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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676449	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Fort Worth, LLC	6301 Oakmont Blvd Fort Worth, TX 76132

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assured accurate administering of all drugs to meet the needs of the residents, for 1 resident (Residents #1) of 5 residents reviewed for medication regimen in that: LVN A and MA B failed to follow physician orders when they administered Resident #1's Bidil (heart medication) on [DATE] and [DATE] and the resident's blood pressure was not within the physician-ordered parameters. This failure could place residents at risk for not receiving the therapeutic benefits of the prescribed medications, which could lead to harm or a decline in health. Findings included: Record review of Resident #1's Face Sheet, dated [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: heart failure, Human Immunodeficiency Virus (HIV), type 2 diabetes, thrombocytopenia (low blood platelet count), kidney failure, severe sepsis (body's extreme reaction to infection), and pulmonary edema (fluid in lungs). Record review of Resident #1's PPS MDS assessment, dated [DATE], reflected the resident had a BIMS score of 03, which indicated severe cognitive impairment. Further review reflected Resident #1 needed moderate to maximal assistance with most ADLs. Record review of Resident #1's care plan, dated [DATE], reflected the resident was not care planned for the administration of the medication, BiDil. Record review of Resident #1's physician orders reflected an order for BiDil Oral Tablet ,d+[DATE].5 MG, give 1 tablet by mouth two times a day for heart failure . hold for SBP < 110, DBP <60, HR <60, ordered and started on [DATE]. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's electronic MAR and vitals record reflected on [DATE], LVN A obtained a blood pressure of ,d+[DATE] and administered the evening dose of medication, BiDil. Further review reflected on [DATE], MA B obtained a blood pressure of ,d+[DATE] and administered the morning dose of medication, BiDil. On [DATE], LVN A obtained a blood pressure of ,d+[DATE] and administered the evening dose of medication, BiDil. On [DATE], LVN A obtained a blood pressure of ,d+[DATE] and administered the evening dose of medication, BiDil. Record Review of Resident #1's progress notes on [DATE] and [DATE] reflected there were no MAR errors documented by LVN A or MA B. In an interview on [DATE] @ 5:45 PM, Resident #1's family stated the resident was sent out to a local hospital on [DATE] and expired on [DATE]. Due to the circumstance, the family stated she was not available to complete a full interview. In an interview on [DATE] at 1:52 PM, the NP stated she was the attending nurse at the nursing facility and saw Resident #1 multiple times. The NP stated Resident #1 admitted to the nursing facility from a local hospital in a critical state and it was recommended for her to go on dialysis or hospice, and the family refused both. The NP stated Resident #1 was taking the medication, BiDil, for her heart and it had been recently adjusted by the MD due to abnormal laboratory results. The NP stated she did not recall staff at the nursing facility calling to inform her that Resident #1's blood pressure was outside of the parameters and her BiDil needed to be held. In an interview on [DATE] at 3:50 PM, the MD stated Resident #1 was terminally ill, and she had a decline in health as anticipated based on comorbidities. The MD stated the family would not consent to any aggressive treatments due to Resident #1's age. The MD stated Resident #1 was ordered BiDil for her heart disease and there were blood pressure parameters placed for administration. The MD stated he was not notified by staff on [DATE] or [DATE] that Resident #'1's blood pressure was outside of the parameters and that her BiDil needed to be held. The MD stated although there were blood pressure parameters, the medication did not have a significant impact on the resident's blood pressure, so if staff would have notified him, he would have likely told them to go ahead and administer the medication; however, his expectation would have been for staff to contact him and provide full clinical details so he could make a determination. In an interview on [DATE] at 4:45 PM, MA B stated he worked at the facility for 7 months. MA B stated he worked with Resident #1 and administered her medications. MA B stated he always checked her blood pressure prior to administering BiDil and any other medications that had blood pressure parameters based on protocol. MA B stated he had never administered Resident #1 medications if her blood pressure was outside of the parameters. MA B stated if he signed the MAR indicating that Resident #1's BiDil was administered on [DATE] and her blood pressure was outside of the parameters, it was a mistake. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 5:25 PM, LVN A stated she worked with Resident #1 and administered her medications. LVN A stated it was protocol to check the blood pressure before administering medications such as blood pressure and heart medications. LVN A stated if the blood pressure was outside of the parameters, she would wait a while and re-check the blood pressure and if it was still outside of the parameters, she would hold the medications. LVN A stated she would hold the medication without notifying the MD if the blood pressure was not too far outside of the parameters. LVN A stated she would notify the MD if the SBP was less than 100, for example. LVN A stated Resident #1 had blood pressure parameters on her heart medication, and she always checked the resident's blood pressure before administering it. LVN A stated if Resident #1's blood pressure was outside of the parameters, she would not have administered the BiDil. LVN A stated she sometimes got Yes happy when signing off on the MAR and could have accidentally marked the BiDil as administered on [DATE] and [DATE]. LVN A stated if she made a mistake on the MAR and caught it, she would make a late-entry progress note to document it; however, she was unaware of this mistake. Interview on [DATE] at 5:45 PM, the Regional Nurse stated it was her expectation for staff to check a resident's blood pressure before administering a medication that had blood pressure parameters on it., and if the blood pressure was outside of the parameters to notify the MD for further instructions. The Regional Nurse stated if staff accidentally marked that a medication was administered when it was not, they could document the error in progress notes. The Regional Nurse stated a medication such as BiDil would have minimal effect on the blood pressure, but generally administering medications when a resident's blood pressure was outside of physician-ordered parameters could place them at risk of extremely low blood pressure. Review of the facility's policy titled Administration of Medications, revised ,d+[DATE], revealed in part the following: Policy: 1. A physician or nurse practitioner order is required for administration of all medication. 2. Medications are administered by licensed personnel only. Procedure: . 20. Vital signs are taken as required prior to medications and written on MAR. Medications with supplementary documentation and/or hold parameters must be reviewed and within range to administer prior to administering the medication.