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	02/05/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for 2 of 6 residents (Resident #1, and Resident #4) reviewed for quality of care. 1. The facility failed to ensure Resident #1's ointment and betadine application, and wound dressing change was completed per physician orders. 2. The facility failed to ensure Resident #4's wound dressing change was competed per physician orders. These failures could place residents at risk of not receiving treatments and medications, worsening of wounds and a decline in health. Findings included: Resident #1 Record review of Resident #1's admission record, dated 02/05/2025, revealed an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included cellulitis (common bacterial skin infection), metabolic encephalopathy(brain disorder that occurs when a chemical imbalance of the blood affects the brain), and type 2 diabetes mellitus. The admission record indicated resident discharged on [DATE] to another facility. Record review of Resident #1's Admission MDS assessment, dated 12/31/2024, revealed a BIMS score of 8, indicating moderate cognitive impairment. Further review of section M - skin conditions of the MDS revealed resident had diabetic foot ulcer(s). Record review of Resident #1's care plan, dated 01/09/2025, revealed Resident #1 had actual impairment to skin integrity r/t vascular - diabetic right bottom foot, right lower leg back and front right top of foot. Record review of Resident #1's active orders, dated 12/05/2025, revealed the following orders: - Apply betadine to top of right foot, leave open to air every day shift for Wound healing start dated 12/28/2025 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleanse RLE with wound cleanser, apply adaptic, calcium alginate, ABD pad, wrap with kerlix every day shift every other day for Wound healing start date 02/01/2025 Record review of Resident #1's December 2024 TAR revealed blanks for the following treatment and days: - Cleanse right elbow, pat dry, apply calcium alginate, cover with dry dressing every day shift for Wound healing Order dated 12/27/24. There were blanks for this order on 12/28/24 and 12/29/24. Record review of Resident #1's January 2025 MAR and TAR revealed blanks for the following treatments and days: - Cleanse RLE with wound cleanser, ABD pad, wrap with kerlix every day shift every other day for Wound healing order dated 01/10/25. There was a blank for this order on 01/11/25. - Cleanse RLE with wound cleanser, apply adaptic, calcium alginate, ABD pad, wrap with kerlix Every day shift for Wound healing order date 12/27/25. There were a blanks for this order on 01/02/25, 01/06/25, and 01/10/25 - Apply betadine to top of right foot, leave open to air every day shift for Wound healing order date 12/27/25. There were a blanks for this order on 01/02/25, 01/06/25, 01/11/25, and 01/12/25. - Mupirocin External Ointment 2 % (Mupirocin) Apply to wounds to BLE topically every shift for wound care order date 12/26/25. There were a blanks for this order on 01/01/25, 01/02/25, 01/06/25, 01/07/25, 01/08/25 x2, 01/09/25, 01/10/25, 01/11/25, 01/12/25, 01/13/25, 01/14/25 x2, 01/15/25 and 01/16/25. Record review of Resident #1's progress notes did not indicate why treatments were not signed as completed on the MAR and TAR. Resident #4 Record review of Resident #4's admission record, dated 02/05/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE] with muscle wasting and atrophy, traumatic ischemia of muscle(when the muscle has inadequate blood supply from trauma causing muscle damage), type 2 diabetes mellitus, and muscle weakness. Record review of Resident #4's progress note, dated 01/28/2025, revealed a BIMS score of 13 out of 15, indicating intact cognition. Record review of Resident #4's care plan, dated 01/27/25, revealed Resident #4 was at risk for alteration in skin integrity and Resident #4 had Diabetes Mellitus - Type 2. Record review of Resident #4's active orders, dated 02/05/2025, revealed Cleanse left second toe, pat dry, apply xeroform, cover with dry dressing every day shift every other day for Wound healing start date 02/02/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's January 2025 TAR revealed a blank on 01/29/2025 for the order to Cleanse left second toe, pat dry, apply calcium alginate w/silver every day shift for Wound healing dated 01/28/2025. Record review of Resident #4's progress note did not indicate why no treatment was provided on 01/29/2025. In an interview on 02/05/2025 at 2:04 pm, the Wound Care Nurse stated she worked Monday through Friday and did all the wound treatments. She said when she completed a resident's wound treatment, she signed off on the TAR. She stated a blank on the TAR meant the treatment did not get done and that it could have been on the weekend. The Wound care nurse then stated if she worked on the floor, the nurse on the hall was supposed to do wound care and sign it off on the TAR. When asked about blanks on Resident #1's TAR, she said she did not work on 01/06/25, she did wounds only and not any creams. She said the (Mupirocin) ointment was not for a wound. She stated she did wound care for Resident #1 on his legs and at first the treatment was xeroform and calcium alginate, then oil emulsion. She said the treatment was betadine on his toes. The Wound Care Nurse stated it was important to sign off on the MAR or TAR to ensure the medication or treatment was given. She said if she noticed any blanks, or that wound treatment had not been done she would notify the ADON and DON. In an interview on 02/05/2025 at 2:36 pm, the DON stated a blank on the MAR or TAR meant that it was not done, or staff just did not sign off. The DON went through the EHR and stated LVN A worked on 12/28/24, 12/29/24, 1/1/25, 1/6/25, 1/11/25, and 1/12/25 but was out of the country at that time. She said she should have signed off on the TAR. An attempted phone interview on 02/05/2025 at 3:12 pm with LVN A was unsuccessful. In an interview on 02/05/2025 at 4:42 PM, RN C stated when she gave medications or did treatments, she would sign off on the MAR and TAR when completed. She said a blank meant it was not done. RN C stated it was important to sign to make sure it was completed, and the necessary care and treatment was provided. She said if not done, it could delay treatment, healing and the residents could get worse by not being treated or getting regular medication. RN C stated if a medication or treatment was not done, then she would document the reason under the nurse's notes. In an interview on 02/05/2025 at 5:17 pm, LVN B stated she did not know what it meant when there was a blank on the MAR or TAR. LVN B stated when she did a treatment or administered a medication, she signed the MAR/TAR to show that it was done. She said if it was not given, she would document under progress notes. In an interview on 02/05/2025 at 5:36 pm, the DON and Administrator stated the person doing the treatment or administering the medication was responsible to sign the MAR and TAR. The Administrator stated the risk to the resident for treatment not being signed off was infection, possibly delay wound healing, or extend their stay. Record review of facility policy, titled Physician Orders revision/reviewed 05/2023, 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 5. 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 physicians order in the progress notes is sufficient. Documentation must state the reason for discharge.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interviews, and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infections for 1 of 6 (Resident #3) residents reviewed for quality of care. The facility failed to ensure Resident #3's wound dressing change was competed per physician orders. This failure could place residents at risk of not receiving treatment, worsening of wounds and a decline in health. Findings included: Record review of Resident #3's admission record, dated 02/05/2025, revealed an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of osteomyelitis of vertebra lumbar region (rare bone infection of lower spine), sepsis (the body's extreme response to an infection), and muscle weakness. Record review of Resident #3's Admission MDS, dated [DATE], revealed a BIMS score of 99, indicating the resident unable to complete interview. The MDS indicated Resident #3's short and long term memory were ok and did not have memory problem. Record review of Resident #3's care plan, dated 01/22/25, revealed Resident #3 had actual impairment to skin integrity r/t Pressure ulcer stage 3 to right buttock. Record review of Resident #3's active orders, dated 02/05/25 revealed Cleanse right buttock, pat dry, apply calcium alginate w/silver, cover with dry dressing every day shift for Wound healing start date 01/24/25. Record review of Resident #3's February 2025 TAR revealed Cleanse right buttock, pat dry, apply calcium alginate w/silver, cover with dry dressing every day shift. There was a blank for this order on 02/01/25. Record review of Resident #3's progress note did not indicate why no treatment was provided 02/01/25. In an interview on 02/05/2025 at 2:04 pm, the Wound Care Nurse stated she worked Monday through Friday and did all the wound treatments. She said when she completed a resident's wound treatment, she signed off on the TAR. She stated a blank on the TAR meant the treatment did not get done and that it could have been on the weekend. The Wound care nurse then stated if she worked on the floor, the nurse on the hall was supposed to do wound care and sign it off on the TAR. The Wound Care Nurse stated it was important to sign off on the MAR or TAR to ensure the medication or treatment was given. She said if she noticed any blanks, or that wound treatment had not been done she would notify the ADON and DON. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/05/2025 at 2:36 pm, the DON stated a blank on the MAR or TAR meant that it was not done, or staff just did not sign off. In an interview on 02/05/2025 at 4:42 PM, RN C stated when she gave medications or did treatments, she would sign off on the MAR and TAR when completed. She said a blank meant it was not done. RN C stated it was important to sign to make sure it was completed, and the necessary care and treatment was provided. She said if not done, it could delay treatment, healing and the residents could get worse by not being treated or getting regular medication. RN C stated if a medication or treatment was not done, then she would document the reason under the nurse's notes. In an interview on 02/05/2025 at 5:17 pm, LVN B stated she did not know what it meant when there was a blank on the MAR or TAR. LVN B stated when she did a treatment or administered a medication, she signed the MAR/TAR to show that it was done. She said if it was not given, she would document under progress notes. In an interview on 02/05/2025 at 5:36 pm, the DON and Administrator stated the person doing the treatment was responsible to sign the TAR. The Administrator stated the risk to the resident for treatment not being signed off was infection, possibly delay wound healing, or extend their stay. Record review of facility policy, titled Physician Orders revision/reviewed 05/2023, 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 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. 5. 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 physicians order in the progress notes is sufficient. Documentation must state the reason for discharge.

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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** 45507 Based on interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 1 of 6 residents (Resident #2) reviewed for respiratory care. The facility failed to ensure Resident #2's albuterol inhaler was given per physician orders. This failure could place residents at risk of not receiving medications, an exacerbation of their condition and a decline in health. Findings included: Record review of Resident #2's admission record, dated 02/05/2025, revealed an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), asthma, and heart failure. The admission record indicated Resident #2 discharged home on 12/28/2024. Record review of Resident #2's most recent MDS, dated [DATE], revealed his BIMS was blank. Record review of Resident #2's physician orders revealed Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 108 with start date of 12/27/2024. Record review of Resident #2's December 2024 MAR revealed Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for SOB or wheezing was not administered on 12/27/24 or 12/28/24 . There were blanks on 12/27/24 and 12/28/24. Record review of Resident #2's progress notes did not indicate why medications were not signed as administered. In an interview on 02/05/2025 at 2:04 pm, the Wound Care Nurse stated she worked Monday through Friday and did all the wound treatments. The Wound Care Nurse stated it was important to sign off on the MAR or TAR to ensure the medication or treatment was given. She said if she noticed any blanks, or that wound treatment had not been done she would notify the ADON and DON. In an interview on 02/05/2025 at 2:36 pm, the DON stated a blank on the MAR or TAR meant that it was not done, or staff just did not sign off. When asked about Resident #2's inhaler, the DON stated deliveries from the pharmacy depended on when the resident admitted . She stated they did not have a house stock of albuterol, and the nurses should have documented if it was not available. The DON stated if residents had those meds at home, they encouraged families to bring them until the pharmacy could deliver, and they would send medications back home once the prescription got there. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/05/2025 at 4:42 PM, RN C stated when she gave medications or did treatments, she would sign off on the MAR and TAR when completed. She said a blank meant it was not done. RN C stated it was important to sign to make sure it was completed, and the necessary care and treatment was provided. She said if not done, it could delay treatment, healing and the residents could get worse by not being treated or getting regular medication. RN C stated if a medication or treatment was not done, then she would document the reason under the nurse's notes. In an interview on 02/05/2025 at 5:17 pm, LVN B stated she did not know what it meant when there was a blank on the MAR or TAR. LVN B stated when she did a treatment or administered a medication, she signed the MAR/TAR to show that it was done. She said if it was not given, she would document under progress notes. LVN B stated if a medication was not available after a resident admitted , she would go to the e-kit, let the doctor know or if they had medicine at home call the family. In an interview on 02/05/2025 at 5:36 pm, the DON and Administrator stated the person doing the treatment or administering the medication was responsible to sign the MAR and TAR. The Administrator stated the risk to the resident for treatment not being signed off was infection, possibly delay wound healing, or extend their stay. Record review of facility policy, titled Physician Orders revision/reviewed 05/2023, 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 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. 5. 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 physicians order in the progress notes is sufficient. Documentation must state the reason for discharge.