STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325132	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Cruces Wellness & Rehabilitation LLC	175 N Roadrunner 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 develop a complete baseline care plan for 1 (R #1) of 3 (R #1, R #2, and R #3) residents sampled for enhanced barrier precautions, (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes). This deficient practice could likely result in staff being unaware of the residents' needs. The findings are: R #1 A. Record review of R #1's medical record no date revealed se was admitted [DATE]. B. Record review of R #1's physician's orders dated 11/21/25 revealed R #1 was on enhanced barrier precautions for a surgical wound to right hip and IV (intravenous therapy is a medical process that administers fluids, medications and nutrients directly into a person's vein) access. C. Record review of R #1's baseline care plan dated 11/23/25 revealed staff did not document R #1 was on enhanced barrier precautions for a surgical wound to right hip and IV access. D. On 11/26/25 at 11:28 am during an interview the DON confirmed the following: 1. R #1 did not have the enhanced barrier precautions on her baseline care plan 2. The facility team should be care planning the EBP 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 a complete comprehensive care plan for 2 (R #2 and R #3) of 3 (R #1, R #2, and R #3) residents sampled for enhanced barrier precautions, (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes). This deficient practice could likely result in staff being unaware of the residents' needs. The findings are: R #2 A. Record review of R #2's medical record no date revealed he was admitted [DATE]. B. Record review of R #2's physician's orders dated 11/03/25 revealed R #2 was on enhanced barrier precautions for a wound to left leg and IV (intravenous therapy is a medical process that administers fluids, medications and nutrients directly into a person's vein) access. C. Record review of R #2's Care Plan dated 11/04/25 revealed staff did not document R #2 was on enhanced barrier precautions for a wound to left leg and IV access. D. On 11/26/25 at 11:28 am during an interview the DON confirmed the following: 1. R #2 did not have the enhanced barrier precautions on his care plan 2. The facility team should be care planning the EBP for residents. R #3 E. Record review of R #3's medical record no date revealed he was admitted [DATE]. F. Record review of R #3's physician's orders dated 10/31/25 revealed R #3 was on enhanced barrier precautions for a wound to right foot and IV access. G. Record review of R #3's Care Plan dated 10/31/25 revealed staff did not document R #3 was on enhanced barrier precautions for a wound to right foot and IV access. H. On 11/26/25 at 11:28 am during an interview the DON confirmed the following: 1. R #3 did not have the enhanced barrier precautions on his care plan 2. The facility team should be care planning the EBP for residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325132	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Cruces Wellness & Rehabilitation LLC	175 N Roadrunner Parkway Las Cruces, NM 88011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to keep residents free from accidents for all 16 residents who reside on the South Unit (residents were identified by the resident matrix provided by the Administrator on 11/26/25) when they failed to secure a treatment cart (cart with medical supplies and equipment for treatment) when they left it unlocked on the South Unit. This deficient practice could likely result in residents obtaining equipment from the unsecured treatment cart and injuring themselves or others. The findings are: A. On 11/26/25 at 9:08 am, during an observation of the South Unit revealed a treatment cart unlocked with the keys in the cart. No staff were present. B. On 11/26/25 at 9:09 am, during an interview CNA #1 confirmed it was unlocked and attempted to secure the treatment cart. C. On 11/26/25 at 9:09 am, during an interview, the Wound Care Nurse confirmed the treatment cart was unlocked with the keys in it. D. On 11/26/25 at 11:28 am, during an interview the DON confirmed that if there are no staff present the treatment cart should be locked.