Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

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	03/13/2026

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the physician was immediately notified of a need to alter treatment (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) to meet the needs of each resident for 1 (Resident #2) of 9 residents reviewed for physician notifications. -The facility failed to notify the physician when Resident #2 experienced elevated blood glucose levels exceeding 400 mg/dL from 02/26/2026 through 03/02/2026. An Immediate Jeopardy (IJ) situation was identified on 03/12/2026. While the IJ was removed on 03/13/2026, the facility remained out of compliance at the scope of isolated and a severity level of no actual harm with the potential for minimum harm, due to the facility's need to evaluate the effectiveness of their corrective systems.This failure could have resulted in a decline in health and placing the resident at risk of adverse outcomes like sepsis, DKA, or death.Findings included:Record review of Resident #2's face sheet dated 03/11/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included Vesicointestinal Fistula (abnormal connection between the bladder and the bowel), hypertension (High blood pressure), type 2 diabetes mellitus with hyperglycemia (diabetes with blood sugar elevation), Alzheimer's Diseases with early onset (form of dementia). Record review of Resident #2's MDS dated [DATE], reflected a BIMS score of 14, indicating the resident was cognitively intact. Record review of Resident #2's Order Summary Report dated 03/11/2026 revealed Glucose Monitoring-notify provider if <60 or >400 before meals and at bedtime for diabetes. Record review of Resident #2's admitting physician orders dated 02/25/26 revealed: -Blood glucose monitoring before meals and at bedtime with notification to provider if <60 or >400.Record review of Resident #2's notes revealed on 02/26/2026 at 12:33pm, Resident #2'sblood glucose was documented as 512 mg/dL; at 12:36pm. No evidence of resident's record physician was notified. On 02/27/2026 at 1:04pm, blood glucose was documented as 482 mg/dL. No evidence of resident's record physician was notified. On 03/01/2026 at 11:08 am, blood glucose was documented as 459 mg/dL. No evidence of resident's record physician was notified. On 03/02/2026 at 6:49am, blood glucose was documented at 492 mg/dL. No evidence of resident's record physician was notified.Record review of the Resident #2's medication administration record and blood glucose logs revealed no evidence of documented nighttime blood glucose checks. Record review of Resident #2's Care Plan dated 03/11/2026, for blood glucose monitoring revealed, focus The resident is receiving insulin active med list in EMR with a goal, Blood Glucose levels will be withing normal limits and interventions Blood glucose monitoring as per physician order, hypo/Hyperglycemia (high blood sugar/ low blood sugar) protocol per physician orders, Monitor/Document/report as needed for following adverse effects of insulin therapy: Hypoglycemia, weight gain, hypokalemia (low blood potassium levels), pain at injection site. For antibiotics the focus revealed The resident is receiving antibiotic therapy. (see active med list in EMR) with a goal The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date And interventions Monitor/document/report PRN adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (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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The ADON stated that he and the DON are responsible for overseeing the medication reconciliation processes. He reported that corporate support was available when medications were not accessible, including determining alternative medications or treatment options. The ADON acknowledged that medication pass audits had not been completed by him and stated he could not speak to whether the DON had completed such audits. He indicated that nursing staff received training upon hire and were provided with additional education or corrective action when errors occur. The ADON further acknowledged communication challenges between the facility and external providers, including PACE, that there was a lack of consistent communication and coordination of care. He stated the admitting nurses were responsible for entering physician's orders into the system at the time of admission. He acknowledged that there have been prior difficulties with the process and described the system as not fully aligned with external providers. In an interview on 03/03/2026 at 04:28 pm, the DON stated medication administration was monitored through and electronic reporting systems (PCC), including medication administration reports, order listing reports, and non-administered medication reports. The DON stated that audits of medication administration were conducted periodically, typically every three weeks to monthly, rather than daily. The DON acknowledged that there was no consistent daily process to review medications for accuracy or completeness. The DON reported ongoing communication challenges with external providers, including PACE, that the facility relies on receiving orders but does not consistently have direct communication with providers. She stated that orders were expected to be entered by the admitting nurses and that a communication board within PCC is used to relay updates between shifts. The DON described instances in which residents with fluctuating blood glucose levels required close monitoring; however, inconsistent oversight and communication processes impacted timely intervention. She acknowledged that if a resident's condition worsens, the facility may transfer the resident to the hospital rather than intervening earlier. In an interview on 03/04/2026 at 11:00 am, the NP from PACE stated she was not notified that Resident #2 blood glucose had been over 400. She stated that the lack of notification created potential for harm, hospitalization related to uncontrolled blood glucose levels. The NP reported that upon review following the resident's hospital discharge, orders had been provided for insulin and blood glucose monitoring; however, they were not implemented as ordered by the facility. The NP further stated ongoing concerns with communication, that failure to notify providers of changes in condition had been a recurring issue with this facility. The NP stated that the residents subsequently developed worsening conditions, including infection, skin breakdown, and eventual sepsis ,(life threatening condition that arises when the body's response to an infection injures its own tissues and organs) requiring hospitalization. The NP stated that the resident had not previously experienced that level of decline and attributed the deterioration (DKA and sepsis) , in part, to missed medications and lack of timely intervention.In an interview with 03/04/2026 at 11:18 am the RN from PACE stated that he was notified of elevated blood glucose levels on 02/27/2026. The RN stated that after notification, additional sliding scale insulin coverage was ordered . He further stated that long-acting insulin (Lantus) had been part of the resident's prior medication regimen and should have continued without interruption. The RN stated that communication occurred with facility staff LVN C regarding elevated blood glucose levels and instructions were given to administer sliding scale insulin, including an additional 12 units, and to closely monitor the resident's condition. He stated that (continued on next page)

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The RN stated that he was notified again early in the morning on 03/02/2026 regarding persistently elevated blood glucose levels, prompting further evaluation by the RN and NP from PACE, who were at the facility to see Resident #2 In an interview on 03/04/2026 at 01:00PM LVN C stated that she had been employed at the facility for approximately one year and received training on medication administration and vital signs monitoring. She stated that PACE physician's orders were typically received via fax and entered into the system; however, she reported that there may be delays in processing orders, particularly during admissions. LVN C stated that during Resident #2's admission, medication orders from PACE required review and verification before implementation. She reported that some medications, including long-acting insulin (Lantus), were not immediately available or did not appear on the medication administration record (MAR), resulting in delays in administration. She further stated that she contacted the external provider (PACE) multiple times regarding elevated blood glucose levels and received instructions to administer sliding scale insulin (there was no documentation found to support this). She stated that she did not complete the admission process and did not verify any medications with providers as that is the admitting nurse's responsibility. LVN C reported that the resident continued to have elevated blood glucose levels despite sliding scale insulin administration . She acknowledged that no new physician's orders were obtained during that time and that communication delays occurred, including lack of response from the on-call provider on the weekend . She further stated that the resident declined transfer to the hospital initially; however, blood glucose levels remained elevated, and monitoring continued for her shifts with Resident #2.In an interview on 03/04/2026 at 01:35 pm, RN M stated that the resident's blood glucose levels remained elevated, including readings in the 400-500 mg/dL range, and at times were unreadable on the glucometer . RN M stated that the resident received sliding scale insulin. She reported that despite elevated blood glucose levels, the resident remained at the facility until the decision was made to transfer the resident to the hospital due to frequent high glucose readings. RN M stated she could not recall who initiated the transfer order but confirmed the transfer was related to critically elevated blood glucose levels. She further reported uncertainty regarding whether antibiotics ordered were administered prior to transfer or during residents stay. In an interview conducted on 03/04/2026 at 4:34 PM, the Medical Director from facility stated that medication reconciliation should be completed promptly upon admission. He reported that in urgent situations residents should be immediately evaluated and appropriate orders implemented without delay with providers from the facility. He further stated that PACE providers should be accessible for communication and that if a resident's condition worsens, the resident should be transferred to a higher level of care. In an interview on 03/05/2026 at 10:07 am the RN from PACE regarding the NP on call the weekend the facility called regarding Resident #2's condition, however, there were communication delays, including missed calls and lack of response from facility staff. He stated that follow-up communication was inconsistent, and documentation did not reflect timely provider notification. He stated that the resident's condition continued, resulting in transfer to the hospital and admission to the ICU . Record review of residents care plan and order summary on 03/05/2026 at 10:25am reveled that MDS revised Resident #2's care plans regarding antibiotic therapy, and blood glucose monitoring. In an interview on 03/05/2026 at 12:20 pm MDS stated that Resident #2 was admitted with a skilled level of care and required ongoing monitoring. She stated that MDS assessments and baseline evaluations were completed after admission; however, she acknowledged that medication-related information was primarily managed by the nursing staff. She stated that she did not recall reviewing documentation indicating the resident was receiving antibiotics therapy or glucose monitoring and acknowledged that follow-up on such (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	03/12/2026, the facility conducted mandatory emergency re-education for all licensed nursing staff (45 RNs and LPNs) covering: the requirements of 42 CFR S483.10(g)(14) regarding immediate physician notification when there is a need to alter treatment significantly; the facility's revised Blood Glucose Monitoring Policy with emphasis on immediate notification requirements and documentation; the clinical consequences of uncontrolled hyperglycemia and DKA, including progression to septic shock. The licensed nursing staff and admission staff were notified in a mandatory in-service conducted in person and via phone from 03/11/26-3/12/26. The staff gave verbal and written confirmation they have been educated and understand the new policies and procedures. Ongoing competency checks will be conducted with staff. Staff were informed these policies are readily available to them from the CNO and ACNO. Effective 03/12/26, the facility implemented mandatory monthly continuing education for all nursing staff on high-risk clinical situations requiring immediate physician notification, with rotating topics including: diabetes management and recognition of hypo/hyperglycemia; recognition and management of sepsis and septic shock; fall prevention and post-fall assessment; and pain management and recognition of acute pain requiring intervention. The CNO, ACNO, or VP of Clinical will conduct post competency trainings. Effective 03/12/26, all newly hired nursing staff will receive intensive orientation training on physician notification requirements during their first week of employment, including: review of all relevant policies; observation of experienced nurses performing blood glucose monitoring and physician notifications; supervised practice with blood glucose monitoring and mock physician notifications; and competency testing prior to being assigned independent patient care responsibilities. This will be conducted by the CNO, ACNO, or other nurse manager. Process Improvements: On 03/11/26, the facility implemented a Daily Blood Glucose Monitoring Audit process requiring: CNO, ACNO, or Nurse manager to review all blood glucose monitoring orders each night and generate a list of residents requiring testing; the charge nurse on each shift to verify that blood glucose testing has been completed for all residents on the list during their shift; documentation of the audit completion in a Blood Glucose Monitoring Log with any missed tests immediately reported to the CNO/ACNO; and follow-up with nursing staff who missed ordered blood glucose testing to determine reason and provide re-education as needed. This will continue daily for one month, weekly for 12 weeks, and monthly thereafter. Leadership Oversight and Accountability: Effective 03/12/26, the CNO and ACNO divide responsibility for conducting daily walking rounds on all units to: They will observe one nursing staff per shift performing blood glucose monitoring and verify proper technique; review blood glucose monitoring logs to ensure all ordered testing has been completed; interview nursing staff about any residents with clinical concerns requiring physician notification; and provide immediate feedback and re-education when deficiencies are identified. Effective 03/10/26, the facility will conduct monthly PACE Coordination Meetings with leadership from the local PACE Organization to: review all PACE residents currently in the facility and discuss any clinical concerns; review communication between facility nursing staff and PACE providers to identify any gaps or delays; review any incidents where PACE residents experienced adverse outcomes and identify opportunities for improved care coordination; and strengthen the partnership to ensure seamless care for PACE residents.Monitoring and Evaluation Plan:The facility has implemented a comprehensive monitoring and evaluation plan to ensure the effectiveness of the systemic changes and preventive measures and to identify any additional areas requiring improvement.Daily Monitoring: Effective 03/12/26, the CNO, ACNO, or nurse manager will conduct a daily audit of all blood glucose monitoring performed in the previous 24-hour period by: reviewing the electronic blood glucose log to verify that all residents with blood glucose monitoring orders had testing completed as ordered; verifying that any out-of-parameter results (outside physician-ordered parameters) had documented physician notification; identifying any instances of non-compliance and immediately reporting to the CNO for follow-up and staff re-education; and documenting the audit completion in the Daily Blood Glucose Monitoring Audit Log.Weekly Monitoring: Effective 03/12/26, the CNO will conduct weekly audits for twelve weeks of 10 randomly selected resident charts (at (continued on next page)

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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.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	least 5 residents with diabetes requiring blood glucose monitoring) to assess: compliance with blood glucose monitoring orders; timeliness and completeness of [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that all alleged violations involving injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1of 8 resident (Resident #9) reviewed for Injury of unknown origin. The facility failed to ensure Resident #9 injury of unknown origin was reported to the state agency. This failure could have resulted in protection of residents from further potential harm. In an interview on 03/10/2026 at 02:20 pm the ADON stated that while conducting rounds, Resident #9 was found in bed in an abnormal position, with the head positioned opposite the foot of the bed. The resident had extremely limited mobility at baseline and required assistance with transfers. The ADON stated that the resident had a history of removing their oxygen and was typically on 2-3 liters. Upon assessment, the resident was noted to have temporal swelling. Emergency Medical Services (EMS) were contacted, and the resident was transferred to the hospital for further evaluation. The ADON stated that initial assessment did not reveal open areas or active bleeding; however, hospital evaluation I [NAME] confirmed that the resident sustained a rib fracture and head injury consistent with a fall. The ADON acknowledged that the fall was unwitnessed. The ADON stated that the incident was communicated to the Director of Nursing (DON), that the resident's family member was also notified. He stated that the resident was confused and unable to clearly describe how the fall occurred.In an interview on 03/10/2026 at 02:45 pm the DON stated that she was aware of the incident and that it was discussed during a morning administrative meeting. She stated that there was uncertainty regarding whether the incident should be reported to the state. The DON reported because the fall was unwitnessed, but staff believed they understood how the fall occurred. It was assumed that it was reported by the Administrator since it was reported to him. The DON stated she was just getting used to the process of reporting which is why she let the Administrator know. In an interview on 03/10/2026 at 02:51pm the Administrator stated that reporting decisions were based on whether the cause of the incident was unknown. He stated that if staff believed they knew how an incident occurred, it may not be considered reportable. The Administrator acknowledged that the resident sustained a fracture following the incident but that reporting was not completed because staff believed the cause of the fall was understood. He further acknowledged that he did not personally interview the resident regarding the incident and relied on information provided to him by staff. The Administrator stated the ADON spoke to the resident when assessing him for the fall and the resident was able to tell him exactly how he fell, which was why he did not report it. Record review of facility policy Abuse & Neglect dated October 2022, revision date April 2025, revealed The administrator/designee ensure that all alleged or suspected violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are investigated and reported immediately to the state agency complaint hotline. Investigations of injuries of unknown origin or suspicious injuries must be immediately investigated to rule out abuse.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provided needed care and services that are centered in accordance with residents preferences, goals for care and professional standards of practice that meet each residents physical, mental, and psychosocial needs for 1 (Resident #2) of 10 residents. The facility failed to assess Resident #2 prior to admission and failed to identify and implement physician orders related to antibiotic therapy and blood glucose management for readings outside established parameters which resulted in hospitalization with diagnoses of DKA and sepsis. An Immediate Jeopardy (IJ) situation was identified on 03/12/2026. While the IJ was removed on 03/13/2026, the facility remained out of compliance at the scope of isolation with the potential for more than minimal harm , due to the facility's need to evaluate the effectiveness of their corrective systems. This failure could have resulted in serious deterioration of the residents health, including infection progression, unstable blood glucose levels, and life-threatening complications. Findings included:Record review of Resident #2's face sheet dated 03/11/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included Vesicointestinal Fistula (abnormal connection between the bladder and the bowel), hypertension (High blood pressure), type 2 diabetes mellitus with hyperglycemia (diabetes with blood sugar elevation), Alzheimer's Diseases with early onset (form of dementia). Record review of Resident #2's MDS dated [DATE], reflected a BIMS score of 14, indicating the resident was cognitively intact. Record review of Resident #2's Order Summary Report dated 03/11/2026 revealed Glucose Monitoring-notify provider if <60 or >400 before meals and at bedtime for diabetes. Record review of Resident #2's admitting physician orders dated 02/25/26 revealed: -Semglee (Insulin Glargine) 23 units subcutaneously at bedtime daily -NovoLOG FlexPen (insulin aspart) for blood glucose management [70-160: 0 units;161-200: 4 units; 201-250: 6 units; 251-300: 8 units; 301-349: 10 units; 350-400: 12 units (call MD)]. -FreeStyle Libre 2 CGM (continuous glucose monitoring) sensor apply subcutaneously in the morning every 14 days. -Blood glucose monitoring before meals and at bedtime with notification to provider if <60 or >400.Record review of Resident #2' MAR from 02/25/2026 through 03/02/2026 showed no evidence of transcribed antibiotic orders and no doses were administered during this period.Record review of Resident #2's notes revealed on 02/26/2026 at 12:33pm, Resident #2'sblood glucose was documented as 512 mg/dL; at 12:36pm. No evidence of resident's record physician was notified. On 02/27/2026 at 1:04pm, blood glucose was documented as 482 mg/dL. No evidence of resident's record physician was notified. On 03/01/2026 at 11:08 am, blood glucose was documented as 459 mg/dL. No evidence of resident's record physician was notified. On 03/02/2026 at 6:49am, blood glucose was documented at 492 mg/dL. No evidence of resident's record physician was notified.Record review of the Resident #2's medication administration record and blood glucose logs revealed no evidence of documented nighttime blood glucose checks. Record review of Resident #2's MAR revealed FreeStyle Libre 2 CGM sensor was applied to Resident #2's on 2/26/2026 at 9:00 am.Record review of Resident #2's Care Plan dated 03/11/2026, for blood glucose monitoring revealed, focus The resident is receiving insulin active med list in EMR with a goal, Blood Glucose levels will be withing normal limits and interventions Blood glucose monitoring as per physician order, hypo/Hyperglycemia (high blood sugar/ low blood sugar) protocol per physician orders, Monitor/Document/report as needed for following adverse effects of insulin therapy: Hypoglycemia, weight gain, hypokalemia (low blood potassium levels), pain at injection site. For antibiotics the focus revealed The resident is receiving antibiotic therapy. (see active med list in EMR) with a goal The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date And interventions Monitor/document/report PRN adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat), report labs results to MD. Review of local hospital (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Emergency Department Note on 03/02/3036, revealed Resident #2's chief complaint was elevated blood glucose levels of approximately 400 mg/dL 400 mg/dL. Resident #2 was administered Lispro 22 units by EMS in route from nursing facility to hospital. After Lispro administration, Resident #2's blood glucose level in route was 23 mg/dL. Resident #2's blood glucose level in the ED on 3/2/2026 at 9:35am revealed 249 mg/dL. Resident's WBC was 14.6. Resident was admitted to hospital for 10 days due to DKA (diabetic ketoacidosis) and septic shock. Resident was admitted to ICU due to critical condition.In an interview on 03/03/2026 at 12:39 pm the Admissions Coordinator stated she had been employed at the facility for 6 months. The Admissions Coordinator stated that the facility utilizes an electronic system (Exacare) which pulled all the medication orders from the hospitals and then the admitting nurse enters it into PCC (electronic records) . For residents with PACE services there are certain communication failures regarding medication orders. PACE either emails, fax, or provided orders verbally. She reported that PACE communication may be limited on weekends since they were closed on the weekends, and that emails and order processing may not occur consistently during that time . She stated that medication orders are typically directed to nursing staff, and that the primary orders received were admission orders or discharge-related orders.In an interview on 03/03/2026 at 02:02 pm RN V from PACE stated Resident #2 underwent surgery for colostomy placement and was admitted to the facility on [DATE] following hospitalization. RN V stated that the facility failed to administer two prescribed antibiotics (Ciprofloxacin 500 mg and Metronidazole [Flagyl] 500 mg), which were ordered prophylactically upon admission. RN V reported that these medications were not administered as ordered . RN V further stated that the resident had four blood glucose readings outside of ordered parameters without physician notification . Additionally, the facility failed to obtain blood glucose readings at night as ordered and did not implement the resident's continuous glucose monitoring system. RN V stated that physician's orders from PACE were sent; however, the physician was not notified of missed medications or abnormal blood glucose levels . RN V indicated that nursing staff were responsible for reviewing and implementing hospital orders and medication administration records (MARs) upon admission. In an interview on 03/03/2026 at 03:36 PM, the ADON stated he had been employed with the facility since January 1st, 2026. The ADON stated that he and the DON are responsible for overseeing the medication reconciliation processes. He reported that corporate support was available when medications were not accessible, including determining alternative medications or treatment options. The ADON acknowledged that medication pass audits had not been completed by him and stated he could not speak to whether the DON had completed such audits. He indicated that nursing staff received training upon hire and were provided with additional education or corrective action when errors occur. The ADON further acknowledged communication challenges between the facility and external providers, including PACE, that there was a lack of consistent communication and coordination of care. He stated the admitting nurses were responsible for entering physician's orders into the system at the time of admission. He acknowledged that there have been prior difficulties with the process and described the system as not fully aligned with external providers. In an interview on 03/03/2026 at 04:28 pm, the DON stated medication administration was monitored through and electronic reporting systems (PCC), including medication administration reports, order listing reports, and non-administered medication reports. The DON stated that audits of medication administration were conducted periodically, typically every three weeks to monthly, rather than daily. The DON acknowledged that there was no consistent daily process to review medications for accuracy or completeness. She stated that medication pass audits were completed intermittently and that staff training was provided during meetings or when issues were identified. She further stated that nursing staff were expected to communicate changes in resident conditions to physicians and include leadership in communication; however, the process was still being implemented and was not consistently followed. The DON reported ongoing communication challenges with external providers, including PACE, that the facility relies on receiving orders but does not consistently have direct communication with providers. She stated that orders were (continued on next page)

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In an interview on 03/04/2026 at 11:00 am, the NP from PACE stated she was not notified that Resident #2 did not receive her antibiotic medication as ordered as well as her blood glucose monitoring sensor. She stated that the lack of notification created potential for harm, including infection and hospitalization related to uncontrolled blood glucose levels. The NP reported that upon review following the resident's hospital discharge, orders had been provided for antibiotics, probiotics, insulin, and other routine medications; however, they were not implemented as ordered by the facility. She stated that there were no recent changes made to these medications that would explain the omissions. The NP further stated ongoing concerns with communication, that failure to notify providers of missed medications and changes in condition has been a recurring issue with this facility. The NP stated that the residents subsequently developed worsening conditions, including infection, skin breakdown, and eventual sepsis ,(life threatening condition that arises when the body's response to an infection injures its own tissues and organs) requiring hospitalization. The NP stated that the resident had not previously experienced that level of decline and attributed the deterioration (DKA and sepsis) , in part, to missed medications and lack of timely intervention.In an interview with 03/04/2026 at 11:18 am the RN from PACE stated that he was notified of elevated blood glucose levels on 02/27/2026. The RN stated that after notification, additional sliding scale insulin coverage was ordered . He further stated that long-acting insulin (Lantus) had been part of the resident's prior medication regimen and should have continued without interruption. The RN stated that communication occurred with facility staff LVN C regarding elevated blood glucose levels and instructions were given to administer sliding scale insulin, including an additional 12 units, and to closely monitor the resident's condition. He stated that LVN C/facility staff were instructed to notify the provider of any changes. The RN stated that on 03/01/2026, the on-call provider from PACE was contacted regarding elevated blood glucose levels; however, there was no documentation available to confirm blood glucose values or provider notification at that time. The facility additionally reported elevated blood glucose readings on 03/02/2026, with continued concerns for lack of documentation and delayed communication . The RN stated that he was notified again early in the morning on 03/02/2026 regarding persistently elevated blood glucose levels, prompting further evaluation by the RN and NP from PACE, who were at the facility to see Resident #2 In an interview on 03/04/2026 at 01:00PM LVN C stated that she had been employed at the facility for approximately one year and received training on medication administration and vital signs monitoring. She stated that PACE physician's orders were typically received via fax and entered into the system; however, she reported that there may be delays in processing orders, particularly during admissions. LVN C stated that during Resident #2's admission, medication orders from PACE required review and verification before implementation. She reported that some medications, including long-acting insulin (Lantus), were not immediately available or did not appear on the medication administration record (MAR), resulting in delays in administration. She further stated that she contacted the external provider (PACE) multiple times regarding elevated blood glucose levels and received instructions to administer sliding scale insulin (there was no documentation found to support this). She stated that she did not complete the admission process and did not verify any medications with providers as that is the admitting nurse's responsibility. LVN C reported that the resident continued to have elevated blood glucose levels despite sliding scale insulin administration . She acknowledged that no new physician's orders were (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	before nor was she ever trained on administering it. In an interview on 03/05/2026 at 03:24 pm the DON stated that while the facility had the capability to utilize Libre devices, implementation depends on availability of supplies and physician's orders . The DON acknowledged that there was not consistent system to ensure the device was in place or functioning upon admission. She further stated the monitoring processes were not consistently verified daily and rely on periodic oversight. The DON acknowledged that medication reconciliation was not completed for Resident #2 upon admission and could not confirm whether all physician's orders, including antibiotics and glucose monitoring, were implemented. She reported that communication gaps exist between the facility and external providers and that corrective actions were typically taken after issues are identified rather than proactively.In an interview on 03/05/2026 at 03:35 pm the NP from PACE stated that antibiotics had been ordered prophylactically to prevent infection and that failure to administer these medications contributed to the resident developing sepsis. She stated that the resident also required insulin management and should have received appropriate treatment upon admission. The NP stated that the resident's condition declined due to lack of treatment, including failure to administer the insulin sensor and antibiotics , and that earlier intervention could have prevented the progression to sepsis. She further stated that the resident required transfer to the hospital for a higher level care, including management of infection and uncontrolled blood glucose. In an interview on 03/05/2026 at 04:02 pm the Medical Director from PACE stated that Resident #2was discharged from the hospital with orders for FreeStyle monitoring device and antibiotics ; however, the medications were not administered at the facility. She stated that the resident required readmission due to failure to implement the orders. The Medical Director stated that the facility failed to notify providers of missed medications, and that appropriate communication could have prevented the resident's deterioration. She stated that the resident's hospitalization for sepsis could have been prevented if ordered antibiotics had been administered as prescribed. Interview on 03/05/2026 at 04:45 pm with Resident #2 revealed the resident was alert and oriented. The resident stated that staff checked her blood sugar using facility equipment where they would poke her finger. The resident further reported that she was unaware that prescribed medications were not being administered .In an interview on 03/05/2026 at 05:00 pm the hospital RN stated that upon admission to the hospital, Resident #2 presented with hyperglycemia and urinary tract infection. The resident required initiation of sepsis protocol and was treated with intravenous antibiotics (Zosyn) and insulin therapy. The RN reported that laboratory findings included significantly elevated white blood cell count (28.3) and confirmed infection, including E. coli and yeast identified in cultures. The resident required intensive treatment, including insulin drip and management of diabetic ketoacidosis (DKA). In an interview on 03/06/2026 at 03:06 pm the ADON stated that he was responsible for tracking new admissions and following up with nursing staff regarding admission processes. He acknowledged that current issues were related to prior system failures and that processes were not fully implemented at the time of Resident #2's admission. The ADON stated that staff training regarding the use of continuous glucose monitoring devices (Libre Freestyle) was not consistently completed. He stated that only limited staff had received training and could not confirm which staff were competent in use of the device. He acknowledged that the nurse assigned to Resident #2 had not been trained to use the Libre device and that it was not implemented. The ADON further stated that admission assessments were not consistently completed prior to residents arriving at the facility. He stated that in some cases, the facility received notification that a resident arrived without prior to review of medical records. He acknowledged that no baseline blood glucose assessment was completed upon admission for Resident #2. The ADON stated that the facility does not have a standardized process to ensure monitoring or use of continuous glucose monitoring systems and confirmed that there was none established policy guiding the use of such devices and also confirmed that they do not carry any supplies of the Libre at the facility. In an interview on 03/06/2026 at 03:53 pm the DON stated that not all admissions were reviewed or receive a pre-admission assessment. She stated that review of (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	hospital records was not consistently required for every admission and may only occur if additional clinical concerns are identified . The DON acknowledged that nursing staff were not consistently instructed to review hospital documentation prior to implementing care. She reported that corporate staff review referrals and approve admissions; however, facility-level review processes are not standardized. The DON further stated that admission documentation, including blood glucose monitoring for diabetic residents, should be completed; however, she could not confirm that this was done for Resident #2. She acknowledged that medication reconciliation is often dependent on timing and communication with on-call providers rather than a consistent internal process. Record review of the facility's policy titled Physician Orders dated November 2018, revised 01/2026 revealed To clarify requirements and ensure that all physician orders are valid and safe for patient care. Documentation of the physician order in the progress notes is sufficient.Record review of the facility's policy titled Blood Glucose Monitoring dated November 2020, revised 01/2026 revealed To ensure blood glucose monitoring is completed per provider orders and in accordance with all state and federal regulations. Each physician order for bedside blood glucose testing will include physician notification parameters and hypoglycemic medication holding parameters as applicable. If the resident's glucose result is outside the physician ordered parameters, follow physician orders for notification and/or medication holding. If the resident has a diagnosis of hyperglycemia (diabetes mellitus or insipidus), insulin will be administered only upon the order of a physician. At no time will nursing staff administer insulin as a nursing judgment. This was determined to be an Immediate Jeopardy (IJ) on 03/12/2026 at 03:28 PM. The Administrator was informed of the IJ. The Administrator was provided with the IJ template on 03/12/2026 at 3:52 PM. The following Plan of Removal submitted by the facility was accepted on 03/13/2026 at 05:00 PM: The facility is committed to ensuring the safety and well-being of all Residents and operates in substantial compliance with Federal and State laws and regulations. This removal plan constitutes Note's written credible allegation of compliance for the immediate jeopardy noted.It is the facility's policy to immediately inform the resident, consult with the resident's physician, and notify the resident representative(s) when there is a need to alter treatment significantly, including the need to discontinue an existing form of treatment due to adverse consequences or commence a new form of treatment, or when there is a significant change in the resident's physical, mental, or psychosocial status, in accordance with 42 CFR S483.10(g)(14). Additionally, it is the facility's policy to ensure that physician orders are documented completely with sufficient content to clearly convey the provider's intent, and that orders that are unclear must be clarified prior to implementation. The facility is further committed to ensuring that blood glucose monitoring is performed as ordered, and that physicians are notified immediately when glucose results are outside ordered parameters.Immediate Action for Affected Residents:On 03/03/26, the facility identified Resident #2 as the affected resident in this citation. The following immediate actions have been taken. The licensed nursing staff and admission staff were notified in a mandatory in-service conducted in person and via phone from 03/05/26-3/12/26. The staff gave verbal and written confirmation they have been educated and understand the new policies and procedures. Ongoing competency checks will be conducted with staff. Staff were informed these policies are readily available to them from the CNO and ACNO . New hires will go through training and written competencies upon hire. On 03/03/26, the facility Administrator and Director of Nursing (DON) reviewed Resident #2's current hospitalization status and confirmed with the hospital that Resident #2 was admitted to the ICU on 03/02/26 for diabetic ketoacidosis (happens when you have a lack of insulin in your body. It's a life-threatening complication of diabetes) and septic shock and is receiving appropriate medical treatment. The resident did not return to the facility. On 03/11/26, the facility conducted nurses meetings with all nursing staff who provided care to Resident #2 between 02/25/26 and 03/02/26 to review the specific failures in this case, including: failure to obtain daily bedtime blood glucose readings as ordered; failure to notify the physician of four blood glucose levels exceeding 400 mg/dl; failure to administer the continuous glucose monitoring device; and failure to (continued on next page)

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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	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	communicate with the physician regarding unavailable supplies. From 03/11/26-3/12/2026, the CNO and ACNO conducted mandatory re-education for all licensed nursing staff (RNs and LPNs) this in-service was conducted both in person and via phone/virtually for staff who were unable to be onsite. Staff confirmed verbal understanding of the policy and procedure. The staff were made aware that policies could be given at that time of any time from the Administrator, CNO, or ACNO. The training covered the facility's Blood Glucose Monitoring Policy and Physician Notification requirements, specifically emphasizing: the requirement to obtain blood glucose readings exactly as ordered by the physician; the requirement to immediately notify the physician when results fall outside ordered parameters; the requirement to notify the physician/CNO/ACNO immediately when ordered supplies or equipment are not available; and the requirement to clarify unclear or unable-to-implement orders prior to implementation. On 03/11/26, the facility established a communication protocol with the local PACE Organization requiring that the facility's nursing staff contact PACE providers immediately for all clinical concerns, significant changes in condition, out-of-parameter laboratory/glucose values, and any inability to implement physician orders due to unavailable supplies or unclear orders. An in-service was conducted with RNs and LVNs both in person and via phone/virtually for staff who were unable to be onsite. Staff confirmed verbal understanding of the policy and procedure. The staff were made aware that policies could be given at that time of any time from the Administrator, CNO, or ACNO. On 03/11/26, the facility implemented a redundant notification system requiring that when any blood glucose result is outside physician-ordered parameters, the nurse must: immediately notify the physician/PACE provider and document the date, time, person contacted, and response received. An in-service was conducted with RNs and LVNs both in person and via phone/virtually f staff who were unable to be onsite. Staff confirmed verbal understanding of the policy and procedure. The staff were made aware that policies could be given at that time or any time from the Administrator, CNO, or ACNO.Identifying Other Residents at Risk:On 03/11/26 through 03/12/26, the facility conducted a comprehensive review to identify all other residents who may be at risk for similar failures in physician notification, blood glucose monitoring, or implementation of physician orders. On 03/12/26, the CNO and ACNO conducted a review of all current residents (census of 49 residents) to identify those with physician orders for blood glucose monitoring. This review identified 15 residents with active blood glucose monitoring orders. On 03/12/26, the DON, ADON, and VP of Operations conducted a comprehensive chart audit of all 15 residents with blood glucose monitoring orders to assess: whether blood glucose monitoring was performed as ordered; whether any blood glucose results fell outside physician-ordered parameters; and whether appropriate and timely physician notification was documented when results were out of parameters. 6 Issues identified and were reported to the physician and clarification of new orders needed were given. Continued monitoring will occur by CNO, ACNO, or nurse manager for daily monitoring. On 03/12/26, the facility conducted a review of all current residents (census of 49 residents) to identify those with physician orders that include continuous monitoring devices or specialized medical equipment. This review identified 15 residents with such orders (including insulin pumps, continuous glucose monitors, cardiac monitors, and oxygen concentrators). No issues identified. On 03/12/26, the CNO and ACNO conducted a physical verification to confirm that all 15 residents had the ordered devices/equipment in place and functioning as ordered. All devices/equipment were confirmed to be present an

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents are free of any significant mediation errors for 1 (Resident #2) of 3 residents reviewed for medication administration errors.The facility failed to assess Resident #2 prior to admission and failed to identify and implement physician orders related to antibiotic therapy and blood glucose management for readings outside established parameters. An Immediate Jeopardy (IJ) situation was identified on 03/12/2026. While the IJ was removed on 03/13/2026, the facility remained out of compliance at the scope of isolation with the potential for more than minimal harm , due to the facility's need to evaluate the effectiveness of their corrective systems. This failure could have resulted in serious deterioration of the residents health, including infection progression, unstable blood glucose levels, and life-threatening complications. Findings included:Record review of Resident #2's face sheet dated 03/11/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included Vesicointestinal Fistula (abnormal connection between the bladder and the bowel), hypertension (High blood pressure), type 2 diabetes mellitus with hyperglycemia (diabetes with blood sugar elevation), Alzheimer's Diseases with early onset (form of dementia). Record review of Resident #2's MDS dated [DATE], reflected a BIMS score of 14, indicating the resident was cognitively intact. Record review of Resident #2's Order Summary Report dated 03/11/2026 revealed Glucose Monitoring-notify provider if <60 or >400 before meals and at bedtime for diabetes. Record review of Resident #2's admitting physician orders dated 02/25/26 revealed: -Semglee (Insulin Glargine) 23 units subcutaneously at bedtime daily -NovoLOG FlexPen (insulin aspart) for blood glucose management [70-160: 0 units;161-200: 4 units; 201-250: 6 units; 251-300: 8 units; 301-349: 10 units; 350-400: 12 units (call MD)]. -FreeStyle Libre 2 CGM (continuous glucose monitoring) sensor apply subcutaneously in the morning every 14 days. -Blood glucose monitoring before meals and at bedtime with notification to provider if <60 or >400.Record review of Resident #2' MAR from 02/25/2026 through 03/02/2026 showed no evidence of transcribed antibiotic orders and no doses were administered during this period.Record review of Resident #2's notes revealed on 02/26/2026 at 12:33pm, Resident #2'sblood glucose was documented as 512 mg/dL; at 12:36pm. No evidence of resident's record physician was notified. On 02/27/2026 at 1:04pm, blood glucose was documented as 482 mg/dL. No evidence of resident's record physician was notified. On 03/01/2026 at 11:08 am, blood glucose was documented as 459 mg/dL. No evidence of resident's record physician was notified. On 03/02/2026 at 6:49am, blood glucose was documented at 492 mg/dL. No evidence of resident's record physician was notified.Record review of the Resident #2's medication administration record and blood glucose logs revealed no evidence of documented nighttime blood glucose checks. Record review of Resident #2's Care Plan dated 03/11/2026, for blood glucose monitoring revealed, focus The resident is receiving insulin active med list in EMR with a goal, Blood Glucose levels will be withing normal limits and interventions Blood glucose monitoring as per physician order, hypo/Hyperglycemia (high blood sugar/ low blood sugar) protocol per physician orders, Monitor/Document/report as needed for following adverse effects of insulin therapy: Hypoglycemia, weight gain, hypokalemia (low blood potassium levels), pain at injection site. For antibiotics the focus revealed The resident is receiving antibiotic therapy. (see active med list in EMR) with a goal The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date And interventions Monitor/document/report PRN adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat), report labs results to MD. Review of local hospital Emergency Department Note on 03/02/3036, revealed Resident #2's chief complaint was elevated blood glucose levels of approximately 400 mg/dL 400 mg/dL. Resident #2 was administered Lispro 22 units by EMS in route from nursing facility to hospital. After Lispro administration, Resident #2's blood glucose level in (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	route was 23 mg/dL. Resident #2's blood glucose level in the ED on 3/2/2026 at 9:35am revealed 249 mg/dL. Resident's WBC was 14.6. Resident was admitted to hospital for 10 days due to DKA (diabetic ketoacidosis) and septic shock. Resident was admitted to ICU due to critical condition.In an interview on 03/03/2026 at 12:39 pm the Admissions Coordinator stated she had been employed at the facility for 6 months. The Admissions Coordinator stated that the facility utilizes an electronic system (Exacare) which pulled all the medication orders from the hospitals and then the admitting nurse enters it into PCC (electronic records) . For residents with PACE services there are certain communication failures regarding medication orders. PACE either emails, fax, or provided orders verbally. She reported that PACE communication may be limited on weekends since they were closed on the weekends, and that emails and order processing may not occur consistently during that time . She stated that medication orders are typically directed to nursing staff, and that the primary orders received were admission orders or discharge-related orders.In an interview on 03/03/2026 at 02:02 pm RN V from PACE stated Resident #2 underwent surgery for colostomy placement and was admitted to the facility on [DATE] following hospitalization. RN V stated that the facility failed to administer two prescribed antibiotics (Ciprofloxacin 500 mg and Metronidazole [Flagyl] 500 mg), which were ordered prophylactically upon admission. RN V reported that these medications were not administered as ordered . RN V further stated that the resident had four blood glucose readings outside of ordered parameters without physician notification . Additionally, the facility failed to obtain blood glucose readings at night as ordered and did not implement the resident's continuous glucose monitoring system. RN V stated that physician's orders from PACE were sent; however, the physician was not notified of missed medications or abnormal blood glucose levels . RN V indicated that nursing staff were responsible for reviewing and implementing hospital orders and medication administration records (MARs) upon admission. In an interview on 03/03/2026 at 03:36 PM, the ADON stated he had been employed with the facility since January 1st, 2026. The ADON stated that he and the DON are responsible for overseeing the medication reconciliation processes. He reported that corporate support was available when medications were not accessible, including determining alternative medications or treatment options. The ADON acknowledged that medication pass audits had not been completed by him and stated he could not speak to whether the DON had completed such audits. He indicated that nursing staff received training upon hire and were provided with additional education or corrective action when errors occur. The ADON further acknowledged communication challenges between the facility and external providers, including PACE, that there was a lack of consistent communication and coordination of care. He stated the admitting nurses were responsible for entering physician's orders into the system at the time of admission. He acknowledged that there have been prior difficulties with the process and described the system as not fully aligned with external providers. In an interview on 03/03/2026 at 04:28 pm, the DON stated medication administration was monitored through and electronic reporting systems (PCC), including medication administration reports, order listing reports, and non-administered medication reports. The DON stated that audits of medication administration were conducted periodically, typically every three weeks to monthly, rather than daily. The DON acknowledged that there was no consistent daily process to review medications for accuracy or completeness. She stated that medication pass audits were completed intermittently and that staff training was provided during meetings or when issues were identified. She further stated that nursing staff were expected to communicate changes in resident conditions to physicians and include leadership in communication; however, the process was still being implemented and was not consistently followed. The DON reported ongoing communication challenges with external providers, including PACE, that the facility relies on receiving orders but does not consistently have direct communication with providers. She stated that orders were expected to be entered by the admitting nurses and that a communication board within PCC is used to relay updates between shifts. The DON further acknowledged that in situations where medications were not available, staff may not consistently notify the physician and instead rely on external systems or processes to obtain (continued on next page)

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She stated that the lack of notification created potential for harm, including infection and hospitalization related to uncontrolled blood glucose levels. The NP reported that upon review following the resident's hospital discharge, orders had been provided for antibiotics, probiotics, insulin, and other routine medications; however, they were not implemented as ordered by the facility. She stated that there were no recent changes made to these medications that would explain the omissions. The NP further stated ongoing concerns with communication, that failure to notify providers of missed medications and changes in condition has been a recurring issue with this facility. The NP stated that the residents subsequently developed worsening conditions, including infection, skin breakdown, and eventual sepsis ,(life threatening condition that arises when the body's response to an infection injures its own tissues and organs) requiring hospitalization. The NP stated that the resident had not previously experienced that level of decline and attributed the deterioration (DKA and sepsis) , in part, to missed medications and lack of timely intervention.In an interview with 03/04/2026 at 11:18 am the RN from PACE stated that he was notified of elevated blood glucose levels on 02/27/2026. The RN stated that after notification, additional sliding scale insulin coverage was ordered . He further stated that long-acting insulin (Lantus) had been part of the resident's prior medication regimen and should have continued without interruption. The RN stated that communication occurred with facility staff LVN C regarding elevated blood glucose levels and instructions were given to administer sliding scale insulin, including an additional 12 units, and to closely monitor the resident's condition. He stated that LVN C/facility staff were instructed to notify the provider of any changes. The RN stated that on 03/01/2026, the on-call provider from PACE was contacted regarding elevated blood glucose levels; however, there was no documentation available to confirm blood glucose values or provider notification at that time. The facility additionally reported elevated blood glucose readings on 03/02/2026, with continued concerns for lack of documentation and delayed communication . The RN stated that he was notified again early in the morning on 03/02/2026 regarding persistently elevated blood glucose levels, prompting further evaluation by the RN and NP from PACE, who were at the facility to see Resident #2 In an interview on 03/04/2026 at 01:00PM LVN C stated that she had been employed at the facility for approximately one year and received training on medication administration and vital signs monitoring. She stated that PACE physician's orders were typically received via fax and entered into the system; however, she reported that there may be delays in processing orders, particularly during admissions. LVN C stated that during Resident #2's admission, medication orders from PACE required review and verification before implementation. She reported that some medications, including long-acting insulin (Lantus), were not immediately available or did not appear on the medication administration record (MAR), resulting in delays in administration. She further stated that she contacted the external provider (PACE) multiple times regarding elevated blood glucose levels and received instructions to administer sliding scale insulin (there was no documentation found to support this). She stated that she did not complete the admission process and did not verify any medications with providers as that is the admitting nurse's responsibility. LVN C reported that the resident continued to have elevated blood glucose levels despite sliding scale insulin administration . She acknowledged that no new physician's orders were obtained during that time and that communication delays occurred, including lack of response from the on-call provider on the weekend . She further stated that the resident declined transfer to the hospital initially; however, blood glucose levels remained elevated, and monitoring continued for her (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	committed to ensuring the safety and well-being of all Residents and operates in substantial compliance with Federal and State laws and regulations. This removal plan constitutes Note's written credible allegation of compliance for the immediate jeopardy noted.It is the facility's policy to immediately inform the resident, consult with the resident's physician, and notify the resident representative(s) when there is a need to alter treatment significantly, including the need to discontinue an existing form of treatment due to adverse consequences or commence a new form of treatment, or when there is a significant change in the resident's physical, mental, or psychosocial status, in accordance with 42 CFR S483.10(g)(14). Additionally, it is the facility's policy to ensure that physician orders are documented completely with sufficient content to clearly convey the provider's intent, and that orders that are unclear must be clarified prior to implementation. The facility is further committed to ensuring that blood glucose monitoring is performed as ordered, and that physicians are notified immediately when glucose results are outside ordered parameters.Immediate Action for Affected Residents:On 03/03/26, the facility identified Resident #2 as the affected resident in this citation. The following immediate actions have been taken. The licensed nursing staff and admission staff were notified in a mandatory in-service conducted in person and via phone from 03/05/26-3/12/26. The staff gave verbal and written confirmation they have been educated and understand the new policies and procedures. Ongoing competency checks will be conducted with staff. Staff were informed these policies are readily available to them from the CNO and ACNO . New hires will go through training and written competencies upon hire. On 03/03/26, the facility Administrator and Director of Nursing (DON) reviewed Resident #2's current hospitalization status and confirmed with the hospital that Resident #2 was admitted to the ICU on 03/02/26 for diabetic ketoacidosis (happens when you have a lack of insulin in your body. It's a life-threatening complication of diabetes) and septic shock and is receiving appropriate medical treatment. The resident did not return to the facility. On 03/11/26, the facility conducted nurses meetings with all nursing staff who provided care to Resident #2 between 02/25/26 and 03/02/26 to review the specific failures in this case, including: failure to obtain daily bedtime blood glucose readings as ordered; failure to notify the physician of four blood glucose levels exceeding 400 mg/dl; failure to administer the continuous glucose monitoring device; and failure to communicate with the physician regarding unavailable supplies. From 03/11/26-3/12/2026, the CNO and ACNO conducted mandatory re-education for all licensed nursing staff (RNs and LPNs) this in-service was conducted both in person and via phone/virtually for staff who were unable to be onsite. Staff confirmed verbal understanding of the policy and procedure. The staff were made aware that policies could be given at that time of any time from the Administrator, CNO, or ACNO. The training covered the facility's Blood Glucose Monitoring Policy and Physician Notification requirements, specifically emphasizing: the requirement to obtain blood glucose readings exactly as ordered by the physician; the requirement to immediately notify the physician when results fall outside ordered parameters; the requirement to notify the physician/CNO/ACNO immediately when ordered supplies or equipment are not available; and the requirement to clarify unclear or unable-to-implement orders prior to implementation. On 03/11/26, the facility established a communication protocol with the local PACE Organization requiring that the facility's nursing staff contact PACE providers immediately for all clinical concerns, significant changes in condition, out-of-parameter laboratory/glucose values, and any inability to implement physician orders due to unavailable supplies or unclear orders. An in-service was conducted with RNs and LVNs both in person and via phone/virtually for staff who were unable to be onsite. Staff confirmed verbal understanding of the policy and procedure. The staff were made aware that policies could be given at that time of any time from the Administrator, CNO, or ACNO. On 03/11/26, the facility implemented a redundant notification system requiring that when any blood glucose result is outside physician-ordered parameters, the nurse must: immediately notify the physician/PACE provider and document the date, time, person contacted, and response received. An in-service was conducted with RNs and LVNs both in person and via phone/virtually f staff who were (continued on next page)

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 03/13/2026

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	unable to be onsite. Staff confirmed verbal understanding of the policy and procedure. The staff were made aware that policies could be given at that time or any time from the Administrator, CNO, or ACNO.Identifying Other Residents at Risk:On 03/11/26 through 03/12/26, the facility conducted a comprehensive review to identify all other residents who may be at risk for similar failures in physician notification, blood glucose monitoring, or implementation of physician orders. On 03/12/26, the CNO and ACNO conducted a review of all current residents (census of 49 residents) to identify those with physician orders for blood glucose monitoring. This review identified 15 residents with active blood glucose monitoring orders. On 03/12/26, the DON, ADON, and VP of Operations conducted a comprehensive chart audit of all 15 residents with blood glucose monitoring orders to assess: whether blood glucose monitoring was performed as ordered; whether any blood glucose results fell outside physician-ordered parameters; and whether appropriate and timely physician notification was documented when results were out of parameters. 6 Issues identified and were reported to the physician and clarification of new orders needed were given. Continued monitoring will occur by CNO, ACNO, or nurse manager for daily monitoring. On 03/12/26, the facility conducted a review of all current residents (census of 49 residents) to identify those with physician orders that include continuous monitoring devices or specialized medical equipment. This review identified 15 residents with such orders (including insulin pumps, continuous glucose monitors, cardiac monitors, and oxygen concentrators). No issues identified.Root Cause Analysis:On 03/05/26 through 03/12/26, the facility conducted a comprehensive Root Cause Analysis (RCA) consisting of the Administrator, CNO, ACNO, VP of Clinical, and VP of Operations to determine the underlying factors that led to the immediate jeopardy situation involving Resident #2.On 03/05/26 through 03/12/26, the RCA team conducted individual interviews with the following staff members: Three additional nursing staff who provided care to Resident #2 during the dates in question The CNO and ACNOFishbone Diagram Key Findings:People: Staff lacked clarity on the specific process for notifying PACE providers versus the facility Medical Director; staff did not understand the criticality of obtaining bedtime blood glucose readings for residents with uncontrolled diabetes and DKA; staff did not recognize that failure to administer an ordered continuous glucose monitoring device due to unavailable supplies required immediate physician notification and order clarification.Process: The facility lacked a standardized process for immediate physician notification when blood glucose results exceeded parameters; the facility lacked a redundant safety check system to ensure blood glucose monitoring was completed as ordered; the admission process did not include verification that all ordered supplies and equipment were available prior to accepting the resident; there was no escalation process when nursing staff were unable to implement physician orders due to unavailable supplies.Environment: There was confusion among nursing staff regarding the scope of responsibility for PACE residents versus non-PACE residents; the facility culture did not emphasize the critical importance of immediate escalation when physician orders could not be implemented.Management: The CNO and ACNO did not have a system in place to audit compliance with blood glucose monitoring orders; there was insufficient oversight of the admission process to ensure all necessary supplies and equipment were available; the facility leadership did not provide adequate education and reinforcement regarding the physician notification requirements under 42 CFR S483.10(g)(14).Root Cause Summary:The RCA team identified the following root causes on 03/12/26:1. The facility lacked a comprehensive, redundant system to ensure physician notification occurred immediately when blood glucose

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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. 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 2 of 7 residents (Resident #10 and Resident #11) reviewed for infection control.The facility failed to ensure RN M performed hand hygiene and/or used PPE while conducting a blood glucose check.The facility failed to ensure LVN R properly discarded of used lancet after use. This failure could place residents at risk for cross contamination and the spread of infection. Findings included: In an Observation on 03/08/2026 at 11:36am revealed LVN R prepared to perform a blood glucose check before lunch for Resident #11. LVN R prepared all his materials for the blood glucose test and entered the resident's room, performed the blood glucose test and read the numbers to the resident. LVN R exited the room and walked to his med cart. He then inputted Observation of the resident's blood glucose level revealed a reading 103 which indicated no insulin to be administered. It was observed that LVN R folded his bilateral (both hands) gloves inwards, removing them from his hands while having the used lancet (finger needle used for blood sugar check on resident) inside the gloves, balled up. When asked what proper disposal method was indicated for that type of sharp, he stated, Since lancets retract, I throw it in the trash. The glucometer was not disinfected; nor did LVN R perform proper hand hygiene after completing the blood sugar check with the resident. In an interview and observation on 03/08/2026 at 11:47am RN M stated this was her first nursing job and had just graduated. She stated it had been about a month that she started at the facility. RN M grabbed her supplies but did not perform sanitation of the supplies prior to entering Resident #10's room. RN M knocked and entered the resident's room. She then asked the resident if she could grab the urinal holder that was located on the floor because he could not reach it. RN M grabbed the urinal holder by the top of the rim and handed it to the resident. Resident #10 stated he would use it once she was done with his blood sugar and handed it back to RN M who placed it on the bedside table. RN M did not perform any hand hygiene or change of gloves and proceeded to use the same gloves to check resident's blood sugar. RN M finished with Resident #10 and then grabbed all her supplies and wrapped the used Lantus in the gloves and tossed them in the trash. RN M stated she did not know where the Lantus went, and she did at times place them in the sharps container but tended to do both but wrapped it around her gloves. RN M then walked to another resident's room without sanitizing/cleaning the glucose monitor or area being used on her med cart and proceeded to gather supplies and conduct another blood glucose test. In an interview with the ADON on 03/09/26 at 11:44 am the ADON stated lancets were to be disposed of in sharps containers and not be disposed of in the trash can as that was considered a sharp. is the ADON said that was standard practice because lancets did not always retract, and that could be harmful to housekeeping and other staff members. In an interview on 03/08/2026 at 12:14pm, the ADON, DON and Administrator, the DON stated a used lancet needed to be disposed of the sharps container; and staff should know they were considered a sharp's and should not throw it in the trash. The DON stated it was considered an infection control issues and the risk was contamination and infection control. The DON stated they had not assessed or trained in blood glucose levels and will be addressed training immediately. In an interview on 03/10/2026 at 11:46 am LVN R stated the facility only provided basic training on the glucometers but that's it. When asked what was the proper way in performing a blood glucose check he stated hand hygiene, outside of the rooms, then gloves, then staff proceeded to get the equipment ready outside the room and then soap in glove up and ask for the residents name verify and then wipe the finger down with the alcohol get the Lantus poke the finger and take the read and dispose of the used items either in the sharps container or trash can, and if needed provide the insulin. LVN R stated, Since the Lantus does retract it should be okay to dispose in the sharps container, but ADON did talk to me about the Lantus not going in the trash, no one told me anything otherwise, and no one has ever observed me at the facility. (continued on next page)

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