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	06/29/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure the assessment accurately reflected the status for 1 (CR#1) of 6 residents reviewed for accuracy of assessments. The facility failed to ensure CR#1's admission MDS assessment accurately reflected he had a Foley catheter. The failure could place residents at risk of receiving inadequate care and services due to inaccurate assessments.Record review of CR#1's face sheet dated 6/26/2026 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and discharge on [DATE]. His diagnoses included hypertension (high blood pressure), hyperlipidemia (high level of fat in the blood), chronic kidney disease stage V (damage kidney that cannot filter blood properly), acute kidney failure (a sudden loss of kidney function that happens a few hours a day). Record review of CR#1's physician's assessment dated [DATE] revealed an order for a bladder scan and if urine was more than 300 ml to insert a Foley catheter. Further record review revealed the bladder scans were done between 5/18/2026, 5/20/2026 and 5/21/2026 for CR#1 and it revealed the following: On 5/18/2026 revealed 375 ml.On 5/20/2026 revealed 10 ml and 100 mlOn 5/21/2026 revealed 0 and 150 ml. Record review of the hospital notes dated 5/26/2026 revealed In the ER, work-up is significant for stable vital signs. He was found to have hematuria in his Foley bag with imaging demonstrating malposition of Foley catheter. The patient reported some discomfort since Foley catheter was replaced last week. Foley catheter was replaced in the ER after which symptoms resolved. Record review of CR#1's initial MDS dated [DATE] revealed he was coded as moderately impaired for cognition for decision making. For H0300 and H0400: Bowel and bladder, he was coded as frequently incontinent. Indicating he did not have an indwelling catheter. Record review of CR 1's physician's order for May 2026 revealed no order for the insertion of a Foley catheter or instruction for Foley care in the physician's order. Record review of CR#1's progress notes dated between 5/18/26 and 5/26/2026 revealed no documentation that a foley catheter was inserted while CR#1 was a resident at the facility in May 2026. In an interview with the ADON on 6/29/2026 at 1:25pm she looked through CR#1's clinical records and said there was an order for a bladder scan but did not see any documentation where the foley was inserted. She said she was going to check the physician's order again. Asked at that time if the foley was inserted by the physician. She said it could be inserted by physician or the RN. In an interview on 6/29/2026 at 2:00pm the MDS Coordinator said she did not see any order for a foley and that was why it was not coded on the MDS. She said if the resident had a foley in the ER then it was inserted at the facility. She reviewed CR#1's record and saw the result of the bladder scan and that the foley was inserted on 5/22/2026. Further interview with the MDS Coordinator revealed that if the foley was documented in the physician order for output and the CNA was documenting output it would populate into the MDS and she would code the MDS and update the care plan. She said if there was a breakdown in communication between the physician and the nurses then the MDS would not be coded correctly. In an interview with the Administrator, he said he spoke with the physician, and she was aware that CR#1's foley was inserted. He said the NP told him the blood in the urine started the day of fall. He said the NP was in the building the day the resident was found on the floor and she assessed the resident and the resident was sent to the hospital. He said he was going to in-service (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff on documentation and proper communication. The facility's policy on accuracy of resident's assessment was requested on 06/29/26 at 2:20 PM. The MDS coordinator said the facility followed the RAI manual