STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676460	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Webster, LLC	16130 Galveston Rd Webster, TX 77598

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement baseline care plans that included the instructions needed to provide effective and person-centered care within 48 hours of admission for 1 of 1 resident (Resident #66) reviewed for baseline care plans: The facility failed to complete Resident #66's baseline care plan in a person-centered manor that accurately depicted resident's condition upon entrance to the facility. This deficient practice could affect residents who receive care at the facility and could result in missed or inadequate care. The findings included: Record review of Resident #66's face sheet dated 6/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, Other Toxic Encephalopathy , Other Seizures, Acute Respiratory Failure with Hypoxia, Extended Spectrum Beta Lactamase (ESBL) Res istance, Local infection of the skin and subcutaneous tissue, unspecified, Quadriplegia, unspecified, Morbid Obesity with Alveolar Hypoventilation, Neuromuscular Dysfunction of bladder, hypotension, hypo-osmolality and Hyponatremia, Pleural Effusion, not elsewhere classified, Sepsis, Unspecified organism, Obstructive sleep Apnea, Autonomic Dysreflexia, Hypertensive Chronic Kidney Disease with stage 1 through 4, Chronic Atrial Fibrillation, Chronic Diastolic (Congestive) Heart Failure, Other Speech and Language Deficits Following Cerebral infarction, Other specified soft tissue disorders, Slurred Speech, and Acute Posthemorrhagic Anemia. Record review of Resident #66's admission MDS dated [DATE] had not been completed before exit on 6/11/25. Record review of Resident #66's baseline care plan, with an initiation date of 6/5/2025 indicated: Focus: The resident is at risk for alteration in skin integrity. Goal: the resident will remain free of new skin impairment through the review date. Interventions: Apply barrier cream per facility protocol to help protect skin from excess moisture, encourage/assist with turning and repositing every 2-3 hours, and provide skin/wound treatments as ordered. Record review of Resident #66's Progress note dated 6/5/2025 at 6:40 PM, titled Nursing Evaluation revealed the following: (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Skin integrity: The Resident has skin integrity concerns. Right knee (front)- skin tear, Left iliac crest (front)- Burn spot, Ulcer on both heels. - Neurological: Is alert. Is oriented to person. Is oriented to place. Is oriented to time. Is oriented to Situation. Resident has clear speech. Hand grasps are weak on right side. Record review of Resident # 66's Wound Rounds dated 6/6/2025 he was Moderately at Risk for skin issues. He was admitted with an Abrasion to Abdomen and left Elbow, a Pressure ulceration of left lateral and medial foot unstageable, Pressure Ulceration Right Heel unstageable, and Fungal infection on right side upper back. All were identified on 6/6/2025. Record review of Resident #66's physician's telephone orders, dated 6/5/2025 revealed the following: - Pressure Reducing cushion for wheelchair Ordered 6/5/2025 - Pressure Reducing Mattress on bed Ordered 6/5/2025 - Prevision boots: Monitor placement every shift for Bilateral heels Ordered 6/6/2025 Record review of Resident #66's Wound TAR dated 6/1/2025-6/30/2025 revealed the following: - Right Toes: Clean with wash cloth, pat dry, paint with betadine, wrap with kerlix everyday shift for wound. First started on 6/6/2025. - Santyl External Ointment 250 unit/GM Apply to left lateral foot topically everyday shift for wound clean with wash cloth, pat dry, apply ointment, and cover with xeroform and wound dressing. First administer 6/7/2025 - Santyl External Ointment 250 Unit/GM Apply to right heal topically every day shift for wound clean with wash cloth, pat dry, apply ointment , cover with Santyl and wound dressing. First administered 6/6/2025. D/C 6/9/2025 - Mupirocin External Ointment 2% Apply to abdomen topically every day shift every other day for wound clean with wash cloth, pat dry, apply ointment, cover with wound dressing. First administered on 6/7/2025. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #66 on 6/9/2025 at 3:40 PM, resident said the facility staff treat him well. Resident was observed having a hard time talking due to having a hard time breathing. At the time he did not have his oxygen on his face. He put his oxygen on his face. Resident stated his oxygen was only as needed. During an interview with MDS Nurse A on 6/11/2025 at 01:04 PM she stated baseline care plans usually include enhanced barriers, fall risk, medications, indwelling catheter, diet, code status, return to community or discharge plan and cognitive state, using oxygen, peg tube, basic skin evaluation will be on there and if there are any interventions. Since it is the baseline, and they are still in the comprehensive window they can still add things. She said if resident comes in with wounds, they should be documented on the 48 Hour care plan. She said she felt the statement on Resident # 66's care plan provide skin/wound care as ordered covered everything. In a follow up interview with MDS Nurse A on 6/11/2025 at 1:11 PM, she stated she had a resident assessment certification from a MDS certification course. It is renewed every 2 years, and she had to take continuing education classes to maintain the certificate. She stated that not completing a care plan accurately could have a potential of negative care and delay in treatment or care of the resident. In an interview with the DON on 6/11/2025 at 3:08 PM, he stated that baseline care plans are started by the nurse who does the assessment for the resident. He stated that they make sure care plans are accurate by documentation during morning meetings and it's an ongoing process. When asked how it can affect the residents care if care plan is not correct, he stated that a baseline care plan gives a picture of the patient it is more minimal for baseline with minimal information as they do not know the resident yet. A detailed report would go on their comprehensive care plan. Record review of the facility document titled, Care Plan Revision date of November 2018 and last reviewed 11/2024 revealed in part: General: Each resident will have a care plan that is current, individualized, and consistent with their medical regimen. Responsible Party: Care Plan/ MDS coordinator, Social Services, Activities, Rehab, Dietary, Nursing, and other members of the interdisciplinary team. A baseline care plan is developed for each resident upon admission, but no later than 48 hours of admission, to the facility, this care plan includes minimum health care information necessarily to properly care for the resident. The care plans are developed by the members of the interdisciplinary team based on their assessments and interaction with the resident and/or resident's significant others. The care plan consists of the following Problems as identified by reviewing the medical record and discussion with the resident/and or significant others.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objective and time frames to meet a resident's medical, nursing, mental and psychosocial needs for 1 (Resident #3) of 6 residents reviewed for care plans. The facility failed to ensure that Resident #3's care plan was person-centered as it did not include information specifying what Resident #3 was resistive of care to and did not specify specific medications for interventions. This failure could place residents at risk of not receiving appropriate care and interventions to meet their needs or staff having complete knowledge regarding a resident's care. Findings included: Record review of Resident #3's face sheet dated 6/11/2025, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection and Need for Assistance with Personal Care. Record review of Resident #3's admission MDS dated [DATE] revealed a BIMS score of 15 that indicated cognition was intact . MDS also revealed Resident #3's rejection of evaluation or care (e.g. bloodwork, taking medications, ADL assistance) that behavior occurred 1 to 3 days. MDS also revealed Resident #3 required varying degrees of assistance from independent to substantial/maximal assistance for functional abilities. Record review of Resident #3's care plan printed 6/11/25 at 11:53 a.m., revealed focus Resident #3 is resistive to care (SPECIFY) r/t with date initiated of 5/22/25 but no information regarding what resident was resistive to. Care plan also had focuses related to diuretic (medication that increases production of urine) use, receiving opioid (medication used to treat pain) medications, and anticoagulant (blood thinner) therapy but specific medications were not listed. Record review of Resident #3's Order Summary Report dated 6/11/25 revealed active orders for Acetaminophen-Codeine (opioid/medication used to treat pain) Tablet 300-30 mg with instructions to give 1 tablet by mouth every four hours as needed for pain, Apixaban (anticoagulant/blood thinner) oral tablet 5 mg with instructions to give 1 tablet by mouth two times a day, Furosemide (diuretic/medication that increases production of urine) oral tablet 20 mg with instructions to give 1 tablet by mouth one time a day for edema (swelling). Record review of Resident #3's May 2025 and June 2025 MAR revealed Resident #3's refusal of medications. Record review of Resident #3's May 2025 and June 2025 TAR revealed Resident #3's refusal of being weighed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 12:59 p.m., MDS Coordinator A said items on the care plan like when resident was receiving opioid (medication used to treat pain) therapy was not written with the specific medication as sometimes they change pain medications. During an interview on 6/11/25 at 12:59 p.m., MDS Coordinator B said she worked at the facility since May 2021 and worked on the hallway with Resident #3. MDS Coordinator B said regarding items on the care plan like if a resident was receiving opioid, antibiotic, diuretic therapy etc., medications were not specific as medications change frequently and it was hard to keep up with medication changes and residents were here short term. MDS Coordinator B said that residents' medications change quickly. MDS Coordinator B said that regarding Resident #3's care plan focus of Resident #3 is resistive to care that the care plan should be specific regarding what resident was resistant to but was probably medication refusal. MDS Coordinator B said she completed the care plan from the MDS and what trigged from the cause. MDS Coordinator B said the nurses did the baseline care plan, so things were pulled from the baseline care plan into the care plan, and she built from that. MDS Coordinator B said it depended on who care plans what. MDS Coordinator B said it was probably them that was responsible for the resistive focus on Resident #3's care plan because it triggered on the cause. MDS Coordinator B said if the care plan did not have all the information needed it would affect the staff's knowledge of how to care for the resident as they used the care plan to care for residents. MDS Coordinator B said if a resident was resistant to care then staff needed to know and what they liked to refuse. MDS Coordinator B said they had a consultant to refer to regarding care plans. MDS Coordinator B said they got any updates that affect care plans regarding MDS through MDS certification and consultant. MDS Coordinator B said the DON will give in-services if there were changes regarding care plans. MDS Coordinator B said that during the morning meeting if the nurse reported changes for residents that was when they care planned changes. MDS Coordinator B said We look to see if things have been care planned from the morning meetings and if changes. During interview on 6/11/25 at 1:23 p.m. MDS Coordinator B said she updated Resident #3's care plan to reflect her resistance of mediations. Record review of Resident #3's care plan printed 6/11/25 at 1:27 p.m. revealed focus Resident #3 is resistive to care (refusal of medications). During interview on 6/11/25 at 3:06 p.m., the DON said the MDS Coordinators was responsible for entering information on the comprehensive care plans. The DON said there was two MDS Coordinators one for the north hall and one for the south hall. The DON said they was to ensure accuracy of the comprehensive care plans through documentation of every department, morning meetings that occurred Monday through Friday and was an ongoing process. The DON said that they received updates from each department and from weekend staff. The DON said if the comprehensive care plan was not accurate then the care plan would not show the picture of the resident. Record review of facility's policy Care Plan with last revision 11/2024 revealed Problems as identified by reviewing the medical record and discussion with the resident and /or significant others.