

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 ensure alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted 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 1 of 3 residents (Resident #1) reviewed for reporting. The facility failed to report abuse of Resident #1 to State Office Agency, Law Enforcement. This failure could place residents at risk for abuse. Record review of Resident #1's face sheet dated 07/08/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included Depressive Disorders (feelings of sadness, tearfulness, emptiness or hopelessness), Post Traumatic Stress Disorder (Mental Health Condition that triggered by experiencing or witnessing a terrifying event), Vascular Dementia (decline in thinking and memory), Hypertension (High blood pressure), Chronic Kidney Disease (kidney damage slowly lose their ability to properly filter waste and extra fluid), Delusional Disorders (mental health issues where a person holds strong, false beliefs that are completely unsupported by reality), Anxiety Disorder (feeling unease or worry). Record review of Resident #1's Quarterly MDS dated [DATE], reflected a BIMS score of 12, which indicated Moderately impaired. Resident #1 had no impairment to of upper extremity (shoulder, elbow, wrist, hand), and no impairment on both sides to lower extremities (hip, knee, ankle, foot). Resident #1 had not exhibit behavior for physical, verbal to others. Resident #1 did not present any reject care for the Quarterly MDS. Record review of Resident #1's Order Summary Report dated 07/08/2026, revealed Behavior Monitoring. Itching, 2. Picking at skin, 3. Restlessness (Agitation), 4. Hitting, 5. Increase in complaints, 6. Biting, 7. Kicking, 8. Spitting, 9. Cussing, 10. Racial slurs, 11. Elopement, 12. Stealing, 13. Delusions, 14. Hallucinations, 15. Psychosis, 16. Aggression, 17. Refusing care. Observe closely for significant side effects of Anti-Anxiety medication including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior every shift every shift Document. Order start date 08/31/2024. Hydroxyzine HCL oral tablet for Anxiety, order start date 01/11/2025. Record review of Resident #1's Progress notes dated 06/09/2026 at 23:41:00, created on 06/12/2026 at 13:41:37 by DON, revealed Resident was observed to be verbally aggressive toward assigned male CNA during routine care. Resident repeatedly made inappropriate comments, including calling the CNA gay in a derogatory manner, and refused to allow the CNA to provide care. CNA remained calm and professional throughout the interaction and attempted to redirect the residents and explain the importance of care. Resident continued to refuse assistance from the male (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
--	-------	-----------

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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA. Charge nurse was notified and assessed the situation. Resident was educated on respectful communication and the importance of allowing staff to provide necessary care. Due to resident continued refusal, alternative staff were assigned when available to ensure residents needs were met. No Physical aggression was noted. Resident remained alert and in no apparent distress. Plan: Continue to monitor residents behaviors, reinforce respectful interactions with staff, and document any further incidents, and notify physician and responsible party as indicated if behaviors persist or escalate. In an observation and interview on 07/08/2026 at 10:19 AM, Resident #1 stated was unable to identify his current location and reported that he was in a hospital, stating, there are two the same as this hospital. Resident #1 was unable to state how long he had been at the facility. He was able to state his name and identify his Family Member C name, but not the time, place, or date. Resident #1 reported bruising to both thumbs and stated that it was caused by a male staff member who worked at the hospital. When asked to clarify, the resident pointed to the floor in reference to the nursing facility. The resident stated that while he was asleep, a younger male wearing glasses attempted to place a hospital gown on him, and when he refused the individual bit him on the left arm and grabbed his thumbs. The resident stated he did not call for help or use the call light because he was asleep and stated, If I would have been awake, I would have punched him in the face, this happened when I was asleep. Resident #1 was unable to describe the individual's appearance other than being a young male wearing glasses and stated he assumed the individual worked at the facility but did not know his name or knew what he was wearing. Resident #1 stated he was unaware of his roommate's name and stated there were no witnesses in the room when the incident happen. The resident verbalized that he knew how to use the call light and denied any other concerns regarding the facility. Throughout the interview, Resident #1 did not appear fearful or exhibit signs of distress and was observed joking with the investigator. In an interview on 07/08/2026 at 1:11 PM, Family Member C, stated the incident allegedly occurred during the early morning hours but couldn't recall the exact date; however, she was not notified until approximately 12 hours later, a voicemail was left and when she was able to get a hold of the voicemail she returned the call back to the facility but the nurse did not answer anymore. Family Member C stated the voicemail she received was vague and did not indicate that an altercation had occurred. She reported being informed only that the resident was complaining of pain in his thumbs and had been sent for x-rays. Family Member C stated she went to the facility that evening after the incident and spoke with the evening nurse, who was unable to provide additional information regarding the incident. Family Member C stated that after obtaining the DON contact information, she immediately contacted the DON, who informed her that a meeting could be held the following Monday to discuss the incident. Family member C described the facility's handling of the allegation as confusing and inadequate. Family member C reported attending the care plan meeting with the Ombudsman, DON, Social Worker, and Administrator, during which multiple and inconsistent explanations were provided regarding the resident's injuries. Facility staff reportedly stated the injuries occurred during a brief change at approximately 5:00 to 6:00 a.m. while attempting to place a hospital gown on the resident. Family member C stated Resident #1 had resided at the facility for approximately two years and routinely slept in only a t-shirt. She stated that if Resident #1 refused to wear a hospital gown, he had the right to refuse. Family Member C stated Resident #1 reportedly informed her that a male individual pulled on his thumbs while attempting to place the gown on him. Family Member C expressed concern regarding a skin tear sustained by the resident and stated facility staff were unable to adequately explain how the injury occurred. In an interview on 07/08/2026 at 1:54 PM LVN C, stated she had been employed at the facility for approximately two years and had not experienced difficulties providing care or assisting Resident #1 with transfers. LVN (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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C stated she typically administered medications and assisted with transfers when necessary. LVN C reported that on 06/10/2026, she assumed care of the resident at approximately at 12:00 p.m. and was informed the resident had sustained a skin tear to his left arm and had refused wound care treatment, NP was called and ordered x-rays. LVN C could not recall what nurse handed off report. LVN C observed bruising to the resident's hand and assessed him for pain. The resident acknowledged pain but did not display facial grimacing or other signs of distress. LVN C stated she contacted the resident's family and left a voicemail providing a general summary of the resident's condition, including notification that x-rays were being obtained. She stated it was common practice to leave a voicemail and pass along brief information in report if family members could not be reached immediately. LVN C stated Resident #1 did not voice any concerns regarding an altercation with a staff member when asked what happened. In an interview on 07/08/2026 at 2:47 PM, DON stated that LVN C reported to her that the resident had sustained a skin tear that same day on 06/10/2026. The DON reported she attempted to interview the resident regarding the injury right away; however, the resident was unable or unwilling to provide details and asked her to leave the room. The resident reportedly informed the wound care nurse that he had beat someone up. The DON stated she spoke with the night shift CNA, who reported that the resident attempted to hit staff during a brief change and required assistance from an additional CNA while providing care due to the resident swinging his arms and became combative. The DON stated a care plan meeting was conducted with the resident's POA and the Ombudsman on Monday the 15th. During the meeting, the Ombudsman expressed concerns that the injury appeared more consistent with a bite mark rather than a skin tear. The DON reported that the POA became upset and ended the meeting before the investigation could be explained. Facility staff later obtained statements indicating the resident had exhibited aggressive behaviors toward staff in the past. The DON stated the POA did not attend a subsequent care plan meeting and had canceled it. The DON stated it was the facility's policy to report allegations of abuse and injuries of unknown origin to the State Agency. She reported uncertainty as to whether the allegation had been reported by another staff member. The DON stated she was informed by wound care nurse R that the resident stated he had struck another individual; however, she was unaware of any witness statements indicating that a staff member had bitten the resident. The DON stated facility staff assumed the resident's injuries may have occurred during the altercation when staff attempted to place a hospital gown on him after he refused care. The DON identified CNA A as the staff member who assisted the other CNA during the overnight shift when the alleged incident occurred. DON stated staff had been trained on ANE and in serviced but not for this specific incident because they assumed that was how the resident sustained his injuries. In an interview on 07/08/2026 at 03:05 PM, Administrator stated she had returned to the facility in April 2026 and attended the resident's care plan meeting with the resident's POA, Ombudsman, and facility staff. The Administrator reported the resident's POA expressed concerns regarding the resident's skin tear and bruising. The Administrator stated facility staff initially believed the resident's injuries were related to combative behaviors exhibited during care. She reported that the resident was prescribed anticoagulant medication and stated that bruising could have resulted from incidental trauma, including contact with the bed rail. The Administrator stated these conclusions were assumptions based on the information available at the time. The Administrator stated the facility reports suspected abuse, neglect, and injuries of unknown origin in accordance with policy. She reported she did not believe another individual intentionally harmed the resident and stated the resident had provided varying statements regarding how the injuries occurred. The Administrator stated the only allegation she had heard regarding a bite injury originated from the Ombudsman's review of photographs of the (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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's injury. The Administrator further stated that no other staff members reported witnessing or alleging that the resident had been bitten. She reported a second care plan meeting was scheduled; however, the resident's POA did not attend and canceled that same day. The Administrator stated communication with the family remained ongoing. The Risk of the allegation not being reported to the State Agency could be potentially constituted of another injury of unknown origin or possible abuse allegation. In an interview on 07/08/2026 at 03:15 PM, Ombudsman stated she was present at the resident initial care plan meeting following the discovery of the incident. She stated photographs of the injury were obtained and discussed during the meeting and stated the facility staff reported that the resident was found spoiled at the end of the shift and was provided with incontinent care. Staff attempted to place a hospital gown on the resident, at which time the resident became physically aggressive. Ombudsmen stated that CNA N, a newly hired CNA and stated that CNA N was new to the facility and had not yet become familiar with the residents care preferences. CAN N attempted to place the gown on the resident and was unaware of the residents preference not to wear hospital gowns. She stated the bruising and skin tear were believed to have occurred during the resident's aggressive behavior and resistance to care. Ombudsman stated that prior to the care plan meeting, she meet with Resident #1 who informed her that someone had bitten him and that the injury appeared consistent with a bite mark, which she brought up at the meeting. Ombudsmad stated during that meeting staff become upset that she would ask in regard to a bite mark, but she just wanted to get a better understanding on what happened. She stated she was not notified of the incident from the facility until later that afternoon on June 10th when Family Member C notified her. Ombudsman stated that she believed the incident may have been preventable with additional staff training and improved communication regarding residents care needs. In an interview on 07/08/2026 at 03:22 PM, NP, stated LVN C notified her on 06/10/2026 at approximately 11:42 a.m. that Resident #1 had sustained bruising and a skin tear and requested orders for wound care and x-rays. The NP stated she observed the bruising and the skin tear during her assessment the same day on 6/10/ 2026 and did not identify any apparent teeth marks or findings consistent with a human bite injury. NP reported the resident was on anticoagulant medication and explained that residents receiving anticoagulants are more susceptible to bruising and bleeding following minor trauma or incidental injury. NP stated she has evaluated bite injuries previously and, based upon her assessment, did not believe the resident's injury appeared consistent with a bite mark. She further stated the resident was able to communicate verbally during her assessment and had not informed her how the injury occurred. Based upon her clinical assessment, the NP concluded that the injury did not appear to be consistent with a bite injury but was unaware of how the injuries occurred. NP stated that even with the minor rubs against the bed rails or anything Resident #1 could have sustained the skin tear, but it was anonymous. In an interview on 07/08/2026 at 04:13 PM, CNA A stated she had been with the facility since December 2025, and was familiar with Resident #1s care needs, behaviors, and history of refusing care. CNA A stated she was not present at the beginning of the care provided by CNA N. CNA N asked for her help and upon entering the room, Resident #1 had a clean brief and only needed assistance with dressing. CNA A stated that CNA N was holding a hospital gown and informed Resident #1 did not like wearing hospital gown; therefore, CNA A assisted by obtaining a t-shirt and placing it on Resident #1. CNA A stated that while assisting Resident #1 with putting his arms through the sleeves of the t-shirt, she did not observe any bruising, or injuries, or bleeding to his skin. The CNA stated, if he had been bleeding, I would have seen it. CNA A stated that Resident #1 was cursing and using inappropriate language toward CNA N, which she reported was consistent with Resident #1s baseline behavior particularly when he comes upset or refuses care. CNA A stated that CNA N remained calm (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort El Paso, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3421 Joe Battle Boulevard El Paso, TX 79936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	throughout the interaction and did not force care or physically engage with Resident #1 in an inappropriate manner. CNA A stated that Resident #1 did not report or indicate that CNA N had been physical or abusive toward him any time during care. CNA A stated she had been trained on ANE, and who to report Abuse or neglect too. In an interview attempt on 07/08/2026 at 01:05pm with CNA N, did not answer and could not leave vm, sent via text. In an interview attempt on 07/08/2026 at 03:20 PM with CNA N, did not answer and could not leave vm, sent via text. In an interview third attempt on 07/08/2026 at 04: 20 PM with CNA N, did not answer and could not leave vm, sent via text. Record review of facility policy Abuse & Neglect dated October 2022, revision date April 2025, stated 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. Injury or unknown origin; The source of the injury was not observed by any person or the source of the injury could not be explained by the resident, The injury suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time.		