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	12/04/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interview and record review the facility failed to ensure the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by the resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment including other personnel, including but not limited to nurse aides for 5 (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5) of 5 residents reviewed for sufficient staff. The facility failed to have sufficient staff, which resulted in missed showers, delayed response to call lights, and delayed incontinent care for dependent residents. This failure could place residents at risk of decreased physical, mental, and psychosocial well-being. Findings include: During an observation on 12/01/25 at 12:51 PM, it revealed the facility had two CNAs and three nurses were working on the first shift scheduled from 6:00 AM through 6:00 PM with a resident census of 51. During an observation on 12/02/25 at 9:00 AM, it revealed the facility had two CNAs and three nurses were working on the first shift scheduled from 6:00 AM through 6:00 PM with a resident census of 51.During an interview on 12/02/25 at 9:32 AM with alert and interviewable Resident #6 revealed resident was alert, oriented to person, place, and time revealed, and the resident had been at the facility for 5 months. She said it took a long time for the staff to answer the call light, because there were not enough staff and the CNAs tried their best to answer the call lights as soon as possible. She said the CNAs come and rush to provide the needed care. During an interview on 12/02/25 at 9:36 AM with alert and interviewable Resident #7 revealed he was alert, oriented to person, place and situation. He said he was admitted two weeks ago from the hospital for rehabilitation services. He said he used his call light to call for assistance as needed and said the staff tried to answer his call light as soon as possible because he knew that the staff were very busy. He said the CNAs rushed to provide care as fast as possible. During an interview on 12/02/25 at 9:44 AM with Resident #3 and family member revealed she visited Resident #3 daily. The family member said it took 30 minutes or more for the staff to answer call lights. She said Resident #3 had been waiting over 20 minutes for staff to come and change her wet brief. She said, the nurse has come to tell us two times that the CNAs are busy and will come to change [Resident #3] as soon as possible. She said the day before yesterday Resident #3's call light was on, and she was left wet for over 30 minutes.During an interview on 12/02/25 at 9:48 AM with LVN C revealed CNA E on the unit was aware Resident #3 needed to be changed. She said, Let me go and tell the CNA again that the resident is wet and needs to be changed. The CNA is busy changing another resident. She said there was only one CNA assigned to work on the 300 Hall for twelve residents, and that was why she had to help her at times to provide incontinent care to dependent residents and tried not to fall behind in her work because she also had to assist in answering call lights. During an observation on 12/02/25 at 9:55 AM, revealed CNA E entered Resident #3's room to provide incontinent care. The resident was lying in bed and resident's family member was at her bedside. The resident's family member told the CNA Resident #3 had been waiting a long time to be changed. The CNA said, I know the nurse had told me she was wet, but I was changing other residents. The CNA washed her hands, put on gloves and prepared to change the resident. The divider curtain was pulled for privacy. The sheets were pulled back and it was observed the fitted sheet was wet with urine. The brief was removed, and perineal area was cleaned with cleaning wipes. It was observed the resident did not have any skin irritation in the perineal area or skin breakdown on buttocks. Once the disposable brief was changed, she changed the sheets, gown and changed gloves. During an interview on 12/02/25 at 12:22 PM, with LVN B assigned to the 100 Hall from 6:00 AM - 6:00 PM, revealed they only had two CNAs assigned to the 100 and 200 Resident Halls and each CAN was assigned 18-19 residents and they tried to do rounds every two hours. She said they should have three CNAs on each shift but were short of CNAs off and on for the past three weeks due to high staff turnover. She said she assisted the CNAs at times to change incontinent residents and answer call lights as time permitted because she was busy doing her work. She said sometimes the families and residents complained the residents were left wet for long periods of time. She said she never found residents with dried urine rings or dried feces. During an interview on 12/02/25 at 12:28 PM with LVN C revealed, there were three LVNs and two CNAs working today. She said they had been working with only two CNAs for about a month. She said, today we have two CNAs and one new CNA in training. She said the CNAs did not have time to make rounds every two hours. She said the CNAs usually

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record review the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors, for 1 of 1 nursing unit reviewed for nurse staffing information. The facility failed to post and maintain the required nursing staffing information since 11/20/25. These failures could place residents, their families, and facility visitors at risk of not having access to information regarding facility regarding staffing schedule and facility census. Findings included: During an observation and record review on 12/01/25 at 12:55 PM revealed, the daily staffing sheet posting information, posted by the main entrance to the facility, was dated 11/20/25. During an interview and record review on 12/01/25 at 4:46 PM with RN D Assistant Chief Nursing Officer revealed, the previous Chief Nurse Officer's last day of work was on 11/20/25 and she posted the nurse staff data daily. She said she had requested access to the electronic PPD reports to complete the nurse staff data daily and as of today she had not been granted access to the needed information. She said, that is why she has not posted an updated nurse staff data sheet since 11/20/25. The Assistant Chief Nurse Officer said that the purpose of the nurse staff data was to communicate with visitors' information on the number of staff available at the facility. The Assistant Chief Nurse Officer said the risk of not having the information posted was that staff members and family members would not know the current staffing situation at the facility. During an interview and record review on 12/02/25 at 12:06 PM with Executive Director revealed the nurse staff data posted by the main entrance to the facility was dated 11/20/25. He said, the previous Chief Nurse Officer's last day of employment was on 11/20/25 and she was responsible for posting the nurse staff data daily. He said he had requested access to the electronic PPD reports for the Assistant Chief Nurse officer on 11/20/25 and as of today, she still had not been granted access to the electronic PPD reports to be able to complete the nurse staff data to post daily. The state surveyor requested the facility's policy on nurse staff data and was not provided prior to exit by the Assistant Chief Nurse Officer.

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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 - Some	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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 5 (Resident #1, #2, #,3, #4, and #5) of 5 residents reviewed for pharmacy services. 1. The facility failed to administer Dapagliflozin Propanediol, Levothyroxine, Acetylcysteine Solution, Eliquis, Memantine HCl, to Resident #1 according to physician's orders. 2. The facility failed to administer Farxiga and Folic Acid, to Resident #2 according to physician's orders. 3. The facility failed to administer Pravastatin Sodium, Alendronate Sodium, Sodium Chloride, Linagliptin, and Calcium 600 + D to Resident #3 according to physician's orders. 4. The facility failed to administer Levothyroxine, Rifaximin, Symbicort Inhalation Aerosol to Resident #4 according to physician's orders. 5. The facility failed to immediately consult with and/or Nurse Practitioner when the facility did not have Dapagliflozin Propanediol, Levothyroxine, Acetylcysteine Solution, Eliquis, Memantine HCl, for Resident #1 to administer as ordered. 6. The facility failed to immediately consult with and/or Nurse Practitioner when the facility did not have Farxiga and Folic Acid, for Resident #2 to administer as ordered. 7. The facility failed to immediately consult with and/or Nurse Practitioner when the facility did not have Pravastatin Sodium, Alendronate Sodium, Sodium Chloride, Linagliptin, and Calcium 600 + D for Resident #3 to administer as ordered. 8. The facility failed to immediately consult with and/or Nurse Practitioner when the facility did not have Levothyroxine, Rifaximin, Symbicort Inhalation Aerosol for Resident #4 to administer as ordered. 9. The facility failed to immediately consult with and/or Nurse Practitioner when the facility did not have Aspirin, Colace, Farxiga, Latanoprost Ophthalmic Solution, Lidocaine External Patch, Pravastatin Sodium, Prenatal Vitamin, Calcium Antacid Chewable, Vitamin C, Advanced Probiotic, Lisinopril, and Amoxicillin for Resident #5 to administer as ordered. These failures could place residents at risk of inadequate therapeutic outcomes and a decline in health due to not receiving medication as ordered. Findings include: 1. Record review of the admission Record dated 12/01/25 for Resident #1 revealed an admission date of 11/10/25. discharge date [DATE] to an Acute Care Hospital.Record review of the Hospital Physician Progress Note for Resident #1 dated 11/09/25, revealed an [AGE] year-old male with a history of esophageal cancer (abnormal cells grow out of control in the food pipe, making it hard to swallow, causing pain, weight loss, and a persistent cough or hoarseness as the tumor blocks the passage or irritates the area) on enteral feedings (giving liquid nutrition formulas directly into their stomach through a tube), and CAD with history of mitral valve replacement (blocked heart arteries damaged the heart muscle, causing the mitral valve to leak, both problems are fixed bypass surgery for the arteries and replacing the faulty valve with a new mechanical one, to improve blood flow and heart function). Record review of the admission MDS assessment, dated 11/16/25, for Resident #1 revealed, Entry Date: 11/10/25. BIMS Summary Score - 10 (cognition was moderately impaired). Clear speech, makes self-understood, and understands others. Active Diagnoses: Cancer, Heart Failure (the heart cannot pump enough blood and oxygen to meet the body's needs), Hypertension (is when the force of blood against your artery wall is consistently too high), Diabetes Mellitus (a chronic disease where the body had high blood sugar levels, either because the pancreas does not produce enough insulin or the body cannot use insulin effectively), Non-Alzheimer's Dementia (brain disorder causing memory, thinking, and behavior problems), Dysphagia (difficulty swallowing, which can make it hard for food and liquids to move from the mouth down to the stomach), lack of coordination, and Gastrostomy (is a feeding tube that goes directly into the stomach through a small opening in the stomach, by bypassing your mouth and throat, to deliver liquid food, medicine, or to help air and fluids come out). Record review of the Care Plan for Resident #1, initiated 11/10/25 revealed: the Resident has an ADL self-care performance deficit and limitations in physical mobility. Interventions: Partial/moderate assistance with toileting hygiene, dressing and turning and repositioning in bed. Resident is NPO, G-tube on bolus feedings every six hours. The resident was receiving anticoagulant therapy and was prone to bleeding and bruising. Interventions: Labs as ordered. Report abnormal results to the MD. Monitor/document/report PRN (as needed) black tarry stools, sudden changes in mental status, significant or sudden changes in vital signs. Record review of the Order Summary Report, dated 12/03/25, for Resident #1 revealed, Farxiga (Dapagliflozin Propanediol) Oral Tablet 10 mg give one tablet via G-Tube one time a day for DM, Levothyroxine Sodium Oral tablet 50 mg give one tablet via G-Tube one time a day for Hypothyroidism, Eliquis 2.5 mg give one tablet via G-Tube every 12 hours for PPX

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to establish procedures for storing and disposing of drugs and biological in accordance with federal, state, and local laws. -The facility failed to ensure medication deliveries were not left unattended at the nurse's station. -The facility failed to ensure licensed staff did not leave medications unattended at the nurse's station This failure could place residents living at the facility at risk of drug diversion. The findings included:During an observation on 12/03/25 at 9:00 AM, revealed a cardboard box was on top of the nurse's station countertop labeled El Paso with a label on one side that documented Dressing Change Kits. During an observation, interview and record review on 12/03/25 at 9:50 AM revealed, LVN I, was sitting at the nurse's station taking medication blister packets out of the cardboard box that was labeled El Paso, that was on the nurse's station countertop unattended earlier that morning. He said the pharmacy ships medications in cardboard boxes from out of town and the boxes should be received by one of the nurses. He said, These blister packets are controlled substances, and I need to store them in the locked medication room next to the nurse's station. The nurse walked away from the nurse's station for approximately two minutes and left several medication blister packets unattended on top of the counter in front of the computer unattended. It was observed that the housekeeper standing in the hallway directly in front of the nurse's station preparing cleaning equipment to enter a resident's room and the facility driver was standing on the side of the nurse's station talking to a resident. The nurse returned to the nurse's station and continued to pull medication blister packets from the cardboard box. The surveyor requested copies of the packing slips from the cardboard box. Record review of the Packing Slips dated 12/02/2025 revealed the following medications were listed on the packing list. Alprazolam 0.5 mg 42 tablets, Dronabinol 2.5 mg 30 tablets, Tramadol HCL 50 mg 30 tablets, and Tramadol HCL 50 mg 30 tablets. The packing slips documented, By signing below, you acknowledge that the items above have been received. It was observed that the packing slips were not signed by the receiving nurse. During an interview on 12/03/25 at 9:57 AM LVN stated, they had been trained to never leave medications unattended at the nurse's station. During an interview on 12/02/25 at 3:12 PM, with RN Assistant Chief Nursing Officer in the presence of the Executive Director and Chief Nursing Officer revealed, they had contracts with two out-of-town pharmacies that provided pharmaceutical services to the facility and with a local pharmacy for after hour services. It was reported that the delivery people should hand the box of medication to one of the nurses on duty and should never leave the box with medication unattended at the nurse's station. She said the delivery person and receiving nurse had to sign and date the packet delivery slip for the person that delivered the medication to the facility. During an interview 12/03/25 at 3:21 PM, with RN Assistant Chief Nursing Officer in the presence of the Executive Director and Chief Nurse Officer revealed, she had followed up with the nurses and they had reported that the cardboard box that contained medication was just left by the delivery person at the nurse's station and was not left with any of the three nurses that were on duty. Review of facility's policy and procedure on Medication Ordering and Receiving Form from Pharmacy ProviderReturns a signed copy of the delivery receipt/manifest to the pharmacy via driver, fax or other method, as defined by the pharmacy provider. Retains a copy of the delivery for an appropriate time to reconcile any ordering issues.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were accurately documented for 1 (Resident #22) of 8 residents reviewed for medical records. -The facility failed to ensure LVN A documented in the Nurse's Notes on 11/18/25 when she notified the physician of resident family's non-compliance of NPO status. -The facility failed to ensure that licensed staff promptly wrote physician's telephone orders and entered new orders in the medication administration record. This failure could place residents at risk of residents records not reflecting accurate and complete information. Findings include:Closes Record Review of the admission Record dated 12/01/25 for Resident #1 revealed, admission date 11/10/25. discharge date [DATE] to Acute Care Hospital.Review of the Hospital Physician Progress Note for Resident #1 dated 11/09/25 revealed, [AGE] year-old male with a history of esophageal cancer (abnormal cells grow out of control in the food pipe, making it hard to swallow, causing pain, weight loss, and a persistent cough or hoarseness as the tumor blocks the passage or irritates the area) on enteral feedings (giving liquid nutrition formulas directly into their stomach through a tube), CAD with history of mitral valve replacement (blocked heart arteries damaged the heart muscle, causing the mitral valve to leak, both problems are fixed by bypass surgery for the arteries and replacing the faulty valve with a new mechanical one, to improve blood flow and heart function). Review of the admission MDS assessment dated [DATE] for Resident #1 revealed, Entry Date: 11/10/25. BIMS Summary Score - 10 (cognition was moderately impaired). Clear speech, makes self-understood, and understands others. Active Diagnoses: Cancer, Heart Failure (the heart cannot pump enough blood and oxygen to meet the body's needs), Hypertension, Diabetes Mellitus (a chronic disease where the body had high blood sugar levels, either because the pancreas does not produce enough insulin or the body cannot use insulin effectively), Non-Alzheimer's Dementia (brain disorder causing memory, thinking, and behavior problems), Dysphagia (difficulty swallowing, which can make it hard for food and liquids to move from the mouth down to the stomach), lack of coordination, and Gastrostomy (is a feeding tube that goes directly into the stomach through a small opening in the stomach, by bypassing your mouth and throat, to deliver liquid food, medicine, or to help air and fluids come out). Review of the Care Plan for Resident #1 dated 11/10/25 revealed: Resident has ADL self-care performance deficit and limitations in physical mobility. Interventions: Partial/moderate assistance with toileting hygiene, dressing and turning and repositioning in bed. Resident is NPO (nothing by mouth) on G-tube on bolus feedings (give a single, large amount of liquid food through a feeding tube, instead of a slow, continuous drip) every six hours. The resident was receiving anticoagulant therapy and are prone to bleeding and bruising. Interventions: Labs as ordered. Report abnormal results to the MD. Monitor/document/report PRN (as needed) black tarry stools, sudden changes in mental status, significant or sudden changes in vital signs. Record review of the IDT Notes revealed that LVN A had not documented the physician she had notified the physician on 11/18/25 when she had seen the resident's family member giving Resident #1 water with ice chips and was not following the NPO order. LVN A only documented she had notified the Speech Therapist Record review of the Medication Administration Record dated November 2025 for Resident #1 did not document the orders for the Chest x-ray, Saline Nasal Spray and Oxygen order for 1 Liter. During an interview and record review on 12/01/25 at 3:39 PM with LVN A in the presence of RN Assistant Chief Nurse Officer revealed she was assigned to Resident #1 on 11/22/25 and had worked from 6:00 AM - 6:00 PM on that day. She said on 11/22/25 Resident #1 was having more chest congestion than usual in the morning, and she had notified the physician, and they had given an order for chest x-ray, Saline Nasal Spray, Oxygen at 1 Liter and she did not write the telephone order and had not entered the new orders on the Medication Administration Record. She said, There is no reason why I did not write the Telephone Order and did not enter the order for the Saline Nasal Spray in the Medication Administration Record. She said licensed staff had been trained to immediately write the Telephone Order for new orders and to enter the new order on the Medication Administration Record. LVN A said the resident was NPO and was not aware that he was ever served regular food while at the facility. She said the resident was always requesting ice chips, and the speech therapist had given an order to give ice chips only when directly supervised by the nurses. She said the resident received three bolus enteral feeding via G-Tube during her shift. She said that on 11/18/25 she had seen the resident's family member giving the resident water with ice. She said the Speech Therapist had

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to have an adequately equipped system that allowed residents to call for staff assistance through a communication system for 2 of 2 call light systems viewed for resident call system. The facility failed to ensure that residents call lights for 3 of 3 Resident Halls were functioning properly. This failure put residents at risk of not being able to call for assistance when needed. Findings included: During an observation 12/01/25 at 12:53 PM in Hall 200 revealed, two residents had turned on the Nurse Call Lights. It was observed that the corridor lights for Nurse Call were on, room [ROOM NUMBER] and 209, and were not ringing in the residents' rooms or at the nurse's station. There were no staff sitting at the nurse's station. During an observation 12/01/25 at 1:33 PM revealed, the resident in room [ROOM NUMBER] had turned on his Nurse Call Light. It was observed that the corridor light for Nurse Call in room [ROOM NUMBER] was on and was not ringing in the residents' room or at the nurse's station. The Nurse was passing medications in the 200 Hall and CNAs were picking up lunch trays throughout the resident halls. There were no staff at the nurse's station. During an observation 12/02/25 at 9:35 AM revealed, the resident in room [ROOM NUMBER] had turned on his Nurse Call Light. It was observed that the corridor light for Nurse Call in room [ROOM NUMBER] was on and was not ringing in the resident's room or at the nurse's station for room [ROOM NUMBER]. There were no staff at the nurse's station or in the 200 Hall. During an observation 12/02/25 at 9:37 AM revealed, the resident in room [ROOM NUMBER] had turned on his Nurse Call Light. It was observed that the corridor Nurse corridor lights for Nurse Call were turned on and were not ringing in the residents' rooms and were not ringing at the nurse's station. It was observed that the call light monitor at the nurse's station directly in front of room [ROOM NUMBER] was not turned on. The Nurse was in the 200 Hall passing medications and the CNAs were picking up lunch trays throughout the resident halls. There were no staff at the nurse's station. During an observation 12/02/25 at 9:51 AM, it was revealed two resident corridor lights for Nurse Call were turned on in the 200 Hall and were not ringing in the residents' room and were not ringing at the nurse's station. The call light monitor at the nurse's station was not on. The Nurse was passing medications and CNAs were in resident rooms assisting residents. There were no staff at the nurse's station. During an observation 12/02/25 at 12:45 PM revealed, the resident in room [ROOM NUMBER] had turned on his Nurse Call Light. It was observed that the corridor Nurse call light was turned on for room [ROOM NUMBER] and was not ringing in the resident's room or at the nurse's station. The CNAs were picking up lunch trays throughout the resident halls and nurses were passing medications in the hallways. During an observation and interview on 12/02/25 at 12:52 PM, with LVN B assigned to the 100 Hall on the 6:00 AM - 6:00 PM, demonstrated to the state surveyor that she had turned on the Nurse Call Light in room [ROOM NUMBER] was not ringing in the resident's room and/or at the nurse's station. She said, I noted yesterday that the Nurse Call Lights only rang once when the call light was turned on by the resident and did not continue to ring and Nurse Call Lights were not ring at the nurse's station. She said she had not reported this to the Maintenance Director. During an observation and interview on 12/02/25 at 1:30 PM, the Maintenance Director revealed he was not aware of any issues with the Nurse call light system. He said he conducted monthly QA checks of the Nurse all light system to ensure the system was working properly. He said he received a reminder via telephone when to complete the scheduled monthly QA checks on the Nurse call light system. He said the next QA check on the call light system was due on 12/31/25. The state surveyor requested copies of the QA checks completed on the Nurse call light system. During an interview on 12/03/25 at 9:15 AM with Chief Nursing Officer revealed that the corridor Nurse call lights were not ringing at the nurse's station or when the residents pushed the red button on the call light for assistance for the last six days. She said, I noticed this week that the corridor light for Nurse Call Lights would turn on and were not ringing resident rooms or at the nurse's station. She said, Prior to that I do not remember if the Nurse call lights rang at the nurse's station. She said the nurses, executive director and some of the department heads today had started to help with answering call lights. She said, The Nurse call lights will light up but do not ring to alert the staff when residents are calling for assistance. During an observation and interview on 12/03/25 at 9:33 AM with RN G revealed, the Nurse call lights should ring at the nurse's station or when the residents called for assistance. She said, I noted this past weekend the Nurse call lights were on and were not ringing, but we can see the corridor Nurse call light, lights up when the residents push the button on the call light for assistance. The surveyor