

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/12/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen in that: The facility failed to ensure food items, placed in the refrigerator, were sealed, dated, and labeled appropriately. The facility failed to ensure food items, placed in the dry storage area, were sealed and kept off the floor. These failures could place residents at risk for food-borne illnesses. Findings included: In an observation on 2-10-2026 at 8:22 AM, revealed the facility's only walk-in refrigerator had a box of lettuce opened, unsealed, scattered outside the box, and on the floor, a plastic container of potato salad, unlabeled and undated, and 11 plastic containers of chocolate pudding undated and unlabeled. The dry storage area had a pack of 17 Styrofoam cups unsealed on the floor, 1-96 oz plastic jar of amber honey, with a cracked lid, which leaked onto the floor, and an orange on the floor underneath the storage shelves. The reach-in refrigerator had a pitcher of lemonade and tea which were undated and unlabeled. In an interview, on 2-12-2026 at 1:50 PM, it was revealed that the Dietary Manager had worked at the facility for only a few days. The Dietary Manager stated she was responsible for ensuring food items in the walk-in and reach-in refrigerators, and the dry storage area, were sealed, labeled, dated, and stored correctly. The Dietary Manager said she was new and didn't have time to make corrective changes. The Dietary Manager said the concern for residents, if proper food storage standards were not met, was that cross-contamination could occur causing food-borne illness. In an interview on 2-12-2026 at 2:00 PM, [NAME] C said she had worked at the facility for 2 weeks. [NAME] C said it was the responsibility of everyone working in the kitchen to ensure food was dated, labeled, sealed, and kept off the floor. [NAME] C said the concern for residents, if proper food storage standards were not met, was that they don't get bad food. In an interview on 2-12-2026 at 3:00 PM the Administrator said it was the Dietary Manager's responsibility to ensure foods were properly dated, labeled, sealed, and kept off the floor. The Administrator's expectations were that food be kept fresh by proper storage, dating, and labeling. Record review of the facility's policy titled: Food Storage dated 6-1-2019 stated: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP guidelines. Procedure: 1. Dry storage rooms. d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. h. Store all items at least 6 above the floor with adequate clearance between goods and ceiling. 2. Refrigerators. d. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Review of the U.S. Public Health Service Food Code, dated 2022, reflected: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to keep garbage storage receptacles in a sanitary condition according to professional standards: 1. The facility failed to keep the outside garbage storage area clean. 2. The facility failed to ensure garbage receptacles in the kitchen had lids on them, when trash was in the containers, not being used. These failures could place residents at risk of attracting rodents, insects, and contracting food-borne illnesses. Findings included: In an observation on 2-10-2026 at 8:25 AM, revealed the facility's only kitchen was observed having a large trash can, with a liner containing trash, open and unsealed. A smaller closed trash can, next to the handwashing sink, was observed to have an open-box full of trash on top of it. A third smaller trash can was observed with the lid propped up containing trash. On 2-10-2026 at 8:30 AM, an observation was made of the facility's only outside trash dumpster area. The trash dumpster was full, had two sliding doors that were open, and trash bags hanging outside the doors. Various trash items were found on the ground around the trash dumpster to include: used latex gloves, used to-go Styrofoam food containers, open boxes of trash, and trash bags that were leaking liquid on the ground. In an interview on 2-10-2026 at 9:00 AM, the Maintenance Director stated he had worked at the facility for 2 weeks. The Maintenance Director said he was responsible for ensuring the outside trash dumpster and surrounding areas were maintained and trash was disposed of properly. The Maintenance Director said if trash was not disposed of properly, it could attract insects and rodents potentially causing health hazards at the facility. In an interview on 2-12-2026 at 1:50 PM, the Dietary Manager said the Dietary Manager was ultimately responsible for ensuring the trash cans in the kitchen had lids on them unless they were being used. The Dietary Manager said the concern for the residents, if trash can lids were not kept on the trash cans, would be the attraction of insects and potentially cause food borne illness. In an interview on 2-12-2026 at 3:00 PM, the Administrator said the Maintenance Director was responsible for keeping the outside dumpster and surrounding area clean to ensure trash was disposed of properly. The Administrator said the Dietary Manager was responsible for ensuring lids were kept on trash cans in the kitchen, unless they were in use. The Administrator said the potential harm to residents, for not maintaining proper disposal of refuse, was it could attract insects and rodents. The expectations of the Administrator were that lids be kept on trash cans in the kitchen, the trash dumpster doors be kept closed, and facility grounds kept free from trash debris. A record review of the facility's policy titled Garbage Receptacles, dated 6-1-2019, stated: Policy: The facility will maintain garbage receptacles in a clean sanitary manner to minimize the risk of food hazards. Indoor receptacles: Waste handling units for refuse and for use with materials containing food residue shall be durable, cleanable, insect and rodent resistant, leak proof, and nonabsorbent. Trash cans will be kept with lid in place when not in use. Outdoor receptacles: Outdoor storage surfaces for refuse shall be constructed to have tight fitting lids, doors or covers and stored in a manner that is inaccessible to insect and rodents with doors/lids kept closed and no waste outside of the receptacle. Review of the U.S. Public Health Service Food Code, dated 2022, reflected: 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one of four medication carts (Med Cart A), One of two treatment carts (Treatment cart B) and 1 of 7 residents (Resident #94) reviewed for medication storage. 1.The facility failed to ensure Nurses Treatment Cart B was not left unlocked and unattended in the corridor by room [ROOM NUMBER] on 02/10/26. 2. LVN G failed to ensure the medication cart (Med Cart B) was not left unlocked and did not have a cup of medication left on top of the cart while out of view. 3. LVN G failed to ensure medications were not left at Resident #94's bedside while she was out of the resident's room. These failures could place residents at risk of lost medications, drug diversion, or harm due to accidental ingestion of unprescribed medications Findings included:1. Observation on 02/10/26 at 08:13 AM revealed the Nurses' Treatment Cart was observed unlocked and unattended with the lock mechanism out which indicated it was unlocked in the corridor outside of room [ROOM NUMBER]. CNA D was observed in the immediate vicinity. When drawers were pulled open, the cart did not contain narcotic medications. The cart included over the counter and prescription medications. CNA D stated it was a nurse's treatment cart, and she did not know who left it unlocked. The Nurses' Treatment Cart had multiple over the counter medications for wound care and one betadine (cleaning solution that can burn eye and mouth if splashed), and prescription strength medication. No residents were observed around the treatment cart. In an interview with the ADON on 02/10/26 at 12:17 PM revealed, she was one of two nurses working on the floor where Nurse Treatment Cart B was left unlocked and unattended. She said Nurse Treatment Cart B was different from the regular wound care cart and used by nursing when the wound nurse was not available. She said she did not know who left the wound cart unlocked. She said all nurses had keys and access to be able to unlock the cart if they needed supplies from it. She said Nurse Treatment Cart B was just overflow and did not have any medication, however it needed to be locked when unattended for security of the carts. She said all nursing was responsible for making sure all carts were locked and secured when not in use. In a phone interview with LVN E on 02/13/26 at 12:06 PM, she was the second nurse working on the hallway where Nurse Treatment Cart B was left unlocked and unattended. She said she did not know who left the wound cart open. 2. Record review of Resident #94's admission record, dated 02/11/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His primary diagnosis included metabolic encephalopathy (this is a brain disease that alters brain function or structure). His secondary diagnoses included bacterium (this is an infection of bacteria within the body) and gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individuals who have difficulty swallowing). Record review of Resident #94's admission MDS, dated [DATE], did not reflect BIMS. Record review of Resident #94's active order summary for February 2026 reflected;-Amiodarone HCl Oral Tablet 100 MG. Give 1 tablet via G-Tube in the morning for arrhythmia [irregular heart rhythm]-Buspirone HCl Tablet 5 MG Give 1 tablet via G-Tube two times a day for anxiety-Metoprolol Tartrate Tablet Give 12.5 mg via G-Tube two times a day for High blood pressure Hold for SBP less than 110 or HR less than 55-Midodrine HCl Oral Tablet 5 MG. Give 1 tablet via G-Tube two times a day for hypotension [low blood pressure]-Sodium Bicarbonate Oral Tablet 650 MG. Give 1 tablet via G-Tube three times a day for acid reflux [heart burn] Record review of Resident #94's care plan, initiated 02/08/26, revealed a focus: Resident #94 had impaired cognitive function and/or impaired thought process. The goal was for Resident #94 to be able to communicate basic needs through the review date. The interventions included queueing, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reorient, and supervision as needed. During continuous medication administration observation with LVN G on 02/11/26 at 08:13 AM, revealed she entered Resident #94's room and left her medication cart unlocked. She left 1 crushed pill in a medication cup (medication in cup unknown) on top of the medication cart (Med Cart A). LVN G did not have a direct view of Med Cart A, and it was out of sight as she entered Resident 94's room. There was a wall between the bedside table and where the medication cart was left. After checking Resident #94's g-tube placement, before starting to administer the medications via the g-tube, LVN G dropped the syringe on the floor. She stopped and secured the g-tube and said she had to go to the medication room and get a clean syringe. She removed her PPE and left all the medications on the bedside, unattended, in Resident #94's room. In an interview with LVN G on 02/11/26 at 08:45 AM, she stated she was very nervous being watched and even though she knew all the steps she was supposed to follow and to secure the medications in the room and the medication cart, she said she forgot. She said she was very nervous she forgot to lock the medication cart, and she forgot the cup of medicine on the cart. She said she was responsible for securing med carts when out of sight and she was responsible for securing medication before walking away. She said the risk was medication safety, and anyone could have access to them. In an interview with the DON on 02/12/26 at 12:23 PM, revealed she expected her staff to lock their medication carts, treatment carts and to secure all medications when unattended and take the keys with them. She said all nurses were responsible for securing medications and herself plus ADONs were responsible for monitoring that was done. She said the risk was anyone could have access to the medications. She said medication safety was necessary to prevent unauthorized access. Record review of the facility's policy titled Medication Storage in The Facility: ID1: Storage of Medication, revision date January 2019, reflected Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medications supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received, and the facility provided food that was palatable and attractive, for five of twenty-four residents (Residents #81, #83, #88, #93, and #95) reviewed for food and nutrition services. The facility failed to provide attractive and palatable regular diet items for the main and alternate regular diet meals for lunch on 02/11/26. This failure could place residents at risk for not enjoying meals and experiencing weight loss. Findings include: 1. Review of Resident #81's admission record, dated 02/12/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #81 had diagnoses which included infection and inflammatory reaction due to internal right knee (knee infection surgery became infected), protein-calorie malnutrition (lack of sufficient intake of protein and/or calories, which can interfere with muscle healing, and make the body more vulnerable to infection), type 2 diabetes (a type of diabetes usually linked to diet and lifestyle), heart disease, and a pacemaker (an internal device which regulates heart activity.) Review of Resident #81's annual MDS assessment, dated 02/06/26, reflected he was able to understand others, and be understood by others. Resident #81 had a BIMS score of 15, which indicated intact cognition. Review of Resident #81's care plans reflected the following:- A care plan for potential for alternations in nutrition and hydration, dated 02/03/26, with interventions of evaluating weight changes, monitoring/documenting/reporting signs of malnutrition, and evaluation and recommendations by a registered dietician. Review of Resident #81's Mini Nutritional Assessment, dated 02/04/25, reflected he was at risk for malnutrition. Review of Resident #81's admission comprehensive nutrition assessment, dated 02/11/26, reflected he was on a regular heart-healthy diet, and his current food intake was between zero and 25% of his meals. It was noted in the document that the resident's family brought him food once daily, he had a significant history of eating high-sodium fast foods. Interventions of a liberalized diet to promote nutritional intake and honor preferences, and a multi-vitamin supplement were recommended. Review of Resident #81's order summary, dated 02/12/26, reflected he was ordered a regular diet, with regular texture and consistency. 2. Review of Resident #83's admission Record, dated 02/12/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #83 had diagnoses which included sepsis (an infection which started as infection in one part of the body, and became widespread potentially causing damage to tissues and organs), chronic obstructive pulmonary disease with acute exacerbation (a progressive, irreversible lung disease which causes difficulty breathing), protein-calorie malnutrition, and type 2 diabetes. Review of Resident #83's admission MDS assessment, dated 01/27/26, reflected she was able to understand others, and was understood by others. Resident #82 had a BIMS score of 15, which indicated intact cognition. Review of Resident #83's care plans reflected the following:- A care plan for potential for alternations in nutrition and hydration, dated 02/01/26, with interventions of evaluating weight changes, monitoring/documenting/reporting signs of malnutrition, and evaluation and recommendations by a registered dietician. Review of Resident #83's Mini Nutritional Assessment, dated 01/26/26, reflected she was at risk for malnutrition. Review of Resident #83's order summary, dated 02/12/26, reflected she was ordered a regular, low-salt, heart-healthy diet. 3. Review of Resident #88's admission record, dated 02/12/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #88 had a primary diagnosis which included metabolic encephalopathy (brain dysfunction caused by other illness, organ failure, or chemical imbalance, such as liver/kidney disease, diabetes, or infection), and secondary diagnoses which included fluid overload (an excess of fluid (blood/water) in the body, commonly characterized by swelling (edema) in limbs, abdominal bloating, and high blood pressure), type 2 diabetes mellitus (a chronic disorder characterized by high blood sugar (hyperglycemia) caused by insulin resistance-where body cells do not respond properly to insulin-and eventual insulin deficiency), and end stage renal disease (the final, irreversible stage of kidney failure (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	where kidney function drops below 15% of normal capacity). Review of Resident #88's care plan, dated 02/02/26, reflected Resident #88 had potential for alterations in nutrition, to monitor for any weight changes, and to get dialysis treatment five days a week. 4. Review of Resident #93's admission record, dated 02/12/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with primary diagnoses which included acute chronic systolic combined congestive and diastolic congestive heart failure (a severe, complex, and high-risk state where the heart suffers from both weakened contraction [systolic] and stiff relaxation [diastolic], with a sudden worsening of chronic symptoms), with secondary diagnoses which included acute respiratory failure with hypoxia (the body cannot absorb oxygen from the lungs properly, causing a lack of oxygen in the blood), type 2 diabetes mellitus, acute kidney disease (loss of kidney function, leading up to waste build-up and fluid imbalance in the blood), and dependence on dialysis (a mechanical means of removing waste and fluid buildup from the blood, by filtering blood with a machine). Review of Resident #93's MDS Assessment, dated 02/06/26, reflected a BIMS Score of 15, which indicated being cognitively intact. 5. Review of Resident #95's admission record, dated 02/12/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #95 had a primary diagnosis which included acute pancreatitis without necrosis (inflammation of the pancreas), and secondary diagnoses which included unspecified severe protein-calorie malnutrition, severe sepsis with septic shock (a life-threatening infection which causes organ damage, or failure or inadequate blood flow to tissues), and type 2 diabetes mellitus. Review of Resident 95's MDS assessment, dated 01/28/26, reflected Resident #95 had a BIMS score of 15, which indicated he was cognitively intact. An observation and interview on 02/10/26 at 10:00 AM, revealed Resident #88 was leaning off the side of her bed throwing up over a trash bucket. Resident #88 said she was sick because of her dialysis treatment, not the food, but the food sucked and made her feel unwell. Observation of test trays on 02/11/26 at 12:55 PM by four state surveyors revealed the regular diet test plate contained thick slices of a turkey product (no meat fibers, and little variation in texture of any kind was visible), green peas, which had a muted green color to them, making them appear overcooked, and noodles, which appeared pale, bloated, limp, and had only sparse dark flecks which might indicate any sort of seasoning. The turkey product had a texture which was spongy, slightly gelatinous, and did not have a mouthfeel of meat. The flavor was mostly of salt, and it had little turkey flavor. The noodles had little flavor, having a very mushy, soft texture. The peas were mushy. The overall appearance of the plate was lacking color. The alternate test plate included a meat patty with brown gravy. The meat patty, fell apart in the mouth, and had a rough, grainy texture, and did not resemble the texture or taste meat. It had little flavor, aside from an unpleasant flavor the surveyors were unable to identify, and of the salt in the gravy. An interview and observation on 02/10/26 at 10:40 AM revealed Resident #95 said the food at the facility was terrible, and had no taste, and made him feel gross. Resident #95 directed the state surveyor to look at his breakfast plate which was on his rolling bedside table. An observation of Resident #95's breakfast plate revealed it appeared to be untouched. Resident #95 said he only took one bite of the food as it was not edible. Resident #95 said the food was so bad he had to have his family bring him food so he would have something he could eat. An interview and observation on 02/10/26 at 10:53 AM revealed Resident #83 in her bed, with her breakfast tray still on her overbed table. She showed the state surveyor she had left almost the entire meal, and she said the food was terrible at every meal. She said she hardly ate, and it was not worth asking for anything different because the same people made that too. Resident #83 said she was on a heart-healthy, low sodium diet, and she understood she could not have salt, but she said there were many seasonings the facility could use to make the food taste better, and they didn't bother. She said the meat didn't taste like meat should taste, and she pointed at her toast which did not appear to have any browning on it from being toasted and only appeared dry. She named a brand of salt-free seasoning mix commonly available at grocery stores, and said that brand had a lot of nice flavors, and it was easy to get. She continued, saying the food was so bad, and it seemed the staff just boil things, and throw them on the plate. She said the (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vegetables were boiled too long, and they did not even bother to put any margarine or anything on them for flavor. An interview and observation on 02/10/26 at 12:49 PM, revealed Resident #93 was observed lying in his bed with a sheet covering his body. Resident #93 said the food was very bland and was as bad as he'd ever had. He said it tasted terrible and made him feel like choking. An anonymous interview on an undisclosed date and undisclosed time revealed the resident said they felt they had the right to have some edible food, and were not at all happy with the food at the facility, which was really bland. An interview and observation on 02/11/26 at 1:04 PM with the Dietician revealed she tasted the items on the regular lunch plate. She said the noodles were very plain and she could see a little bit of parsley in them. She said the turkey matched the packaging it came in, which was a frozen round turkey, but not a true turkey and she felt the texture was almost like bologna, and it had a salt flavor, and she could taste a little bit turkey flavor. She said this was only her fourth time in the building, and she was working with the kitchen staff, who were new, to get things working properly in the kitchen. She said the food distributor they bought from was not the one she was used to in the company's buildings, and she would have to look into the quality of the food they were receiving. She said the kitchen staff had recipes out while they were preparing the food, and she believed they were following them. She said the responsibility to have palatable food was on the Dietary Manager, and it was important because if the food was not palatable, the patients might not eat it, and they needed the nutrition to heal from their illnesses and injuries. An interview on 02/12/26 at 2:00 PM with [NAME] C revealed the cooks were responsible for ensuring food was cooked correctly and tasted good. She said the food should be flavorful, and the negative effect for the residents was if the food did not taste good, it might cause them to not eat, get weak, and not heal properly. An interview on 02/11/26 at 2:09 PM with Resident #81 revealed, he complained his lunch was not at all good, and it did not look good, but he tasted one noodle and spat it out because it was so bland. An interview on 02/11/26 at 2:23 PM with Resident #81 revealed he was not at all happy with the food. He said his breakfast that morning had a hard, stale slice of bread cut in two. He said only the fruit and tea from his lunch were good that day, and the noodles were ugly and mushy so he did not eat. Resident #83 said he usually did not eat the facility's meals, and his family member came once or twice every day and brought him fast food or something else to eat, so he was getting enough to eat. He said because he would be leaving soon, he did not feel it was worth complaining to the staff. He said he felt sad for people who did not have someone to bring them different food. An interview on 02/11/26 at 3:38 PM with the Hospitality Director revealed she had some complaints about food, but she felt the complaints she got were more about preferences, usually came from people who were on the heart-healthy diet, and were not anything out of the ordinary. She said when they got food complaints, they addressed them with the individual, and when people complained she referred them to the Dietitian and Chef. She said recently they had changed someone to a liberalized diet, instead of their prescribed heart-healthy diet, to accommodate their preferences. An interview on 02/12/26 at 8:40 AM with the Administrator revealed the facility had been going through a tremendous amount of change recently, and the Chef was new at being a dietary manager, and the Dietician was also new. He said in addition to that, they hired six new dietary staff in the past week. He described some problems he found in the facility when he started, which included the dietary staff being cut back so much that the former kitchen manager had been functioning more like just another one of the kitchen staff and he had to get some new leadership in the kitchen. He said corporate dietary leadership were in the facility recently, and would be coming back, to help get the kitchen running smoothly again. He said the facility tried to present an elevated experience and it was frustrating to hear the food was not good. He said the food was important, because if it was bad, people would not want to eat it, and they were in the facility to heal and get stronger, which required good nutrition. He said he was ultimately responsible for the quality of the meals, and he would be getting test trays going forward, so he would know the quality of what was being served. An interview on 02/12/26 at 1:50 PM with the Dietary Manager revealed the cooks were responsible for (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	making sure the food looked good on the plate and tasted good. She said if residents did not like it, they probably would not eat, and if they didn't eat, they might get weak. She said her expectation was for the residents to like the food and want to request second helpings. Review of the policy Food & Nutrition Services; Meal Service; Food Palatability- Hot Food Temperatures, copyright 2021, reflected: POLICY: The healthcare community prepares and serves food and beverages that is palatable, attractive and at safe and appetizing temperature. Review of the policy Food & Nutrition Services; Food Preparation; Seasoning in Food Preparation, copyright 2021, reflected POLICY: Cooks and chefs may experiment with salt-free seasonings, spices, herbs and flavor enhancers for the purpose of enhancing the flavor of the food [.] PROCEDURE: Examples of seasonings that may be adjusted on standard recipes are: black pepper, white pepper, cayenne pepper, paprika, onion powder, garlic powder, oregano, thyme, basil, dill, chili powder, cumin, curry, mustard powder, cinnamon, Italian seasoning, poultry seasoning, [name of commercially available brand] spice blends, [name of commercially available salt substitute], lemon juice, etc. Seasonings that may not be increased or added are: salt, garlic salt, onion salt, celery salt, seasoning salt, salt substitute, soy sauce, Worcestershire sauce, monosodium glutamate. The ingredients of spice blends are examined to assure that they do not contain salt or sodium (i.e., lemon pepper seasoning and Cajun seasoning often list salt as the first ingredient and therefore are not appropriate). Other ingredients may be added to improve flavor and appearance include chopped parsley, chopped red peppers, onion, garlic etc. The above lists are not comprehensive. Any questions about adding or changing an ingredient may be referred to the dietitian to determine the nutritional content and appropriateness.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options to choose the alternative or option he or she preferred for one of three residents (Resident #101) reviewed for consent to receive psychotropic medications. The facility failed to obtain a written consent form for Resident #101 before starting the medications alprazolam (for treating anxiety), bupropion (for treating depression), hydrocodone-acetaminophen (an opiate pain killer), and zolpidem tartrate (to aid in sleeping). This failure could place residents at risk of being unable to exercise their rights to make informed decisions regarding their treatment. Findings include: Review of Resident #101's admission record, dated 02/12/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His admitted diagnoses included pneumonia (a lung infection), chronic respiratory failure (difficulty breathing), kidney failure, and heart disease. His face sheet reflected no psychiatric diagnoses. Review of Resident #101's admission MDS, dated [DATE], reflected he was usually understood by others, and usually able to understand others, and had a BIMS of 10, which indicated moderate cognitive impairment. His depression indicator score was 13, which indicated a moderate level of depression. He had no behavioral problems and showed no signs of psychosis. The document reflected no active psychiatric diagnoses. He had not received pain medication in the five-day look-back period. Resident #1 was taking an antidepressant. Review of Resident #101's order summary, dated 02/12/26, included the following:- Start date 02/03/26, end date 02/17/26- Alprazolam Oral Tablet 0.25 MG- Give 1 tablet by mouth every 8 hours as needed for anxiety for 14 Days- Start date 01/22/26, no end date noted- Bupropion HCI ER (XL) Tablet Extended Release 24 Hour 150 MG Give 1 tablet by mouth one time a day for depression-Start date 01/22/26, no end date noted- Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for severe pain- Start date 02/10/26, no end date noted- Zolpidem Tartrate Oral Tablet 10 MG (Zolpidem Tartrate) Give 1 tablet by mouth as needed for insomnia at bedtime Review of Resident #101's care plans reflected the following:- Hypnotic therapy (Zolpidem Tartrate), initiated 02/01/26, including monitoring for adverse effects of daytime drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness,- Antidepressant medication (bupropion), initiated 01/31/26, including monitoring for adverse effects of change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, dry mouth, dry eyes- Opioid medications (Hydrocodone- acetaminophen), initiated 01/31/26, including monitoring for adverse effects of altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, urinary retention- Antianxiety medication (Alprazolam), initiated 02/03/26, including monitoring for adverse effects of drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion, and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, or unexpected side effects of mania, hostility, rage, aggressive or impulsive behavior, or hallucinations Review of Resident #101's electronic medical record reflected no consent forms for alprazolam, bupropion, hydrocodone-acetaminophen, or zolpidem. An interview on 02/12/26 at 4:24 PM with the DON revealed she had been unable to find the consent forms for Resident #101 but was going to continue to look for them. She said the ADON, who was on leave for a major life event and not available for interview, was the person responsible for getting the medication consents. She said when a resident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was admitted , the ADON did the consents, and if they were admitted at night, she did the following morning. She said they went over the ones from the last 24 hours in the morning meetings, and on Monday mornings they went over the ones from the weekend. She said the ADON did a very good job of keeping up with them, and if they were not done, she did not have an idea of why. The DON said if they were not done, they were at worst delayed. She said on the weekends, the weekend supervisors did them on admission. She said there was a form in their electronic medical software, which they printed to have the resident sign. She said the consents were important because they made the patients aware of the effects and side-effects of medications, and what to expect from the medications. Review of the Psychotropic Medications policy, most recently reviewed in January of 2026, reflected Any and all psychotropic medication orders will be initiated by the facility only after the physician has completed and returned an Informed Consent related to the drug with the elder and/or responsible party/family. The drug order will include a start date on completion of the Informed Consent Form. [.] Psychotropic medications include drugs from the following classes: hypnotics, antipsychotics, long and short-acting benzodiazepines, sedatives/anxiolytics and antidepressants.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident received reasonable accommodation of needs and preferences, for 1 of 17 Residents (Resident #62) reviewed for accommodations of needs. The facility failed to ensure Resident #62 had a call light within her reach. This failure could place residents at risk of not getting their needs met and diminishing their quality of life. Findings included: A record review of Resident #62's face sheet dated 2-10-2026 revealed a [AGE] year-old female who re-admitted to the facility on [DATE] with a primary diagnosis of encounter for orthopedic aftercare following surgical amputation and secondary diagnoses of absence of right leg above knee, sepsis (a life-threatening medical emergency occurring when the body's immune system overreacts to an infection, causing widespread inflammation, tissue damage, and organ failure), type 2 diabetes mellitus (disorder where the body develops insulin resistance and cannot use insulin properly), and cerebral infarction (stroke). Record review of Resident #62's Comprehensive MDS revealed a BIMS score of 11, which indicated Resident #62 was moderately impaired. Record review of Resident #62's care plan dated 1-16-2026 stated Resident #62 was at risk for falls and instructed staff to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. In an observation and interview on 2-11-2026 at 1:10 PM, Resident #62 was observed lying on her bed in a tilted-up position with her call light on the floor underneath her bed. Resident #62 said she used her call light and did not know where it was. Resident #62 said she did not feel safe because she could not reach her call light. In an interview on 2-11-2026 at 1:18 PM, CNA A said she had been working at the facility for 6 months, worked the 6AM-6PM Shift, and was the CNA responsible for Resident #62's room. When CNA A saw Resident #62's call light was on the floor underneath her bed, she said the Administrator was responsible for ensuring resident's call lights were kept within reach. CNA A said when a call light was in a location where a resident could not reach it, the resident would be put in harm's way because they would not be able to receive help when needed. CNA A said the way staff ensured resident's call lights were kept within reach was by making rounds every two hours. In an interview on 2-11-2026 at 1:30 PM, LVN B said she had worked at the facility for 4 days, worked the 6:00 AM - 6:00 PM shift, and was the nurse responsible for Resident #62's room. LVN B said all staff, especially direct care staff, were responsible for ensuring Resident's call lights were kept within reach. LVN B said the risk to residents, for not having their call lights kept within reach, was it could put them at risk of falling. In an interview on 2-12-2026 at 12:45 PM, the DON said she had worked at the facility for 4 months. The DON said it was the responsibility of every staff member who came into a resident's room to ensure the call light of a resident was kept within reach before they left the room. The DON said the risk to a resident who could not reach their call light, might be they could need something and not get it. The DON said her expectations were for staff to ensure a resident's call light was within reach before they left the room. In an interview on 2-12-2026 at 3:00 PM, the Administrator said every caregiver who went into a resident's room was responsible for ensuring their call light stayed within reach. The Administrator said the concern for residents, who could not reach their call light, was they could not call for help if they needed it. The Administrator said his expectations were that all residents' call lights be kept within reach by all staff. A record review of the facility's call light policy titled Call Light Response dated 1-2023 and revised 1-2024, 1-2025, and 1-2026 stated: Policy/Procedure: 1. It is the expectation that all staff members respond to call lights. 2. If the request is outside the scope of practice for the person answering the light, the appropriate personnel will be contacted immediately to respond to the resident's needs, and the call light may remain engaged until the resident's needs have been met. 3. Call lights will be answered in a timely manner.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of six residents (Residents #8 and #81) reviewed for infection control. 1. The facility failed to ensure LVN E wore a gown for EBP before accessing an indwelling catheter (foley) to collect urine from Resident #8 on 02/10/26. 2.The facility failed to ensure LVN D wore a gown for EBP before accessing Resident #81's Central Venous Catheter (this is a flexible tube inserted in the vein for intravenous medication therapy) IV to administer intravenous antibiotics on 02/11/26. These failures could place residents at risk of Multidrug-resistant Organisms infections. Findings included:1. Record review of Resident #8's admission record, dated 02/12/26, reflected an [AGE] year-old female with an initial admission of 10/23/25 and readmitted to the facility on [DATE]. Resident #8's had diagnoses which included metabolic encephalopathy (this is a brain disorder caused by a chemical imbalance in the blood that affects brain function), unspecified open wound to the left hand and unspecified organism sepsis (this is a life-threatening complication of an infection). Record review of Resident #8's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated intact cognition. Resident #8 was able to understand others and could be understood by others. Resident #8 had an active additional diagnosis which included Sepsis, and she had an unspecified open wound in the left hand. Record review of Resident #8's active order summary for February 2026 reflected:- Wound cleanser, pat dry apply xeroform and calcium alginate cover with ABD pad and kerlix dressing as needed reapply if soil. Ordered 01/29/26.- Wound care: Cleanse trauma open wound to left lateral leg with normal saline or wound cleanser, pat dry, apply xeroform cover with dry dressing as needed. Reenforce if soiled or dislodged. Order date 01/16/26.-Insert foley catheter and maintain, measure output and report to PA [name of PA] one time only for 3 Days. Order date 02/10/26. Record review of Resident #8's care plan, initiated 01/26/26, reflected a focus of Resident #8 was on Enhanced Barrier Precautions related to foley catheter and IV therapy. The goal was for Resident #8 to not experience complications related to condition/device(s) requiring EBP. The intervention was to provide Enhanced Barrier Precautions as indicated involves the use of personal protective equipment (PPE) specifically gowns and gloves during high contact resident activities. Observation and interview on 02/10/26 at 12:45 PM revealed Resident #8 had a sign on her door for Enhanced Barrier Precaution. There was no PPE cart observed outside the resident's room. The resident was lying in her bed. LVN E said Resident #8 did not void (urinate) overnight and this morning. LVN E said she notified the PA of not voiding and obtained an order to insert a foley catheter and obtain a sample of urine analysis for UTI. LVN E put on gloves, but she did not wear a gown for EBP. She attached a statlock (sticky stabilizing device) to the foley tubing and secured it to the resident's right leg. She sanitized the foley bag opening and took some urine in a cup for the UA. In a phone text interview with LVN E on 02/13/26 at 12:06 PM, She said she was supposed to wear a gown and gloves when collecting urine. When LVN E was asked what the risk was if EBP was not implemented, she said increased risk of infection. 2. Record review of Resident #81's admission record, dated 02/12/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #81 had a primary diagnosis which included infection and inflammatory reaction due to internal right knee (knee infection surgery became infected), protein-calorie malnutrition (lack of sufficient intake of protein and/or calories, which can interfere with muscle healing, and make the body more vulnerable to infection), type 2 diabetes (a type of diabetes usually linked to diet and lifestyle), heart disease, and a pacemaker (an internal device which regulates heart activity). Record review of Resident #81's admission MDS assessment, dated 02/06/26, reflected Resident #81 had a BIMS score of 15, which indicated intact cognition. Resident #81 was able to understand others. Record review of Resident (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#81's active order summary for February 2026 reflected:- Enhanced Barrier Precautions (IV ACCESS) every shift. Order date 2/6/26- Normal Saline Flush Solution. Use 10 ml intravenously every shift for CVC Line Patency as well as before and after each infusion. Order date 02/07/26- Cefazolin Sodium Solution Reconstituted 1 GM Use 20 ml intravenously every 8 hours for bacteremia in right lower leg until 03/10/2026 05:59 2 gram/20ml solution. Order date 02/07/26- IV CVC LEFT CHEST: Monitor site and dressing. Document in progress to note any signs and symptoms of infection, notify provider of s/sx of infection. Every shift per protocol. Order date 02/07/26. Record review of Resident #81's care plan, initiated 02/03/26, reflected a focus: Resident #81 was on Enhanced Barrier Precautions related to CVC left chest and surgical incision on right lower extremity. The goal was for Resident #81 to not experience complications related to condition/device(s) requiring EBP. The intervention was to provide Enhanced Barrier Precautions as indicated involves the use of personal protective equipment (PPE) specifically gowns and gloves during high contact resident activities Observation on 02/11/26 at 2:09 PM revealed door signage for Enhanced Barrier Precaution for Resident #81. There was no PPE cart outside the resident's room. The resident was lying in his bed. Resident #81 had a CVC IV port on his chest which was clean and intact. It was dated 02/10/26. Resident #81 said he liked having the central line so he did not get poked for blood draws. LVN D verified all information with the resident before administering his antibiotics. LVN D wore gloves, but he did not wear a gown before accessing Resident #81 central line IV for flushing and administering antibiotics (Cefazolin 2 gm). In an interview with LVN D on 02/11/26 at 2:17 PM, he said he forgot to put on his gown. He said it was important to put PPE on (gown) for residents on EBP for infection control. In an interview with the DON on 02/12/26 at 12:23 PM, revealed if a resident was on EBP, it meant staff were to wear gloves and gowns while providing care. She stated all staff were expected to wear PPE to prevent the spread of infection. She said all procedures were in place to prevent infection, and all nursing staff were responsible for making sure EBP was followed. The DON said she had completed services on EBP a few weeks ago. She said she was the infection control preventionist and was responsible for monitoring infection processes that were being followed. Interview on 02/12/26 at 03:45 PM with the Administrator revealed all staff members were expected to follow the infection control protocol as indicated. He said the risk of staff not following standard infection control protocols could cause a spread of infection. Record review of In-Service, dated 2/03/26, led by DON titled Enhanced Barrier Precautions, Hand Washing/Hand Hygiene revealed staff were trained on Enhanced Barrier Precaution signage which included Staff to wear gloves and gown for the following High contact Resident care activities: Dressing, Bathing/Showering, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: Central lines, urinary catheter, feeding tube, tracheostomy. Wound care: Any skin opening requiring dressing, 11 Staff signed the Inservice including LVN D and LVN E. Record review of the facility's policy titled Infection Control Policy, revision date May 2023, reflected . All Staff: Any/all staff who provide direct care and indirect care functions, contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility and students are responsible for complying with isolation precautions and for tactfully calling observed variances to policy to the attention of any person(s) not following the policy. Record review of the facility's policy Implementation of Standard and Transmission-Based Precautions, dated 03/24, reflected, .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO .Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO .post signage .high-contact resident care activities requiring gown and glove use		