STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676449	A. Building B. Wing	02/07/2026

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 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a resident who required dialysis received such services, consistent with professional standards of practice for 1 (Resident #1) of 1 resident reviewed peritoneal dialysis.The facility failed to ensure nursing staff received training to administer, monitor and intervene for Resident #1 who required PD (During peritoneal dialysis, a cleansing fluid flows through a tube into part of the stomach area, also called the abdomen. The inner lining of the abdomen, known as the peritoneum, acts as a filter and removes wastes from blood. After a set amount of time, the fluid with the filtered waste flows out of the abdomen and is thrown away). Resident #1 was admitted to the hospital with peritonitis (bacteria into the peritoneum).The facility failed to ensure Resident #1 had dialysis supplies available on 01/25/26 and 01/26/26 to perform PD. Resident #1 was not dialyzed on 01/25/26 and 01/26/26 because she did not have supplies (cycler) available. This failure could place residents at risk of not receiving life-sustaining medical treatment which could diminish the quality of life. Findings included:Record review of Resident #1's face sheet dated 02/05/26 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke caused by a blockage in a blood vessel supplying the brain), end stage renal disease (permanent stage of kidney failure), type 2 diabetes (a chronic condition where the body develops insulin resistance and fails to produce enough insulin causing high blood sugar levels), and heart failure (the heart cannot pump blood efficiently causing fluid buildup, fatigue, and shortness of breath).Record review of Resident #1's care plan dated 1/20/26 reflected she needed dialysis. The goal was for Resident #1 to have immediate intervention should any s/sx complications from dialysis occur. Resident #1 would have no s/sx complications from dialysis. Intervention was to monitor PD catheter site redness/drainage, report cloudy effluent, inadequate drainage or inflows problems, sudden weight gain or loss, shortness of breath, abdominal pain, fever. Monitor/document report PRN any s/sx of infection to access site, redness, swelling, warmth or drainage, renal insufficiency. PD dialysis 6p-6am, guest to complete independently and supply own supplies.Record review of Resident #1's comprehensive MDS assessment dated [DATE] reflected that she had a BIMS score of 15 (Cognitively Intact). Hemodialysis was indicated while a resident. Record review of hospital H&P dated 2/01/26 reflected, admission date 01/31/26 chief complaint: Abdominal pain, nausea/vomiting. Patient was recently admitted at [local hospital] from 01/11 to 01/20 for LLE weakness + possible peritonitis from PD catheter-cranial imaging showed bilateral MCA + left PCA watershed infarcts, neurology was consulted + started patient on DAPT. ID was consulted and obtained PD fluid studies which were negative for peritonitis. Patient reports during this hospitalization had generalized abdominal pain which was thought to be opioid-induced constipation improved with PRN antiemetics + bowel regimen. Patient was eventually discharged to [facility] but reports during the time she was there she was not eating much food due to continued abdominal pain. Patient's [family] at bedside reports patient's (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 0698 Level of Harm - Actual harm Residents Affected - Few	decreased oral intake at the [facility] was more so from the food's suboptimal taste instead of abdominal pain as she was eating some of the food she was bringing, but over the last 3 days she was unable to eat much due to the abdominal pain. Patient also denies any pain around her PD catheter site or any discolored fluid coming out of her PD catheter. Due to these worsening symptoms, patient was brought to [local] ED for further evaluation. CT of adb/pelvis was obtained and showed small-moderate free intraperitoneal air from PD or from possible perforation along with free fluid in the abdomen, and mild diffuse wall thickening of the colon.* In an interview with Resident #1 on 02/04/2026 at 4:19 PM she stated she did her own dialysis. She stated the nursing staff did not monitor her when she did her dialysis. She stated they did not come to check on her to during the process. She stated earlier in the week about Monday or Tuesday, she could not remember the exact date, she did not have the equipment she needed to do her dialysis. She stated she did not have the Clycler (machine automates peritoneal dialysis by performing fluid exchanges overnight while a patient sleeps) because the one she was using was broken and she was waiting for her family to bring the supplies from home. She stated she did not ask the facility for any supplies because her family was supposed to bring them to her. She stated her family would usually bring supplies to last about five days at a time. She said that she told the DON that she had missed two or three days in the past and she did not have any issues. She stated the nurses took her vitals and listened to her chest and sent her chest x-rays after she had missed her days of dialysis. She stated she could not remember when she was sent for x-rays. She stated on Friday she vomited what she thought was bile. She stated she was assessed by the nursethen she was sent to the hospital . She stated that she knew that not doing the dialysis caused her to retain more fluid and it could be dangerous to her health.In an interview with CNA-B on 02/05/2026 at 2:10 PM, she stated that Resident #1's family would hook her up to the dialysis machine and leave the facility . She stated that the family would get upset because they would be waiting for them to unhook Resident #1 from the machine so they could provide care. She stated that they tried to explain to the family that it was dangerous for the resident to be moved during her dialysis time, her blood pressure could drop to low. She stated that if the family was late returning to the facility in the morning, Resident #1 would have to disconnect herself. In an interview with the DON on 02/05/2026 at 10:50 AM, she stated the facility was able to meet the needs of Resident #1. She stated that the treatment was not staff assisted and admission to the facility was contingent upon Resident #1 or designated family member's ability and willingness to perform all aspects of the PD treatment independently. She stated when Resident #1 was admitted the admission paperwork was not signed. She stated she did not know why the paperwork was not signed. She stated the previous marketing director did not complete the paperwork. She stated the nurses were responsible for monitoring not assisting Resident #1 with her dialysis. She stated that per the doctor's orders monitoring consisted of reminding Resident #1 to hook up or unhook the dialysis system. She stated the evening shift would remind the resident to hook up to the machine and the morning shift would remind her to unhook the machine. She stated that the nurses would only need to document if the patient had an issue, such as if the dialysis started late. She stated that weekly weights were done on Resident #1, she was at the facility for nine days. She stated Resident #1 missed two days of dialysis during the winter storm, the family did not bring the supplies and stated they could not get to the facility because of the roads, and the cycler had been broken. She stated that Resident #1 stated she was fine with missing the two days of dialysis, stating she had missed two to three days in the past and there was no negative effect on her. She stated the facility did not have emergency PD equipment on site. She stated she had been trained on PD prior to working at this facility. She stated that when Resident #1 (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	missed a treatment, they were to notify the PCP who will decide next steps. She stated when Resident #1 missed the treatments, the PCP was notified on 01/31/26 at 6:17 PM and an assessment was completed, Resident #1 received x-rays, and the results were clear. She stated Resident #1 was at risk of infection and that was the reason she was sent to the hospital. She stated that Resident #1 was admitted to the hospital for intractable nausea/vomiting and generalized abdominal pain suspect 2/2 viral gastroenteritis (a common, contagious intestinal infection causing watery diarrhea, cramps, nausea vomiting) vs peritonitis (severe, inflammation of the peritoneum, which is the thin membrane lining the inner abdominal wall and covering abdominal organs) vs gastroparesis (chronic disorder where the stomach takes too long to empty food into the small intestine) vs developing peptic ulcer (an open sore found on the lining of the stomach) or H pylori infection (infects the stomach lining, causing chronic inflammation, ulcers, and occasionally cancer). In an interview with RN-A on 02/06/26 at 10:03 AM, she stated that she was not aware that Resident #1 had an infection. She stated that part of her monitoring consisted of looking at the site to ensure there was no redness or drainage and she did vital signs, making sure the resident connected and disconnected to the machine . She stated she gave Resident #1 the vitals and Resident #1 would put the information into the dialysis machine. She stated that when Resident #1 was admitted to the facility the family said they would help her with her dialysis treatments. She denied she had been trained in how to connect, monitor, or disconnect the machine from the resident. Record review of Progress note written by RN-A dated 1/28/26 at 7:48 AM reflected no skin/wound alterations . Record review of Progress note written by LVN-B dated 1/31/26 at 17:21 (5:21 PM) reflected PA notified of [Resident#1] complaint of nausea/vomiting and poor appetite. New orders received as follows: 1.Phenergan 12.5mgx1 now, 2. STAT CBC, CMP, 3. Reglan 5mg TID. [Resident #1] made aware of new orders. Phenergan administered. STAT labs drawn at approximately 1730 (5:30 PM).Interview with MD/PCP on 02/06/2026 at 10:17 AM she stated that the facility could meet the needs of Resident #1 for care and rehabilitation. She stated that the family was asked to assist with PD if Resident #1 could not connect with the machine on her on. She stated that she had seen Resident #1 prior to the ice storm 01/24/26 and the resident informed her the machine had malfunctioned. She told her she was not able to do dialysis on Thursday prior. She stated the resident told her she had missed a few days of dialysis in the past and she (resident) was not concerned about it. She stated at first she had concerns about if Resident #1 was doing it correctly as far as keeping a sterile environment, so she watched her put the numbers in the machine and start the machine. She stated Resident #1 had been treated for peritonitis with abdominal pain. She stated that the resident had been treated at another hospital and discharged but the family was not satisfied and brought her to local area for a second opinion. She stated that it was during DON's conversation with the dialysis clinic in this area that it was determined that she did not have a pulmonologist doctor in this area. She stated that the nursing staff provided the resident with her morning and evening numbers to put into the machine. She stated that the resident would put herself on dialysis in the evening and come off in the morning she thought it was about 12-hour process. She stated that Resident #1 did not mention to her that she was lacking supplies. She stated that when the DON informed her that the resident had missed more treatments she made the decision to send her to the hospital because she needed to get the cultures from her stomach to determine if she had peritonitis. She stated that the resident not having the supplies to properly do her dialysis placed her at risk becoming septic. She stated the risk of admitting a resident with PD and the staff not being trained to administer/monitor/intervene would be that the staff would not know if the patient was doing it properly. Record review of facility Peritoneal Dialysis (PD) Essentials Inservice/Training dated 09/2025, (continued on next page)

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