STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676449	A. Building B. Wing	12/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 3 (Resident #1, Resident #9, and Resident #22) of 4 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1, Resident #9, and Resident #22 MDS were coded for BiPAP/CPAP treatments.The facility staff failed to ensure that Resident #9 was coded for a PICC line per MD orders. This failure could place residents at risk of receiving the incorrect care and treatments. During an observation and interview with Resident # 1 on 10/23/2025 at 1:15 PM his BIPAP/CPAP mask was on the floor on the left side of his bag. Resident #1 stated that he used the mask at night. Resident#1 said while he was s patient at the facility, he has not observed staff cleaning or bagging his CPAP mask. He does receive treatments from the machine at night. Resident #1 stated that he could not move or stand, due to surgery on his knee, and he could not have put the mask on the floor. Record review of Resident #1's face sheet dated 10/23/2025, reflected he was an [AGE] year-old male that was admitted on [DATE] with diagnoses including: infection and inflammatory reaction due to internal left knee prothesis, subsequent encounter (infection of other causes), Chronic Systolic (congestive) heart failure (condition of the heart muscle weakens overtime.), Hypertensive heart disease with heart failure (a condition where prolonged high blood pressure (hypertension) damages the heart muscle over time), and OSA Obstructive Sleep Apnea (Adult). (is a sleep disorder where the airway repeatedly collapses during sleep, leading to pauses in breathing. Record review of Resident #1's quarterly MDS Assessment, dated 10/07/2025, reflected the resident BIMS score was 15 indicating his cognition was in-tact. The resident required set up and clean up assistance for oral hygiene, personal hygiene, and eating, and partial to moderate assistance for showers. He required supervision and touching assistance for toileting, lower body dressing, and putting on footwear. Section O -special treatments, procedures, and programs, G1. reflected use of a Non-invasive Mechanical Ventilator while he was a resident, however, Sections O, G2. BiPAP and G3. CPAP were left blank, not identifying the specific treatment type. BiPAP (a non-invasive ventilation therapy that provides two different levels of air pressure to help patients with breathing problems.) CPAP (a treatment for sleep apnea that uses a machine to deliver pressurized air through a mask to keep airways open during sleep.) Record review of Resident #1's care plan dated 10/04/25 reflected he requires BiPAP .keep head of bed elevated, to prevent Shortness of Breath, Titrate and provide BiPAP/CPAP per physician orders. Record review of Resident #1's MD orders reflected 1. Wipe mask, nasal pillows, daily with damp cloth. 2 empty humidifier chambers, 3. Fill humidifier with warm soapy water, shake well. 4. Rinse, and air dry. Resident #9 During an observation 10/23/2025 at 1:20 PM of resident #9's BiPAP/CPAP mask was observed lying on his nightstand unbagged. Resident #9 stated that he could not recall the last use of the sleep apnea machine. Record review of Resident 9's face sheet dated 10/22/2025 reflected he was a revealed [AGE] year-old-male that was admitted on [DATE] with current DX: COPD (COPD is a chronic lung disease that causes ongoing inflammation and narrowing of the airways, making it difficult to breathe.), Osteomyelitis of Vertebra, lumbar region (infections of the bones in lower back). Sepsis (life threatening condition that occurs when the body's immune system overreacts to an infection.) Record review of Resident #9's quarterly MDS Assessment, dated 10/07/2025, reflected the resident BIMS score was 15 indicating his cognition was in-tact. The residents' ADL functioning required setup and cleaned up for oral hygiene, personal hygiene, eating, and partial to moderate assistance for showers. He required supervision and touching for toileting, lower body dress, and putting on footwear. Section O -special treatments, procedures, and programs: Resident #9's BiPAP (a device that provides air pressure to help patients with breathing problems.) and CPAP (machine used to deliver pressurized air through a mask to keep airways open during sleep.) were left blank. Section O4: Central PICC Line was left blank. (PICC lines are central lines designed for long-term therapies with different benefits and considerations.) Record review of Resident #9's care plan dated 10/09/2025 reflected he was receiving antibiotic therapy Cefazolin Sodium infections Solution.interventions administer the antibiotic medications as order by physician. Monitor and document side effects. Resident #9 was receiving IV medications Cefazolin. If IV is infiltrated: Antidote for vesicant/irritant med MAY be infused into IV catheter.prior to removal. Check nursing drug handbook or pharmacy for recommended antidote. Section: Respiratory reflected Resident #9 has altered respiratory status/difficulty breathing COPD.interventions -Admit to Cardiopulmonary Program. Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 4 of 10 (Resident #1, Resident #9, Resident #14, and Resident #22) residents reviewed for respiratory care. The facility failed to ensure:Resident #1's, Resident #9's, and Resident #22's BiPAP/CPAP mask were stored properly when it was not in use, per facility protocol for sanitation. Resident #14's NC (a medical device that delivers supplemental oxygen through a flexible tube with two prongs that rest in the nostrils.) was discarded properly when changed, and dating the new NC tubing was installed.These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. Resident #1 During an observation and interview with Resident # 1 on 10/23/2025 at 1:17 PM revealed his BIPAP/CPAP mask on the floor on the left side of his bag. Resident #1 stated staff administer his treatment at night for sleep and he did not know how the mask got on the floor. Record review of Resident #1's face sheet dated 10/23/2025, reflected he was an [AGE] year-old male that was admitted on [DATE] with diagnosis including: infection and inflammatory reaction due to internal left knee prothesis, subsequent encounter (infection of other causes), Chronic Systolic (congestive) heart failure (condition of the heart muscle weakens overtime. Hypertensive heart disease with heart failure (a condition where prolonged high blood pressure (hypertension) damages the heart muscle over time). Record review of Resident #1's face sheet dated 10/23/2025, reflected he was an [AGE] year-old male that was admitted on [DATE] with diagnosis including: Obstructive Sleep Apnea (Adult), Chronic Systolic (congestive) heart failure (condition of the heart muscle weakens overtime. Record review of Resident #1's quarterly MDS Assessment, dated 10/07/2025, reflected the resident BIMS score was 15 indicating his cognition was in-tact. The residents required set up and cleaned up assistance for oral hygiene, personal hygiene, and eating, and partial to moderate assistance for showers. He required supervision and touching for toileting, lower body dress, and putting on footwear. Section O -special treatments, procedures, and programs, G1. reflected use of a Non-invasive Mechanical Ventilator while he was a resident, however, Sections O, G2. BiPAP and G3. CPAP were left blank, not identifying the specific treatment type. BiPAP (a non-invasive ventilation therapy that provides two different levels of air pressure to help patients with breathing problems.) CPAP (a treatment for sleep apnea that uses a machine to deliver pressurized air through a mask to keep airways open during sleep.) Record review of Resident #1's MD order dated 10/04/25 reflected 1. Wipe mask, nasal pillows daily with damp cloth 2. Prescriber Empty Humidifier Chamber3. Fill humidifier with warm Written soapy water, shake well 4. Rinse, air dry in the morning. admission Protocol: may administer supplemental oxygen as needed. Resident #9 During an observation 10/23/2025 at 1:20 PM of resident #9's BiPAP/CPAP mask was observed lying on his nightstand unbagged. Resident #9 stated that he could not recall the last use of the sleep apnea machine. Record review of Resident #9"s face sheet dated 10/22/2025 reflected he was a revealed [AGE] year-old-male that was admitted on [DATE] with current DX: COPD, Chronic Bronchitis (a long-term lung condition characterized by persistent inflammation of the airways (bronchi), leading to excessive mucus production and a chronic cough.), Acute respiratory failure with hypoxia (faint), pneumonia (lung infection). Record review of Resident #1's quarterly MDS Assessment, dated 10/07/2025, reflected the resident BIMS score was 15 indicating his cognition was in-tact. The residents' ADL functioning required setup and cleaned up for oral hygiene, personal hygiene, and eating, and partial to moderate assistance for showers. He required supervision and touching for toileting, lower body dress, and putting on footwear. Section M-high risk drug class reflected he was taking antibiotics, anticoagulant, hypoglycemic, diuretic, and opioid as a resident. Section O -special treatments, procedures, and programs Resident #9's MDS was not coded for BiPAP/CPAP use. Record review of Resident #9's care plan dated 10/09/2025 reflected Resident #9 has altered respiratory status/difficulty breathing COPD.interventions Admit to Cardiopulmonary Program. Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. Monitor for s/s of potential respiratory infection.Monitor for s/sx of acute respiratory insufficiency: Anxiety, Confusion, Restlessness SOB at rest, Cyanosis (bluish discoloration of skin), Somnolence (strong drowsiness). Monitor for s/sx of acute respiratory insufficiency.increased heart rate.Monitor vitals as orders. Monitor/document/report abnormal breathing patterns to MD. Record review of Resident #9's MD orders

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with state and federal laws in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 3 Residents reviewed for medication storage. LVN-C failed to ensure Resident #1's PICC line medication was secured in a locked compartment. This failure could place residents at risk for consuming or tampering with medications that could result in adverse medication reactions.Record review of Resident #1's face sheet dated 10/23/2025, reflected he was an [AGE] year-old male that was admitted on [DATE] with diagnosis including: infection and inflammatory reaction due to internal left knee prothesis, subsequent encounter (infection of other causes). Record review of Resident #1's quarterly MDS Assessment, dated 10/09/2025, reflected the resident BIMS score was 15 indicating his cognition was in-tact. Resident #1's ADL functioning required setup and clean up for oral hygiene, supervision and touching, depending on staff for showers. He required supervision and touching for toileting, lower body dress, and putting on footwear. Section M-skin conditions reflected he had a surgical wound, nutrition or hydration interventions, and applications of ointments. Section N-high risk drug class reflected he was taking antibiotics. Section O -special treatments, procedures, and programs, reflected resident was receiving IV medications (medical procedure where a needle or catheter is inserted in the vein to administer fluid.), IV access were addressed. Record review of Resident # 1's Care Plan dated 10/04/2025 reflected he was on Enhanced Barrier Precautions related to IV therapy and interventions included Provide Enhanced Barrier Precautions as indicated.Involves the use of personal protective equipment (PPE), specifically gowns and gloves, during high contact resident care activities (i.e., prolonged direct contact) Resident #1 was receiving IV medication(s).Vancomycin , ceftriaxone (a potent antibiotic used to treat serious bacterial infections.The resident will not have any complications related to IV.Intervene accordingly before discontinuing IV site. IV DRESSING: Observe dressing. Record review of Resident #1's MD orders reflected an order dated 10/04/2025 at 3:48 AM, Wipe mask, nasal pillows [NAME] with damp cloth Empty humidifier chamber. Fill humidifier with warm soapy water, shake well.Rinse, air dry in the morning. Record review of Resident #1's MD order dated 10/04/2025 at 5:39 PM reflected ceftriaxone Sodium Intravenous Solution Reconstituted 2 GM (Ceftriaxone Sodium) Use 2 gram intravenously in the afternoon for L knee infection until 11/11/2025 11:59 PM. MD orders dated 10/04/2025 at 5:43 PM reflected Change needleless connector every week with dressing change and following blood draws every day shift every 7 day(s) for per protocol.changes occurred on 10/05/2025, 10/12/2025, and 10/19/2025. Change PICC (a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart.) line dressing every 7 days (sterile process disinfecting and sterilization of reusable medical instruments) every day shift every Sun for PICC Line IV PICC: order monitor site and dressing. Document in progress note any signs and symptoms of infection, notify provider of s/sx of infection every shift for per protocol. Normal Saline Flush Solution (Sodium Chloride saltwater Flush) every shift for PICC Line Patency (being open allowing for free flow of fluids, air, or blood) as well as before and after each infusion (a method of putting fluids including drugs into the bloodstream.) Change PICC line dressing every 7 days (sterile process) every day [NAME] every Sun for PICC Line. Check IV dressing each shift and PRN every shift. reflected Enhances Barrier Precautions-IV/PIPC every shift. Vancomycin HCl Intravenous Solution 750 MG/150ML (Vancomycin HCl) Use 1500 mg intravenously every 24 hours for L Knee joint Infection until 11/11/2025 11:59 PM. Record review of Resident #1's October MAR/TAR Vancomycin HCl (powerful antibiotic used to treat serious bacterial infections) Intravenous 24-hour use was administered on 10/23/2025, the day of the investigation at 12:00 PM, by LVN C. Ceftriaxone was administered on 10/23/2025 at 12:00 PM by LVN C During an observation and interview with Resident # 1 on 10/23/2025 at 1:15 PM revealed he was receiving antibiotic therapy via IV for infections. During an observation on 10/23/2025 at 1:17 PM revealed Resident #1's PICC line medication labeled Ceftriax 2G/100 ML was observed lying on the exit door handle located at the end of the resident hall. The medication was exposed to the sunlight reflecting through the glass door. The medication was prescribed to Resident #1. The medication was observed with a light blue sticker that stated, keep refrigerated. The nurse MDS nurse was notified of the concern. She went to observe the medication then left the hall to locate LVN-C. During an Interview with LVN-C on 10/23/2025 at 3:10 PM, revealed he was the assigned nurse that left the IV/PICC line medication on the door handle of the back door until he was