STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676454	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Katy, LLC	1222 Park West Green Drive Katy, TX 77493

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents (CR #1) reviewed for pressure ulcer treatment.The facility failed to ensure CR#1 with a documented sacral pressure injury (sustained force applied to the sacrum, the triangular bone at the base of the spine) received necessary wound treatment and monitoring.This failure could place the residents at risk of worsening wounds, infection, and hospitalization. Record review of CR #1's face sheet, dated 11/30/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and discharged on 11/16/2025. Record review of CR #1's admission MDS assessment, dated 09/22/2025, reflected diagnoses included of Sepsis unspecified organism (occurs when your immune system has a dangerous reaction to an infection) and Type 2 Diabetes (a lifelong disease that keeps your body from using insulin the way it should). CR #1's BIMS score was not reflected. The MDS revealed CR #1 had cognitive impairment. The MDS further revealed that Section M - Skin Conditions indicated CR #1 had pressure ulcers (injury to the skin and the tissue below the skin that are due to pressure on the skin for a long time), among other skin alterations; upon admission to the facility on [DATE]. Record review of CR #1's care plan, dated 09/23/2025, reflected: Focus Area: Unstageable (wound) to sacrum. Goal: The resident will have no complications related to documented skin impairment through the review date. Interventions /Tasks: Evaluate and treat per physician's orders; evaluate resident for signs and symptoms of possible infections; follow facility protocols for treatment of injury; low air loss mattress, ensure functioning properly; nurse to assess/record/monitor wound healing with dressing changes. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements or declines to the MD; Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations, by wound nurse or provider. Record review of CR#1's clinical record revealed nursing staff submitted a wound care consultation at admission on [DATE]. Record review of CR #1's progress noted dated 09/19/2025, completed by Wound Care NP, revealed initial visit with Wound Care NP on 09/19/2025, there was no record of CR #1's identified sacral pressure injury being treated or assessed by the Wound Care NP at initial encounter on 09/19/2025 through CR #1's discharge date of 11/18/2025. Record review of CR #1 nurse progress note date 11/18/2025, reveal resident was transferred to hospital due to facial swelling to right side of face in the cheek area and eye. Record review of CR #1's EMR clinical documentation (MAR, TAR, Progress Notes and Physician order summary for September, October, and November 2025) revealed from 09/16/2025 through 11/18/2025:No documentation of wound care treatment was provided to the sacral pressure injury.No documented evidence of dressing changes on the sacral pressure injury.No documented evidence of wound staging and updates on the sacral pressure injury.No documented evidence of wound assessments of the sacral pressure injury.No documented evidence of measurements of the wound on the sacral pressure injury. There was also no documented evidence that nursing staff:Followed up with the provider regarding missing orders.Notified the DON or Administrator that orders were not provided.Escalated concerns when the wound was not being treated. Initiated interim wound care consistent with standards when no orders were received. Record review of CR #1' s Hospital admission record dated 12/05/2025 revealed CR #1 was admitted to the hospital on [DATE] with chief compliant of recurrence of R parotitis (term for a swollen parotid gland. Your parotid glands are located on the side of your face, between your ear and your jaw). CR #1 was previously admitted for sepsis on 09/08/2025 - 09/16/2025, underwent 2 tooth extractions of right upper molars with parotid duct fluid samples growing MRSA; discharged to SNF on 10 days of Bactrim, minocycline, Flagyl. There was multiple chronic pressure identified on CR # 1's admission to the hospital on [DATE]. There was no specific sacral pressure injury documented on CR # 1's admission to the hospital on [DATE]. As of 12/05/2025, the hospital noted pending SNF reauthorization for CR #1's return to the facility. Interview on 11/30/2025 at 2:00 PM, the DON stated that according to CR#1 admission evaluation and assessment completed on 09/16/2025 identified that CR #1 was admitted with a sacral pressure injury and several other identified skin conditions and injuries. She stated the expectation was when skin breakdown was identified, a wound consultation was submitted, and resident was assessed and treated by the Wound Care NP. She stated the Wound Care NP was responsible for providing orders related to wound care treatment. She stated