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	01/21/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for 3 out of 7 residents (Resident #1, Resident #2, and Resident #5) reviewed for ADLs.- The facility failed to provide scheduled showers and/or bed baths three times a week for Resident #1, Resident #2, and Resident #5, for the weeks of 1/12/26-1/16/26 and 1/19/26-1/23/26.This failure could place residents at risk of skin breakdown, infection, and reduced feelings of self-worth.Findings included:1. Record review of Resident #1's undated face sheet revealed she was an [AGE] year old female admitted on [DATE] with diagnoses of acute respiratory failure (not enough oxygen), malignant neoplasm of mouth (cancer of the mouth), pulmonary fibrosis (lungs are scarred, thick, and stiff, making it difficult to breathe), tracheostomy (hole into windpipe to breath), type 2 diabetes mellitus (body does not produce insulin or resists it), c-diff (diarrhea caused by bacteria), dysphagia (trouble swallowing), and gastrostomy (hole into stomach for nutrition).Record review of Resident #1's admission MDS assessment dated [DATE], revealed a BIMS score of 13 out of 15 which indicated normal cognition. The resident had an impairment on both sides of her upper and lower extremities. According to the assessment, the resident was dependent (helper does all of the effort and resident does none of the effort to complete the activity) for showers/baths. The resident was always incontinent of bowel and bladder. The assessment also revealed the resident had shortness of breath or trouble breathing with exertion (walking, bathing, transferring), when sitting at rest, and when lying flat. The resident had a PEG (hole into stomach) tube for nutrition, had a tracheostomy, and was on oxygen.Record review of Resident #1's Care Plan dated 12/19/25, revealed a Focus: The resident had ADL self-care performance deficits and limitations in physical mobility due to acute respiratory failure with trach placement (Initiated: 12/19/25). The goal was that the resident would improve self-care and mobility by the review date (Initiated: 12/19/25, Target Date: 3/29/26). The interventions were dependence for oral care, substantial/max assist (helper does more than half the effort) for upper body dressing, and substantial/max assist for lower body dressing. Showers/baths were not on the care plan. Focus: The resident was incontinent of bowel and bladder (Initiated: 12/19/25). The goal was for the resident to have minimal complications related to incontinence episodes through the review date (Initiated: 12/19/25, Target Date: 3/29/26). Interventions were changing the briefs as needed, cleaning the peri-area (area where genitals are) with each incontinence episode, checking every 2-3hrs and PRN for incontinence, washing/rinsing/drying the perineum (where genitals are), changing clothing PRN after incontinence, and providing skin care with each incontinence episode.Record review of Resident #1's Progress Note from 1/13/26 by APRN B said, .Requiring max assist with ADLs and transfers. Musculoskeletal [muscles and bones]: Severe weakness.In an observation and interview on 1/21/26 at 11:02am, Resident #1 was sitting up in bed with a trach and oxygen connected to it at 10L. The resident was unable to (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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NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Katy, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1222 Park West Green Drive Katy, TX 77493	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	speak due to the trach and used a communication board to say she only received a bed bath 1 time a week. She said she would like to get at least 2 baths a week. Her family member, who was also in the room, said they had spoken to the ADM about it, and he said they were working on hiring more staff.Record review of Resident #1's Progress Notes from 1/2/26 through 1/20/26 revealed no refusals of baths/showers.Record review of Resident #1's Shower Sheets in the EMR on 1/21/26, revealed she was scheduled to receive her showers/baths on Mon/Wed/Fri on the night shift from 7pm-7am. The Shower Sheet revealed the question, Task Completed? that was to be answered each shift for her shower/bath. The answers to the question were: yes, no, resident not available, resident refused, or not applicable. For the past 30 days there were only 2 entries, one on 1/13/26 and one on 1/17/26. The entry on 1/13/26 at 3:19am was checked off for Not Applicable and the entry for 1/17/26 at 3:44am was also checked off for Not Applicable. Entries that documented she had received a bath on 1/12/26, 1/14/26, 1/16/26, 1/19/26, and 1/21/26 were missing.Record review of Resident #1's paper Shower Sheets provided by the facility after exit, on 1/21/26 at 6:00pm, revealed the resident had a bed bath on 1/13/26 at 2:00pm, 1/16/21 at 4:22pm, 1/19/26 at 2:51pm, and 1/21/26 at 10:00am. 2. Record review of Resident #2's undated face sheet revealed she was a [AGE] year old female admitted [DATE] with diagnoses of diverticulitis (inflammation/infection of pockets in intestine) of large intestine with perforation (hole) and abscess (infection), type 2 diabetes mellitus (body does not produce insulin or resists it), heart failure (heart does not pump effectively), abscess (infection) of spleen, acute respiratory failure (lungs are not delivering oxygen), ESRD (kidneys stop working), dependence on renal dialysis (machine has to filter blood), gastrostomy (hole into stomach for nutrition), and colostomy (opening in abdomen for stool to collect in bag).Record review of Resident #2's admission MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15, which indicated normal cognition. The resident had impairment on both sides of her lower extremities and used a wheelchair. According to the assessment, the resident was dependent for showers/baths. The resident had a colostomy and was always incontinent of bladder. The assessment also revealed the resident had shortness of breath or trouble breathing with exertion (walking, bathing, transferring), when sitting at rest, and when lying flat. The resident had a PEG tube for nutrition, was on oxygen, and received hemodialysis (machine filters blood).Record review of Resident #2's Care Plan dated 1/9/26 revealed a Focus: The resident had ADL self-care performance deficits and limitations in physical mobility (Initiated: 1/9/26). The goal was to improve self-care and mobility function by the next review date (Initiated: 1/9/26, Target Date: 4/19/26). The interventions were needing substantial/max assist with baths/showers. Focus: The resident was incontinent (Initiated: 1/9/26). The goal was for the resident to have minimal complications related to incontinence episodes through the review date (Initiated: 1/9/26, Target Date: 4/19/26). Interventions were changing the briefs as needed, cleaning the peri-area with each incontinence episode, checking every 2-3hrs and PRN for incontinence, washing/rinsing/drying the perineum, changing clothing PRN after incontinence, and providing skin care with each incontinence episode.In an observation and interview on 1/21/26 at 11:31am, Resident #2 was lying on her side in bed with oxygen via a nasal cannula on. She had family at her bedside with her. Resident #2's family member said the only bath she had received so far was on 1/16/26, and she only received it because she had to ask for it. The resident said she would like baths at least twice a week to help prevent any infections, because she was immunocompromised.Record review on 1/21/26 at 3:05pm of the 100 hall Shower Sheet binder, revealed there were no paper Shower Sheets for Resident #2 in the binder, and no indications of any refusals. Record review of Resident #2's Progress Notes from 1/9/26 through 1/20/26 revealed no refusals of baths/showers.Record review of Resident #2's Shower Sheets in the EMR as of 1/21/26, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed she was scheduled to receive her showers/baths on Tue/Thu/Sat, during the day shift from 7am to 7pm. The Shower Sheet revealed the question, Task Completed? that was to be answered each shift for her shower/bath. The answers to the question were: yes, no, resident not available, resident refused, or not applicable. For the past 30 days there was No Data Found, meaning there were no entries for the month of January, and she was supposed to have a bath every Tue/Thu/Sat.Record review of Resident #2's paper Shower Sheets provided by the facility after exit, on 1/21/26 at 6:00pm, revealed the resident had a bed bath on 1/13/26 at 3:00pm, 1/15/26 at 11:00am, and 1/21/26 at 5:00pm. 3. Record review of Resident #5's undated face sheet revealed he was a [AGE] year old male admitted [DATE] with diagnoses of right hip fracture, afib (irregular heart beat), cardiac pacemaker (device to control heart beat), muscle weakness, and abnormalities of gait (walking) and mobility (getting around).Record review of Resident #5's admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident had impairment on both sides of his lower extremities and used a wheelchair. According to the assessment, the resident was substantial/max assistance (helper does more than half the effort) with showers/baths. The resident was always incontinent of bowel and bladderRecord review of Resident #5's Care Plan dated 12/25/25 revealed a Focus: The resident had ADL self-care performance deficits and limitations in physical mobility r/t right femur fracture (right hip fracture), pain management, and fall (Initiated: 12/25/25). The goal was to improve self-care and mobility function by the next review date (Initiated: 12/25/25, Target Date: 4/2/26). The interventions were needing substantial/max assist with baths/showers. Focus: The resident was incontinent of bowel and bladder (Initiated: 12/25/25). The goal was for the resident to have minimal complications related to incontinence episodes through the review date (Initiated: 12/25/25, Target Date: 4/2/26). Interventions were changing the briefs as needed, cleaning the peri-area with each incontinence episode, checking every 2-3hrs and PRN for incontinence, washing/rinsing/drying the perineum, changing clothing PRN after incontinence, and providing skin care with each incontinence episode.In an observation and interview on 1/21/26 at 11:28am, Resident #5 was lying in bed. He said the only complaint he had was not receiving baths three times a week. He said he had to get a bed bath because he could not walk and said he did not remember the last time he had received a bed bath.Record review of Resident #5's Progress Notes from 12/31/25 through 1/19/26 revealed no refusals of baths/showers.Record review of Resident #5's Shower Sheets in the EMR as of 1/21/26, revealed he was scheduled to receive his showers/baths on Tue/Thu/Sat during the day shift from 7am to 7pm. The Shower Sheet revealed the question, Task Completed? that was to be answered each shift for her shower/bath. The answers to the question were: yes, no, resident not available, resident refused, or not applicable. For the past 30 days there four entries, on 1/8/26 at 6:17pm, 1/10/26 at 5:52pm, 1/13/26 2:29pm, and 1/15/26 at 11:50am. All four dates had yes answered to the question. Entries that documented he had received a bath on 1/17/26 and 1/20/26 were missing.Record review on 1/21/26 at 3:05pm of the 100 hall Shower Sheet binder, revealed there was one sheet for Resident #5 for January 2026. A paper Shower Sheet dated 1/8/26 revealed the resident had a bath on that day. There were no other Shower Sheets or refusals.Record review of Resident #5's paper Shower Sheets provided by the facility after exit, on 1/21/26 at 6:00pm, revealed the resident had a bed bath on 1/17/26 at 11:25am, and 1/21/26 at 4:32pm.In an interview on 1/21/26 at 1:35pm, the DON said showers/baths were documented in the EMR under the tasks section of the resident's chart. She said the only reason they used the paper Shower Sheet was for the CNA to mark if there was a skin issue, and then they gave it to the nurse.In an interview on 1/21/26 at 3:12pm, CNA A said she worked the front part of the 100 hall. She said on Mon/Wed/Fri the even numbered rooms received showers/baths, and on Tue/Thu/Sat the odd (continued on next page)

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