

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/03/2025
NAME OF PROVIDER OR SUPPLIER  Luna Wellness Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  900 West Ash Street Deming, NM 88031	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment was accurate for 1 (R #24) of 3 (R #16, R #17, and R #24) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: A. Record review of R #24's admission record revealed he was admitted to facility on 05/16/25 with the following diagnoses: 1. Chronic Peripheral [NAME] Insufficiency (is a form of venous disease that occurs when veins in your legs are damaged). 2. Type 2 Diabetes with other skin complications (happens when the body cannot use insulin correctly and sugar builds up in the blood). 3. Unilateral primary osteoarthritis left knee (is a degenerative joint condition that primarily affects one side of the body, typically in the knees, hips, or hands). 4. Muscle weakness, generalized (occurs when your body is not able to contract your muscles properly, leading to reduced strength in one or more of your muscles). 5. Need assistance with personal care (refers to the support provided to individuals who require assistance with daily living activities). 6. Unspecified Dementia, unspecified severity, with agitation (is the loss of cognitive functioning and thinking). B. Record review of the facility's incident list, dated 05/13/25 through 08/27/25, revealed R #24 fell on the following date: 1. 05/30/25, 2. 05/20/25, 3. 07/22/25. C. Record review of R #24's physician's orders, dated 06/13/25, revealed R #24 may use 2 1/4 side rails (a type of bed rail that is typically used in medical settings to prevent patients from exiting their beds) for increased mobility and independence. D. Record review of R #24's care plan dated 06/13/25 revealed R #24 uses 2 1/4 side rails to assist in bed mobility and transfers to maximize independence. E. On 08/27/25 at 2:35 PM, during an interview, the MDS coordinator confirmed the fall with injury that occurred on 05/20/25 should have been documented in R #24's admission assessment dated [DATE] and should have included the use of side rails to assist in bed.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 325079
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to ensure care plan revisions occurred for 2 (R #16 and R #24) of 3 (R #16, R #17, and R #24) residents reviewed for falls, when the staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are:</p> <p>R #16</p> <p>A. Record review of R #16's admission documents, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #16 was admitted to the facility on [DATE].</li> <li>2. R #16 had a diagnosis of repeated falls.</li> </ol> <p>B. Record review of the facility's incident list, dated 05/13/25 through 08/27/25, revealed R #16 fell on the following dates:</p> <ol style="list-style-type: none"> <li>1. 07/13/25,</li> <li>2. 07/27/25 at 3:35 PM,</li> <li>3. 07/27/25 at 11:15 PM,</li> <li>4. 08/15/25,</li> <li>5. 08/19/25.</li> </ol> <p>C. On 08/27/25 at 1:38 PM, during an observation of R #16 in her bed, a fall mat was on the floor next to R #16's bed.</p> <p>D. Record review of R #16's Interdisciplinary Team Meeting for Falls spreadsheet (document with information that IDT team discussed regarding resident falls), no date, revealed after R #16's fall on 07/13/25, the IDT team added a fall mat as an intervention for R #16's falls.</p> <p>E. Record review of R #16's care plan, dated 07/08/25, revealed staff did not revise R #16's care plan to include a fall mat.</p> <p>R #24</p> <p>F. Record review of R #24's admission record revealed he was admitted to facility on 05/16/25.</p> <p>G. Record review of the facility's incident list, dated 05/13/25 through 08/27/25, revealed R #24 fell on the following date:</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. 05/30/25,</p> <p>2. 05/20/25,</p> <p>3. 07/22/25.</p> <p>H. On 08/27/25 at 1:30 PM, during an observation of R #24's room, a fall mat was on the floor against the wall on R #24's side of the room, and 2-1/4 side rails up (a type of bed rail that is typically used in medical settings to prevent patients from exiting their beds) on top of R #24's bed.</p> <p>I. On 08/27/25 at 1:36 PM, during an interview, CNA #25 stated R #24 had the following interventions in place to prevent falls:</p> <ol style="list-style-type: none"> <li>1. R #24 uses side rails for mobility in bed and when he gets up R #24 side rails to assist with his balance.</li> <li>2. R #24 call light within reach.</li> <li>3. R #24 has a fall mat placed on the floor when laying in bed.</li> <li>4. R #24 is placed in common area so staff can keep a close eye on R #24.</li> </ol> <p>J. Record review of R #24's care plan, dated 06/13/25, revealed the following:</p> <ol style="list-style-type: none"> <li>1. Staff did not document R #24 call light within reach as an intervention.</li> <li>2. Staff did not document the use of a fall mat as an intervention to prevent injury if R #24 falls.</li> <li>3. Staff did not document that R #24 is placed in a common area as an intervention to prevent falls.</li> </ol> <p>K. On 08/27/25 at 2:29 PM during an interview LPN #28, she confirmed R #24's care plan does not indicate R #24's use for a fall mat, and interventions and it should be care planned.</p> <p>L. On 08/27/25 at 2:35 PM, during a joint interview, the MDS coordinator and DON confirmed the following:</p> <ol style="list-style-type: none"> <li>1. R #16's and R # 24's care plan was not revised to include a fall mat next to bed.</li> <li>2. Staff are expected to revise the care plan when a new intervention is added for falls.</li> </ol>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to ensure residents were assessed for risk of entrapment (state of being stuck or caught on bed rail) from bed rails for 2 (R #16, and R #24) of 3 (R #16, R #17, and R #24) resident reviewed for accidents. This deficient practice has the potential to cause serious injury by becoming trapped between the mattress and bed rail. The findings are:</p> <p>R #16</p> <p>A. Record review of R #16's admission documents, no date, revealed R #16 was admitted to the facility on [DATE].</p> <p>B. On 08/27/25 at 1:38 PM, during an observation of R #16 in her bed, revealed the following:</p> <ol style="list-style-type: none"> <li>1. A fall mat was on the floor next to R #16's bed.</li> <li>2. Bed rails were in place at the top of both sides of R #16's bed.</li> </ol> <p>C. On 08/27/25 at 1:44 PM, during an interview with LPN #17, she stated the following:</p> <ol style="list-style-type: none"> <li>1. About three (3) weeks before LPN #17's interview with the surveyor (she did not know specific dates), R #16 had several falls.</li> <li>2. Prior to her falls, she used to use a walker but now required a wheelchair.</li> <li>3. R #16 would try to get up without assistance.</li> <li>4. R #16 was unaware that it was unsafe for her to get up without assistance.</li> <li>5. She had a fall mat and bed rails to prevent falls.</li> </ol> <p>D. Record review of R #16's change of condition MDS (a significant decline or improvement in a resident's status, impacting two or more areas and requiring an Interdisciplinary Team (IDT) review and potential care plan revision), dated 07/15/25, revealed staff completed a change in condition MDS on 07/15/25.</p> <p>E. Record review of R #16's entire medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>1. Staff completed a bed rail assessment for R #16 on 01/17/25.</li> <li>2. Staff did not document a bed rail assessment after R #16's change in condition on 07/15/25.</li> </ol> <p>F. Record review of R #16's physician's orders, dated 04/21/25, revealed an order R #16 may utilize side rails to assist with repositioning.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R #24</p> <p>G. Record review of R #24's admission record revealed he was admitted to facility on 05/16/25.</p> <p>H. Record review of R #24's physician's orders, dated 06/13/2025, revealed R #24 may use 2 1/4 side rails for increased mobility and independence.</p> <p>I. Record review of R #24's progress notes no date, revealed the progress note did not contain any documentation of R #24 use of side rails on R #24's bed.</p> <p>J. Record review of R #24's entire medical record revealed a side rail assessment (carried out by a competent person considering the bed occupant, assessing the rail is suitable for use) was not completed.</p> <p>K. Record review of R #24's care plan dated 06/13/25 revealed R #24 uses 2 &amp;frac14; side rails to assist in bed mobility and transfers to maximize independence.</p> <p>L. On 08/27/25 at 1:30 PM, during an observation of R 24's bed, revealed bed rails were in place at the top of both sides of R #24's bed.</p> <p>M. On 08/27/25 at 2:15 PM during an interview with the Therapy Director, she stated that therapy did not do any assessments for R #24 regarding using side rails on his bed. She stated nursing is responsible for that.</p> <p>N. On 08/28/25 at 10:23 AM, during an interview with LPN #16, the following was revealed:</p> <ol style="list-style-type: none"> <li>1. Upon admission the admitting nurse obtains consents for bed rails for all residents.</li> <li>2. The only residents who did not get bed rails were residents who were immobile (unable to move without assistance) and residents who refused to sign the consent.</li> <li>3. The admitting nurse did not complete an assessment for the safety of bed rails prior to the placement of bed rails on any residents.</li> <li>4. She was not sure if therapy evaluated residents for the safety of bed rails.</li> </ol> <p>O. On 08/28/25 at 10:29 AM, during a joint interview, the MDS and the DON confirmed the following:</p> <ol style="list-style-type: none"> <li>1. The IDT team determines the safety of bed rails prior to placing bed rails on resident's beds.</li> <li>2. Residents should be assessed for the safety of bed rails prior to placing bed rails on the resident's bed.</li> <li>3. They were unsure if a consent was required prior to placing bed rails on a resident's bed.</li> <li>4. Residents should be reassessed for the continued safety of bed rail use at least every three (3) months and with any change in condition.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. R #16 had not had an assessment for the safety of the use of bed rails since 01/17/25.</p> <p>6. R #16 had a change in her condition in July 2025 (did not give specific date).</p> <p>7. Staff should have completed a bed rail assessment on R #16 after her change in condition in July 2025.</p> <p>8. Staff did not document a bed rail assessment prior to placing bed rails on R #24's bed.</p> <p>9. Staff did not obtain a consent prior to placing bed rails on R #24's bed.</p>		