dated May 2023, revealed, POLICY: 1. An occurrence report is completed for all medication errors. 2. The DON reviews medication errors and reports them as appropriate.		

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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 observations, interviews, and record reviews the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access, for 1 of 6 medication carts (200-hall medication cart), reviewed for security. LVN G left the 200-hall west medication cart unattended and unlocked. This failure could place residents at risk for having their medications accessible to unauthorized people. The findings included: During an observation and interview on 9/23/2025 at 10:43 AM revealed the 200-hall west medication cart parked in the 200-hall west hallway unlocked and unattended. Further review revealed staff and residents ambulated nearby in the hallway. During an interview on 9/23/2025 at 10:45 AM ADON J stated the cart was assigned to LVN G. ADON J stated the expectation was for the medication carts to be locked when not attended. During an interview on 9/23/2025 at 10:49 AM LVN G stated he was in a resident's room assessing their blood sugar. LVN G stated he could not see his medication cart from within the residents' room because he provided privacy for the Resident and had the residents room door closed. LVN G stated he left the medication cart unlocked because of human error. LVN G stated a potential negative outcome could be loss of control of residents' medications. During an interview on 9/24/2025 at 4:00 PM the administrator and the DON stated the facility's expectation was for medication carts to be secured and locked when the staff were not directly using the medication cart. The DON stated the potential negative outcome could be loss of control of resident's medications. A record review of the facility's policy STORAGE OF MEDICATION dated January 2023 revealed, POLICY Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. PROCEDURES . 3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.		