STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325079	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luna Wellness Rehabilitation LLC	900 West Ash Street Deming, NM 88030

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive MDS assessment was completed within 14 calendar days after admission for 2 (R #1 and R #3) of 3 (R #1, R #2 and R #3) residents reviewed for MDS timing. This deficient practice could likely result in residents' needs not being met. The findings are: R #1A. Record review of R #1's admission Record, no date, revealed R #1 was admitted to the facility on [DATE]. B. Record review of R #1's MDS assessments revealed staff did not complete his admission MDS assessment until 02/04/26. R #3C. Record review of R #3's admission Record, no date, revealed R #3 was admitted to the facility on [DATE]. D. Record review of R #3's MDS assessments revealed staff did not complete his admission MDS assessment until 01/28/26. E. On 03/12/26 at 1:55 PM, during an interview, the MDS Coordinator stated staff did not complete R #1's and R #3's admission MDS assessments within 14 days of admission to the facility.

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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident upon their admission to the facility) within 48 hours of admission for 2 (R #1 and R #2) of 3 (R #1, R #2 and R #3) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that may cause harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: R #1A. Record review of R #1's admission Record, no date, revealed he was admitted into the facility on [DATE]. B. Record review of R #1's baseline care plan, dated 01/18/26, revealed that it was not signed and locked (finalized by all authors) until 01/21/26. R #2C. Record review of R #2's admission Record, no date, revealed he was admitted into the facility on [DATE]. D. Record review of R #2's baseline care plan, dated 02/26/26, revealed that it was not signed and locked until 03/02/26. E. On 03/12/26 at 1:50 PM, during an interview, the MDS coordinator confirmed R #1 and R #2's baseline care plans were not completed within 48 hours of admission. The expectation was for baseline care plans to be completed within the first 48 hours of admission.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure there was a pressure injury risk assessment completed to determine the risk of developing a pressure ulcer (Injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) for 1 (R #10) of 1 (R #10) residents reviewed for pressure ulcers. This deficient practice could likely result in a delay in preventative measures and residents developing pressure ulcers. The findings are: A. Record review of R #10's progress note, dated 03/06/26, revealed that R #10 had a pressure ulcer to her coccyx (small bone at the bottom of the spine). B. Record review of R #10's assessments revealed that staff had not completed a Braden Scale (tool for predicting pressure ulcer risk) on R #10 since 01/07/25. C. On 03/12/26 at 4:39 PM, during an interview, the MDS coordinator confirmed that R #10 had not had a Braden Scale assessment since 01/07/25. The MDS coordinator confirmed that the assessment should be completed quarterly or when there is a change in the resident's condition. D. Record review of the Pressure Injury Prevention and Management Policy, no date, revealed that licensed nurses will conduct pressure injury risk assessments (Braden Scale) on all residents upon admission/re-admission, weekly for four weeks, and then quarterly or whenever the resident's condition changes.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain appropriate staffing levels to meet the needs of the residents. This failure has the potential to affect all 46 residents (residents were identified by the resident census list provided by the Administrator on 03/10/26). This deficient practice could likely result in residents not receiving the care and service needed while in the facility. The findings are: A. On 03/11/26 at 12:00 PM, during an interview, CNA #8 stated that there are not enough CNA's scheduled. CNA #8 stated that she was not able to take her time providing resident care. She felt that she is always rushed. CNA #8 stated that there are three residents that need two-person assistance (two trained caregivers are required to safely move, transfer, or reposition a patient who is too weak, unsteady, or heavy to move on their own) of her assigned residents. CNA #8 stated that she has to wait for someone from another unit to assist her. It can take a while because the other CNA's are busy on their unit (CNA #8 was not specific on which two residents needed two-person assistance). B. On 03/11/26 at 2:32 PM, during an interview, CNA #9 stated that she is responsible for 15 residents. She has two to three residents that require two-person assistance. She stated that she has to wait for someone to help her with the residents needing the Hoyer lift (a mechanical, portable, or stationary patient lift designed to assist caregivers in transferring individuals with limited mobility between beds, wheelchairs, toilets, or the floor). Waiting can take a while. CNA #9 stated that there are not enough CNA's. CNA #9 stated when showering a resident, the call lights are on for up to 30 minutes sometimes. C. On 03/11/26 at 2:46 PM, during an interview, CNA #10 stated that staff complete showers during the day shift because there aren't enough staff on the night shift to do showers. CNA #10 stated that she has to rush to do resident showers. While she is showering the residents, there are not any other CNA's on her unit. CNA #10 stated they are all busy in the morning. They have to get the residents up and ready for the day, getting them changed, and providing ADL care. She is always rushing and moving. The nurses will watch the floor sometimes, but they are busy too. D. On 03/12/26 at 10:45 AM, during an interview, the Scheduler stated that they do 12-hour shifts. She stated that she schedules two to five CNA's per shift. It just depends on who is available. The Scheduler stated that staff had told her that they need more help. The Scheduler stated that she schedules staff by what she has available. They have a high turn around and can't keep people. The Scheduler stated she will try to schedule staff to cover call ins, but that she doesn't always have staff to fill it. E. Record review of R #9's care plan, revised on 04/09/25, revealed R #9 requires setup/clean-up assistance with eating and hydration. R #9 requires setup assistance with dressing both upper and lower body and toilet hygeine F. On 03/12/26 at 11:57 AM, during an interview, R #9 stated that sometimes there are not enough staff. R #9 stated that he has to wait to get assistance because staff get pretty busy. G. Record review of R #11's Quarterly MDS, dated [DATE], revealed that R #11 needs substantial/maximal assistance with sit to stand. R #11 is partial/moderate assistance with toilet transfer and sit to lying. R #11 is supervision or touching assistance for lying to sitting on the side of his bed. H. On 03/12/26 at 1:26 PM, during an observation of the [NAME] Unit revealed the following: 1. CNA #12 stated to the WCN that she was going to lunch. 2. R #11's call light was on. There were no available staff on the unit. I. On 03/12/26 at 1:42 PM, during an observation of the [NAME] Unit, the Scheduler came onto the unit. She answered R #11's call light. As the Scheduler was walking into R #11's room, R #11 was wheeling himself out of his room in his wheelchair. The Scheduler asked him Did you need help? He stated that he did it himself. J. On 03/12/26 at 1:59 PM, during an interview, LPN #8 (R #11's nurse) stated that at the time R #11's call light was on, that he was doing wound care. CNA #11 (R #11's CNA) was assisting him. K. On 03/12/26 at 2:18 PM, during an interview with R #11 and R #11's sister, R #11 stated that his call light was on because he wanted to get out of bed and needed help. R #11 stated that he got tired of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	waiting so he did it himself. R #11's sister stated that she had gone to find staff. She also stated that R #11 has to wait up to 30 minutes or more to get help. It is sometimes hard to find staff. L. On 03/12/26 at 2:26 PM, during an interview, the Administrator stated that staffing is a challenge due to staff calling in. The Administrator stated that he would like to have four to five CNA's on the floor. He doesn't have enough CNA's to schedule four to five CNAs per shift. The Administrator stated that for the night shift, he usually has two CNA's scheduled. The Administrator stated he has other staff that will help cover the units as needed. For R #11, if there wasn't coverage, it was a communication issue between the staff to cover lunch breaks. The Administrator stated that the units should have coverage at all times.