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	09/04/2024

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one (Resident #1) of six residents reviewed for ileostomy care. The facility failed to follow proper ileostomy care which led to Resident #1's skin being excoriated around the site area and caused stool to seep out of the ileostomy. This failure could place residents with an ostomy at risk of infection, ostomy occlusion, or decreasing feelings of self-esteem. Findings included: Resident #1 Review of Resident #1's admission record dated 09/04/2024, revealed a [AGE] year-old male who was readmitted to the facility on [DATE] with an initial admitted [DATE] . His diagnoses included abscess of the liver (this is a mass in the liver filled with pus), Type 2 diabetes mellitus (uncontrolled blood sugar), Parkinsonism (a progressive nervous system disorder, which affects the ability to move muscles), non-traumatic perforation of the intestine (loss of continuity of the bowel wall/a hole in the wall of the colon), acquired absence of other parts of the digestive tract (part of the digestive tract was removed), need for assistance with personal care, ileostomy status (this is a small surgical opening in the abdomen where part of the intestine is cut for bowel movement to come out due part of the colon being removed), anemia (low red blood cells), and neoplasm of the large intestine (cancer of large intestine). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Care plan dated 08/23/2024, reflected a BIMS score of seven out of fifteen, indicating Resident #1 had impaired cognitive function and/or impaired thought process. Goal-Resident #1 would be able to communicate basic needs daily through the review date 09/10/2024. Interventions included asking yes/no questions to determine the resident's needs. Date Initiated: 08/23/2024. The care plan also reflected Resident #1 had actual impaired skin integrity related to a surgical wound and Resident #1 had an ileostomy which was an excoriated site [damaged or removed part of top layer of skin] that caused appliances not to stick causing increased burning. Initiated 08/23/2024. Goal was that Resident #1's skin injury would be healed by review date 09/10/2024 and Resident #1 would have no complications r/t documented skin impairment through the review date 09/10/2024. Interventions included: Keep skin clean and dry. Use lotion on dry skin, nurse to assess record/monitor wound healing with dressing changes. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements or declines to the MD . Date Initiated: 08/23/202 Pain: Evaluate residents for changes in pain level and if appropriate request a scheduled pain medication from the physician. Date Initiated: 08/23/2024 wound care consults and follow up as needed. Date Initiated: 09/03/2024. Record review of Resident #1's physician orders on 09/04/2024 reflected: 1.Acetaminophen Capsule 500 MG. Give 2 tablets by mouth every 8 hours as needed for Pain, Temp. Order Date-08/29/2024 1543. 2.Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 100 MG by mouth every 6 hours as needed for pain. Order Date- 08/20/2024 1805. 3. Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 50 MG by mouth every 6 hours as needed for pain. Order date 08/20/24. 4. Gabapentin oral capsule 300 MG. Give 1 capsule by mouth three times a day for nerve pain. Order date 08/20/2024. 5. Pack abdominal wound with calcium alginate, cover with dry dressing every day shift. Order date 09/02/2024. Record review of Resident #1's MARs/TARs revealed: Pain medications Tramadol and/or Acetaminophen were not administered on 09/04/2024 by RN G or by RN H before wound care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #1 and RN H on 09/04/2024 at 10:45 AM, revealed Resident #1 lying in bed awake. Resident #1 could answer simple questions. RN H was at the bedside preparing to start ileostomy skin-adhere bag change. [this is the process where the ileostomy bag is stuck to the skin around the stoma/opening to be able to collect bowel movement into the bag]. Resident #1 had a white dressing in the middle of his abdomen. On the right side of his abdomen was his ileostomy bag. RN H asked Resident #1 if he had his fan to help with the pain of changing the ileostomy. RN H said that the small handheld fan helped to sooth the burning of Resident #1's skin during the ileostomy bag change. Resident #1 said that he had not had pain medication. RN H interjected and stated, yes you had pain medicine a little while ago, before wound care. Resident #1 then replied, oh ok, I guess I forgot. I need to get off these pain meds anyway. RN H then proceeded to remove the ileostomy bag that was stuck to his skin. After RN H removed the ileostomy bag, the skin was noted as bright, red, raw, with a top layer of skin missing around the ileostomy stoma and bright redness cascading towards the lower right side of Resident #1's abdomen. Resident #1 moaned and grimaced with pain for ten minutes as RN H removed the ileostomy bag from his skin, pat dried his skin, and covered the stoma with the new ileostomy bag. RN H told Resident #1 to use his fan for pain relief. Interview with Resident #1 on 09/04/2024 at 11:15 AM, he stated he did not remember getting any pain medication. He said he was not sure he was given pain medication before his colon bag change. He stated he was aware that he took his gabapentin for his leg pain due to diabetic nerve pain, but it did not help with the abdominal pain. Resident #1 did not state his pain level but he stated the procedure was painful. Interview with RN H on 09/04/2024 at 10:59 AM, she stated she was sure that RN G administered pain medication to Resident #1 this morning. RN H said that she did not check the MAR to verify pain medication administration before wound care. She said it was her responsibility as well as the attending nurse to make sure the resident was medicated before wound care. She said that the ileostomy bag on Resident #1 was changed up to 5 times a day because it was leaking around the stoma which was causing skin excoriation around the abdomen. She said that she was aware that Resident #1 had burning pain during the bag change and that was why she encouraged him to use the fan to help blow the stinging off his skin. RN H did not state the risk to Resident #1 not receiving pain medication before the procedure. In an interview with RN G on 09/04/2024 at 11:39 AM, she stated she had administered Resident #1's Tylenol [Acetaminophen] with all his other medications earlier when she administered his morning meds. RN G stated she gave the Tylenol because the nightshift nurse had already administered Tramadol during the night. RN G stated she documented the other medications given to Resident #1, but she forgot to document that she had administered the Tylenol. She stated she did not verify the time the Tramadol was last administered to Resident #1. She stated she was not aware the last dose of Tramadol was on 09/03/24 at 7:26 PM. She stated residents have a right to their medication and that medication administration should be documented at the time of administration. She said the risk to the resident was that it appeared as if he did not get his pain medicine. She did not state Resident #1's pain level. She stated pain medication should be given before ileostomy care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 09/04/2024 at 05:16 PM, she stated the nurses should document medication administration at the time of giving the medication. She stated that waiting to chart medication administration an hour or more later could cause the potential for a medication error. She stated the risk to Resident #1 was someone else could administer more pain medication to the resident not knowing that another nurse had already administered medication because it was not reflected on the MAR causing an adverse effect. The DON stated she expected the nursing staff to administer pain medication as ordered and the wound care nurse (RN H) was highly favored by the wound doctor because of her attention to detail. The DON sated RN H should have assessed Resident #1's pain before wound care. She stated she expected all nursing staff to do a pain assessment to determine the effectiveness of the pain medication. She said herself and the ADONs were monitoring pain assessments and auditing pain scales over five every week. She stated she expected the nursing staff to utilize the PRN pain medication until pain was acceptable. She said this failure could affect the resident by increasing his pain level. In an interview with the ADM on 09/04/2024 at 06:41 PM, she stated the DON and the ADON's had just done in-service training on pain management and pain assessments. She stated she expected all staff to follow the facility policies and to monitor pain effectively. She stated all staff should document everything they do. She stated nurses were responsible for pain management and assessments. ADM stated not following pain management and assessments protocols could cause residents increased pain. Record review of the facility's policy titled Pain Management dated 10/2022 (revised 5/2023, 05/2024) reflected .It is the policy of this facility to respect and support the resident's right to optimal pain assessment and management. This facility recognizes that residents may have decreased sensations or perceptions of pain. They may consider pain an inevitable part of aging. Chronic pain may produce anorexia, lethargy, depression, immobility, social isolation. Residents may not report pain due to fear of expense, possible treatment, or a fear of dependency or addiction. Residents often describe pain in non-medical terms such as hurt or ache. Each and every resident has a right to the assessment and management of pain.Pain Recognition Expressions of pain may be verbal or nonverbal and are subjective to the resident including but not limited to: ? Negative verbalizations and vocalizations (groaning, crying, whimpering, screaming) ? Facial expressions (grimacing, frowning, fright, clenching of jaw ? Changes in gait, skin color, vital signs, perspiration ? Behavior such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities ? Loss of function or inability to perform ADLs. ? Difficulty eating or loss of appetite. ? Difficulty sleeping .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services according to professional standards of maintenance for one (Resident #2) of one resident reviewed for enteral feeding The facility failed to ensure Resident #2's eternal tube water flush was set at 200 ML/every 4 hrs. as per order. This failure could place residents at risk of infection due to not following appropriate procedures. Findings included: Resident #2 Review of Resident #2's admission record dated 09/04/2024, revealed a [AGE] year-old male that admitted to the facility on [DATE]. His diagnoses included encephalopathy (this is a brain disease that alters brain function or structure), gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing aka G-tube/external tube), adult failure to thrive, hypertension (high blood pressure), difficulty walking, refractory cytopenia with multilineage dysplasia and ring, side oblasts (this is a syndrome in which the body has low levels of at least two types of blood cells and abnormal bone marrow cell appearance), personal history of malignant neoplasm of other organs and systems (cancer in other organs), and irritable bowel syndrome with diarrhea. Review of Resident #2's quarterly MDS dated [DATE], revealed it was in progress. Review of Resident #2's orders dated 09/04/2024, reflected Enteral Feed Order every shift for Hydration enteral tube: continuous Water flush at 200 ML/4HR per Feeding Tube via Pump. Communication method: Prescriber Written. Active 09/03/2024. Enteral Feed Order every shift Osmolite 1.5 per TF via pump at 55cc/hour continuous communication method: Prescriber Written Active 08/31/2024. Review of Resident #2's admission MDS dated [DATE] reflected in progress. Observation on 09/04/2024 at 09:54 AM, revealed Resident #2 lying in bed. He could not answer questions. His tube feeding was connected to him running. Feed rate at 55 mL/hr. Water flush rate 150 mL every 4 hrs. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LVN C on 09/04/2024 at 12:46 PM, LVN C flushed Resident #2's g-tube and connected it to the feeding pump. Rate was set as feed rate at 55 mL/hr. Water flush rate was 150 mL every 4 hrs. LVN C said that she had worked with Resident #2 for so long that she forgot to check his external feed orders because she thought it was still the same rate. She stated the physician changed the order for Resident #2 on 09/03/2024 according to orders on her computer from 150 mL to 200 mL every 4 hours. She stated she should have looked at the orders for Resident #2 before reconnecting his tube feeding. She stated the risk to Resident #2 was that his water was increased therefore if not set at the new rate it could cause dehydration. She stated when physicians change the fluid rates it was due to some imbalance of the residents' labs. In an interview with ADON B on 09/04/2024 at 2:27 pm, she stated both herself and ADON A monitored all orders for wound dressings, central lines, urinary catheters, feeding tubes, tracheostomy, and isolations. She stated it was the responsibility for the nurses to put in the orders, and then she would go in and verify or change accordingly. ADON B stated she expected all nursing staff to obtain orders for care and to follow orders as prescribed. She stated if a nurse had a question about the orders to ask her, ADON A, the DON, or the physician for clarity . She stated failure to obtain orders could delay care for residents. In an interview with the DON on 09/04/2024 at 5:16 PM, she stated LVN C should have checked orders before reconnecting Resident #2 to his feeding pump. She stated everyone was human and could make errors. She stated it was good practice to check orders before a procedure. She stated LVN C has had several non-compliant issues and she would be terminated. She stated she expected all nursing staff to obtain orders for care and to follow orders as prescribed. She stated orders drive care . She stated failure to obtain orders could cause missing procedures. In an interview with the ADM on 09/04/2024 at 06:41 PM, she stated the policies were put in place to make the job easier not harder. She stated she did not expect staff to memorize the facility policy but to refer to it and to ask questions when they did not understand something . She stated the expectation was for nurses to obtain orders. She stated failure to obtain orders could delay treatments and care. Review of facility policy titled Physician Orders dated November 2018. Revision dates 10/2019, 11/2020, 11/2021, 12/2022, and 05/2023. Policy reflected . 1. Orders may be called, hand-written, faxed, or electronically generated by physician. 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 transcribe all written orders promptly and accurately. The RN or LPN must include his/her signature, the date and time of the transcription and credentials. Orders that are unclear must be clarified prior to implementation. 4. In the event of an emergency, including but not limited to: a. 911 calls b. Involuntary discharges c. Other notable emergencies (IE natural disasters, building emergencies etc.) Documentation of the physician's order in the progress notes is sufficient. Documentation must state the reason for discharge.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of six residents (Resident #1) reviewed for pain management. The facility failed to administer Resident #1's pain medication Acetaminophen 1000 mg and/or Tramadol 100 mg for pain before wound care. This failure could place residents at risk for increased pain due to not having their pain medication when it was available. Findings included: Resident #1 Review of Resident #1's admission record dated 09/04/2024, revealed a [AGE] year-old male who was readmitted to the facility on [DATE] with an initial admitted [DATE] . His diagnoses included abscess of the liver (this is a mass in the liver filled with pus), Type 2 diabetes mellitus (uncontrolled blood sugar), Parkinsonism (a progressive nervous system disorder, which affects the ability to move muscles), non-traumatic perforation of the intestine (loss of continuity of the bowel wall/a hole in the wall of the colon), acquired absence of other parts of the digestive tract (part of the digestive tract was removed), need for assistance with personal care, ileostomy status (this is a small surgical opening in the abdomen where part of the intestine is cut for bowel movement to come out due part of the colon being removed), anemia (low red blood cells), and neoplasm of the large intestine (cancer of large intestine). Review of Resident #1's Care plan dated 08/23/2024, reflected a BIMS score of seven out of fifteen, indicating Resident #1 had impaired cognitive function and/or impaired thought process. Goal-Resident #1 would be able to communicate basic needs daily through the review date 09/10/2024. Interventions included asking yes/no questions to determine the resident's needs. Date Initiated: 08/23/2024. The care plan also reflected Resident #1 had actual impaired skin integrity related to a surgical wound and Resident #1 had an ileostomy which was an excoriated site [damaged or removed part of top layer of skin] that caused appliances not to stick causing increased burning. Initiated 08/23/2024. Goal was that Resident #1's skin injury would be healed by review date 09/10/2024 and Resident #1 would have no complications r/t documented skin impairment through the review date 09/10/2024. Interventions included: Keep skin clean and dry. Use lotion on dry skin, nurse to assess record/monitor wound healing with dressing changes. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements or declines to the MD . Date Initiated: 08/23/202 Pain: Evaluate residents for changes in pain level and if appropriate request a scheduled pain medication from the physician. Date Initiated: 08/23/2024 wound care consults and follow up as needed. Date Initiated: 09/03/2024. Record review of Resident #1's physician orders on 09/04/2024 reflected: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	1.Acetaminophen Capsule 500 MG. Give 2 tablets by mouth every 8 hours as needed for Pain, Temp. Order Date-08/29/2024 1543. 2.Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 100 MG by mouth every 6 hours as needed for pain. Order Date- 08/20/2024 1805. 3. Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 50 MG by mouth every 6 hours as needed for pain. Order date 08/20/24. 4. Gabapentin oral capsule 300 MG. Give 1 capsule by mouth three times a day for nerve pain. Order date 08/20/2024. 5. Pack abdominal wound with calcium alginate, cover with dry dressing every day shift. Order date 09/02/2024. Record review of Resident #1's MARs/TARs revealed: Acetaminophen had not been administered since 08/30/2024 at 11:56 AM by LVN RN G pain rated at five out of ten. Tramadol 100 MG (2 tablets) were administered on 09/01/2024 at 11:00 AM for pain of five out of ten by RN G Tramadol 50 MG (1 tablet) was administered on 09/02/2024 at 11:14 AM by LVN E. Pain rated at seven out of ten. Tramadol 50 MG (1 tablet) was administered on 09/02/2024 at 05:39 PM by LVN E. Pain rated at five out of ten. Tramadol 100 MG (2 tablets) were administered on 09/03/2024 at 7:26 PM by LVN F. Pain rated six out of ten. Pain medications Tramadol and/or Acetaminophen were not administered on 09/04/2024 by RN G or by RN H before wound care. Gabapentin 300 MG for nerve pain was administered as ordered. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Observation and interview with Resident #1 and RN H on 09/04/2024 at 10:45 AM, revealed Resident #1 lying in bed awake. Resident #1 could answer simple questions. RN H was at the bedside preparing to start ileostomy skin-adhere bag change. [this is the process where the ileostomy bag is stuck to the skin around the stoma/opening to be able to collect bowel movement into the bag]. Resident #1 had a white dressing in the middle of his abdomen. On the right side of his abdomen was his ileostomy bag. RN H asked Resident #1 if he had his fan to help with the pain of changing the ileostomy. RN H said that the small handheld fan helped to sooth the burning of Resident #1's skin during the ileostomy bag change. Resident #1 said that he had not had pain medication. RN H interjected and stated, yes you had pain medicine a little while ago, before wound care. Resident #1 then replied, oh ok, I guess I forgot. I need to get off these pain meds anyway. RN H then proceeded to remove the ileostomy bag that was stuck to his skin. After RN H removed the ileostomy bag, the skin was noted as bright, red, raw, with a top layer of skin missing around the ileostomy stoma and bright redness cascading towards the lower right side of Resident #1's abdomen. Resident #1 moaned and grimaced with pain for ten minutes as RN H removed the ileostomy bag from his skin, pat dried his skin, and covered the stoma with the new ileostomy bag. RN H told Resident #1 to use his fan for pain relief. Interview with Resident #1 on 09/04/2024 at 11:15 AM, he stated he did not remember getting any pain medication. He said he was not sure he was given pain medication before his colon bag change. He stated he was aware that he took his gabapentin for his leg pain due to diabetic nerve pain, but it did not help with the abdominal pain. Resident #1 did not state his pain level but he stated the procedure was painful. Interview with RN H on 09/04/2024 at 10:59 AM, she stated she was sure that RN G administered pain medication to Resident #1 this morning. RN H said that she did not check the MAR to verify pain medication administration before wound care. She said it was her responsibility as well as the attending nurse to make sure the resident was medicated before wound care. She said that the ileostomy bag on Resident #1 was changed up to 5 times a day because it was leaking around the stoma which was causing skin excoriation around the abdomen. She said that she was aware that Resident #1 had burning pain during the bag change and that was why she encouraged him to use the fan to help blow the stinging off his skin. RN H did not state the risk to Resident #1 not receiving pain medication before the procedure. In an interview with RN G on 09/04/2024 at 11:39 AM, she stated she had administered Resident #1's Tylenol [Acetaminophen] with all his other medications earlier when she administered his morning meds. RN G stated she gave the Tylenol because the nightshift nurse had already administered Tramadol during the night. RN G stated she documented the other medications given to Resident #1, but she forgot to document that she had administered the Tylenol. She stated she did not verify the time the Tramadol was last administered to Resident #1. She stated she was not aware the last dose of Tramadol was on 09/03/24 at 7:26 PM. She stated residents have a right to their medication and that medication administration should be documented at the time of administration. She said the risk to the resident was that it appeared as if he did not get his pain medicine. She did not state Resident #1's pain level. She stated pain medication should be given before ileostomy care. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In an interview with the DON on 09/04/2024 at 05:16 PM, she stated the nurses should document medication administration at the time of giving the medication. She stated that waiting to chart medication administration an hour or more later could cause the potential for a medication error. She stated the risk to Resident #1 was someone else could administer more pain medication to the resident not knowing that another nurse had already administered medication because it was not reflected on the MAR causing an adverse effect. The DON stated she expected the nursing staff to administer pain medication as ordered and the wound care nurse (RN H) was highly favored by the wound doctor because of her attention to detail. The DON sated RN H should have assessed Resident #1's pain before wound care. She stated she expected all nursing staff to do a pain assessment to determine the effectiveness of the pain medication. She said herself and the ADONs were monitoring pain assessments and auditing pain scales over five every week. She stated she expected the nursing staff to utilize the PRN pain medication until pain was acceptable . She said this failure could affect the resident by increasing his pain level. In an interview with the ADM on 09/04/2024 at 06:41 PM, she stated the DON and the ADON's had just done in-service training on pain management and pain assessments. She stated she expected all staff to follow the facility policies and to monitor pain effectively. She stated all staff should document everything they do . She stated nurses were responsible for pain management and assessments. ADM stated not following pain management and assessments protocols could cause residents increased pain. Record review of the facility's policy titled Pain Management dated 10/2022 (revised 5/2023, 05/2024) reflected .It is the policy of this facility to respect and support the resident's right to optimal pain assessment and management. This facility recognizes that residents may have decreased sensations or perceptions of pain. They may consider pain an inevitable part of aging. Chronic pain may produce anorexia, lethargy, depression, immobility, social isolation. Residents may not report pain due to fear of expense, possible treatment, or a fear of dependency or addiction. Residents often describe pain in non-medical terms such as hurt or ache. Each and every resident has a right to the assessment and management of pain.Pain Recognition Expressions of pain may be verbal or nonverbal and are subjective to the resident including but not limited to: ? Negative verbalizations and vocalizations (groaning, crying, whimpering, screaming) ? Facial expressions (grimacing, frowning, fright, clenching of jaw ? Changes in gait, skin color, vital signs, perspiration ? Behavior such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities ? Loss of function or inability to perform ADLs. ? Difficulty eating or loss of appetite. ? Difficulty sleeping .

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	676449	A. Building B. Wing	09/04/2024

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for one of two hallways (A hallway) medications carts in hallways that were reviewed for security and storage of drugs and biologicals. The facility failed to ensure LVN C locked and secured medication cart when unattended and out of view on A hallway. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversions. Findings included: Resident #2 Review of Resident #2's admission record dated 09/04/2024, revealed a [AGE] year-old male that admitted to the facility on [DATE]. His diagnoses included encephalopathy (this is a brain disease that alters brain function or structure), gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), adult failure to thrive, hypertension (high blood pressure), difficulty walking, refractory cytopenia with multilineage dysplasia and ring, side oblasts (this is a syndrome in which the body has low levels of at least two types of blood cells and abnormal bone marrow cell appearance), personal history of malignant neoplasm of other organs and systems (cancer in other organs), and irritable bowel syndrome with diarrhea. Observation on A hallway on 09/04/2024 from 12:38 pm to 12:46 pm, revealed LVN C entered Resident #2's room after putting on PPE. She placed the medication cart in the doorway. LVN C was observed not locking the medication cart as she went into Resident #2's bathroom to get some water to flush the G-tube. LVN C could not visually see the medication cart from the bathroom. LVN C then went to Resident #2's bed to reconnect his feeding. Before reconnecting the feeding, LVN C went to the medication cart took her gloves off and sanitized her hands but dropped the bottle of hand sanitizer. She opened the medication cart and took out an alcohol pad. She closed the top drawer of the medication cart and walked back into Resident #2's room leaving the medication card unlocked again. LVN C could not see the medication cart as the wall blocked the view to the doorway. ADON B walked over to the unlocked medication and pushed it to the right side of doorway to make room so that ADON B was able to pick up the hand sanitizer than LVN C dropped and placed it on top of the unlocked medication cart. LVN C did not see ADON B move the unlocked medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 09/04/2024 at 12:46 PM, she stated she left the medication cart unlocked because she was using it while in Resident #2's room. She stated the medication cart was out of view when she was in Resident #2's bathroom and when she was at his bedside reconnecting the feeding tube. She said that she did not see ADON B touch and move the unlocked medication cart to pick up the hand sanitizer bottle that she had dropped on the floor. LVN C stated she should have locked the medication cart when it was out of sight. She stated failure to lock the medication cart when unattended could cause risk to residents gaining access the medication that could be harmful to them and gives access to drug diversion. In an interview with ADON B on 09/04/2024 at 2:27 pm, she stated that when she saw the state surveyor checking the medication cart, she did not know that LVN C had left it unlocked and out of sight. She stated when she pushed it out of the way to pick up the sanitizer, she should have made sure that the medication cart was locked. ADON B stated she usually checked all unattended medication carts on hallways when she was walking by to make sure that they were locked and secured. She stated the risk was that anyone can have access to unlocked medication cart and even Tylenol, Benadryl, and OTC medication could harm a person if taken unsafely. She stated medication carts should be locked when not in use and out of sight. In an interview with DON on 09/04/2024 at 5:16 PM, she stated the medication carts have to be locked when not used. She said it was not ok to leave medication carts unlocked when not in use. She stated she had just done an in-service for med carts. She said that she even made rounds and did one on one with staff when she finds a cart was not locked. The DON stated the medication cart could be placed in doorway and unlocked when in use, however the nurse or medication aide must have the medication cart in their line of vision (can see the cart wherever they are in the room). The DON stated the risk was safety and security and there were dangerous things on the cart that someone could have access to on the medication cart. In an interview with the ADM on 09/04/2024 at 06:41 PM, she stated the DON and the ADON's had just done an in-service training on medication carts. She stated she expected all staff to follow the facility policies. The ADM stated that her expectations were for the medications to be locked up anytime a nurse walked away from it. She stated that the person that was assigned to a medication cart was responsible for it. She said that staff were all trained on medication expectations and know not to leave med carts unlocked . ADM stated no locking med carts could affect residents by providing access to medications that they should not have. Record review of in-service training completed on 08/27/2024. Instructed by the DON titled follow up on missing medications (document in notes attempts to obtain medications, contact physicians/NP when meds are unavailable) keep meds carts locked when not in front of the cart. Nurses to assistant on the floor with care when aides are tied up with another guest . Signed by 9 staff RN's and LVN. LVN C signed in-service. Record review of facility policy titled Medication Storage in The Facility: ID1: Storage of Medication, revision date January 2019, reflected, Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medications supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete, accurately documented, readily accessible, and systematically organized for two of seven residents (Resident #1) reviewed for resident records. The facility failed to ensure Resident #1 had physician orders for PICC line dressing and care. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information records. Findings included: Resident #1 Review of Resident #1's admission record dated 09/04/2024, revealed a [AGE] year-old male who was readmitted to the facility on [DATE] with an initial admitted [DATE]. His diagnoses included abscess of the liver (this is a mass in the liver filled with pus), Type 2 diabetes mellitus (uncontrolled blood sugar), Parkinsonism (a progressive nervous system disorder, which affects the ability to move muscles), non-traumatic perforation of the intestine (loss of continuity of the bowel wall/a hole in the wall of the colon), acquired absence of other parts of the digestive tract (part of the digestive tract was removed), need for assistance with personal care, ileostomy status (this is a small surgical opening in the abdomen where part of the intestine is cut for bowel movement to come out due part of the colon being removed), anemia (low red blood cells), and neoplasm of large intestine (cancer of large intestine). Review of Resident #1's quarterly MDS dated [DATE] was in progress. Review of Resident #1's progress notes on 09/04/2024 did not reflect PICC line/IV dressing changes and IV management physician orders. Review of Resident #1's Care plan date initiated 08/23/2024, revealed Resident #1 was receiving IV medication Daptomycin and Ceftriaxone for VRE. Goal was Resident #1 would not have any complications related to IV therapy through the review date 09/10/2024. Interventions included If IV is infiltrated: Antidote for vesicant/irritant med MAY be infused into IV catheter prior to removal. Check nursing drug handbook or pharmacy for recommended antidote. Check facility policy re administration of vesicant, vaso-constricting [vein narrowing], or corrosive medications and extravasation antidotes. Intervene accordingly before discontinuing IV site. o If IV is infiltrated: stop infusion and thoroughly examine the site. If the catheter appears to be lodged in the tissues, an attempt to aspirate any fluid remaining in the catheter can be made to lessen the amount of drug at the site. After (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removing the cannula, elevate the affected arm, notify the physician (for large infiltrations and extravasations), and apply cool compresses (warm, if [NAME] alkaloids are involved). o IV DRESSING: Observe dressing every shift. Change dressing and record observations of site weekly. o IV flushes per physician's orders. Date Initiated: 08/23/2024. o Monitor/document/report PRN s/sx of infection at the site: Drainage, Inflammation, Swelling, Redness, Warmth. o Monitor/document/report PRN s/sx of leaking at the IV site: Edema at the insertion site, taut, shiny, or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of I.V. fluid out of the insertion site. o Resident is on Enhanced Barrier Precautions. Review of Resident #1's active order dated 09/04/2024, reflected Ceftriaxone Sodium Intravenous Solution. Reconstituted 2 GM (Ceftriaxone Sodium) Use 2 gram intravenously one time a day for Infection until 09/16/2024 23:59. Start date 08/31/2024. Daptomycin Intravenous Solution Reconstituted (Daptomycin) Use 750 mg intravenously one time a day for infection until 09/16/2024 23:59. Start date 08/30/2024. Resident #1's orders did not reflect IV dressing change, management, or care of IV. Observation and interview with Resident #1 and RN H on 09/04/2024 at 10:45 AM, revealed Resident #1 had a PICC line with two ports. The dressing was dated 09/04/2024. RN H stated Resident #1's nurse, RN G, would have a better idea about his PICC line dressing. In an interview with RN G on 09/04/2024 at 1:09 PM, she stated she readmitted Resident #1 when he returned from the hospital on 09/02/2024. She said his PICC line dressing and maintenance orders may have fallen off when he was readmitted . She stated because Resident #1 returned to the facility the same day, she thought his orders would all be in place. RN G stated she had changed Resident #1's PICC line because it was due. She stated PICC line dressings were to be changed every 7 days. She stated ADON A monitored and followed up on all orders for PICC and other lines like catheters, g-tube, drains, wound vacuums, etc. but ADON A had not been in the office and that might have been the reason the PICC orders were missed. She stated it was the responsibility of the nurse to make sure they put in orders at admission. RN G did not state the risk for not having PICC line orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON B on 09/04/2024 at 2:27 pm, she stated both herself and ADON A monitored all orders for wound dressings, central lines, urinary catheters, feeding tubes, tracheostomy, and isolations. She stated she personally checked the IV dressings on A hallway to make sure that they were dated, clean, and intact. She stated ADON A monitored B hallway for the same things. ADON B stated it was the responsibility for the nurses to put in the orders, then she would go in and verify or change accordingly. ADON B stated the IV order was a batch order that included monitoring IV, maintenance, and dressing changes. She stated she expected all nursing staff to obtain orders for care and to follow orders as prescribed. She stated if a nurse had a question about the orders to ask her, ADON A, the DON, or the physician for clarity . She stated failure to obtain orders could delay care for residents. In an interview with the DON on 09/04/2024 at 5:16 PM, She stated everyone was human and could make errors. She stated it was good practice to check orders before a procedure. The DON stated RN G should have added IV batch order set which would have had IV dressing, monitoring, and maintenance orders for Resident #1's PICC line. She stated the ADON's would go into the charts and make the batch orders patient specific. She stated she expected all nursing staff to obtain orders for care and to follow orders as prescribed. She stated orders drive care . She stated failure to obtain orders can cause missing procedures. In an interview with the ADM on 09/04/2024 at 06:41 PM, she stated the policies were put in place to make the job easier not harder. She stated she did not expect staff to memorize the facility policy but to refer to it and to ask questions when they did not understand something . She stated the expectation was for nurses to obtain orders. She stated failure to obtain orders could delay treatments and care. Review of facility policy titled Physician Orders dated November 2018. Revision dates 10/2019, 11/2020, 11/2021, 12/2022, and 05/2023. Policy reflected . 1. Orders may be called, hand-written, faxed, or electronically generated by physician. 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 transcribe all written orders promptly and accurately. The RN or LPN must include his/her signature, the date and time of the transcription and credentials. Orders that are unclear must be clarified prior to implementation. 4. In the event of an emergency, including but not limited to: a. 911 calls b. Involuntary discharges c. Other notable emergencies (IE natural disasters, building emergencies etc.) Documentation of the physician's order in the progress notes is sufficient. Documentation must state the reason for discharge.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, 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 disease and infections for one of five (Resident #1), residents reviewed for infection control. The facility failed to ensure RN H sanitized her hands and changed soiled gloves during ileostomy bag change for Resident #1 . Facility failed to ensure RN H did not take supplies from Resident #1's room who was on isolation and placed them on the treatment cart in the hallway. These failures placed residents at risk for contamination, spread of infection, and can cause infections to get worse. The finding included: Resident #1 Review of Resident #1's admission record dated 09/04/2024, revealed a [AGE] year-old male who was readmitted to the facility on [DATE] with an initial admitted [DATE]. His advanced directive was full code. His diagnoses included VRE infection due to abscess from colon, resistance to vancomycin (resistant to the antibiotic vancomycin usually due to prolonged use), MRSA (this is a type of staph bacteria that is resistant to certain antibiotics), craniotomy (blood clot removed from the brain), Parkinsonism (a progressive nervous system disorder, which affects the ability to move muscles), abscess of the liver (this is a mass in the liver filled with pus), non-traumatic perforation of the intestine (loss of continuity of the bowel wall/a hole in the wall of the colon), acquired absence of other parts of the digestive tract (part of the digestive tract was removed), need for assistance with personal care, ileostomy status (this is a small surgical opening in the abdomen where part of the intestine is cut for bowel movement to come out due part of the colon being removed), and neoplasm of large intestine (cancer of large intestine). Review of Resident #1 active orders dated 09/04/2024 reflected the following: Contact Isolation: Strict one room isolation with all services provided in room alone (VRE) every shift for VRE. Start date 08/30/2024. Ostomy care every shift Check appliance and empty. Start date 08/21/2024. Ostomy: Change Wafer and Bag weekly in the evening every Mon and as needed. Start date 08/26/2024. Silvadene Cream 1% Apply thin layer to the surrounding colostomy area for excoriation BID every morning and at bedtime for Excoriation. Start date 09/02/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with RN H on 09/04/2024 at 10:45 AM, revealed RN H gathered her supplies before entering Resident #1's room. On top of her treatment cart was a large nonstick gauze individually sealed, wound cleanser in a white spray bottle, some pieces of 4X4 gauze in a cup wet (sprayed with wound cleaner), a large package of 4x4 gauze, 4 packets of Silvadene Cream, ileostomy wafer, and bag attached. RN H stated she needed to find some wax paper from the supply room and walked away leaving her supplies on top of the cart. The sign on Resident #1's door read Contact Precautions. Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. RN H returned stating she could not find any wax paper and she would use the red biohazard bag. RN H put on her gown and gloves and took the supplies into Resident #1's room. No hand hygiene was observed before entering Resident #1's room. RN H then spread the red biohazard bag on half of Resident #1's bedside table. On the bed side table was a white Styrofoam cup with a yellow drink with ice, a larger plastic cup with water in it with a blue top, and another empty plastic cup. RN H did not wipe Resident #1's bedside table and she did not remove the drink cups from the bedside table. RN H placed the supplies on top of the red biohazard bag. She reached into her right uniform pocket with her gloved hand and removed two straws and the scissors. She handed the straws to Resident #1 for his drink. She then adjusted the bed. She removed Resident #1's bedding to expose the abdomen area. She pulled a stool soiled towel from Resident #1's right side to position it to catch the extra stool drainage as she removed the old ileostomy wafer and bag. RN H reached over the clean supplies and took some wet gauze from the cup and started to remove the wafer stuck to Resident #1's skin around the stoma. She then reached onverthe clean supplies again with BM on her gloves, took the scissors, and cut the area that was too stuck to Resident #1's skin. She placed the scissors back on the biohazard bag next to the clean supplies. After removing the leaking ileostomy bag, she disposed it in the trash can. She then got more wet gauze and dubbed/pat the excoriated skin. The skin was noted as bright, red, raw, with top layer of skin missing around the ileostomy stoma and bright redness cascading towards the lower right side of Resident #1's abdomen. RN H did not change her gloves that were visibly soiled with stool. RN H reached into a clean package of gauze, took a few pieces out, picked up wound cleanser, and sprayed the gauze to wipe the BM from the scissors. She then picked up the new ileostomy wafer with the bag attached and cut the wafer for Resident #1's stoma opening. She removed the gauze that was left on Resident #1's excoriated skin and threw it in the trash. She then stuck the new wafer onto Resident #1's stoma with her soiled gloves. RN H stated she had already done wound care on the abdomen and picked up one packet of Silvadene Cream, opened it, and applied it to Resident #1's excoriated area with her soiled gloved finger. After RN H was done with Resident #1, she covered him with his beddings with her soiled gloves. RN H then took the trash, tied it with her soiled gloves, collected the remaining supplies of large nonstick gauze, 3 packets of Silvadene Cream, the large package of gauze, the wound cleanser, the scissors, and the red biohazard bag. She carried everything to Resident #1's bathroom. She disposed of the trash and red biohazard bag, placed the extra supplies on the counter next to sink, and removed her gloves and gown. RN H then washed her hands and with her clean hands carried the contaminated supplies out of Resident #1's room and placed them on top of the treatment cart. RN H did not clean Resident #1's bedside table after using it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN H on 09/04/2024 at 11:10 AM, she stated she was very nervous and forgot to change her gloves and perform hand hygiene. She stated the wound cleanser stayed in Resident #1's room and she forgot to leave it in his room. She stated she was nervous because she was not the one who usually did the ileostomy care. She stated she just did the wound care. She stated she contaminated the larger package of gauze and the sealed package of gauze because she reached into it with soiled hands. She stated Resident #1's ileostomy bag change was not a sterile procedure therefore the biohazard bag or wax paper helped to keep the supplies clean. RN H stated she was aware that she had contaminated the treatment cart and she should have thrown away the supplies that she brought out of Resident #1's room. She stated the risk was contamination and spread of infection. In an interview with ADON B on 09/04/2024 at 2:27 pm, she stated she had completed the infection control preventionist training. She stated herself and ADON A did hallway audits frequently to monitor hand hygiene by watching staff foaming in and out of rooms and making sure that they were putting on PPE when they entered rooms that required it. ADON B stated she expected staff going into an isolation room to gather all their supplies before entering the room. She stated a plastic bag could be used in place of wax paper however the table should be cleaned before and after use. She stated having residents drink on the bedside table during ileostomy care was unacceptable practice because it contaminated the residents' drink. ADON B stated she expected nurses to change gloves after removing soiled dressing and wear clean ones for clean application. She stated RN H's gloves were contaminated and she should have changed her gloves before sticking the new ileostomy bag on Resident #1. She stated the following correct procedures and adhering to infection control practices prevented the spread of bacteria. She stated RN H was checked off on skills check-off and she didn't make any mistakes. ADON B stated we are all human, we make mistakes sometimes. In an interview with the DON on 09/04/2024 at 5:16 PM, she stated she was the infection control preventionist and was always giving staff in-services on infection control. She stated she was very surprised by the outcome of the wound care observation because RN H was highly favored and spoke highly of by the wound care physician. The DON stated all staff were expected to follow hand hygiene practices. She stated all supplies that were taken into an isolation room should not be brought out. She stated the items were contaminated and should not be put back on the treatment cart. She stated she expected RN H to have removed Resident #1's drinks from the bedside table and to have wiped the table. She stated the drink could spill onto the supplies being used. She said even though the procedure was not sterile it required a clean field. The DON stated she had reached out to a specialized ileostomy nurse to come and look and train the nurse on Resident #1's ileostomy. The DON stated it was her responsibility to make sure that all staff followed infection control precautions. The DON stated the risk was spread of infection. In interview with the ADM on 09/04/2024 at 06:41 PM, she stated she expected all staff to follow the facility policies. The ADM stated that her expectations were for all staff to follow the infection control policy. She stated not following the policy and procedure could lead to spread of infection. Record review of infection control preventionist revealed the DON completed 19.3 contact hours on 09/11/2019 and ADON B completed training as an infection control preventionist on 06/22/2024. Record Review of an in-service training dated 05/11/2023, titled Wound Policy and Procedure instructed by the DON, did not reflect RN H's signature for completion. (continued on next page)

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	09/04/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of an in-service training dated 08/15/2024, titled Infection Control, C-diff, hand hygiene, and COVID-19, instructed by ADON B, did not reflect RN H's signature for completion. Review of the facility policy titled Hand Hygiene dated September 2022 (revision April 2023), it reflected . Policy: All staff members will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of healthcare-associated infections (HAIs) .