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	11/07/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review the facility failed to ensure that residents who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents goals and preferences for 1 of 5 residents (Resident #26) reviewed for respiratory care. The facility failed to ensure Resident #26's oxygen tubing was replaced every week on Sunday, according to physician's orders. This failure could place residents at risk for respiratory compromise and infection. Findings include: Record review of Resident #26's Admission Record, dated 11/7/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #26's 5-day MDS Assessment, dated 10/18/24, reflected he had moderately impaired cognition and received continuous oxygen therapy. Resident #26 had diagnoses which included anemia (lack of red blood cells needed to carry oxygen through the body); chronic obstructive pulmonary disease (lung disease that block airflow and causes difficulty breathing); and lumbar spinal fusion surgery. Record review of a physician's Progress Note, dated 10/28/24, reflected Resident #26 had a history of lumbar spine surgery on 9/23/24 and a recent acute hospitalization for hypoxia (low levels of oxygen in the body) and was found to have sepsis (life threatening complication of infection) secondary to pneumonia (lung infection). He received IV antibiotics and was transferred to the facility for skilled nursing care. Record review of Resident #26's care plan reflected the following entry, dated 10/16/24: [Resident #26] requires oxygen therapy. Interventions included, Administer oxygen per physician orders. Record review of Resident #26's Order Summary Report, dated 11/7/24, reflected the following orders: Respiratory: Oxygen @ 2L/M continuous every shift for dyspnea [difficulty breathing] Order date 10/13/24. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Fort Worth, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6301 Oakmont Blvd Fort Worth, TX 76132	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continuous O2 Via (NC/MASK) at 2 lpm. Order date 10/15/24. Change O2 tubing every night shift every Sun [Sunday] and as needed. Order date 10/15/24. Record review of Resident #26's Medication Administration Report, dated October 2024, reflected the following entries: Change O2 tubing every night shift every Sun and as needed. Order date 10/15/24. The order was initialed as completed on 10/20/24 by RN B and on 10/27/24 by LVN C. Record review of Resident #26's Medication Administration Report, dated November 2024, reflected the following entries: Change O2 tubing every night shift every Sun and as needed. Order date 10/15/24. The order was initialed as completed on 11/3/24 by LVN D. An observation on 11/5/24 at 10:25 AM revealed Resident #26 was in his bed sleeping. He was wearing oxygen which ran at 2L NC via concentrator machine. The machine had a water bottle attached to provide humidification. His oxygen tubing was labelled with a white label and dated 10/20/24. His water bottle was dated 10/20/24. An observation and interview on 11/5/24 at 2:20 PM revealed Resident #26 sat up in bed, awake and alert. He was wearing his oxygen which was still running at 2L NC. His oxygen tubing and water were still dated 10/20/24. An observation and interview on 11/6/24 at 11:21 AM revealed Resident #26 was lying in bed. He was wearing his oxygen running at 2L NC. His Oxygen tubing and water were both, dated 11/5/24. During an interview with the DON on 11/7/24 at 10:35 AM, she stated oxygen tubing and water should be changed weekly and as needed. She stated the tubing changes were placed on the MARs as a reminder, but anyone could change the tubing. The DON stated residents were at risk for infection if the tubing was not changed. During a telephone interview on 11/7/24 at 2:15 PM, LVN C stated if a resident was wearing oxygen, she checked to ensure they were wearing it properly, she kept the head of the bed up, and changed the tubing and water when needed. When LVN C was asked about Resident #26 and informed his tubing was observed to be dated 10/20, she stated, Are you sure? Even his water needs to be changed more often than that, he goes through it pretty often. LVN C stated she never signed anything on the MAR before it was completed and always dated the oxygen tubing by writing directly on the tube itself. She stated the risks of not changing the water and oxygen tubing included the water could run out causing the resident to dry out which could lead to nose bleeds. She stated tubing could get hard causing irritation to the resident's face ear and nose and could also become dirty increasing risk for infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/7/24 at 3:47 PM, LVN D stated oxygen tubing should be replaced weekly and as needed. She stated nurses were supposed to ensure the tubing was not coiled and could flow freely and check the tank to ensure it was functioning properly. LVN D stated she marked the tubing with tape and added the date and her initials when she changed it. She stated she was surprised to hear the tubing was dated 10/20/24 and stated she would never mark the MAR just to mark it. LVN D stated when she worked on 11/3/24, it was her second day at the facility. She stated she may have confused the order for a PRN order meaning it was to check the tubing. She stated risks included tubing could get old and decrease the resident's oxygen saturation levels or cause hypoxia. She stated there was a risk for infection if the tubing became dirty. Record review of the facility's policy titled, O2 Hygiene, dated November 2018, reflected Policy: 1. Any resident or guest receiving any type of oxygen delivery will have orders in the electronic medical record. Examples of oxygen delivery can include oxygen via nasal cannula .3. Tubing will be changed and/or cleaned in accordance with physician order to prevent infection.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45507 Based on observation, interview and record review the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen reviewed for nutrition services. 1. The facility failed to ensure food in the refrigerators and freezer was properly stored, labeled and dated. 2. The facility failed to ensure temperatures were taken and recorded for reach in refrigerators. 3. The facility failed to ensure all items on the steam table were temped for the correct holding temperature 4. The facility failed to ensure the thermometer on the dishwasher was functioning. These failures could place residents at risk for foodborne illness. Findings include: Observation and record review on 11/05/2024 from 8:22 AM to 8:30 AM in the facility kitchen revealed the following: -medium stainless steel pan of brown gravy, covered with plastic wrap, was not dated, in the walk-in refrigerator. -small stainless steel pan of rice, covered with plastic wrap, with only 11/4 written on it, in the walk-in refrigerator. -small stainless steel pan of what appeared to be mashed potatoes, covered with plastic wrap, with only 11/4 written on it, in the walk-in refrigerator. -small plastic container labeled grilled chicken prepared 11/2/24 with no lid, and loosely covered with plastic wrap, in the walk-in refrigerator. -medium stainless steel pan of what appeared to be white gravy, with plastic wrap, not dated, in the walk-in refrigerator. -Temperature logs were missing entries for AM shift on 11/01/24, 11/02/24, 11/03/24, and 11/05/24 and for PM shift on 11/03/24 and 11/04/24 for both reach in refrigerators. -One pitcher of a brown liquid and one pitcher of a red liquid were not labeled or dated, in the reach in refrigerator. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2 small bowls of canned pineapple, covered with plastic wrap, were not labeled or dated, in the reach in refrigerator. Observation and interview on 11/06/2024 at 11:28 AM, revealed [NAME] G took temperatures of mashed potatoes, green beans and beef tips that were on the steam table. [NAME] G did not take the temperature of the white gravy or the beef patties (alternate) that were also on the steam table. [NAME] G stated she did not temp those items because they were not on her sheet. Interview on 11/06/2024 at 11:47 AM, the Dietary Manager stated the beef patties should have been temped and all items on the steam table should be before serving. She stated she would go temp those items. Interview on 11/07/24 at 11:06 AM, [NAME] G stated everything on the line should be on the temp list. She said if a food item was not at the correct temperature, she would take it off the line and put it back in the oven. She said the risk to residents was they could get sick. Observation and interview on 11/07/24 at 10:54 AM revealed a bag of frozen carrots was not labeled or dated in the small freezer. The Dietary Manager took the bag of carrots, placed them in a resealable bag, labeled and dated the outside of the bag, and put them back in the freezer. In the reach in refrigerator, 2 large salads were not labeled or dated and were on the shelf. The Dietary Manager moved the salads to a tray to the shelf below. She said they were not supposed to write or date on the plastic wrap and the date was on the tray. The label on the tray read 10/3/24 and did not indicate an item. The Dietary Manager removed the old label, replaced it with a new one, and stated the salads were made yesterday . Interview and record review on 11/07/24 at 11:00 AM, revealed the temperature logs on both reach in refrigerators were completed for the missing dates that were reviewed on 11/05/24. The Dietary Manager said the fridge and freezer temperatures should have been documented on the sheets and were not logged anywhere else. She stated her expectation was that staff should check and document the temperatures for the fridges and freezers for each shift. She said the small fridges were supposed to be done by the dietary aides and the fridge and freezer done by the cook . She said if they were not the correct temperature the staff should tell her. She said if the temperatures were not checked, and the fridge or freezer was not working, the residents could get spoiled food. The Dietary Manager stated her expectation was for staff to label and date items before putting them in the fridge. She said whoever got and put an item away was supposed to write the date, and what it was. The Dietary Manager stated if food was not labeled and dated bad food could be served to the residents and they could get sick. Interview on 11/07/24 at 1:00 PM, the Dietitian stated all foods on the steam table should have the temperature taken, and the logs came from the menu, so if a substitution was on the menu, it could be written in. The Dietitian stated she in-serviced staff on taking temperatures and made sure everything had a date and label and who was to label the food items. The Dietitian stated her expectation was prepared food would have the date prepared and the use by date. The Dietitian stated she in-serviced staff on taking temperatures and making sure everything had a date and label and who was to label the food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 11/07/24 at 2:19 PM, Dietary Aide H was washing dishes . He stated he was not the only aide who washed dishes in the kitchen. He stated he did not know how to take the temperature of the dish machine and he just wrote what the person before him wrote on the temperature log. Dietary Aide H stated he knew the wash cycle should be at 160 degrees F and the rinse should be at 180 degrees F. The Dietary Manager came over and stated Dietary Aide H had been trained. She ran the dish cycle, and the temperature read 138 degrees on the dish machine. She stated when that happened, they had test strips and placed a strip on a knife and reran the cycle. The temperature on the dish machine read 139, then 92, and then 140 throughout the wash and rinse cycles. The Dietary Manager pulled the dish rack out and read the test strip, which revealed an orange line, which indicated the temperature was 160 degrees F. The Dietary Manager ran another strip on a plate to test the rinse cycle, which revealed a brown line which indicated the temperature was 160 degrees F. The Dietary Manager stated it worked fine that morning and no staff had told her it was not reading the correct temperature. She stated if the dishwasher was not working properly the dishes would not get sanitized and they would have to use the sink to wash dishes. The Dietary Manager stated she would inform the Maintenance Director if the dishwasher was not working . Interview and record review on 11/07/24 at 3:06 PM, the Maintenance Director stated he just learned about the dishwasher not reading the correct temperature. He said it was repaired about a month ago and thought they replaced the temp module. Record review of invoice, dated 10/02/24, reflected in part, after replacing the thermistor, the technician found that the dishwasher has a bad breaker along with the digital thermostat reading p4 during rinse cycle. Record review of the facility policy titled Storage of Refrigerated foods, dated 2021, reflected in part: Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality .Air temperature inside the refrigerator is checked and recorded twice daily .Food in the refrigerator is covered, labeled and dated with a use by date. Open products that have not been properly sealed and dated are discarded. Record review of the facility policy titled Food Temperatures, dated 2021, reflected in part: To ensure food safety, hot food is cooked to a minimum safe temperature and is held at no lower than 135 F .Hot food holding temperatures are taken and recorded for food on the steam table(s). Record review of the facility policy titled Machine Washing and Sanitizing (High temperature dishwashing machine), dated 2021, reflected in part: Dishwashing machines using hot water for sanitizing may be used if the temperature of the wash water is no less that that specified by the manufacturer, which may vary from 150 F to 165 F .and if the final rinse temperature is no less than 180 F. The final rinse temperature is tested with a paper thermometer .The paper thermometer turns color when it registers 160 F which sanitizes the plate, tableware, utensils etc. (160 F on the dis or utensil surface reflects 180 F at the manifold where the temperature of the dishwashing machine final rinse is measured). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed section 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed section 3-501.16 (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5 C (41 F) or less . Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: (1) For a stationary rack, single temperature machine, 74oC (165oF); (2) For a stationary rack, dual temperature machine, 66oC (150oF); (3) For a single tank, conveyor, dual temperature machine, 71oC (160oF); (4) For a multitank, conveyor, multitemperature machine, 66oC (150oF). FDA Food Code 2022 Chapter 4 Equipment, Utensils, and Linens Chapter 4 - 18 (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49oC (120oF). And review of section 4-501.112 revealed Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90oC (194oF), or less than: Pf (1) For a stationary rack, single temperature machine, 74oC (165oF); Pf or (2) For all other machines, 82oC (180oF). Pf (B) The maximum temperature specified under (A) of this section, does not apply to the high pressure and temperature systems with wand-type, hand-held, spraying devices used for the in-place cleaning and SANITIZING of EQUIPMENT such as meat saws.

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F 0909

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48122

Based on observation, interview and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment leading to potential entrapment hazards for 1 (Resident #202) of 14 residents reviewed for safety in rooms.

The facility failed to conduct regular inspections of resident bed frames and mattresses to identify risks and problems and to ensure Resident #202's twin sized bed did not have an oversized bariatric mattress.

These failures could place residents at risk of injury resultant from equipment malfunction, entrapment, or falls.

The findings include:

Record review of Resident #202's face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #202 was listed as her own responsible party. Resident #202 had relevant diagnoses of Unspecified Fracture of Left Pubis (break in one or more bones in the pelvis), Repeated Falls, Unsteadiness on Feet, Difficulty in Walking, Need for Assistance with Personal Care, Muscle Weakness (Generalized), Hyperlipidemia (high levels of fat or lipids in the blood), Hyperkalemia (too much potassium in the blood), and Type II Diabetes Mellitus (disease that occurs when the body does not use insulin properly, resulting in high blood sugar levels).

Record review of Resident #202's admission MDS, dated [DATE], reflected a BIMS score of 15, which indicated the resident was cognitively intact. Resident #202 was listed as having Moderate Difficulty with hearing, which meant a speaker had to increase volume and speak clearly with the resident. Resident #202 was documented as using a manual wheelchair and walker to aid in mobility.

Observation and interview on 11/05/2024 at 9:45 AM revealed Resident #202 sitting in a manual wheelchair at bedside. Family member J shared the resident was not one to bring up concerns and showed how the mattress on the bedframe had a large depression in the middle that caused Resident #202 pain and prevented her from resting in the bed. Family member J shared the foot of the mattress was slipping when the resident tried to sit down as it did not fit inside the frame's corner brackets, and the standard twin size fitted sheets did not fit properly frequently coming off. Family member J stated the resident would never share this information but the family had inquired about the mattress being the incorrect size of several nursing staff since Resident #202 admitted . Family member J stated this mattress was on the bed frame since the resident admitted on [DATE] and had at times restricted the functioning of the bed frame however no injuries to this point.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/05/2024 at 2:20 PM with the Administrator revealed all staff should be making sure all items were in correct working order in the resident rooms and report anything that needed repair or replacement through the maintenance log system. Usually when a resident discharged housekeeping, which was under the maintenance department, would clean and prepare a room for the next resident. The incorrect mattress should have been identified at this point if it was on the bed frame, or at any point the sheet was changed, and requested to be replaced with a properly fitting mattress. The Administrator stated she was not aware there was a bariatric mattress on a standard twin bed frame in this room however would have the situation addressed immediately. Observation and interview on 11/06/2024 at 10:30 AM with Resident #202 and Family member J revealed Resident #202 laying on a standard twin sized mattress on a new bedframe that was an appropriate fit. Resident #202 stated the new bed was much more comfortable, she slept better overnight, and allowed her to lay down and rest more. Family member J stated staff members came in on 11/05/2024 and asked if they could evaluate the bed. The staff members agreed the mattress needed to be changed out and they brought in a new bed with a properly fitting mattress. Interview on 11/06/2024 at 12:56 PM with CNA A revealed if a staff member was informed by a resident or other party that a mattress was uncomfortable or furniture in the room needed repair were to report this to the charge nurse and see if the mattress or item could be changed out. CNA A stated if a mattress was the incorrect size for a frame, then the entire bed was usually changed out for safety. CNA A stated a bariatric mattress on a standard twin bed frame could move when the resident moved and cause the resident to slip off of the bed or fall. Interview on 11/06/2024 at 1:08 PM with CNA E revealed if a resident reported being uncomfortable in bed, that should be reported to the floor nurse or charge nurse for a maintenance request to be filed. CNA E stated if a wrong mattress was discovered on a bed frame when changing sheets, the floor nurse or charge nurse would be informed. CNA E stated having a wrong sized mattress could potentially lead to unsafe conditions like causing a resident to fall out of the bed. CNA E also stated there could have been another resident who needed the bariatric mattress causing two residents to be impacted. In an interview on 11/06/2024 at 1:20 PM, the ADON stated when a resident expressed discomfort with a mattress or a mattress was reported to be incorrect for the frame, the mattress should be changed right away; a new mattress could be obtained by a call to housekeeping to bring the correct size mattress from the storage room. The ADON stated staff would check the condition of a mattress if a resident complained of discomfort to see if the mattress needed to be exchanged or for an air mattress to be requested. The ADON stated some of the risks of having an incorrect size mattress on a bed frame could be safety related like the sides of a bariatric mattress on a standard frame not being supported and could fold under and cause the resident to fall, the bed mechanics would not function properly and if a resident was unable to raise the head of the bed timely they could aspirate, and the mattress could move and cause the resident to fall. (continued on next page)

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2024 at 1:54 PM, LVN F stated when broken, damaged, mismatched frame/mattress, or inoperable equipment or furniture was found a work order would be placed for maintenance and the DON to review and act on. LVN F stated if a resident stated their mattress was uncomfortable the mattress would be changed with one from the storage closet and a work order entered to inform the maintenance director. LVN F said the risks to residents who had a bariatric mattress on a standard size bed frame was if a resident had balance issues and the mattress slipped in the frame it could cause a fall, the resident could slide out of the bed and be injured as the sides of the mattress would not be supported, and the overall healing process could be effected as the resident would not be able to relax or rest. Interview on 11/06/2024 at 3:00 PM, the facility Maintenance Director stated if a staff member found something wrong with a bed or mattress, they would inform central supply for a replacement. Since some mattresses required a provider's order, if a mattress was replaced it needed to be with the same type and size or be evaluated by the provider to change. If a mattress was being changed out for comfort, it could be with an identical type of mattress. The Maintenance Director stated during the make ready process of a resident room the compatibility of the bed frame and mattress should be checked when the bed was being made. The CNAs should have been checking when changing sheets on the bed as bariatric mattresses required a flat bottom sheet to fit properly. The Maintenance Director stated a mismatched mattress with bed frames could pose a risk to residents by sliding and not being safe for a resident. The Maintenance Director stated bedframes and mattresses were inspected and maintained which included having a 6-point entrapment review at least monthly, during each make ready, and any time the sheets are changed. The Maintenance Director stated there were times with too many hands on the mattresses from staff members to rental company employees depending on if the mattress was the property of the facility or a specialty care item like an air mattress. The Maintenance Director also stated a night staff member or family member may have swapped out the mattress overnight one night for the resident's comfort as it had not been determined who put the bariatric mattress on the bed. During an interview on 11/07/2024 at 3:00 PM with the Administrator, she stated if a bariatric mattress was placed on a standard twin bed frame it should have been caught during the make ready process. The Administrator continued and stated if a request was made during the night shift, a nurse would go upstairs and obtain a new mattress to make the resident more comfortable. The Administrator stated she expected any staff member who saw the mattress and bed frame were mismatched should be filing a maintenance report. The Administrator stated the maintenance team was responsible for monitoring the equipment and making sure the frames and mattresses monthly as well and the bedframe and grab bars or bed rail. The Administrator stated if a mattress or part of the bed frame needed to be replaced due to malfunction or being worn out, the requests were reviewed monthly, and she approved and submitted the purchase order. The Administrator stated about five bed frames and mattresses were replaced each month. The Administrator stated if a resident said the mattress on their bed was uncomfortable or there was an issue such as the mattress being the wrong size for the frame the staff member informed, which included herself, was to go and evaluate the mattress and frame for replacement from current supply. The Maintenance Director and team was to perform weekly rounding to evaluate the status of furniture and bedding. The Administrator stated the risks of the wrong mattress on a bed frame could range from the bed mechanics being impacted, linens would not fit correctly, to the resident experiencing discomfort.