

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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:  676428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for two residents (Residents #1, and #2) of 4 residents reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident # 1 and #2 to address resident's wound vac. These failures could affect residents and put them at risk for not receiving care and services to meet their needs. Findings included: Resident #1 Record review of Resident #1's admission record dated 10/27/2025 revealed a [AGE] year old male with an admission date of 09/22/25. Review of Resident #1's history and physical dated 09/23/2025 revealed resident had a left 5th toe amputation and the presence of a wound vac to distal lower leg. Review of Resident #1 's admission MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Section M- skin conditions -revealed surgical wound care and application of dressing to feet. Review of Resident #1's Physician orders dated 09/24/2025 revealed WOUND CARE TO LEFT FOOT: NPWT@125mmHG CONTS. NOT TO BE REMOVED/CHANGED UNTIL SEEN BY SURGEON ON 9/25. Review of Resident #1 's Care Plan initiated on 09/23/2025 revealed the care plan did not address resident's use of wound vac. Resident #2 Record review of Resident #2's face sheet revealed a [AGE] year-old male with an admission date of 10/01/25. Record review of Resident #2's history and physical dated 10/01/25 revealed medical history of high blood pressure, chronic kidney disease (condition where the kidneys gradually lose their ability to filter waste products from the blood), coronary artery disease (heart condition where the arteries that supply blood to the heart become narrowed or blocked), and diabetic foot ulcer (open sore or wound that develops on the foot of a person with diabetes). Record review of Resident #2's 5 day MDS dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact. Section M- Skin Conditions revealed surgical wound care, and application of dressings to feet. Record review of Resident #2's physician orders dated 10/01/2025 revealed WOUND CARE TO RIGHT FOOT: IRRIGATE WITH NSS, PAT DRY, APPLY SKIN PREP TO PERIWOUND, APPLY TRANSPARENT FILM TO PERIWOUND, FILL SPACE WITH BLACK GRANUFOAM, SECURE WITH TRANSPARENT FILM, ATTACH STINGRAY, RESUME NPWT @125mmHG CONTS. 3XWK every day shift every Mon, Wed, Fri. Record review of Resident #2's care plan with initiation date of 10/01/25 revealed the care plan did not address resident's use of wound vac. In an interview on 10/27/25 at 1:40pm with RN A revealed if a resident was using wound vac, that treatment would have to be included in the care plan, as the care plan was a blueprint of residents care and the wound vac was something that needed to be taken care of. She stated that a risk of not being care planned would be the chance of it being missed by someone new to caring for the resident. In a telephone interview on 10/28/25 at 10:54am with RN B revealed that the admitting nurse was responsible for completing a baseline care plan. She stated that she then was responsible for completing the comprehensive care plan. She stated that wound care or wound vac would be included in the baseline care plan and if it became a new treatment during the residents stay, then it would be the floor nurses responsibility to update the care plan. She stated that it was important for the care plan to be accurate because it was part of their treatment, and reason for stay at the facility. She stated that there was no risk for the residents wound vac not being care planned because treatment was still being done because it showed up on the MAR. She stated that it was the responsibility of nursing staff including herself to ensure that care plans were up to date. She stated that she could not recall last Inservice done regarding care plans. In an interview on 10/28/25 at 11:20am with the DON revealed, that the purpose of a care plan was so staff could know the needs of the resident and was a form of individualized care. She stated that wound vac was supposed to be included in the care plan because it was something pertaining to residents care. She stated that initially the admitting nurse was responsible for completing the baseline care plan and then the MDS nurse would go through each and revise, she would add it because it would not have to be added to baseline care plan but it would have to be added in the comprehensive care plan done by MDS nurse. She stated that it was important for wound vac to be included so that every nurse could know that it was a required care and it was a form of personalized care. She stated that it was the DONs responsibility along with ADON to monitor that care plans were correct . She stated that her and the ADON conduct chart audits upon admission daily to monitor care plans were correct along with IDT meetings</p>		