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	12/11/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of neglect for 1 (R #2) of 121 residents that were in the building between 06/25/24-08/23/24 (residents were identified by the Census Report from 06/25/24-08/23/24 provided by the DON 12/11/25), when they failed to report missed medications and medications left at the bedside of R #2 by Staff Member (SM) #1. If the facility fails to report allegations of neglect, then residents could be subjected to continued neglect resulting in a worsening condition of health and life. The findings are: A. Record review of the facility's investigation report dated 11/03/25 revealed that SM #1 was working at the facility from 06/10/24 to 08/28/24 using false credentials and posing as an LPN. B. Record review of SM #1 disciplinary actions revealed the following: 1. On 07/08/24 Residents have expressed concern regarding a nurse presenting him with medications that he did not recognize as his own. He also stated that she attempted blood sugar checks although he isnt diabetic. *Serious - Resident perceived that nurse was not proficient in IV administration as during his treatment he questioned there being air in the line. He noticed that this is not correct and got her to agree. ADON performed immediate education and she demonstrated and taught back IV set up and proper administration. Nurse has received full orientation and an additional two weeks on the floor. We will continue to educate As of 7/13/24 admission R.S. was not complete, daily charting was not completed. Fall risk management was not completed 2. Second counseling, no date revealed the following: medications were found at resident's (R #2) bed side. SM #1 was re-educated on medications. admission paperwork not completed. discharged assessment no complete. C. On 12/11/25 at 3:10 pm, during an interview LPN #1 confirmed that she worked on the other unit when SM #1 worked. LPN #1 stated that staff would come to her on her unit to care for residents because she was not doing her work. LPN #1 stated that SM #1 gave R #2 the wrong medications and attempted to improperly start an IV on him. LPN #1 stated that SM #1 did not want to start IVs so LPN #1 would tell her to get the supplies for it. LPN #1 stated that SM #1 would not get the right supplies for the IV. LPN #1 stated that SM #1 documentation was very off. LPN #1 stated that I did not want her working my unit. LPN #1 stated that she had informed her supervisor of the concerns. D. On 12/11/25 at 3:37 pm, during an interview CNA #1 stated that she had worked with SM #1 as the CNA. CNA #1 stated that she was not good and would be constantly on her phone. CNA #1 stated that SM #1 attempted to improperly start an IV on R #2. CNA #1 stated that SM #1 did not really go out on the floor and was always sitting down at the nurse's station. CNA #1 stated that SM #1 seemed like she did not know much about nursing. CNA #1 stated that she would ask SM #1 if she needed to pass medications, SM #1 would say she already did pass them. E. Record review of R #2's medical record revealed the following: 1. R #2 was admitted on [DATE]. 2. R #2 was discharged on 09/09/25. F. Record review of R #2's physician's orders revealed the Cefepime (antibiotic?used to treat a wide variety of bacterial infections) HCl Intravenous Solution 1 GM/50ML (Cefepime HCl) Use 1 gram intravenously every 6 hours (continued on next page)

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

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	12/11/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for antibiotic until 08/03/2024. G. On 12/11/25 at 2:15 pm, during an interview the DON confirmed that the facility had not reported the allegations of SM #1's neglect to the State Agency.

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	12/11/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that nursing staff had the appropriate competencies and skill sets to provide nursing services for all 121 residents that were in the building between 06/25/24-08/23/24 (residents were identified by the Census Report from 06/25/24-08/23/24 provided by the DON 12/11/25) when the facility employed Staff Member (SM) #1 as LPN when she did not have a license or skill set to provide nursing services to residents. This deficient practice could result in residents receiving inappropriate care and interventions for both routine and emergency situations. The findings are: A. Record review of the facility's investigation report dated 08/29/24 revealed R #1 needed to go to the restroom. SM #1 went to assist R #1. R #1 had foley catheter. The urine collection bag was attached to bed. When SM #1 went to assist R #1 she did not take the bag off the bed, and this resulted in R #1 foley catheter tubing to pull on his penis and cause him pain. R #1 was assessed by another nurse and no injuries noted just pain. B. Record review of R #1's medical record revealed the following: 1. R #1 was admitted on [DATE]. 2. R #1 was discharged on 09/09/24. C. Record review of R #1's History and Physical dated 08/24/24 revealed R #1 had a foley catheter. D. On 12/09/25 at 12:45 pm, during an interview Human Resources (HR) stated that SM #1 did not cooperate with the investigation of R #1's incident and quit as a result. E. Record review of the facility's investigation report dated 11/03/25 revealed that SM #1 was working at the facility from 06/10/24 to 08/28/24 using false credentials and posing as an LPN. F. On 12/09/25 at 1:57 pm, during an interview the ADON confirmed that it was until just recently that the facility learned that SM #1 was not an LPN. The ADON stated that she passed the background checks and there would have been no reason to think SM #1 was not an LPN as she was claiming to be. The ADON stated that SM #1 had lapses in her skills. The ADON explained that normal orientation for a nurse was 3 days. However, SM #1 was not able to complete her competencies and required an additional two weeks of supervised orientation. After the additional orientation she was working as LPN on the unit floor. The facility did have to discipline SM #1 a few times and were building a case for termination. The ADON stated that at that time their cooperation wanted a solid case for termination to prevent any wrongful termination allegations. G. Record review of SM #1 disciplinary actions revealed the following: 1. On 07/08/24 Residents have expressed concern regarding a nurse presenting him with medications that he did not recognize as his own. He also stated that she attempted blood sugar checks although he isn't diabetic. *Serious - Resident perceived that nurse was not proficient in IV administration as during his treatment he questioned there being air in the line. He noticed that this is not correct and got her to agree. ADON performed immediate education, and she demonstrated and taught back IV set up and proper administration. Nurse has received full orientation and an additional two weeks on the floor. We will continue to educate As of 07/13/24 admission R.S. (admission paperwork) was not complete, daily charting was not completed. Fall risk management was not completed 2. Second counseling, no date revealed the following: medications were found at resident's bed side. SM #1 was re-educated on medications. admission paperwork not completed. discharged assessment no complete. H. On 12/11/25 at 8:24 am, during an interview with the DON and Administrator revealed the following: -SM #1 had a background check performed with finger printing. It came back no concerns. -SM #1 license was run through and initial license verifications system and came back as review. -SM #1 license was then run through an additional license verification system. The name and license number matched an active license for an LPN. Neither system requires further verification such as birthday or social security number. -SM #1 had some disciplinary actions against her. -When she refused to (continued on next page)

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	12/11/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cooperate in the investigation of R #1's foley catheter incident, she quit immediately. I. On 12/11/25 at 11:17 am, during an interview ADON stated that after the extended orientation SM # 1, even though she was working the floor he had to regularly check in her. The ADON also stated that the nurse on the other hallway would have to check on her and give care to residents. J. On 12/11/25 at 3:10 pm, during an interview LPN #1 confirmed that she worked on the other unit when SM #1 worked. LPN #1 stated that staff would come to her on her unit to care for residents because she was not doing her work. LPN #1 stated that SM #1 gave R #2 the wrong medications and attempted to improperly start an IV on him. LPN #1 stated that SM #1 did not want to start IVs so LPN #1 would tell her to get the supplies for it. LPN #1 stated that SM #1 would not get the right supplies for the IV. LPN #1 stated that SM #1 documentation was very off. LPN #1 stated that I did not want her working my unit. LPN #1 stated that she had informed her supervisor of the concerns. K. On 12/11/25 at 3:37 pm, during an interview CNA #1 stated that she had worked with SM #1 as the CNA. CNA #1 stated that she was not good and would be constantly on her phone. CNA #1 stated that SM #1 attempted to improperly start an IV on R #2. CNA #1 stated that SM #1 did not really go out on the floor and was always sitting down at the nurse's station. CNA #1 stated that SM #1 seemed like she did not know much about nursing. CNA #1 stated that she would ask SM #1 if she needed to pass medications, SM #1 would say she already did pass them. L. Record review of R #2's medical record revealed the following: 1. R #2 was admitted on [DATE]. 2. R #2 was discharged on 09/09/25. M. Record review of R #2's physician's orders revealed the Cefepime (antibiotic?used to treat a wide variety of bacterial infections) HCl Intravenous Solution 1 GM/50ML (Cefepime HCl) Use 1 gram intravenously every 6 hours for antibiotic until 08/03/2024. This deficient practice was cited as past noncompliance: -Based on the facility's investigation, change in ownership, and changes in Administration the following interventions were implemented prior to the survey investigation which included: -The facility has hired a new Administrator, HR, and Staff Development Coordinator. -The facility has a new hiring process for staff that includes the following: 1. License verification. 2. A more in-depth background check that would be able to catch error in birthday and social security. 3. Four staff are assigned to the hiring process. One local HR, two cooperate Payroll staff, and one cooperate HR. Communications throughout the hiring process. -The facility has implemented new competencies for new hires. -The facility is now using the Staff Development Coordinator for competencies.