

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of quality of life for 4 (Resident #1, Resident #2, Resident #3, and Resident #4) of 9 reviewed for dignity.</p> <p>1. The facility failed to ensure that Resident #1's gown was properly closed, which exposed her shoulder and upper chest areas.</p> <p>2.</p> <p>The facility failed to provide Resident #2, Resident #3, and Resident #4 a privacy cover for the indwelling urinary catheter drainage bags on 05/30/25.</p> <p>These failures could place the residents at risk of psychosocial harm feeling uncomfortable, disrespected and could decrease residents' self-esteem and/or diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident 1's face sheet, dated 05/17/25, revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and discharged on 05/13/25. Resident #1's diagnoses included: Sepsis due to MSSA (a serious bloodstream infection that can lead to septic shock, a life-threatening condition), cerebral infraction (also known as a stroke or ischemic stroke, is a condition where a portion of the brain's tissue is damaged due to a blockage or narrowing of a blood vessel supplying blood to the brain), aphasia following cerebral infraction (aphasia, a language disorder affecting communication, can occur following a cerebral infarction (stroke), dysphagia following a cerebral infarction (dysphagia, or difficulty swallowing, is a common and potentially serious complication following a cerebral infarction (stroke), hemiplegia (complete) and hemiparesis (weakness) following cerebral infarction affecting left non-dominant side, ADL assistance for personal care, abnormalities in gait and mobility, syncope and collapse (syncope (fainting) is a sudden, temporary loss of consciousness due to decreased blood flow to the brain, while collapse can be caused by various factors, including syncope, but also other conditions like seizures, head injury, or medical issues), end stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer function adequately to support life), and dependence on renal dialysis.</p> <p>(continued on next page)</p>		

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: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's MDS assessment, dated 04/27/25, revealed the resident had severe cognitive impairment with a BIMS score of 5. The assessment reflected Resident #1 needed assistance from staff with her ADL's, such as eating, oral hygiene, personal hygiene, toileting hygiene, shower/bath, upper and lower body dressing, and putting on/taking off footwear. The assessment reflected Resident #1 needed assistance from staff with functional abilities, such as being rolled from left and right, sitting to lying, lying to sitting in bed, and tub/toilet transfers.</p> <p>Record review of Resident #1's Discharge MDS assessment, dated 05/13/25, revealed that she was discharged from the facility on 05/13/25 to a Short-Term General Hospital. In Section C0500 there was no information indicating that Resident #1 was unable to complete the interview. In Section C - Cognitive Patterns, Section C0700 for Short-term Memory indicated Resident #1 had a memory problem. In Section C1000 for Cognitive Skills for Daily Decision Making was coded a 3 indicating Resident #3 cognition was severely impaired and she never/rarely made decisions.</p> <p>Record review of Resident #1's Care Plan dated 04/25/25 revealed the following:</p> <p>Focus:</p> <p>[Resident #1] had ADL self-care performance deficit and limitations in mobility.</p> <p>Date Initiated: 04/29/2025</p> <p>Goal:</p> <p>The resident/guest will improve self-care and mobility function by the next review date.</p> <p>Date Initiated: 04/25/2025</p> <p>Target Date: 06/22/2025</p> <p>Interventions:</p> <p>Upper body dressing: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Lower body dressing: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Personal hygiene: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025 .</p> <p>Focus:</p> <p>The resident has the potential for altercations in psychosocial well-being.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Date Initiated: 04/25/2025</p> <p>Goal:</p> <p>The resident will have no indications of psychosocial well being problems by/through review date.</p> <p>Date Initiated: 04/25/2025</p> <p>Target Date: 06/22/2025</p> <p>Interventions:</p> <p>Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears.</p> <p>Date Initiated: 04/25/2025 .</p> <p>In an interview with LVN B on 05/17/25 at 12:07 PM, she stated that she had been employed at the facility for 2 years. She stated that Resident #1 was admitted to the facility for about 3 weeks. LVN B stated that Resident #1 was a total care patient that required total assistance from staff. LVN B was shown photographs of Resident #1 and she stated that she was unaware that Resident #1 was laying in her bed with her gown being pulled down exposing her right shoulder and upper chest areas. LVN B stated that staff perform rounds on the floor with their assigned residents about every 2 hours, or more if needed. She stated that she had never observed Resident #1's gown being open, such as in the photograph she was shown. LVN B stated that it would be a resident rights and dignity issue anytime a resident had any part or parts of their body exposed for anyone to view. She stated that it can cause harm or hurt to a residents self-confidence if any part of their body was exposed for anyone to view, which can be harmful to a residents feelings.</p> <p>An email was sent to the Administrator and CFO On 05/17/2025 at 1:04 PM requesting the facilities policy for Resident Rights.</p> <p>An observation of Resident #1 at the hospital on [DATE] at 2:40 PM, revealed that she was asleep.</p> <p>In an interview with Resident #1's family member at the hospital on [DATE] at 2:45 PM, revealed that she was discharged from the facility on 05/13/25 due to having an irregular blood pressure. The family member stated that Resident #1 had been admitted to the hospital since her discharge from the facility. The family member stated that a Ring video was installed in Resident #1's room during her stay at the facility. The family member was able to provide the State Surveyor photographs, which according to them showed [Resident #1] slumped over in her bed, wearing a gown with her upper arm and upper chest being exposed to anyone that enter Resident #1's room. The family member stated that the photographs also revealed that Resident #1 was asleep in her bed and her gown exposed her shoulder and upper chest area, which is unacceptable.</p> <p>Record review of a photograph (unknown date and time) taken by Resident #1's family member, revealed that Resident #1 asleep and wearing a yellow and red shirt with her right shoulder and upper breast being exposed. Resident #1 was laying forward in a crouched position with the top of the left side of her head laying on the bed rails. Resident #1's hair was disheveled and appeared to be matted.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a photograph (unknown date and time) taken by Resident #1 ' s family member, revealed that Resident #1 was asleep and wearing a yellow and red gown with her right shoulder and upper breast being exposed. Resident #1 was lying forward in a crouched position with the top of the left side of her head laying on the bed rails.</p> <p>In an interview with CNA C on 05/19/25 at 7:12 PM, she stated that she had been employed at the facility for 2 years. She stated that the staff on the floor did routine rounds in each resident ' s room at least every 2 hours, or as needed. CNA C was shown a photograph of Resident #1 laying in bed with a yellow and red gown with her right shoulder and upper left breast exposed. CNA C stated that she had never observed Resident #1 in her bed, such as the photograph she was shown. CNA C stated that if she observed a resident laying in the bed with their gown open and exposing their right shoulder and upper chest areas, she would ensure that the resident is properly covered and would then notify the Nurse on duty of the condition she found the resident. CNA C stated that she had taken several In-Service Trainings on Abuse, Neglect, Exploitation and Resident Rights during her employment at the facility. CNA C stated that Resident #1's family member did not mention anything to her regarding concerns for the dignity of Resident #1. CNA C stated that Resident #1's family member never revealed any of the photographs that were revealed to her by the State Surveyor. CNA C stated that Resident #1 could feel embarrassed if anyone had entered her room with her gown being open exposing her right shoulder and upper chest areas. CNA C stated that Resident #1 could feel harmed if anyone walked into her room and saw her gown open exposing her right shoulder and upper chest areas.</p> <p>In an interview with the CFO on 05/19/2024 at 7:39 p.m., the CFO stated that Resident #1 had a stroke prior to being admitted to the facility and had paralysis (the loss of voluntary muscle movement) on her left-hand side and was required total care with her ADL's. The CFO was shown the photographs of Resident #1 that were provided to the State Surveyor. The CFO stated that he had never seen the photographs of Resident #1 that were provided by the State Surveyor. The CFO stated that it is her expectation for staff to do Care Rounds every 2 hours or more times in between, if needed to assist the residents with their needs. The CFO stated that Resident #1's family member never mentioned to her anything about the resident being observed in her room with her gown being open exposing her upper right arm and chest areas. The CFO stated that if Resident #1's family member would have shown her the photographs or informed staff on the day the photographs were taken, the issues or concerns would have been addressed immediately. The CFO stated that she would have retrained and reeducated her staff via In-Service Trainings to ensure that the situation would not occur or happen again. The CFO stated that she would be doing some In-Service Training with her staff to address the issues that were of concern. She stated that in the photograph, there was an issue of Resident Rights relating to the residents dignity. The CFO stated that there is a risk of a resident's rights being compromised anytime they are in their room and someone walks into their room and the residents shoulder and upper chest areas are exposed. The CFO stated that she did not believe that there was any harm caused to Resident #1 due to her shoulder and upper chest areas are exposed, such as in the photographs.</p> <p>On 05/19/25 at 8 PM, an attempted telephone call to the DOH was unsuccessful.</p> <p>On 05/19/25 at 8:17 PM the Survey Team exited the facility and did not receive a copy of the facility's Resident Rights Policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #2's admission MDS Assessment, dated 05/11/25, revealed an [AGE] year-old male who admitted on [DATE]. Resident #2 had a history and diagnoses of Diabetes (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar (glucose) levels to be abnormally high); Acute Respiratory Failure with Hypoxia (having too little oxygen); and Retention of urine. A BIMS score of 15 suggested Resident #2 was cognitively intact. Resident #2 had an indwelling urinary catheter, present on admission, and was always incontinent of bowel.</p> <p>A record review of Resident #2's comprehensive care plan, initiated 05/13/25, reflected the following:</p> <p>[Resident #6] is on enhanced Barrier Precautions related to presence of indwelling urinary catheter. Interventions included Provide enhanced Barrier Precautions as indicated. (Date initiated: 05/31/25</p> <p>The care plan did not reflect interventions to position catheter bag and tubing below the level of the bladder and in a privacy bag or ensure foley bag is in privacy bag.</p> <p>A record review of Resident #2's Order Summary Report printed 05/30/25 did not reflect indwelling urinary catheter orders.</p> <p>Record review of Resident #2 Physician progress note, date 05/09/25, revealed documentation of a New Foley (indwelling urinary catheter) for urinary retention and was unable to be weaned off the indwelling urinary catheter.</p> <p>During an observation on 05/30/25 at 10:19 AM, Resident #2 was in a semi-sitting position in bed. Resident #2 had an indwelling urinary catheter in place. The indwelling urinary catheter tubing laid across Resident #2's right leg connected to a closed system drainage bag that hung on the bed rail. The drainage bag did not have a privacy cover.</p> <p>A record review of Resident #3's admission MDS Assessment, dated 05/24/2025, revealed an [AGE] year-old male initial admission date of 11/13/23 and re-admitted on [DATE]. A BIMS score of 7 suggested Resident #3 had severe cognitive impairment. Resident #3 had diagnoses of Diverticulosis of intestine (a condition characterized by small pouches in the walls of the intestines); chronic kidney disease; and Benign Prostatic Hyperplasia (a condition that occurs when the prostate gland enlarges). The admission MDS Assessment revealed Resident #3 had an indwelling urinary catheter and was always continent of bowel.</p> <p>A record review of Resident #3's comprehensive care plan, initiated 09/12/24 to present, reflected:</p> <p>[Resident #3] has a urinary catheter - urinary retention (Resolved on 05/29/25). Interventions included . position catheter bag and tubing below the level of the bladder and away from entrance room door, check placement of tubing each shift, Monitor and document intake and output as per facility policy, and monitor/document for pain/discomfort due to catheter (Date Initiated: 05/27/25).</p> <p>A record review of Resident #3's Order Summary Report printed 05/30/25 at 5:30 PM, reflected the following:</p> <p>Order date 05/25/25: Change (indwelling urinary catheter) drainage bag as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Order date 05/29/25 (start date 05/30/25): Discontinue (indwelling urinary catheter) 5/30/25 AM. If guest does not void within 8 hours, re-insert (indwelling urinary catheter) and schedule an appointment with urologist. One time only for 1 day.</p> <p>Order date 05/25/25: (indwelling urinary catheter) Care to include anchoring tubing (catheter strap around leg to hold in place) and checking skin integrity every shift and PRN.</p> <p>Record review of Resident #3's May 2025 MAR printed 05/30/25 at 5:29 PM, did not reflect a nurse's initials that the (indwelling urinary catheter) was discontinued per the orders as written.</p> <p>During an observation on 05/30/25 at 10:34 AM, Resident #3 sat upright in a chair in his room. An ambulatory assistive device, rolling walker, was within reach at Resident #3's left side. Resident #3 (indwelling urinary catheter) tubing hung through the bottom of his left pajama pants leg attached to a drainage bag that hung on the bottom rail of the walker. There was approximately 200 cc amber urine in the catheter bag. The catheter bag did not have a privacy cover.</p> <p>Record review of Resident #3's progress notes reflected the following:</p> <p>Effective Date: 05/29/25 at 2:16 PM, documented: Called urologist in regards to removing Foley (indwelling urinary catheter) . Awaiting for a returned call to receive appointment date and time.</p> <p>Effective Date: 05/30/25 at 4:58 PM, LVN C documented: Guest [Resident #3] Foley (indwelling urinary catheter) DC (discontinued). Guest voided 500 cc on 6A - 6P shift. No c/o pain or discomfort voiced of urination or to pelvis area.</p> <p>Record review of Resident #4's Discharge MDS Assessment, dated 05/08/25, revealed a [AGE] year-old male initial admission date was 04/21/25. Resident #4 had diagnosis of chronic kidney disease. Resident #4 had an indwelling urinary catheter and a colostomy.</p> <p>A record review of Resident #4's Entry MDS Assessment, dated 05/20/25 reflected a re-admission date of 05/20/25</p> <p>A record review of Resident #4's comprehensive care plan, initiated 04/22/25 to present, reflected:</p> <p>[Resident #4] is on enhanced Barrier Precautions related to presence of indwelling urinary catheter. Interventions included Provide enhanced Barrier Precautions as indicated. (Date initiated: 04/22/25)</p> <p>[Resident #4] has a urinary catheter. Interventions included . . position catheter bag and tubing below the level of the bladder and away from entrance room door, check placement of tubing each shift, Monitor and document intake and output as per facility policy, and monitor/document for pain/discomfort due to catheter.</p> <p>A record review of Resident #4's Order Summary Report printed 05/30/25 at 11:51 AM, reflected the following:</p> <p>Order date 04/23/25: Change (indwelling urinary catheter) drainage bag as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Order date 04/23/25: (indwelling urinary catheter) Care to include anchoring tubing (catheter strap around leg to hold in place) and checking skin integrity every shift and PRN.</p> <p>During an observation on 05/30/25 at 10:48 AM, Resident #4 was in a left lateral position in bed. Resident #4 had an indwelling urinary catheter in place. The catheter tubing laid across Resident #4's right leg connected to a closed system drainage bag that hung on the right side bed rail. The drainage bag did not have a privacy cover. Resident #4 was pleasant and willingly participated in an interview. Resident #4 was alert and oriented to person, place, time of day, and situation. Resident #4 said that the nurse provided catheter care every morning and the CNAs emptied the drainage bag before the shift change. Resident #4 denied pain or discomfort at the insert site or symptoms of an UTI.</p> <p>During an interview on 05/30/25 at 2:09 PM, CNA E said that he reviewed facility training videos on catheter care and it had been covered during in-services. CNA E said that he would empty the drainage bag when providing peri-care to a resident and would report how much, if the urine had an odor, and if dark in color because of a possible UTI to the nurse. CNA E said that there should be a blue cover on the catheter drainage bags for privacy and dignity. CNA E said it was the nurse and the CNAs responsibility to ensure a privacy cover was on the drainage bags. CNA E could not explain why Residents #2, #3, and #4 did not have privacy covers or why he did not retrieve a privacy cover and place over the drainage bag.</p> <p>During an interview on 05/31/25 at 2:19 PM, LVN D said he provided catheter care based upon standards of practice, physician orders, and the care plan. LVN D said that he was observed for catheter care competency during new hire training and orientation. LVN D said that he checked for placement, for signs of infection such as redness, discharge, or swelling at insert site, and urine characteristics when she provided catheter care daily. LVN D said that catheter drainage bags should have a privacy cover. LVN D could not explain why Resident's #2, #3, and #4 did not have a privacy cover on the drainage bag. LVN D said that all direct care staff were responsible for making sure a privacy cover was on the catheter drainage bag. LVN D said that he was the primary responsible person when assigned to the resident. LVN D said that he would place privacy covers on the drainage bags. Walking rounds revealed LVN D followed through with privacy covers and Resident #3's indwelling urinary catheter was to be removed.</p> <p>During an interview on 05/31/25 at 4:00 PM, the CNO said that the implementation of care plan interventions was reviewed every morning during the clinical meeting. The CNO said that a preceptor observed and monitored nurses for competency skills and would sign off on the competency skills check off when successfully met. The CNO said that nurses who were successfully checked off for catheter care competencies and skill sets were allowed to insert, provide care for, and remove indwelling urinary catheters. The CNO said that residents were assessed and evaluated if indwelling catheters were clinically indicated. The status of residents' catheter needs was discussed during IDT meetings. The CNO said that interventions in place for residents with indwelling catheters included water intake, supplements, and catheter care every shift. The CNO indicated that residents were at risk of UTI development if the catheter was not changed or managed appropriately.</p> <p>Record review of the facility's In-Service Training Record revealed that on 05/08/25, staff were In-Serviced on Abuse/Neglect and Exploitation's Policies and Procedures.</p> <p>Record review of the facility's policy, Abuse & Neglect, dated October 2022, revised April 2023, April 2024, April 2025, revealed,</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>. o</p> <p>Attendance at a yearly in-service on the Abuse Policy and on Resident Rights is mandatory for all employees . at a minimum .</p> <p>All staff will be informed and will acknowledge procedures of resident rights .</p> <p>Orientation (Residents, Representatives and Staff)</p> <p>o Individuals will be provided orientation to the Abuse Policy and Resident Rights at the time of admission in a language/method that is understood .</p> <p>All staff will be required to attend an annual in-service presentation on resident rights; .</p> <p>All residents and their responsible parties are given a copy of resident rights information and the abuse and neglect reporting information at the time of admission in a language understandable by the resident and representative .</p> <p>Resident Rights will be reviewed with each resident and/or representative at least annually in a language understandable by the resident .</p> <p>Record review of the facility's policy, ADL, dated 11/2020, revised 10/2021, 08/2022, 04/2023, 04/2025, revealed,</p> <p>This facility will provide each resident with care, treatment and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff will ensure that each resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that the decline was unavoidable, including: .</p> <p>o Dressing .</p> <p>Record review of the facility's Indwelling Catheter Protocol, dated November 2018 and last reviewed 11/2024, reflected:</p> <p>Policy: Residents with an indwelling catheter will be reassessed by a licensed nurse weekly for 30 days after insertion of the catheter, then monthly thereafter to determine further need for the recording of intake and output and the resident's progress and continued need for a urinary catheter. The physician is responsible for writing the order for placement of the Foley catheter. The registered nurse or licensed practical nurse is responsible for placing an indwelling urinary catheter (Foley catheter). The above personnel must have demonstrated the knowledge and skills to perform this procedure as evidenced by verification on a competency checklist.</p> <p>Procedure:</p> <p>The Foley drainage bag will be covered with a catheter drainage bag dignity cover and the cover will be changed daily and whenever appears soiled or stained.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain proper grooming, hygiene (personal and oral hygiene) and proper feeding for 1 (Resident#1) of 6 residents reviewed for activities of daily living care.</p> <p>1. The facility failed to provide bed baths, grooming and hygiene for Resident #1 on a consistent basis according to the facility's ADL Schedule.</p> <p>2. LVN B used an incorrect feeding technique to feed Resident #1. LVN B was observed standing up while assisting Resident #1 with feeding on 04/28/25.</p> <p>These failures could place the residents at risk of psychosocial harm feeling uncomfortable, disrespected and could decrease residents' self-esteem and/or diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident 1's face sheet, dated 05/17/25, revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and discharged on 05/13/25. Resident #1 ' s diagnoses included: Sepsis due to MSSA (a serious bloodstream infection that can lead to septic shock, a life-threatening condition), cerebral infraction (also known as a stroke or ischemic stroke, is a condition where a portion of the brain's tissue is damaged due to a blockage or narrowing of a blood vessel supplying blood to the brain), aphasia following cerebral infraction (aphasia, a language disorder affecting communication, can occur following a cerebral infarction (stroke), dysphagia following a cerebral infarction (dysphagia, or difficulty swallowing, is a common and potentially serious complication following a cerebral infarction (stroke), hemiplegia (complete) and hemiparesis (weakness) following cerebral infarction affecting left non-dominant side, ADL assistance for personal care, abnormalities in gait and mobility, syncope and collapse (syncope (fainting) is a sudden, temporary loss of consciousness due to decreased blood flow to the brain, while collapse can be caused by various factors, including syncope, but also other conditions like seizures, head injury, or medical issues), , end stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer function adequately to support life), dependence on renal dialysis.</p> <p>Record review of Resident #1's MDS assessment, dated 04/27/25, revealed the resident had severe cognitive impairment with a BIMS score of 5. The assessment reflected Resident #1 needed assistance from staff with her ADL ' s, such as eating, oral hygiene, personal hygiene, toileting hygiene, shower/bath, upper and lower body dressing, and putting on/taking off footwear. The assessment reflected Resident #1 needed assistance from staff with functional abilities, such as being rolled from left and right, sitting to lying, lying to sitting in bed, and tub/toilet transfers.</p> <p>Record review of Resident #1 ' s Discharge MDS assessment, dated 05/13/25, revealed that she was discharged from the facility on 05/13/25 to a Short-Term General Hospital. In Section C0500 there was no information indicating that Resident #1 was unable to complete the interview. In Section C - Cognitive Patterns, Section C0700 for Short-term Memory indicated Resident #1 had a memory problem. In Section C1000 for Cognitive Skills for Daily Decision Making was coded a 3 indicating Resident #3 cognition was severely impaired and she never/rarely made decisions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Care Plan dated 04/25/25 revealed the following:</p> <p>Focus:</p> <p>[Resident #1] had ADL self-care performance deficit and limitations in mobility.</p> <p>Date Initiated: 04/29/2025</p> <p>Goal:</p> <p>The resident/guest will improve self-care and mobility function by the next review date.</p> <p>Date Initiated: 04/25/2025</p> <p>Target Date: 06/22/2025</p> <p>Interventions:</p> <p>Eating, Setup or clean-up assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Eating: Supervision or touching assistance</p> <p>Date Initiated: 04/25/2025</p> <p>Eating: Partial/moderate assistance</p> <p>Date Initiated: 04/25/2025</p> <p>Oral Hygiene: Substantial/maximal assistance</p> <p>Date Initiated: 04/25/2025</p> <p>Toileting: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Shower/bathe self: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Upper body dressing: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Lower body dressing: Substantial/maximal assistance.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Date Initiated: 04/25/2025</p> <p>Putting on/taking off footwear: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Personal hygiene: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Roll left and right: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>Chair/bed-to-chair transfer: Substantial/maximal assistance.</p> <p>Date Initiated: 04/25/2025</p> <p>-uses wheelchair.</p> <p>Date Initiated: 04/25/2025</p> <p>Focus:</p> <p>[Resident #1] is at risk for falls.</p> <p>Date Initiated: 04/25/2025</p> <p>Goal:</p> <p>The resident/guest will remain free from injury related to falls through the review period.</p> <p>Date Initiated: 04/25/2025</p> <p>Target Date: 06/22/2025</p> <p>Interventions:</p> <p>Anticipate and meet the resident's needs.</p> <p>Date Initiated: 04/25/2025 .</p> <p>Focus:</p> <p>The resident has the potential for altercations in psychosocial well-being.</p> <p>Date Initiated: 04/25/2025</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Goal:</p> <p>The resident will have no indications of psychosocial well being problems by/through review date.</p> <p>Date Initiated: 04/25/2025</p> <p>Target Date: 06/22/2025</p> <p>Interventions:</p> <p>Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears.</p> <p>Date Initiated: 04/25/2025</p> <p>Initiate referrals as needed for personal care, counseling, psych services as needed.</p> <p>Date Initiated: 04/25/2025</p> <p>Provide opportunities for the resident and family to participate in care.</p> <p>Date Initiated: 04/25/2025.</p> <p>In an interview with LVN B on 05/17/25 at 12:07 PM, she stated that she had been employed at the facility for 2 years. She stated that Resident #1 was admitted to the facility for about 3 weeks. LVN B stated that Resident #1 was a total care patient that required total assistance from staff. She stated that Resident #1 received her showers 3 x ' s per week, which were on Mondays, Wednesdays and Fridays. LVN B stated that the CNA's are provided with a shower/bed baths sheets tofor residents. LVN B stated after the CNA's bath/shower a resident, the shower/bed bath sheets are completed for each and placed in their files. She stated that if a resident refused a Shower/Bed Bath, the CNA's will write Refused on the residents Shower/Bed Bath Sheet. She stated that Resident #1 ' s family member did not mention anything to her regarding any concerns regarding issues with Personal Hygiene including grooming, and Bed Baths not being given by staff.</p> <p>An email was sent to the Administrator and CFO On 05/17/2025 at 1:04 PM requesting the facility ' s policy for Resident Rights.</p> <p>An observation of Resident #1 at the hospital on [DATE] at 2:40 PM, revealed that she was asleep.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #1 ' s family member at the hospital on [DATE] at 2:45 PM, revealed that she was discharged from the facility on 05/13/25 due to having an irregular blood pressure. The family member stated that Resident #1 had been admitted to the hospital since her discharge from the facility. The family member stated that there were some concerns regarding the ADL care Resident #1 was receiving from the facility. The family member stated the resident was at the facility for almost 3 weeks and did not receive her bed baths on a routine basis due to her assigned bathing days. The family member stated that Resident #1 ' s schedule bathing days were on Mondays, Wednesdays and Thursday. The family member stated that a Grievance was filed at the facility on 05/13/25 on the same day Resident #1 was discharged from the facility. The family member stated that they visited Resident #1 on a daily basis and her hair was disheveled throughout her stay at the facility. The family member stated that there were not any issues with Resident #1 having any body odors, but he stated that she should have been given a bath on her given scheduled days. The family member stated that a Ring video was installed in Resident #1 ' s room during her stay at the facility. The family member was able to provide the Ring video footage of Resident #1 during her stay at the facility. The family member stated that the Ring video footage revealed LVN B was standing up while feeding Resident #1. The family member stated that the photographs that were provided of Resident #1, showed [Resident #1] slumped over in her bed with her hair being matted and dishveled. The family member stated that the photographs also revealed that Resident #1 was asleep in her bed and her gown exposed her shoulder and upper chest area, which is unacceptable.</p> <p>Record review of the facility ' s Grievance Log with an entry on 05/13/25 for Resident #1 regarding Nursing Care. Resident #1 ' s family member stated that they had a concern and was quite upset with the fact that staff were not assisting with keeping guest [Resident #1] fresh and clean. The Grievance Log Entry was completed by the DOH on 05/14/25.</p> <p>Record review of a photograph (unknown date and time) taken by Resident #1 ' s family member, revealed that Resident #1 was asleep and wearing a yellow and red gown with her right shoulder and upper breast being exposed. Resident #1 was lying forward in a crouched position with the top of the left side of her head laying on the bed rails. Resident #1 ' s hair was disheveled and appeared to be matted.</p> <p>Record review of a photograph (unknown date and time) taken by Resident #1 ' s family member, revealed that Resident #1 was asleep and wearing a yellow and red gown and she was asleep. Resident #1 ' s hair was disheveled and appeared to be matted.</p> <p>Record review of (unknown date and time) taken by Resident #1 ' s family member, revealed that Resident #1 alert and wearing a yellow and red gown and her hair was disheveled and appeared to be matted.</p> <p>Record review of Ring video footage on 04/28/25 (without a timestamp) in Resident #1 ' s room revealed that LVN B was standing up while feeding Resident #1.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA C on 05/19/25 at 7:12 PM, she stated that she had been employed at the facility for 2 years. She stated that the staff on the floor did routine rounds in each resident ' s room at least every 2 hours, or as needed. CNA C stated she gave Resident #1 a bed bath on her scheduled bathing days, which were Mondays, Wednesdays and Fridays. CNA C stated that a bed bath for residents includes washing, combing hair, cleaning and clipping nails and toenails. CNA C stated that she completed a Shower Sheet for each resident, including Resident #1 when they were given bed baths. CNA C stated that if a resident refused a bed/shower, she would write Refused on the resident ' s Bed Bath/Shower Sheet which will be in a Shower Log at the Nurses Station. CNA C stated that if Resident #1's hair was disheveled, she would comb her hair. She stated that she did not observe Resident #1's hair appearing to be disheveled or matted during her shifts. CNA C stated that she never observed the yellow and red gown on Resident #1 exposing her upper chest area. CNA C stated that she had never observed any staff standing up while feeding Resident #1. CNA C stated that she did not provide any feedings to Resident #1. CNA C stated that she had taken several In-Service Trainings on how to properly feed residents, but she could not remember the last In-Service Training she received on feeding residents. stated that she was trained via In-Service Trainings to sit while feeding residents. CNA C stated that Resident #1's family member did not mention to her any concerns regarding the ADL Care she was receiving during her stay at the facility. CNA C stated that if a resident was fed while standing up, there was a risk for a resident to cough, choke and possibly aspirate (the accidental inhalation of foreign substances, like food or liquid, into the lungs).</p> <p>In an interview with the The CFO on 05/19/2024 at 7:39 p.m., she stated that Resident #1 had a stroke and had paralysis on her left-hand side and needed assistance from staff to assist her with her ADL's. The CFO stated that staff who assist with feeding residents should not be standing up while feeding the resident. She stated that staff should be seated in a chair while feeding residents and it was her expectation that staff sit to assist residents while feeding. She stated that staff have received in-service trainings on the proper guidelines and her expectations for staff while feeding residents. The CFO stated that if residents are fed while standing, there was a potential risk for residents to choke, which can lead to the harm of choking and aspiration. The CFO was shown the photographs of Resident #1 that were of Resident #1 ' s during her stay at the facility. Int he photographs, Resident #1 was observed with disheveled and matted hair. The CFO stated that Resident #1 received her bed baths per her bathing schedule, which would have been 3 x's per week. The CFO stated that CNA's complete the tasks of giving the Bed Bath/Shower to residents and they complete a Bed Bath/Shower Sheet for each resident, which is kept in their files. She stated that grooming, which included cleaning of the nails(toes and fingers), and shampooing and combing of the hair. The CFO stated Resident #1's family member completed a Grievance on the same day that Resident #1 was discharged from the facility due to being transferred to the hospital. The CFO stated that Resident #1's family member did not mention to herself or her staff anything about having concerns regarding the ADL Care the resident was receiving during her stay at the facility. The CFO stated that her expectation is for the staff to provide ADL Care for the residents that require assistance and that the residents received their showers or bed baths per their shower/bed bath schedule. The CFO stated that if a resident is not bathed, he or she can have issues with their skin having a possible skin breakdown and possible wounds.</p> <p>On 05/19/25 at 8 PM, an attempted telephone call to the DOH was unsuccessful.</p> <p>On 05/19/25 at 8:17 PM the Survey Team exited the facility and did not receive a copy of the facility ' s Resident Rights Policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN B on 05/27/25 at 11:35 PM, she was advised that a video was provided to the Surveyor revealing that she was observed standing up while feeding Resident #1. She stated that she remembered on an occasion, she was standing up while feeding Resident #1. LVN B stated that she had received in-service training on feeding residents, which included not standing up while feeding residents. LVN B stated that she did not know why she was standing up while feeding Resident #1 on 04/28/25. LVN stated that her last in-service training was last week (after the State Surveyors exited the building) on the proper techniques on feeding residents and keeping eye contact with the resident during feeding. LVN B stated that if someone was standing up while feeding a resident, there was a risk of the resident could possibly choke on the food, which could lead to aspiration (the accidental inhalation of foreign substances, like food or liquid, into the lungs).</p> <p>Record review of the Shower Sheets for Resident #1 revealed that she was given a Bed Bath on 04/30/25 (Wednesday), signed by CNA C, 05/02/25 (Friday), signed by CNA C, 05/05/25 (Monday), 05/08/25 (Thursday), and 05/12/25 (Monday), signed by CNA C.</p> <p>Record review of the facility ' s In-Service Training Record revealed that on 05/08/25, staff were in-serviced on Abuse/Neglect and Exploitation ' s Policies and Procedure.</p> <p>Record review of the facility ' s policy, ADL, dated 11/2020, revised 10/2021, 08/2022, 04/2023, 04/2025, revealed,</p> <p>This facility will provide each resident with care, treatment and services according to the resident ' s individualized care plan. Based on the individual resident ' s comprehensive assessment, facility staff will ensure that each resident ' s abilities in activities of daily living do not diminish unless circumstances of the resident ' s clinical condition demonstrate that the decline was unavoidable, including:</p> <ul style="list-style-type: none"> &middot;Bathing &middot;Dressing &middot;Grooming &middot;Transferring &middot;Locomotion &middot;Ambulation &middot;Toileting &middot;Eating &middot; Communication including using speech, language or other functional communication systems specific to the needs of the individual resident. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #1) of 3 residents reviewed for pressure ulcers, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to provide preventive care, consistent with professional standards of practice, to Resident#1 who was at risk for pressure injury development. On 04/24/25, Resident #1's admission progress note revealed skin integrity concerns that included, Resident #1 had redness to bilateral heels, Eschar (a hardened, dry, black, or brown dead tissue that forms a scab-like covering over deep wounds) to the left big toe, redness to the groin area, and redness to the buttock and coccyx (tailbone) area. 2. The facility failed to consult the Wound Medical Doctor (WMD) or implement additional pressure relieving devices for Resident #1 to prevent skin breakdown of the heels or coccyx and buttocks on 04/25/25. 3. The facility failed to monitor early signs of a pressure injury (PI) to promote the prevention of pressure ulcer (PU) development to Resident #1's right heel, left heel, and sacrum. On 05/09/25, the RP discovered altered skin integrity on Resident #1's right heel, left heel, and sacrum. On 05/09/25, the WCN inspected Resident #1 based on the RP's concern(s). The WCN took pictures and documented that Resident #1 had a pressure injury to the right heel, a pressure injury to the left heel, and a Stage 3 pressure ulcer to the sacrum. 4. The facility failed to appropriately place pressure offloading wedges when staff repositioned Resident #1 to reduce pressure on bony prominences. <p>An Immediate Jeopardy (IJ) was identified on 05/30/25. The IJ template was provided to the facility on [DATE] at 3:00 PM. While the IJ was removed on 05/31/25, the facility remained out of compliance at a scope of Isolated and severity level of No Actual Harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>These failures placed residents at risk of developing new or worsening pressure ulcers.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #1's admission MDS Assessment, dated 04/27/25, revealed a [AGE] year-old female who admitted on [DATE]. Resident #1 had Medically Complex Conditions that included active diagnoses of Diabetes Mellitus (DM) (a chronic condition that affects the way the body processes glucose [blood sugar]); Stroke; Aphasia (a disorder that impairs the expression and understanding of language, as well as reading and writing abilities); Hemiplegia (refers to complete paralysis) or Hemiparesis (characterized by weakness on one side of the body) of the right side; and Malnutrition. A BIMS score of 05 suggested Resident #1 had severe cognitive impairment. Resident #1 was dependent in self-care and mobility needs. Resident #1 was always incontinent of bladder and occasionally incontinent of bowel. The admission MDS reflected Resident #1 did not have current unhealed pressure ulcers/injuries at any stage and was at risk of developing pressure ulcers/injuries. Resident #1 was transferred to the hospital on [DATE] for a non-wound related issue at the RP's request.</p> <p>Record review of Resident #1's Discharge MDS assessment, dated 05/13/25, revealed Resident #1 had one or more unhealed pressure ulcers/injuries. The Discharge MDS assessment reflected one Stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough (a type of dead tissue that accumulates on the surface of a wound. It is typically soft, yellowish, or white) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) and four unstageable pressure injuries presenting as deep tissue injury (a unique form of a pressure injury that affects the underlying layers of skin, muscle, and other soft tissues) that were not present on admission.</p> <p>A record review of Resident #1's care plan report, initiated 04/25/25 reflected the following:</p> <p>[Resident #1] is incontinent. (Initiated: 04/25/25). Interventions included Brief Use: The resident uses disposable briefs. Change as needed.; Clean peri-area with each incontinence episode; Incontinent: Check every 2 - 3 and as needed for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.; Skin: Provide skin care with each incontinent episode. (Initiated: 04/25/25). Goal: [Resident #1] will have minimal complications related to incontinence episodes through the review date. (Target Date: 06/22/25).</p> <p>[Resident #1] is at risk for alteration in skin integrity. (Initiated: 04/25/25). Interventions (Initiated: 04/25/25) included Apply barrier cream per facility protocol to help protect skin from excess moisture; Change bedding/clothing if moist; Do not allow linens to be creased/folded under resident, keep bedding as smooth as possible; Encourage/assist with turning and repositioning ever 2-3 hours; Guest refuses offloading and turning/re-positioning at times. Provide re-education and re-approach when care is refused.; Monitor skin when providing care, notify nurse of any changes in skin appearance; Provide skin/wound treatments as ordered. Goal: [Resident #1] will remain free of new skin impairment through the review date. (Target Date: 06/22/25).</p> <p>[Resident #1] has actual impairment to skin integrity r/t Poor Nutrition. 5/28/25 - DTI - left great toe, left heel, right heel; Stage 3 right lateral foot. (Initiated: 05/09/25). Interventions (Initiated: 04/25/25) included Evaluate and treat per physician's orders; LALM (Low Air Loss Mattress) as ordered (Initiated: 05/12/25); Prevalon boots as ordered (Initiated: 05/12/25); and Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observation by wound nurse or provider. Goal: [Resident #1] skin injury will be healed by review date -and- will have no complications r/t documented skin impairment through the review date. (Target Date: 06/22/25).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #1's Order Summary Report printed 05/19/25 reflected the following:</p> <p>Order date 04/24/25: Wound Consult as needed.</p> <p>Order date 04/25/25: Barrier Cream apply after Incontinent episodes every shift.</p> <p>Order date 04/27/25: Skin Checks Weekly every Day shift every Monday. Must open and document Skin Evaluation for each assessment (including no new areas found).</p> <p>Order date 05/08/25: Wound care to eval and treat coccyx area one time a day for wound care. [Discontinued 05/11/25]</p> <p>Order date 05/09/25: Monitor for LALM (Low Air Loss Mattress) every shift for wound healing.</p> <p>Order date 05/09/25: Monitor for Prevalon boots (for heel protection) every shift for wound healing.</p> <p>Order date 05/09/25: Cleanse right heel, pat dry, apply skin prep every Day shift for wound healing.</p> <p>Order date 05/09/25: Cleanse left great toe, pat dry, apply skin prep every Day shift for wound healing.</p> <p>Order date 05/09/25: Cleanse left heel every Day shift for wound healing.</p> <p>Order date 05/09/25: Cleanse right lateral foot every Day shift for wound healing.</p> <p>Order date 05/09/25: Cleanse sacrum, pat dry, apply collagen [did not indicate form or type of collagen] and Anasept (an antimicrobial skin and wound cleanser), cover with dry dressing every Day shift for wound healing.</p> <p>Order date 05/09/25: [Prescriber (Physician) Entered] Vascular consult. [Order status: Pending Confirmation]</p> <p>Record review of Resident #1's April 2025 MAR revealed a weekly skin check was completed on 04/28/25 and barrier cream was applied after incontinent episodes every shift as the order was written.</p> <p>Record review of Resident #1's May 2025 MAR revealed a weekly skin check was completed on 05/05/25 and barrier cream applied after incontinent episodes every shift were implemented as written. The orders to monitor for LALM and Prevalon boots every shift for wound healing was implemented 05/09/25 during the night shift and every shift thereafter as written.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's May 2025 TAR revealed orders to cleanse right heel, great toe, left heel and right lateral foot, pat dry, apply skin prep everyday shift for wound healing were implemented on 05/10/25 and performed daily as written. The order to cleanse sacrum, pat dry, apply collagen [did not indicate form or type of collagen] and Anasept, cover with dry dressing every day shift for wound healing was implemented 05/10/25 and performed daily as written. The WCN signed off on the order entered on 05/08/25 for Wound care to eval and treat coccyx area one time a day for wound care on 05/09/25.</p> <p>Record review of Resident #1's admission progress note, dated 04/24/25 at 8:59 PM, completed by RN A, revealed Resident #1 had skin integrity concerns that included, redness to bilateral heels, Eschar (a hardened, dry, black, or brown dead tissue that forms a scab-like covering over deep wounds) to left big toe, redness to groin area, and redness to buttock. RN A entered an order on 04/24/25 for a Wound Consult as needed. The Wound Care Nurse (WCN) completed a skin assessment on Resident #1 on 04/25/25.</p> <p>Record review of Resident #1's completed Weekly Skin Observations reflected:</p> <p>admission Skin Observation</p> <p>Date: Friday, 04/25/25. Completed by the WCN.</p> <p>Does the Resident have ANY Skin Issues Observed (including new and old)? No</p> <p>If No, Reason: No open wounds noted.</p> <p>Document and Describe ALL Skin Issues: Coccyx (tailbone) - Redness; Left toe(s) - Big toe has scab Other Observations: Skin clean dry and intact.</p> <p>The Wound Team was not notified and there were no intervention/treatment in place.</p> <p>admission Skin Observation</p> <p>Date: Monday, 04/28/25. Completed by LVN B.</p> <p>Does the Resident have ANY Skin Issues Observed (including new and old)? Yes</p> <p>MD notified: Yes</p> <p>Document and Describe ALL Skin Issues: Coccyx (tailbone) - Redness; Other Observations: No new skin issues noted at this time.</p> <p>The Wound Team was not notified. Intervention/treatment in place: Yes.</p> <p>Weekly Skin Observation</p> <p>Date: Monday, 05/05/25. Completed by the WCN.</p> <p>Does the Resident have ANY Skin Issues Observed (including new and old)? No</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>If No, Reason: No open wounds noted.</p> <p>Document and Describe ALL Skin Issues: Right buttock - Redness; Left buttock - Redness; Other Observations: Skin clean dry and intact.</p> <p>The Wound Team was notified, and intervention/treatment was in place.</p> <p>Weekly Skin Observation</p> <p>Date: Monday, 05/12/25. Completed by LVN B.</p> <p>Does the Resident have ANY Skin Issues Observed (including new and old)? Yes</p> <p>MD notified: Yes</p> <p>Document and Describe ALL Skin Issues: Coccyx (tailbone) - Pressure Sore; Other (specify) - Eschar to multiple toes; Groin - Redness; Other (specify) - Redness/pressure sore to BIL heels (Boots applied); Other Observations: No new skin issues noted at this time.</p> <p>The Wound Team was not notified. Intervention/treatment in place: Yes.</p> <p>During an interview on 05/17/25 at 12:07 PM, LVN B said that she worked at the facility for 2 years. LVN B said that she was familiar with Resident #1. LVN B said that she completed the weekly skin assessments for Resident #1. LVN B said that she recalled Resident #1 had redness on her coccyx (tailbone) and CNAs applied barrier cream to the area to protect from breakdown. LVN B said that the CNAs should reposition, and offload pressure points every 2 hours. LVN B said that Resident #1 was at risk for skin breakdown because she had a poor nutritional intake, was incontinent, and made occasional slight changes in body position and was unable to make frequent changes independently. LVN B said the last skin assessment (05/12/25) she completed on Resident #1, the reddened area at the coccyx was open and the WCN documentation reflected a Stage 3 pressure ulcer. LVN B said that Resident #1 had dark discolorations at the heels, and she made sure that the Prevalon boots (heel protectors) were placed on Resident #1's feet before (LVN B) exited the room. LVN B said that all nursing staff was responsible for ensuring residents at risk for skin breakdown have appropriate interventions in place. LVN B said that the CNAs would use pillows to offload Resident #1's ankles before the Prevalon boots were ordered by the WCN. LVN B said that Resident #1 was turned and repositioned every two hours. LVN B said the purpose of turning and repositioning a resident every two hours was to prevent avoid skin breakdown. LVN B could not verbalize how she monitored if Resident #1 was repositioned, and offloading devices were properly placed.</p> <p>During an interview on 05/17/25 at 2:45 PM, Resident #1's RP stated that Resident #1 was admitted to the facility for nearly 3 weeks and was discharged to the hospital for a low blood pressure on 05/13/25. The RP said that he had electronic monitoring in Resident #1's room and was able to provide images of [Resident #1] slumped over to the right side in bed and the green (pressure offloading) wedges were not placed under Resident #1. The RP said that a (pressure offloading) wedge was at the foot of the bed and the other (pressure offloading) wedge was on a chair next to the bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an undated and timed picture submitted by the RP, revealed Resident #1 asleep in bed. The head of bed was raised approximately 45 degrees. Resident #1 was in a semi-seated position with knees bent. Resident #1's upper body was leaned over to the right side. A green (pressure offloading) wedge was observed at the right-side foot of the bed. A corner of the (pressure offloading) wedge hung off the edge of the bed. At the left-side head of the bed, 2 green (pressure offloading) wedges were observed stacked on the chair resting on the left arm and the seat of the chair.</p> <p>During record review and an interview on 05/19/25 at 3:09 PM, the WCN said that she provided wound care, new resident skin assessments, measured and took pictures of wounds; performed weekly skin assessments on residents she followed for wound care and occasionally assisted nurses with weekly skin assessments if they became too busy. The WCN said that she took wound pictures every 7 days to monitor improvement and followed all altered skin integrity that included skin tears to pressure wounds. The WCN said that the nurses performed wound care in the WCN's absence and on the weekends. The WCN said that she conducted the admission skin assessment on Resident #1 and skin was intact. The WCN said that Resident #1 did not have redness to the right and left heels and although there was redness to the buttocks she was not concerned because the skin was intact. The WCN said that the facility policy and procedure for PU/PI prevention was to order a LALM for residents with actual skin breakdown, keep residents clean and dry if incontinent, turn and reposition every 2 hours to prevent skin breakdown if the resident could not reposition on their own. The WCN said that staff were aware of care plan interventions by reviewing the care plan. The WCN said that she did not participate in care plan develop or updates and did not monitor if care plan interventions were implemented for the management of skin. The WCN said the wound doctor was involved with intervention suggestions. The WCN said that she did not need to follow Resident #1 because she did not have any skin issues. The WCN said that the RP complained of bruises to Resident #1's right and left heels (on 05/09/25) and she told the RP that they were blood blisters. The WCN replied when asked if blood blisters were considered DTIs, she said no. The WCN went on to say that the RP was concerned about Resident #1's buttocks and the WCN said that she visualized the area and said that it looked like shearing from friction (a superficial injury that occurs when skin is dragged across a surface). The WCN stood up and demonstrated how a resident's brief could be placed incorrectly and rubbed against the skin when pulled across the bed. The WCN denied that was the situation with Resident #1 and said that she was just giving an example. The WCN said that she thought the shearing could have been caused by skin contact with the mechanical lift sling. The WCN said that she did not think that Resident #1's bottom would be bare on the mechanical lift sling and said that she was giving an example. The WCN said that she took pictures of the discovered areas and forwarded to the NP for guidance. The WCN said that the NP was unsure about Resident #1's altered skin issues. The WCN said that she documented the right and left heels as DTIs and the sacrum as a Stage 3 pressure ulcer. When the WCN was asked, what information was obtained to determine the altered skin integrity was a Stage 3, she said that she measured the wound and it looked like a Stage 3 (pressure ulcer). The investigator reviewed the picture of the sacrum with the WCN, asked about the measurements entered underneath the picture (6.00 cm length x 3.00 cm width x unknown depth), and if a depth of a wound was necessary to consider a pressure ulcer a Stage 3; the WCN said No, the depth was not needed to stage a wound. The WCN could not define in her own words the differences between Stage 1 & 2 (partial thickness), Stage 3 & 4 (full thickness), Unstageable/DTI, or eschar. The WCN said that she obtained orders from Resident #1's PCP and did not consult the Wound Medical Doctor (WMD).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/19/25 at 7:12 PM, CNA C stated she worked at the facility for 2 years. CNA C denied ever seeing the green (pressure offloading) wedges at the bottom of Resident #1's bed or on the chair beside the bed. CNA C said that the wedges must be placed underneath Resident #1 to prevent falls. CNA C said that the wedges were placed at the shoulders and at the hips. CNA C said that rounds were done every 2 hours and as needed. CNA C said if she observed the wedges placed incorrectly or not underneath the resident, she would immediately correct the issue. CNA C was unaware of the purpose for the wedges to help maintain a lateral side-lying position and to ensure proper offloading for pressure injury prevention.</p> <p>During record review and an interview on 05/19/25 at 7:53 PM, the CNO said that she expected nurses and the WCN to follow facility protocols for pressure ulcer prevention and skin management. The CNO said the green wedges were to be placed underneath Resident #1 to off-load pressure and prevent skin breakdown. The CNO said the green wedges were also used to support Resident #1 when sitting upright due to her stroke related left sided weakness. The CNO said, labeled Patient's Side, were not used properly in the pictures shown to her. The CNO stated if the green (pressure offloading) wedges were not placed properly underneath Resident #1, there was a risk of pressure ulcer development due to pressure on the skin for a long time. The CNO said that the LALM assisted with off-loading pressure to the resident to prevent wounds and avoid pre-existing wounds from worsening. The CNO said that the facility recently held a Skills Fair with nurses to ensure up-to-date knowledge and competency in skin management and wound care. The CNO said that Resident #1's wounds were unavoidable and that she started the documentation on 05/09/25 to reflect the factors that made the wounds unavoidable but did not complete the documentation. The CNO said that a resident should be assessed and evaluated at admission to determine if at risk for unavoidable PI/PU. The CNO said that Resident #1 was not assessed or evaluated during admission because the electronic health record, PCC, did not include that type of assessment at admission. The CNO said that the WMD did not need to be consulted for redness and could be treated by the WCN, but the WCN should have consulted the WMD on 05/09/25 when the altered skin integrity was discovered and if she had questions about wound staging. The investigator reviewed the picture of the sacrum with the CNO, and she said that the area to Resident #1's buttocks looked like a superficial skin injury and not a Stage 3. The CNO said that the measurements of a Stage 3 wound would include the length, width, and depth. The CNO said if there was not a measurable depth to a wound because the margins were even with the surrounding skin or was covered by slough or eschar, the wound would be considered unstageable and would require the WMD to be consulted.</p> <p>On 05/19/25, an outbound call to the NP was unanswered and forwarded to an automated service that prompted to leave a voicemail. A return call was not received prior to the exit on 05/31/25.</p> <p>Record review of the facility's Skin Integrity Management policy, revised October 5, 2016, reflected:</p> <p>Reposition residents at risk for pressure sore or with pressure sores at least every two (2) hours, if unable to turn themselves.</p> <p>Use pillows or foam wedges to keep bony prominences from direct contact .</p> <p>The presence of a pressure reducing device/specialty bed does not negate the need to turn/reposition the resident at least every two (2) hours in order to prevent pulmonary and renal complications as well as pressure sores .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>If eschar or necrotic tissue is present, debridement may be indicated. Physicians do surgical debridement only.</p> <p>The National Pressure Ulcer Advisory Panel ([NPUAP], 2016) revised the definition and stages of pressure injury. Review of the new definition of suspected DTI is: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Further description is also given: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. (Reference: Edsberg LE, Black JM, [NAME] M, [NAME] L, [NAME] L, Sieggreen M. Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System: Revised Pressure Injury Staging System. J Wound Ostomy Continence Nurs. 2016; 43(6):585-597. doi:10.1097/WON.0000000000000281 https://pmc.ncbi.nlm.nih.gov/articles/PMC5098472/)</p> <p>The Centers for Medicare & Medicaid Services ([CMS], 2024), defined pressure ulcer/injury characteristics as:</p> <p>-</p> <p>Stage 1 Pressure Injury: Non-blanchable erythema of intact skin</p> <p>Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI.</p> <p>-</p> <p>Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration</p> <p>Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. (Reference: Centers for Medicare & Medicaid [CMS], State Operations Manual, Appendix PP. (Rev. 225; Issued: 08-08-24). F686 Skin Integrity, p. 298. https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The NFA was notified of an Immediate Jeopardy (IJ) on 05/30/25 at 3:00 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal (POR) was accepted on 05/31/25 at 11:14 AM and included:</p> <p>[FACILITY NAME] is committed to ensuring the safety and well-being of all Residents and operates in substantial compliance with Federal and State laws and regulations. This removal plan constitutes [FACILITY NAME]'s written credible allegation of compliance for the immediate jeopardy noted.</p> <p>Policy Statement</p> <p>It is the facility's policy to ensure that residents receive care, consistent with professional standards of practice, to prevent pressure ulcers/injuries and do not develop pressure ulcers/injuries unless clinically unavoidable, and that residents with pressure ulcers/injuries receive necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing, in accordance with F686.</p> <p>Immediate Action for Affected Residents</p> <p>On 05/30/25:</p> <p>Resident #1 is currently hospitalized . Upon return to the facility, the resident will:</p> <ul style="list-style-type: none"> o <p>Receive a complete skin assessment by two licensed nurses</p> <ul style="list-style-type: none"> o <p>Have a new care plan developed addressing all areas of skin integrity</p> <ul style="list-style-type: none"> o <p>Be evaluated by the Wound Care Physician within 24 hours of readmission</p> <ul style="list-style-type: none"> o <p>Have pressure-relieving devices implemented including heel protectors and pressure-redistributing mattress</p> <ul style="list-style-type: none"> o <p>Receive repositioning every 2 hours and as needed</p> <p>Identifying Other Residents at Risk</p> <p>On 05/30/25:</p> <p>Conduct skin sweep of current residents completed by licensed nurses</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of current residents' medical records to identify those with diabetes, impaired mobility, or other risk factors for pressure injuries</p> <p>Creation of a facility-wide list of at-risk residents requiring enhanced monitoring</p> <p>Root Cause Analysis</p> <p>Root causes identified through staff interviews, record reviews, and process analysis on 05/30/25:</p> <p>Lack of communication between nursing staff and Wound Care Nurse</p> <p>Systemic Changes and Preventive Measures</p> <p>Effective 05/30/25:</p> <p>Revised skin assessment protocol requiring two-nurse verification of skin concerns on admission</p> <p>Residents with skin alterations will be reviewed during clinical stand-up meetings</p> <p>DON and or Designee will provide mandatory in-service education to all nursing staff until all nurses have been trained prior to next shift worked.</p> <ul style="list-style-type: none"> o Pressure injury prevention and identification o Proper wound staging o Communication requirements o Documentation requirements o Reporting requirements <p>DON and or Designee will provide mandatory in-service education to all</p> <p>Updated wound care policy requiring physician notification of identified skin concerns</p> <p>Implementation of wound care rounds weekly by WCN and or designee</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Monitoring and Evaluation Plan</p> <p>Beginning 05/30/25:</p> <p>Director of Nursing or designee will:</p> <ul style="list-style-type: none"> <input type="radio"/> Audit 100% of new admissions for skin assessments daily for 2 weeks, then 50% weekly for 4 weeks <input type="radio"/> Review wound documentation daily for 2 weeks, then 3x/week for 4 weeks <input type="radio"/> Monitor physician notification compliance daily for 2 weeks <input type="radio"/> Observe random wound care rounds weekly for 8 weeks <p>Quality Assurance Nurse And or Designee will:</p> <ul style="list-style-type: none"> <input type="radio"/> Conduct random audits of 10 resident skin assessments weekly for 8 weeks <input type="radio"/> Review new pressure injuries for appropriate interventions and physician notification <input type="radio"/> Monitor staff compliance with new protocols weekly <p>The Director of Nursing will report monitoring results to the QAPI committee weekly for 8 weeks, then monthly until sustained compliance is achieved for 3 consecutive months. The QAPI committee will adjust the plan as needed based on audit findings.</p> <p>On 05/31/25 the investigator began monitoring if the facility implemented their plan of removal sufficiently to remove the IJ by the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interviews conducted with nursing staff scheduled on 05/31/25 between 11:30 AM - 3:00 PM, included PRN and new hire staff [RN F, LVN G, LVN B, and LVN D] indicated they participated in the mandatory in-service education about Pressure Injury Prevention and Identification, Proper Wound Staging, Communication Requirements, Documentation Requirements, and Reporting Requirements. The nurses summarized the topic of discussion included policy, procedure, and the facility/leadership expectations. Each nurse stated in their own words the procedures for resident skin management to prevent pressure injury/ulcer development rather avoidable or unavoidable (pressure injury development or failure to heal because of the resident's clinical condition regardless of the interventions provided to treat or prevent development). Nurses said that they would notify the WCN and/or ADONs and notify the physician immediately of resident change in condition and verbalized steps on how to notify attending physician/NP/physician designee and the wound physician, if applicable, including what actions to take if unable to contact a physician.</p> <p>Observations on 05/31/25 of nurses [RN F, LVN G, LVN B, and LVN D] demonstrated in the chart how to locate observation documents, how to complete a weekly skin assessment, document skin observations in a daily skilled note, and how to enter an order for a wound consultation for the WCN to assess, evaluate, and treat. The WCN would consult the third-party WMD as needed.</p> <p>Observation on 05/31/25 of CNAs [CNA P and CNA E] performed pressure relief measures that included, resident positioning; support device placement to offload and prevent pressure to bony areas; and apply skin protectant to intact peri-wound skin during incontinent care.</p> <p>Interviews co[TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services for 3 of 3 residents (Resident #2, Resident #3, and Resident #4) reviewed for quality of care.</p> <p>1.</p> <p>The facility failed to ensure Resident #2 and Resident #4 had an indwelling urinary catheter strap in place to prevent pulling or tugging on 05/30/25.</p> <p>These failures could place residents at risk for discomfort, urethral trauma, loss of dignity and urinary tract infections.</p> <p>Findings included:</p> <p>A record review of Resident #2's admission MDS Assessment, dated 05/11/25, revealed an [AGE] year-old male who admitted on [DATE]. Resident #2 had a history and diagnoses of Diabetes (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar (glucose) levels to be abnormally high); Acute Respiratory Failure with Hypoxia (having too little oxygen); and Retention of urine. A BIMS score of 15 suggested Resident #6 was cognitively intact. Resident #6 had an indwelling urinary catheter, present on admission, and was always incontinent of bowel.</p> <p>A record review of Resident #2's comprehensive care plan, initiated 05/13/25, reflected the following:</p> <p>[Resident #6] is on enhanced Barrier Precautions related to presence of indwelling urinary catheter. Interventions included Provide enhanced Barrier Precautions as indicated. (Date initiated: 05/31/25</p> <p>The care plan did not reflect interventions to position catheter bag and tubing below the level of the bladder and in a privacy bag or ensure catheter strap in place and holding so that tubing is not pulling on the urethra.</p> <p>A record review of Resident #2's Order Summary Report printed 05/30/25 did not reflect indwelling urinary catheter orders.</p> <p>Record review of Resident #2 Physician progress note, date 05/09/25, revealed documentation of a New Foley (indwelling urinary catheter) for urinary retention and was unable to be weaned off the indwelling urinary catheter.</p> <p>During an observation on 05/30/25 at 10:19 AM, Resident #2 was in a semi-sitting position in bed. Resident #2 had an indwelling urinary catheter in place. There was no indwelling urinary catheter strap in place to prevent pulling or tugging. The indwelling urinary catheter tubing laid across Resident #2's right leg connected to a closed system drainage bag that hung on the bed rail.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #3's admission MDS Assessment, dated 05/24/2025, revealed an [AGE] year-old male initial admission date of 11/13/23 and re-admitted on [DATE]. A BIMS score of 7 suggested Resident #3 had severe cognitive impairment. Resident #3 had diagnoses of Diverticulosis of intestine (a condition characterized by small pouches in the walls of the intestines); chronic kidney disease; and Benign Prostatic Hyperplasia (a condition that occurs when the prostate gland enlarges). The admission MDS Assessment revealed Resident #3 had an indwelling urinary catheter and was always continent of bowel.</p> <p>A record review of Resident #3's comprehensive care plan, initiated 09/12/24 to present, reflected:</p> <p>[Resident #3] has a urinary catheter - urinary retention (Resolved on 05/29/25). Interventions included . position catheter bag and tubing below the level of the bladder and away from entrance room door, check placement of tubing each shift, Monitor and document intake and output as per facility policy, and monitor/document for pain/discomfort due to catheter (Date Initiated: 05/27/25).</p> <p>A record review of Resident #3's Order Summary Report printed 05/30/25 at 5:30 PM, reflected the following:</p> <p>Order date 05/25/25: Change (indwelling urinary catheter) drainage bag as needed.</p> <p>Order date 05/29/25 (start date 05/30/25): Discontinue (indwelling urinary catheter) 5/30/25 AM. If guest does not void within 8 hours, re-insert (indwelling urinary catheter) and schedule an appointment with urologist. One time only for 1 day.</p> <p>Order date 05/25/25: (indwelling urinary catheter) Care to include anchoring tubing (catheter strap around leg to hold in place) and checking skin integrity every shift and PRN.</p> <p>Record review of Resident #3's May 2025 MAR printed 05/30/25 at 5:29 PM, did not reflect a nurse's initials that the (indwelling urinary catheter) was discontinued per the orders as written.</p> <p>During an observation on 05/30/25 at 10:34 AM, Resident #3 sat upright in a chair in his room. An ambulatory assistive device, rolling walker, was within reach at Resident #3's left side. Resident #3 (indwelling urinary catheter) tubing hung through the bottom of his left pajama pants leg attached to a drainage bag that hung on the bottom rail of the walker. There was approximately 200 cc amber urine in the catheter bag.</p> <p>Record review of Resident #3's progress notes reflected the following:</p> <p>Effective Date: 05/29/25 at 2:16 PM, documented: Called urologist in regards to removing Foley (indwelling urinary catheter) . Awaiting for a returned call to receive appointment date and time.</p> <p>Effective Date: 05/30/25 at 4:58 PM, LVN C documented: Guest [Resident #3] Foley (indwelling urinary catheter) DC (discontinued). Guest voided 500 cc on 6A - 6P shift. No c/o pain or discomfort voiced of urination or to pelvis area.</p> <p>Record review of Resident #4's Discharge MDS Assessment, dated 05/08/25, revealed a [AGE] year-old male initial admission date was 04/21/25. Resident #4 had diagnosis of chronic kidney disease. Resident #4 had an indwelling urinary catheter and a colostomy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #4's Entry MDS Assessment, dated 05/20/25 reflected a re-admission date of 05/20/25</p> <p>A record review of Resident #4's comprehensive care plan, initiated 04/22/25 to present, reflected:</p> <p>[Resident #4] is on enhanced Barrier Precautions related to presence of indwelling urinary catheter. Interventions included Provide enhanced Barrier Precautions as indicated. (Date initiated: 04/22/25)</p> <p>[Resident #4] has a urinary catheter. Interventions included . . position catheter bag and tubing below the level of the bladder and away from entrance room door, check placement of tubing each shift, Monitor and document intake and output as per facility policy, and monitor/document for pain/discomfort due to catheter.</p> <p>A record review of Resident #4's Order Summary Report printed 05/30/25 at 11:51 AM, reflected the following:</p> <p>Order date 04/23/25: Change (indwelling urinary catheter) drainage bag as needed.</p> <p>Order date 04/23/25: (indwelling urinary catheter) Care to include anchoring tubing (catheter strap around leg to hold in place) and checking skin integrity every shift and PRN.</p> <p>During an observation on 05/30/25 at 10:48 AM, Resident #4 was in a left lateral position in bed. Resident #4 had an indwelling urinary catheter in place. There was no indwelling urinary catheter strap in place to prevent pulling or tugging. The catheter tubing laid across Resident #4's right leg connected to a closed system drainage bag that hung on the right side bed rail. Resident #4 was pleasant and willingly participated in an interview. Resident #4 was alert and oriented to person, place, time of day, and situation. Resident #4 said that the staff never placed a strap to prevent the catheter tubing from getting pulled or tugged. Resident #4 said that the nurse provided catheter care every morning and the CNAs emptied the drainage bag before the shift change. Resident #4 denied pain or discomfort at the insert site or symptoms of an UTI.</p> <p>During an interview on 05/30/25 at 2:09 PM, CNA E said that he reviewed facility training videos on catheter care and it had been covered during in-services. CNA E said that he would empty the drainage bag when providing peri-care to a resident and would report how much, if the urine had an odor, and if dark in color because of a possible UTI to the nurse. CNA E said that there should be a blue cover on the catheter drainage bags for privacy and dignity. CNA E said it was the nurse and the CNAs responsibility to ensure a privacy cover was on the drainage bags. CNA E could not explain why Residents #2, #3, and #4 did not have a catheter securement device around the thigh and should report it to the nurse when noticed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/31/25 at 2:19 PM, LVN D said he provided catheter care based upon standards of practice, physician orders, and the care plan. LVN D said that he was observed for catheter care competency during new hire training and orientation. LVN D said that he checked for placement, for signs of infection such as redness, discharge, or swelling at insert site, and urine characteristics when she provided catheter care daily. LVN D said residents with catheters should have a catheter support strap around the upper leg to hold the catheter tubing in place and prevent trauma or the catheter tubing from being pulled out. LVN D said that catheter drainage bags should have a privacy cover. LVN D could not explain why Resident's #2, #3, and #4 did not have a catheter stabilization device in place or a privacy cover on the drainage bag. LVN D said that he was the primary responsible person when assigned to the resident. LVN D said that he would ensure a leg support strap was in place. Walking rounds revealed LVN D followed through with catheter securement devices were placed and Resident #3's indwelling urinary catheter was to be removed.</p> <p>During an interview on 05/31/25 at 4:00 PM, the CNO said that the implementation of care plan interventions was reviewed every morning during the clinical meeting. The CNO said that a preceptor observed and monitored nurses for competency skills and would sign off on the competency skills check off when successfully met. The CNO said that nurses who were successfully checked off for catheter care competencies and skill sets were allowed to insert, provide care for, and remove indwelling urinary catheters. The CNO said that residents were assessed and evaluated if indwelling catheters were clinically indicated. The status of residents' catheter needs was discussed during IDT meetings. The CNO said that interventions in place for residents with indwelling catheters included water intake, supplements, and catheter care every shift. The CNO indicated that residents were at risk of UTI development if the catheter was not changed or managed appropriately.</p> <p>Record review of the facility's Indwelling Catheter Protocol, dated November 2018 and last reviewed 11/2024, reflected:</p> <p>Policy: Residents with an indwelling catheter will be reassessed by a licensed nurse weekly for 30 days after insertion of the catheter, then monthly thereafter to determine further need for the recording of intake and output and the resident's progress and continued need for a urinary catheter. The physician is responsible for writing the order for placement of the Foley catheter. The registered nurse or licensed practical nurse is responsible for placing an indwelling urinary catheter (Foley catheter). The above personnel must have demonstrated the knowledge and skills to perform this procedure as evidenced by verification on a competency checklist.</p> <p>Procedure:</p> <p>The catheter tubing will always be secured to the resident's thigh with approved catheter securement device to prevent movement, irritation, and decrease risk of infection.</p>		