

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/18/2024
NAME OF PROVIDER OR SUPPLIER  Los Alamos Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1011 Sombrillo Court Los Alamos, NM 87544	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47091</p> <p>Based on observation, record review, and interview, the facility failed to meet professional standards of quality for 1 (R #1) of 1 (R #1) residents when staff failed to implement a resident's care plan for fall precautions. If fall prevention measures are not implemented then residents are likely to sustain falls that can result in serious harm or injury and the resident's decline in health and quality of life.</p> <p>The findings are:</p> <p>A. Record review of R #1's face sheet revealed resident was admitted to facility on 04/07/23 with the following diagnoses which made the resident a high fall risk:</p> <ol style="list-style-type: none"> <li>1. Senile degeneration of brain, not elsewhere classified.</li> <li>2. Muscle weakness (a decrease of strength in muscles.)</li> <li>3. Muscle wasting and atrophy (the wasting or thinning of muscle mass.)</li> <li>4. Type II diabetes mellitus (a condition results from insufficient production of insulin, causing high blood sugar.)</li> <li>5. Hypertension (high blood pressure.)</li> <li>6. Respiratory failure, hypoxia (a condition in which a person's lungs have difficulty exchanging oxygen and carbon dioxide with the blood).</li> </ol> <p>B. Record review of the facility's fall incident report, dated 12/13/23 to 03/13/24, revealed R #1 had falls without injury on 01/08/24, 01/22/24, and 03/08/24.</p> <p>C. Record review of R #1's care plan, dated 10/24/23, revealed R #1 was at risk for falls and had actual falls including a fall on 01/22/24 due to cognition, weakness, narcotics, and history of falls. Fall Interventions included:</p> <ol style="list-style-type: none"> <li>1. Fall mat to left side of bed while in bed</li> <li>2. Increased staff supervision with intensity based on resident need.</li> </ol> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Lock brakes on wheelchair at all time.</p> <p>4. Non-skid socks at all times.</p> <p>5. Offer toileting when awake after meals and just prior to bedtime.</p> <p>6. Physical therapy to screen status after fall</p> <p>D. On 03/18/24 at 1:39 pm during observation, R #1 lay in bed and wore regular socks instead of nonskid socks. The resident's call light was between the wall and the dresser, and it was out of resident's reach. The resident had water on their bedside table, and it was out of the resident's reach. Further observation revealed there was not a fall mat on floor at the resident's bedside, the resident's bed was not positioned in the lowest position, and the brakes on the resident's wheel chair at bedside were not locked.</p> <p>E. On 03/18/24 at 1:43 pm during interview with LPN #1 she stated R #1 was not wearing nonskid socks. She further stated she did not know why R #1 did not have a fall mat on the side of the bed. She stated the brakes on R #1's wheelchair were not locked and should be locked at all times according to the resident's current care plan.</p> <p>F. On 03/18/24 at 2:06 pm during interview with the Director of Nursing (DON), the DON stated if fall preventions (fall prevention measures such as fall mat) were in a resident's care plan then facility staff should implement the preventions at all times.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>47091</p> <p>Based on observation, record review, and interview, the facility failed to provide activities of daily living (ADL) assistance with bathing and showers for 1 (R #1) of 1 (R #1) resident reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the resident. The findings are:</p> <p>A. On 03/18/24 at 11:50 am during observation, R #1 lay in bed asleep. Her brief was soiled, her hair was disheveled, and her fingernails were long with heavy debris under her nails.</p> <p>B. Record review of the shower schedule revealed R #1's showers were scheduled for Saturday and Wednesday.</p> <p>C. On 03/18/24 at 11:58 am during an interview with LPN #1, she stated R #1's fingernails were dirty with debris under the nails.</p> <p>D. Record review of the [NAME] Hall shower book on 03/18/24 at 12:13 pm revealed the book did not contain documentation to show R #1 had a shower since 03/13/24.</p> <p>E. On 03/18/24 at 12:40 pm during interview LPN #1 stated the last documented shower for R #1 was dated Wednesday 03/13/24.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47091</b></p> <p>Based on observation, interview, and record review the facility staff failed to follow proper infection prevention protocols when they did not ensure staff utilized personal protective equipment (PPE; i.e., gown and gloves) when they entered the room of a resident (R #1) confirmed positive for COVID 19 (infectious disease). Failure to adhere to an infection control program is likely to cause infections and illness to all residents and staff within the facility. The findings are:</p> <p>A. On 03/14/24 at 1:48 pm during an observation, R #1 lay in bed in their room. In the hallway beside R #1's doorway was a container with PPE (indicating that PPE must be put on before entering the room). Further observation at 1:50 pm revealed the Administrator and the Regional Administrative Officer ([NAME]) entered the resident's room without donning (put on) PPE.</p> <p>B. On 03/14/24 at 1:52 pm during an interview with RN #1, she stated any staff who entered R #1's room should put on PPE. She stated R #1 was COVID 19 positive. RN #1 confirmed the Administrator and the [NAME] did not put on PPE before they entered R #1's room.</p> <p>C. On 03/14/24 at 2:22 pm during an interview with Director of Nursing (DON), she stated if R #1 was in the room then staff needed to put on PPE before they entered the room.</p> <p>D. On 03/14/24 at 2:48 pm during an interview, the Administrator stated he and the [NAME] should have worn PPE when they entered the R #1's room. He stated they did not become aware the resident was on precautions until they exited the room.</p>