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	05/06/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 8 (R #13, R #15, R #28, R #30, R # 31, R #41, R #54, and R #59) of 8 (R #13, R #15, R #28, R #30, R # 31, R #41, R #54, and R #59) residents reviewed for comprehensive care plans. 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 #13 A. Record review of R #13's admission Record, no date, revealed R #13 was admitted to the facility on [DATE]. B. Record review of R #13's physician's orders revealed the following orders; 1. Dated 03/15/26 and discontinued 04/13/26, for hydrocodone-acetaminophen (a prescription opioid combination used to treat moderate to severe pain) 5-325 mg every 6 hours PRN for pain. 2. Dated 04/13/26, for hydrocodone-acetaminophen 5-325 mg every 4 hours as needed for pain. 3. Dated 03/16/26 for Lovenox (a prescription low molecular weight heparin (LMWH) injection used to treat and prevent deep vein thrombosis (DVT, a serious condition where a blood clot forms in a deep vein) and pulmonary embolism (PE)) injection 40mg/0.4mL once a day for DVT prophylaxis (to prevent diseases). C. Record review of R #13's admission MDS, dated [DATE], revealed staff documented R #13 was taking the following high-risk medications (drugs with a heightened risk of causing significant patient harm, or even death): 1. Anticoagulants (often called blood thinners, prevent or reduce blood clot formation by interfering with the body's coagulation process). 2. Opioid medication (powerful, regulated pain-relievers used for moderate-to-severe pain). D. Record review of R #13's care plan, dated 03/16/26, revealed staff did not document that R #13 was taking anticoagulant or opioid medications. E. On 05/04/26 at 2:21 PM, during an interview, the DON and Regional Clinical Nurse (RCN) confirmed the following: 1. R #13 had orders for anticoagulants and opioid medications. (continued on next page)

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 - Some	CC. Record review of R #41's Physician's Progress notes revealed the following: 1. Encounter note, date of service 02/03/26: +4 (the most severe grade of pitting edema, characterized by very deep swelling that lasts more than 2–5 minutes and causes gross distortion of the affected area) pretibial edema (swelling in the front part of the lower legs, just over the shin bones, caused by fluid accumulation in the tissues). 2. Encounter note, date of service 02/04/26: Patient with severe dependent edema (serious form of swelling where excess fluid accumulates in the lower body due to impaired circulation, often worsened by gravity) patient is refusing to elevate legs DD. Record review of R #41's Care Plan revealed that staff did not document resident's edema and his refusal to elevate legs. EE. On 05/05/26 at 3:30 PM, during an interview, the DON confirmed staff did not document R #41's edema and refusal to elevate legs on his care plan. She stated that it should be documented on the care plan due to being a significant medical issue for R #41. R #54 FF. Record review of R #54's admission Record, no date, revealed R #54 was admitted to the facility on [DATE]. GG. On 04/29/26 at 11:01 AM, during and observation and interview, the following was revealed: 1. An oxygen concentrator (a medical device that filters ambient air, providing a 90%–95% concentrated oxygen supply for patients with low oxygen levels) was sitting next to R #54's bed. 2. R #54 said she used oxygen when she lays down in bed. HH. Record review of R #54's Convalescent Care Orders (written orders for admission to a nursing facility, detailing necessary therapies (e.g., physical therapy), medications, and wound care), dated 04/15/26, revealed an order for oxygen by nasal cannula (a lightweight, flexible device used to deliver supplemental oxygen) PRN. II. Record review of R #54's admission MDS Assessment, dated 04/24/26, revealed staff documented R #54 used oxygen intermittently (at irregular intervals). JJ. Record review of R #54's care plan, dated 04/24/26, revealed staff did not document that R #54 uses oxygen or any interventions in place for R #54's oxygen use. KK. On 05/05/26 at 9:58 AM, during an interview, the DON and RCN confirmed the following: 1. R #54 used oxygen at night. 2. Staff did not document R #54's oxygen use on her care plan. 3. Staff were expected to document oxygen use and any interventions for oxygen use in resident care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #59 MM. Record review of R #59's admission record, no date, revealed R #59 was admitted on [DATE]. NN. On 04/29/26 at 11:07 AM, during an interview, R #59 stated he went to dialysis. OO. Record review of R #59's care plan, dated 04/28/26, revealed staff did not document where and how often R #59 received dialysis. PP. On 04/30/26 at 2:56 PM, during an interview, the DON confirmed staff did not document where or when R #59 went to dialysis. The DON confirmed the care plan should document R #59's dialysis information.