STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676428	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort El Paso, LLC	3421 Joe Battle Boulevard El Paso, TX 79936

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 observations, interviews, and record reviews, the facility failed to ensure that the residents had the right to a dignified existence for 2 (Resident #2 & Resident #3) of 3 residents reviewed for resident rights. The facility failed to ensure the urinary collection bags for Resident #2 and Resident #3's catheters were covered with a privacy bag. This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem.Resident #2 Record review of Resident #2's face sheet dated 12/15/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included type 2 diabetes with hyperglycemia (high amount of glucose in blood), Hypermagnesemia (too much magnesium), and Acute kidney failure (kidneys stop working). Record review of Resident #2's MDS dated [DATE], reflected a BIMS score of 09, which indicated moderate cognitive impairment. Resident #2 had no impairment to one side of upper extremity, and no impairment to both sides of lower extremities. Resident #2 had an indwelling catheter (including suprapubic catheter and nephrostomy tube). Record review of Resident #2's Order Summary Report dated 12/17/2025, did not reflect any order to Ensure foley bag is in privacy bag every shift and as needed. Record review of Resident #2's hospital history and physical dated 11/23/25 revealed an [AGE] year-old female diagnosed with hypertension (high blood pressure), paroxysmal atrial fibrillation chronically anticoagulated with Eliquis (the use of medication for an abnormal heart rhythm), hypothyroidism (thyroid gland produces too much hormone), and sleep apnea (interruptions in breathing during sleep), morbid obesity (overweight). Record review of Resident #2's Care Plan dated 12/15/2025, stated focus The resident has a urinary catheter for obstructive uropathy and prone to infections. The goal stated, The resident will have minimal complications related to catheter use through the review date. With interventions stating check placement of tubing each shift, monitor/document for pain/discomfort due to catheter, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. In an interview and observation on 12/12/2025 at 4:02 pm Resident #2 was asleep in bed. Investigator was speaking to Resident #2's roommate when investigator saw Resident #2's catheter bag lying on the floor. Investigator called CNA A to address the catheter bag on the floor she stated staff have training every month on infection control and it probably just fell. CNA A said all catheter bags should be in privacy bags, it's a dignity issue. Resident #3 Record review of Resident #3's face sheet dated 12/17/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included chronic kidney disease (loss of kidney function), type 2 diabetes with hyperglycemia (high amount of glucose in blood), Hypertension (high blood pressure), and Chronic Obstructive Pulmonary Disease with Exacerbation (chronic lung disease that affects the airflow making it hard to breath). Record review of Resident #3's MDS dated [DATE], reflected a BIMS score of 15, which indicated the person had intact cognition. Resident #2 had no impairment to one side of upper extremity, and no impairment to both sides of lower extremities. Resident #2 had an indwelling catheter. Record review of Resident #3's Order Summary Report dated 12/17/2025, did not reflect an order to Ensure foley bag is in privacy bag every shift and as needed. Record review of Resident #3's Care Plan dated 12/17/2025, stated focus The resident has a urinary catheter. The goal The resident will have minimal complications related to catheter use through the review date. With interventions check placement of tubing each shift, monitor/document for pain/discomfort due to catheter, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. In an observation and interview on 12/12/2025 at 4:13 p.m., Resident #3 was sitting in a wheelchair watching television. She was alert and oriented. Her catheter bag was hanging low below the bladder with no privacy bag covering it. Resident #3 stated it did not bother her that the collection bag was left uncovered. In an observation and interview on 12/15/2025 at 9:20 a.m., Resident #3 was sitting in bed eating breakfast, her catheter bag was hung on the right side of her bed, on the side of the door visible to anyone walking the hallways with no privacy bag. Resident #3 wanted to sit up in bed, so investigator called for assistance. CNA F entered room to help with resident's needs and was asked if the catheter bag needed to have a privacy bag. CNA F stated they always have to have privacy bags on and was unsure why it was not on Resident #3's catheter bag. CNA F walked outside to a med cart where a LVN was present and asked

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 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 interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 2 reviewed for medication administration in that: The facility failed to ensure that Resident #1 was provided with wound care treatment according to physician's routine, PRN, and STAT orders, due to the order being placed incorrectly in the MAR. This failure could place residents at risk of a decline in health due to incorrect medication administration and inaccurate orders. Record review of Resident #1's face sheet dated 12/15/2025, revealed admission on [DATE] to the facility. Record review of Resident #1 's H&P dated 11/09/2025, revealed an [AGE] year-old male diagnosed with pulmonary embolism (a blood clot blocking the flow to the lungs), rheumatoid arthritis (arthritis in the joints), chronic congestive heart failure/cardiomyopathy with reduced EF (heart failure where the heart is unable to pump blood to meet the body's needs), osteoporosis (disease that weakens bones), chronic pain syndrome (pain lasting longer than three months) and chronic back pain (pain lasting longer than three months) and chronic left foot ulcer (open sore on the foot). Record review of Resident #1's baseline care plan dated 11/25/2025 revealed, a focus The resident has actual impairment to skin integrity, with a goal the resident will have no complications r/t documented skin impairment through the review date and interventions, apply barrier cream, evaluate and treat per physician orders, follow facility protocols for treatment for injury and keep skin clean and dry , wound consult as needed. Record review of Resident #1's admission MDS dated [DATE], revealed a BIMS score of 15, which indicated the person was intact cognitively. Resident #1 was diagnosed with sepsis for his wound care when he entered the facility and was on antibiotics through a PICC line. Record review of wound assessment dated [DATE] at 7:11 pm completed by DON, revealed Resident #1 had a clinical stage 3 pressure ulcer in sacrum. Record review of Resident #1's physician order dated 11/26/2025 revealed, coccyx wound to be cleaned with wound cleanser, pat dry, apply mupirocin and cover daily and PRN for soilage/dislodgement. Record review of Resident #1's daily skilled note readmission dated 11/28/2025 at 04:01 pm, revealed treatment was provided by admitting nurse J for pressure ulcer on coccyx. Record review of Resident #1's 'Former wound assessment dated 12/03/2025 indicated the pressure ulcer remained a stage 3 with wound exudate levels (fluid that leaks out of the wound) and wound characteristics not showing any signs of infections, which were marked as low. In an interview on 12/15/2025 at 12:11 PM, with the DON, she stated Resident #1 received wound care during his stay; however, she was unable to provide documentation verifying that wound care was consistently completed. The DON stated she did not work on the weekends but indicated a wound care nurse was assigned on weekends to complete wound care. She further stated nursing staff are trained to date and sign wound care bandages and document when the wound care is complete; however, no documentation was available for review. In an interview on 12/15/2025 at 12:50, the RN stated he works weekends providing wound care and did not recall Resident #1. He explained wound care documentation is completed by clicking the physicians order in the electronic record to indicate treatment was completed. He stated if wound care orders are properly entered into the TAR they populate for completion. He did not recall signing documentation for Resident #1. The RN stated the DON are responsible for reviewing wound care documentation upon return on Mondays. RN stated wound deterioration and infection risk could result if wound care was not provided depending on the wound severity and the resident's nutritional status. RN stated he is certified and trained in wound care and has been a wound care nurse for at least 9 years. In an interview on 12/15/2025 at 3:13 PM, the Medical Record Director stated he does not show any documentation regarding wound care treatment for Resident #1. In an interview on 12/15/2025 at 03:15 PM, with DON stated that the order that was placed into the TAR is wrong. The DON is the one responsible for reviewing the orders and that is when the old DON left so the orders were not reviewed. There was no one left to review the orders unfortunately. Administrator was present during this interview and stated there was nothing documented even though he knows that current DON is good and very thorough and knows it was completed but there is no documentation to provide at this time. In an interview on 12/17/2025 at 01:54 pm, the physician stated the risk of not receiving wound care was uncertain. He stated he would need to review the medical record for Resident #1 to determine if the wound stage worsened or remained the same. He stated the resident was already receiving antibiotics via a PICC line. The physician stated that regardless of uncertainty regarding outcome, the resident should have

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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. (continued on next page)

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F 0880 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 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 disease and infection for 1 of 3 residents (Resident #2) reviewed for infection control. The facility failed to ensure the urinary catheter bag for Resident #2 was anchored and secured to prevent infection. This failure could place residents at risk of infection due to improper care practices. Record review of Resident #2's face sheet dated 12/15/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included type 2 diabetes with hyperglycemia (high amount of glucose in blood), Hypermagnesemia (too much magnesium), and Acute kidney failure (kidneys stop working). Record review of Resident #2's MDS dated [DATE], reflected a BIMS score of 09, which indicated moderate cognitive impairment. Resident #2 had no impairment to one side of upper extremity, and no impairment to both sides of lower extremities. Resident #2 had an indwelling catheter (including suprapubic catheter and nephrostomy tube). Record review of Resident #2's Order Summary Report dated 12/17/2025, stated to ensure foley catheter care to include anchoring tubing and checking skin integrity every shift and PRN. Record review of Resident #2's hospital history and physical dated 11/23/25 revealed an [AGE] year-old female diagnosed with hypertension (high blood pressure), paroxysmal atrial fibrillation chronically anticoagulated with Eliquis, (the use of medication for an abnormal heart rhythm) hypothyroidism (thyroid gland produces too much hormone), sleep apnea (interruptions in breathing during sleep), morbid obesity (overweight). Record review of Resident #2's Care Plan dated 12/15/2025, stated focus The resident has a urinary catheter for obstructive uropathy and prone to infections. The goal stated, The resident will have minimal complications related to catheter use through the review date. With interventions stating check placement of tubing each shift, monitor/document for pain/discomfort due to catheter, Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. In an interview and observation on 12/12/2025 at 4:02 pm Resident #2 was observed asleep in bed. While speaking with Resident #2's roommate, investigator observed Resident #2's catheter drainage bag resting on the floor. Investigator notified CNA A to address the catheter bag. CNA A stated staff receive monthly infection control training and indicated the catheter bag likely fell to the floor. CNA A stated staff are expected to check residents every two hours. CNA A acknowledged the risk associated with catheter bag contacting the floor could lead to an infection. In an interview on 12/15/2025 at 10:00 a.m. the DON stated that a catheter bag on the floor was a risk for infection control. All nursing staff were responsible to assure that catheter bags are not on the floor and positioned correctly so there is no risk of infection. In an interview on 12/16/2025 at 12:03 pm, LVN C stated she has been a LVN at the facility for over a year. If there was a catheter bag on the floor, the risk was infection because bacteria can transfer. Nursing and CNAs are to be rounding on residents every two hours or as needed to ensure catheter bags are being looked after. LVN C stated she was trained on a workshop from the company a couple of months back relating to infection control. In an interview on 12/16/2025 at 12:19 pm CNA D stated she has been a CNA for 30 years but at the facility only a month. She stated that catheter bags are not supposed to be on the floor. That is a risk for infection. CNAs are to round on residents every 2 hours or as needed. In an interview on 12/16/2025 at 12:41 pm CNA E stated she has been a CNA at the facility for over a year. She stated it was everyone's (staff) responsibility and nursing departments to ensure that catheter bags are not on the floor. It could be contaminated, or it can empty out on the floor and that is not proper protocol. Staff are supposed to round every 2 hours. Record review of facility policy titled Infection Control Policy dated March 2020, revised 11/2024, stated This facility will facilitate a safe care of all residents and staff with known or suspected communicable disease by establishing and maintaining 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.