STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325111	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northrise Wellness & Rehabilitation	2884 North Road Runner Parkway Las Cruces, NM 88011

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1 (R #2) of 2 (R #2 and R #4) 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 caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are:?? A.?Record review of R #2's admission Record, no date, revealed he was admitted into the facility on [DATE].?? B. Record review of R #2's Admission?MDS, dated [DATE], revealed the following:? 1. Staff documented R #2 had?one unstageable?pressure ulcer?(not stageable due to coverage of wound bed by slough [dead tissue in a wound, typically soft, yellow or white, that can impede healing if not properly managed] and/or eschar [hardened, dry, black or brown dead tissue that forms a scab-like covering over deep wounds])?present upon admission.? 2.?Staff documented R #2 needed pressure ulcer/injury care.?? C. Record review of R #2's baseline care plan, dated 02/19/26, revealed the following:? 1.?Staff did not document R #24's pressure ulcer.? 2. Staff did not document R #24's need for wound care.? D.?On 02/20/26 at 1:31 PM, during an interview, the?DON confirmed R?#2's?care plan did not?indicate?R #2 had a pressure ulcer or needed wound care. The DON?stated?her expectation was for?the nurses?to care plan the wounds and necessary wound care?within the first?48?hours?of admission.?

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement accurate, person-centered comprehensive care plans for 2 (R #1 and R #3) of 2 (R #1 and R #3) residents reviewed for care plans when staff failed to document pressure ulcers and the need for wound care. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents and worsening of the pressure ulcers. The findings are: R #1 A. Record review of R #1's admission record, no date, revealed she was admitted into the facility on [DATE]. B. Record review of R #1's Admission?MDS,?dated?01/15/26, revealed the following:? 1. Staff documented R #1 had?one unstageable?pressure ulcer?(not stageable due to coverage of wound bed by slough [dead tissue in a wound, typically soft, yellow or white, that can impede healing if not properly managed] and/or eschar [hardened, dry, black or brown dead tissue that forms a scab-like covering over deep wounds]) present upon admission.? 2. Staff documented R #1 had two unstageable pressure injuries presenting as deep tissue injury (type of pressure ulcers that present as a purple or maroon localized area of discolored intact skin or blood?filled blister due to damage of underlying soft tissue) present upon admission. 3.?Staff documented R #1 needed pressure ulcer care under the Care Area Assessment (section of the MDS that indicates whether a new care plan, care plan revision, or continuation of current care plan is necessary), dated 01/21/26. C. Record review of R #1's care plan, dated 01/16/26, revealed R #1's care plan did not include a care plan for pressure ulcers. R #3 D. Record review of R #3's admission record, no date, revealed she was admitted into the facility on [DATE]. E. Record review of R #3's admission MDS, dated [DATE], revealed the following: 1. Staff documented R #3 had one unstageable pressure ulcer present upon admission. 2. Staff documented R #3 needed pressure ulcer care under the Care Area Assessment, dated 01/06/26. F. Record review of R #3's care plan, initiated (date care plan started) 12/28/25, revealed R #3's care plan did not include a care plan for pressure ulcers (It was added 02/20/26.)G. On 02/20/26 at 1:33 PM during an interview, the?DON stated the following: 1. R?#1's?care plan did not have a comprehensive care plan for R #1's pressure ulcers and the need for wound care. 2. R?#3's comprehensive care plan did not have a plan in place for R #3's pressure ulcer and the need for wound care. 3. The expectation?was for staff to complete the comprehensive care plans to include pressure ulcers and the need for wound care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review,?observation,?and interview, the facility?failed to?ensure medical records were complete and?accurate?for 1 (R #1 and R #3) of?3 (R #1, R #2, and R #3) residents reviewed accuracy of documentation when staff?failed to accurately document the completion of wound care. This deficient practice has the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are: R #1A. Record review of R #1's admission record, no date, revealed she was admitted into the facility on [DATE]. B. Record review of R #1's physician order, dated 01/15/26, revealed an order for wound care to the right buttocks. Cleanse site with normal saline (NS; solution similar to salt concentration in human blood making it ideal for cleaning wounds) and pat dry, Medihoney (medical grade honey often used in wound dressings) to the wound bed. Cover with calcium alginate gauze (highly absorbent wound dressings designed to manage drainage and promote a moist healing environment). Cover with a silicone bordered dressing every day shift. C. Record review of R #1's Treatment Administration Record (TAR, electronic document where facility staff document wound care was completed), dated January 2026, revealed staff did not document the wound care was completed?for the following dates:??? 1. Monday 01/19/26,? 2. Wednesday 01/21/26,? 3. Friday 01/23/26. R #3 D. Record review of R #3's admission record, no date, revealed she was admitted into the facility on [DATE]. E. Record review of R #3's physician order, dated 01/01/26, revealed an order for wound care to bilateral (both) buttocks. Cleanse site with NS and pat dry. Sureprep (fast drying transparent barrier film that forms a protective layer over the skin) to the surrounding tissue. Medihoney to the wound bed (bottom part of the wound where new skin and tissue grow) and cover with a sacral silicone bandage (absorbent wound dressing used for wounds on the sacrum which is the area at the base of the spine). F. Record review of R #3's TAR, dated January 2026, revealed staff did not document wound care was completed from 01/02/26 through 01/23/26. G. On 02/20/26 at 11:07 AM, during an interview, the Wound Care Nurse (WCN) stated the following: 1. She worked Monday through Friday and completed all wound care in the facility on those days. 2. She completed wound care for R #1 on 01/19/26, 01/21/26 and 01/23/26 but did not document the completion on the resident's TAR. 3. She completed wound care for R #3 on the following dates but did not document on the resident's TAR: a. 01/01/26 and 01/02/26. b. 01/05/26 through 01/09/26. c. 01/12/26 through 01/16/26. d. 01/19/26 through 01/23/26. 4. Sometimes the nurse that worked the unit (the WCN did not state which nurse) documented the completion of wound care on the TAR. 5. She should make sure that either she or the unit nurse document the wound care as completed on the TAR.