STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325056	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Alamos Wellness & Rehabilitation	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #1) of 3 (R #1, #2 and #3) resident reviewed for medication administration when staff did not obtain and provide prescribed medications. This deficient practice is likely to result in residents experiencing pain, discomfort, and less than optimal care. The findings are: A. Record review of R #1's face sheet revealed he was admitted to the facility on [DATE] with multiple diagnoses including: - Low back pain. - Chronic pain syndrome. - Intervertebral (the space between each bone of the back) disc (the soft liquid filled sac between each bone of the back) degeneration (gradual deterioration). - The resident discharged from the facility on 05/07/24. B. Record review of R #1's provider orders revealed an order, dated 05/01/24, for Pregabalin capsule 50 mg. Give 50 mg by mouth three times a day for pain-no end date noted C. Record review of R #1's Medication Administration Record, dated May 2024, revealed staff did not administer Pregabalin to the resident on the following dates: - On 05/05/24 at 5:00 pm. - On 05/05/24 at 9:00 pm. - On 05/06/24 at 9:00 am. - On 05/06/24 at 5:00 pm. D. Record review of R #1's daily care notes revealed the following: - Dated 05/05/24 5:45 pm, staff did not administer Pregabalin medication pending delivery. (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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 05/05/24 8:51 pm, Pregabalin medication was on order with pharmacy. - Dated 05/06/24 9:05 am, staff did not administer Pregabalin pending delivery. - Dated 05/06/24 4:09 pm, staff did not administer Pregabalin pending delivery. - Dated 05/07/24 4:09 am, the resident called 911, but the nurse not aware until the Emergency Medical Technicians (EMTs) arrived. Reason for call was for pain meds. Resident transported to hospital and returned to the facility 1.5 hours later. E. On 08/22/24 at 12:15 pm during a phone interview with R #1's companion, R #1's companion stated that R #1's pain was managed until early morning on 05/07/24. She stated that on that morning, R #1's pain was not being managed and was so intense that R #1 had to call 911 to take him to the hospital due to pain. She stated he returned a few hours later and was discharged that afternoon. F. On 08/22/24 at 2:55 pm during interview with Director of Nursing (DON) she stated R #1's pain medications included Pregabalin, and he was to receive this medication three times daily. DON acknowledged Pregabalin was not administered to R #1 for four scheduled times as required by provider orders.