

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER Northrise Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 observation, record review, and interview, the facility failed to create a 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 #24, and R #25) of 3 (R #24, R #25, and R #26) 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: A. Record review of the facility Care Plan Policy, dated June 2020 revealed the following: 1. The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission. 2. The Baseline Care Plan will be updated to reflect changes in the residents' condition or needs occurring prior to the development of the Comprehensive Care Plan. R #24 B. Record review of R #24's admission Record, no date, revealed the following: 1. R #24 was admitted to the facility on [DATE]. 2. R #24 was discharged on 04/28/26. 3. R #24 had the following diagnosis: a. Acute Pyelonephritis (a sudden and severe kidney infection. It causes the kidneys to swell and may permanently damage them. Pyelonephritis can be life-threatening). b. Hypothyroidism, unspecified (an abnormally low activity of the thyroid gland, resulting in metabolic changes). c. Type 2 Diabetes Mellitus without complications. C. Record review of R #24's medical record revealed staff did not document a baseline care plan for R #24's. R #25 D. Record review R #25's admission Record, no date, revealed she was admitted to the facility on [DATE] with the following diagnosis: 1. Urinary Tract Infection, site not specified (an infection in the organs of your urinary tract, which includes the bladder and kidneys). 2. Vascular Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a type of cognitive impairment caused by reduced blood flow to the brain, often due to stroke, atherosclerosis, or hypertensive cerebrovascular disease). 3. Difficulty in walking, not elsewhere classified (refers to an impairment in gait or mobility without a specific underlying diagnosis). E. Record review of R #25's base line care plan dated 06/09/26 revealed staff did not document a baseline care plan within 48 hours of R #25's admission to the facility. F. On 06/16/26 at 1:30 PM, during an observation and interview with R #25, R #25 was in bed and appeared pleasantly confused. R #24 stated she had no concerns at this facility. G. On 06/18/26 at 11:24 AM, during an interview, the DON confirmed the following: 1. Staff did not document a baseline care plan for R #24. 2. Staff did not document a baseline care plan for R #25 within 48 hours of admission to the facility. 3. DON's expectation is that staff complete a baseline care plan within 48 hours upon admission for residents.		

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plan revisions occurred for 1 (R #1) of 4 (R #1, R #2, R #3, and R #4) residents reviewed for care plan accuracy, when staff failed to revise R #1's 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. The findings are: ^ A. Record review of the facility Care Planning Policy, dated June 2020 revealed the following: 1. A Licensed Nurse will initiate the Care Plan. 2. The plan will be updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an as needed basis. B. Record review of R #1's admission Record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 was discharged on 05/28/26. 3. R #1's diagnoses include difficulty in walking not elsewhere classified (refers to an impairment in gait or mobility without a specific underlying diagnosis). C. Record review of R #1's Occupational Therapy (OT; focuses on enabling people to engage in everyday occupations of life, which include self-care activities such as dressing, bathing, and preparing food) notes revealed the following: 1. OT Evaluation note dated 05/13/26 the OT documented the following: a. R #1 can bathe or shower himself independently. b. R #1 can transfer himself in and out of the tub or shower independently. 2. OT Treatment note dated 05/15/26 the OT documented the following: a. R #1 can bathe or shower himself independently. b. R #1 can transfer himself in and out of the tub or shower independently. 3. OT Discharge summary dated [DATE] the OT documented the following: a. R #1 can bathe or shower himself independently. b. R #1 can transfer himself in and out of the tub or shower independently. D. On 06/22/26 at 12:42 PM, during an interview, the OT confirmed the following: 1. R #1 can bathe or shower himself independently. 2. R #1 can transfer himself in and out of the tub or shower independently. 3. R #1 did not require any assistance to shower or bathe himself. E. Record review of R #1's care plan, dated 05/15/26, revealed the following: 1. R #1 has decreased ability to perform activities of daily living: a. Bathing/showering: R #1 requires physical assistance of one staff participation with bathing/showering. ^ F. On 06/22/26 at 12:42 PM, during an interview, the DON confirmed the following: 1. R #1's care plan did not reflect R #1's level of function for bathing or showering as determined by R #1's OT Discharge summary dated [DATE]. 2. R #1's care plan should have been revised to accurately reflect R #1's level of function related to bathing and showering himself independently.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident who enters the facility with diagnosis of urinary tract infection (UTI) received appropriate treatment for 1 (R #24) of 2 (R #24 and R #25) residents reviewed for UTI, when they failed to ensure that a resident received all doses of antibiotic as prescribed to treat the UTI. This deficient practice could result in residents being susceptible to worsening infection or becoming septic (potentially life-threatening when the body responds to infection by damaging its own tissues). The findings are: A. Record review of the facilities policy for UTI's, dated June 2014 revealed the following: As part of the initial assessment, the physician will help identify individuals who have a history of symptomatic urinary tract infections, and those who have risk factors (for example, an indwelling urinary catheter, urinary outflow obstruction, etc.) for UTIs. 1. The physician and nursing staff will review the status of individuals who are being treated for a UTI and adjust treatment accordingly. 2. Decisions should be made primarily on the basis of clinical signs and symptoms. The goal of treatment in most cases is to control signs and symptoms of infection, not to eliminate bacteriuria. 3. Follow-up urine cultures after antibiotic treatment are not indicated routinely but may be helpful if the symptoms are not resolving or complications are present. 4. When someone's urinary tract infection persists or recurs after treatment with an initial course of antibiotics, the physician should review the situation carefully with the nursing staff and possibly examine the individual before prescribing repeated courses of antibiotics. 5. Physicians should justify continuing or resuming antibiotic treatment beyond an initial course of treatment, especially if based solely on a positive culture result. B. Record review of R #24's admission Record, no date, revealed the following: 1. R #24 was admitted to the facility on [DATE] 2. R #24 was discharged on 04/28/26. 3. R #24 had the following diagnosis: a. Acute Pyelonephritis (a sudden and severe kidney infection. It causes the kidneys to swell and may permanently damage them. Pyelonephritis can be life-threatening). b. Hypothyroidism, unspecified (an abnormally low activity of the thyroid gland, resulting in metabolic changes). c. Type 2 Diabetes Mellitus without complications. C. Record review of R #24's hospital discharge instructions for medication reconciliation report dated 04/17/26 revealed: 1. Continue antibiotic medication, taking: Augmentin (prescription medication to treat a wide range of bacterial infections including infections of the bladder or kidneys caused by susceptible bacteria.) 500 mg by mouth two (2) times a day for six (6) more days. End date for Augmentin 500 mg is 04/26/26. D. Record review of R #24's MAR for April 2026 revealed the following: 1. Staff did not document an order for Augmentin. 2. Staff documented an order dated 04/28/26 for Levaquin (is a fluoroquinolone antibiotic used to treat various bacterial infections, including urinary tract infections) give 500 mg by mouth one time a day for UTI. E. Record review of R #24's Skilled Evaluation progress note, dated 04/22/26 revealed the following: 1. Urine color: dark yellow, 2. Urine clarity: cloudy, 3. Urine has foul odor, 4. Urine analysis ordered. F. On 06/17/26 at 11:32 AM, during an interview, the Physician stated the following: 1. If R #24 was admitted with orders to continue a medication for UTI from the hospital, then it should be followed on admission to the facility. 2. When the staff receive results from a urine analysis the staff should call the physician and get the order put in. G. On 06/18/26 at 1:50 PM, during an interview, the DON confirmed the following: 1. R #24 had convalescent orders from the hospital to continue Augmentin antibiotics, and the order was not placed in the system. 2. The admission nurse should have caught this, and DON when the audit is done the next day. 3. When a resident comes from the hospital, the staff are to follow the orders unless the doctor changes it. 4. Staff did not document contacting the physician to change the order from Augmentin to Levaquin. 5. On 04/22/26 staff took the urine sample from R #24. 6. The facility receive R #24's results on 04/26/28. 7. Staff did not obtain orders until 04/28/26 for Levaquin.		

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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 and interview, the facility failed to ensure resident record were complete and accurate for 1 (R #24) of 3 (R #24, R #25, and R #26) residents reviewed for pressure ulcers, when they failed to obtain an order and documentation R #24's wound care treatment. These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are: A. Record review of the facilities Wound Management policy, dated June 2020, revealed the following: 1. A Licensed Nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident. Upon identification of a new wound the Licensed Nurse will: a. Measure the wound (length, width, depth); b. Initiate a Wound Monitoring Record sheet; c. A Wound Monitoring Record will be completed for each wound. d. See Staging Guidelines for more information about assessing wounds. e. The Wound Monitoring Record is optional for recording skin tears, lacerations, cuts, and abrasion. If the Wound Monitoring Record is not used, documentation will be recorded within then medical record which may include nursing notes, treatment records or care plans. f. Implement a wound treatment per physician's order. g. An assessment of care needs for pressure injury and wound management will be made with emphasis on, but not limited to: i. Identifying Risk Factors ii. Treatment iii. Mechanical offloading and pressure reducing devices iv. Reducing skin friction, sheer, and moisture v. Nutritional status vi. Evaluating and modifying interventions for a resident with an existing PU/PI. B. Record review of R #24's admission Record, no date, revealed the following: 1. R #24 was admitted to the facility on [DATE] 2. R #24 was discharged on 3. R #24 had the following diagnosis: a. Acute Pyelonephritis (a sudden and severe kidney infection. It causes the kidneys to swell and may permanently damage them. Pyelonephritis can be life-threatening). b. Hypothyroidism, unspecified (an abnormally low activity of the thyroid gland, resulting in metabolic changes). c. Type 2 Diabetes Mellitus without complications. C. Record review of R #24's admission Evaluation dated 04/17/26 revealed a small open shearing area on R #24's coccyx (or tailbone, is the small triangular bone at the base of the spine, formed by the fusion of three to five rudimentary vertebrae, serving as an attachment site for muscles, ligaments, and supporting weight while sitting. D. Record review of R #24's physician orders revealed no orders for the small open shearing area on R #24's coccyx. E. Record review of R #24's Treatment Record revealed no treatments for wound care on the small open shearing area on R #24's coccyx. F. Record review of R #24's 5-day MDS assessment, dated 04/23/26 revealed staff did not document the small open shearing area on R #24's coccyx. G. On 06/18/26 at 1:28 PM, during an interview with the Wound Care Nurse (WCN), she stated the following: 1. R #24 did have a shear and blanching tissue on his coccyx area. 2. R #24 had no treatment besides the barrier cream that was not on the orders. R #24 should have had an order for treatment. 3. The WCN did not know why R #24's order did not come in on admission for the shear and blanching tissue on R #24's coccyx area. H. On 06/17/26 at 1:50 PM, during an interview with the DON, she confirmed the following: 1. There was a small shearing area on R #24's coccyx on admission. 2. The admission nurse did not obtain orders for the small open shearing area on R #24's coccyx. 3. Her expectation is for the staff to obtain orders when upon admission of the resident. 4. The admission nurse should have obtained orders for the small open shearing area on R #24's coccyx.		