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	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Alamos Wellness & Rehabilitation	1011 Sombrillo Court Los Alamos, NM 87544

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46064 Based on observation and interview the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) where unauthorized persons had access to the PHI for 1 (R #4) of 1 (R #4) resident reviewed during random observation. If resident's clinical information is not safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors and staff. The findings are: A. On 03/19/25 at 5:40 PM during a random observation, the Admissions Coordinator (AC) left a clipboard with R #4's PHI face up and unattended in the facility lobby, visible to unauthorized residents, visitors and staff. B. On 03/19/25 at 5:42 PM, during an interview, the Human Resources Director (HR) confirmed the clipboard with R #4's PHI was left faced up and unattended in the facility lobby and PHI should not have been visible. 34439

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439 Based on interview and record review, the facility failed to keep residents free from abuse for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for abuse when the facility failed to protect a resident. This deficient practice is likely to result in residents continuing to be at risk for abuse. The findings are: A. Record review of a complaint report for R #1 revealed on 12/30/24 an alleged incident of abuse had occurred as follows: a Certified Nurse Aide and another staff had witnessed a Registered Nurse (RN) #1 yell and push R #1. The incident had been reported to the Administrator. The unidentified reporter had not witnessed an investigation, and the nurse remained in the unit and the residents in the unit were at risk for further abuse by the accused nurse (RN) #1. B. Record review of R #1's face sheet, dated 03/18/25, revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: - Personal history of Traumatic Brain Injury. - Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. - Psychotic disorder with delusions due to known physiological condition. - Mild neurocognitive disorder due to known physiological condition with behavioral disturbance. C. On 03/18/25 at 12:31 PM during an interview with Laundry Aide (LA) #1, she stated she was in the memory care unit and she heard RN #1 yelling and saw R #1 push RN #1's medication cart towards her (RN #1) and the wall. Then RN #1 came around the medication cart and pushed R #1 into a room and R #1 fell down. LA #1 stated there was a resident (R #3) in the room and R #3 stated Oh my gosh what is happening. RN #1 proceeded to close the door, after she closed the door LA #1 spoke with Certified Nurse Aide (CNA) #1 that was also present and had also witnessed the incident and they went to talk to the Administrator and wrote statements. The incident occurred on 12/30/24 between 9:00-9:30 am and was reported approximately and hour and a half later RN #1 continued to work in the unit with the residents. LA #1 did notice that there was a cut on R #1's nose after the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. On 03/18/25 at 1:33 PM during an interview with Certified Nursing Assistant (CNA) #1, she stated she had witnessed an incident between RN #1 and R #1 on 12/30/24. CNA #1 stated she was in the TV room area when she heard arguing, she got up from where she was sitting and she proceeded to walk towards RN #1 and R #1. R #1 push RN #1's medication cart and RN #1 came around the medication cart and RN #1 pushed R #1. R #1 fell on the floor in the room and hit his head on the footboard of the bed. RN #1 picked him up by the shirt. CNA #1 was going towards the room to check on R #1 and RN #1 closed the door. CNA #1 stated she heard R #3 yell to both RN #1 and R #1. Stop, Stop, oh my goodness what is happening, please stop. A few minutes later R #1 walked out of the room and went to his room, he had a cut on his nose that had not been there earlier when she saw him for breakfast. CNA #1 stated she heard [name of R #3] tell them to stop over and over again. CNA #1 along with LA #1 reported incident to Administrator and wrote a statement. CNA #1 then was asked to return back to the unit. CNA #1 stated she did witness RN #1 put her hands on R #, so she knew she had to report it. CNA #1 was told by the Administrator about an hour later that the incident had been investigated and everything was ok and just to continue to work in the unit with RN #1. E. On 03/18/25 at 1:50 PM during an interview with RN #1, she stated she remembered that R #1 was having aggressive behaviors the day of the incident (12/30/24). RN #1 was at the nurses station and R #1 approached her and was using foul language with her. She was passing medications and proceeded to head to the TV room when R #1 pushed her against the wall with the medication cart, she stated she came around the medication cart and and put her arms around him and lowered him to the ground, after she lowered him to the ground he got up and that was it, he walked back to his room. RN #1 stated she just kept telling him to relax and calm down. RN #1 further stated there was no injury to R #1. RN #1 reported the incident to Administrator and wrote a statement on 12/30/24. RN #1 stated she was not removed from patient care that day. Administrator was able to view the tape later that day and cleared her to continue working. F. Record review of the witness statement provided by LA #1 to the Administrator (ADM) on 12/30/24 revealed: About 9:30 am, I heard [name of R #1] and [name of RN #1] arguing in hall then [name of R #1] pushed [name of RN #1] against the wall. So [name of RN #1] came around from med (medication) cart and pushed [name of R #1] on the floor in the room and [name of R #1] fell to the floor. [name of R #1] has a cut on his face, and his lip a little swollen. I don't now [sic] what [name of R #1] hit in the room but he did hit the floor. [name of R #3] was telling them not to fight and she was screaming. G. Record review of the witness statement provided by CNA # 1 to ADM dated 12/30/25 revealed: Around 9:30 am I heard people arguing while I was combing residents hair. I walked toward the hallway on [NAME] (memory care unit), I then saw [name of RN #1 and R #1 arguing. I walked toward the window and where another employee LA #1 was. Then I heard yelling and foul language between the two [RN#1 and R #1] then the arguing continued into the room. I then saw RN #1 and R #1 with physical fighting, where she pushed him down fell on .bed and picked him (R #1) upwards with his shirt. I have noticed a scratch on his L (left) face and a swollen lip and he stated his mouth hurts. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 03/19/25 at 3:10 PM during an interview with the ADM, she provided a written account of the incident as she could recall. Written statement was generated earlier on this day (03/19/25) per her recollection of incident. ADM stated she had looked for handwritten notes she may have taken regarding the incident and could not located them. ADM stated family had not been called, the only thing that she had done was interview the three staff that were present on the day of the incident (12/30/24) and interviewed R #1. ADM confirmed that she felt a thorough investigation had been conducted and there was no need to remove staff from the area and she (ADM) believed that abuse had not occurred.

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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. 34439 Based on record review and interview, the facility failed to provide an incident report to the State Survey Agency, for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed for abuse. If the facility fails to report incidents of possible abuse to the State Agency, then the State Agency is unable to ensure residents have a safe environment. The findings are: A. Record review of a complaint report for R #1 revealed on 12/30/24 an alleged incident of abuse had occurred as follows, a Certified Nurse Aide and and another staff had witnessed Registered Nurse (RN) #1 yell and push R #1. The incident had been reported to the Administrator and the unidentified reporter had not witnessed an investigation, and the nurse remained in the unit and the residents in the unit were at risk for further abuse by the accused nurse (RN). B. Record review of the facility's incident log dated 03/08/25 revealed the log did not contain any documentation of the incident for an allegation of of abuse toward R #1. C. On 03/19/25 at 2:42 PM during interview with the Administrator (ADM), she confirmed she is the Abuse Coordinator. ADM stated she did not believe that abuse had occurred and did not believe that the incident needed to be reported to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34439 Refer to F-600 Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse. If the facility is not conducting thorough abuse investigations then residents are likely to continue to be at risk of abuse. The findings are: A. Record review of a complaint report for R #1 revealed on 12/30/24 an alleged incident of abuse had occurred as follows, a Certified Nurse Aide and another staff had witnessed a Registered Nurse (RN) #1 yell and push R #1. The incident had been reported to the Administrator. The unidentified reporter had not witnessed an investigation, and the nurse remained in the unit and the residents in the unit were at risk for further abuse by the accused nurse (RN) #1. B. On 03/19/25 at 2:42 PM during interview with the Administrator (ADM), she confirmed she is the Abuse Coordinator. ADM further stated the procedure of an abuse allegation is if a resident makes an accusation of abuse/neglect, if it is a specific allegation of abuse towards a staff member, we place that staff member on leave and start the investigation. In the case of alleged abuse with R #1 the video tape was reviewed immediately after she was informed of the incident and determined that abuse had not occurred the way it was reported by staff. The accused staff was not removed from the unit because ADM did not feel that the residents were in any danger. The video tape was not available to State Agency for review. ADM further stated she did not conduct any type of investigation to rule out abuse other then review the video camera tape and got written statements. ADM spoke with CNA #1, Laundry Aide (LA) #1 and RN #1. ADM stated she would looked for any notes she may have taken after the incident, but she had nothing formal written out. ADM did not notify the family of the allegation/incident. ADM did provide a written account of about what she could recall of the incident on 12/30/24. ADM stated she had written the statement on 03/19/25. C. Record review of facility's Abuse Prevention and Prohibition Program (policy) dated 08/2020 revealed the following: VI: Investigation: A. The facility promptly and thoroughly investigates reports of resident abuse . C. The facility ensures protection of residents during abuse investigations. J. Facility staff who have been accused of resident abuse may be reassigned to duties that do not involve resident care or suspended from duty until Administrator has reviewed the investigation results. M. The Administrator will provide a written report of the results of abuse investigations and consequent actions to the appropriate agencies .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439 Based on record review and interview, the facility failed to ensure the facility was free of accident hazards for 1 (R #2) of 2 (R #1 and #2) residents reviewed for accidents and hazards when staff failed to supervise a resident that was considered a fall risk and required the use of an ambulatory assistance device (walker, wheelchair) in the locked unit. This deficient practice is likely to result in residents experiencing avoidable falls. The findings are: A. Record review of R #2's face sheet revealed R #2 was admitted to the facility on [DATE] with the following diagnosis: - Fracture of Unspecified Part of Neck of Right Femur (Femur fracture). - Closed Right Femur Fracture with Routine (normal) Healing. - Cognitive Communication Deficit (problems with communication caused by impaired cognitive processes, such as attention, memory, language, and reasoning). B. Record review of R #2's Fall Risk Evaluation dated 03/12/25 revealed the following: - Chair bound and required assist with toileting. - Resident is not able to stand. C. Record review of Skilled nurses note dated 03/12/25 at 11:00 pm revealed, resident experienced a fall while transferring from bed to chair at 0850 (8:50 am). D. Record review of Restorative Nursing Screener notes dated 03/12/25 at 11:55 pm revealed, Mobility: Lower extremity (hip, knee, ankle, foot) Impairment on both sides. R #2 used a Wheelchair (manual or electric). E. Record review of care plan dated 03/13/25 revealed R #2 is High risk for falls r/t (related to) generalized weakness. F. Record review of a photo taken on 03/13/25 at 12:30 pm revealed Registered Nurse (RN) #1 was asleep during observation of R #2. R #2 was several feet away standing against a wall in the locked unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Record review of the investigation report dated 03/13/25 revealed at 12:30 pm Speech Therapist (ST) took a photo of RN #1 on the couch. At 4:35 pm ST came to Human Resources (HR) and let Human Resource Director (HRD) know that Certified Nurse Aide (CNA) #1 had asked ST to take photo of the nurse (RN #1) on the couch. At 4:44 pm, the ST sent the photo to HR. At 4:50 pm, the Administrator was called and asked to review the cameras around noon time. The nurse was asked by HR if she was sleeping on the couch at any point in the afternoon. RN #1 responded she did not fall asleep on the couch, but she was sitting on the couch and resting. She was watching the new resident because she did not want her to fall. HR asked if her eyes were closed at any point while she was on the couch and she said they could have been for a couple of seconds as she did have her hand over her face. On 03/14/25 the camera was reviewed for the investigation and nurse RN #1 was not sleeping and she was monitoring the new resident (R #2). H. Record review of the video camera footage dated 03/13/25 revealed: At 12:07 pm R #2 sat in the TV room. At 12:08 pm RN #1 entered the TV room with wheelchair and is communicating with R #2. RN #1 sits on the chair across from R #2 with her hand in her pocket. At 12:18 pm, R #2 got off the chair and attempt to move her wheelchair, another resident walked in front of RN #1. RN #1 makes no sound or movement. R #1 walked away from camera view and RN #1 had not noticed her move away from her chair nor does she notice that R #1 is ambulating. At 12:25 pm R #2 returned to grab the wheelchair again for assistance and RN #1 does not attempt to re-direct R #2. At 12:27 pm, end of the video RN #1 is still sitting in same position and R #2 is not within camera range. I. On 03/24/25 at 3:08 pm during an interview with the ST, he stated he walked into the locked unit and he saw the new resident (R #2) standing next to the wall on 03/15/25 at approximately 12:30 pm, and he knew R #2 had two falls (unknown dates, but prior to 03/15/25). The ST was concerned because the nurse (RN #1) was asleep on the chair behind the resident. ST made attempts to wake up RN #1. ST notified CNA #1 and another CNA walked over as well. ST guided R #1 back to her wheelchair. ST further stated R #2 was a concern because of her history of RN #1 sleeping, he wanted to assure R #2 was safe and back in her wheelchair. R #2 was to ambulate with wheelchair.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46064 Based on observation and interview the facility failed to ensure medication carts were locked when unattended. This deficient practice is likely to negatively impact the health of residents if they were to ingest medications not intended for them. The findings are: A. On 03/18/25 at 10:25 AM during the initial walk through of the locked unit, the medication cart was unlocked and staff left the cart unattended. B. On 03/18/25 at 10:25 AM during interview with Registered Nurse (RN) #2, she confirmed the medication cart should not be left unlocked and unattended. 34439

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46064 Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: 1. All items were labeled and dated in the locked unit refrigerator. 2. Daily temperatures of the locked unit refrigerator were documented. These deficient practices are likely to affect all 20 residents in the locked unit and could lead to foodborne illnesses in residents. The findings are: A. On 03/18/25 at 10:33 AM, during the initial walk through of the facility's locked unit, a refrigerator was in the dining area. The refrigerator contained food items and snacks for the residents. The refrigerator contained the following: 1. Two containers of punch/juice, one package of cheese, one head of lettuce, one package of turkey sandwich meat, one container of salsa, a partial loaf of bread, all items were unlabeled and undated. 2. One uncovered container of punch/juice dated 03/11/25. 3. Packaged frozen food items in the freezer that were unlabeled and undated. 4. Refrigerator temperature log was not available for review. B. On 03/18/25 at 10:44 AM, Certified Nursing Assistant (CNA) #1 verified the food items in the unit refrigerator belonged to the residents, all items should be labeled and dated and they were not. C. On 03/18/25 at 10:45 AM, Registered Nurse (RN) #1 verified that there was not a refrigerator temperature log available for review. She further stated that nursing staff was not responsible for the temperature log. That was done by kitchen staff. 34439