

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  03/30/2026
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to keep residents free from neglect for 2 (R #8 and R #43) of 4 (R #8, R #26, R #43 and R #59) residents reviewed for hospitalization, when they failed to provide transportation from the hospital to the facility after being discharged from the emergency room (ER). If residents are left at the hospital after discharge, then they could likely feel confused, angry, fearful, and anxious. The findings are: R #8 A. Record review of the Intake Report (consumer complaint from the public to the state agency), dated 02/20/26, revealed residents that were transported to the ER at the local hospital were being left there for extended periods of time after being discharged . B. Record review of R #8's admission record, no date, revealed the following: 1. An admission date of 10/13/25. 2. R #8 had the following diagnoses: a. Alzheimer's disease (progressive, incurable neurodegenerative disease and the most common cause of dementia, causing severe memory, thinking, and behavior problems), unspecified. b. Vascular dementia, unspecified severity, with agitation (cognitive decline from vascular disease accompanied by behaviors like restlessness, pacing, shouting, or aggression). c. Vascular dementia, unspecified severity, with other behavioral disturbance d. Mild cognitive impairment of uncertain or unknown etiology (a slight, noticeable decline in cognitive functions-such as memory or reasoning-that is more significant than normal aging but not severe enough to interfere with daily independence). e. Cognitive communication deficit (communication impairments resulting from underlying cognitive disruptions-such as memory, attention, or executive function issues-rather than primary language deficits). f. Restlessness and agitation. C. Record review of R #8's change of condition MDS, dated [DATE], revealed the following: 1. A BIMS score of 1.2. Resident was frequently incontinent of urine and bowel movements. D. Record review of R #8's nursing progress notes revealed the following: 1. On 01/31/26 at 3:00 AM, 911 was called. R #8 was transferred to the ER after a fall. 2. On 01/31/36 at 8:37 AM, R #8 returned from the hospital. E. Record review of R #8's medical record, no date, revealed R #8 was not discharged from the facility on 01/31/26. F. Record review of hospital discharge instructions, dated [DATE], revealed R #8 was discharged from the hospital at 5:21 AM. G. On 04/01/26 at 2:38 PM, during an interview with the local ER Nurse (ERN), she stated that R #8 was discharged on 01/31/26 at approximately 5:30 AM. She stated that she called the facility numerous times and was unable to reach anyone. The ERN stated that R #8 was very disoriented. The ER didn't have enough staff to sit with R #8 1-on-1. The ERN stated when she finally reached the Administrator, she was told the facility would send staff to pick R #8 up as soon as possible. The ERN stated that R #8 was picked up by facility staff at approximately 8:30 AM on 01/31/26. R #43H. Record review of R #43's admission record, no date, revealed the following: 1. An admission date of 11/25/25. 2. R #43 had the following diagnosis: a. Alzheimer's disease, unspecified. b. Dementia, unspecified severity with other behavioral disturbance. c. Bipolar disorder, current episode depressed, severe with psychotic features (a serious psychiatric emergency characterized by severe depression combined with hallucinations or delusions). d. Depression (mood disorder that causes a persistent feeling of sadness and loss of interest). e. Anxiety disorder (mental health conditions characterized by excessive, uncontrollable (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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>fear or worry that interferes with daily life). I. Record review of R #43's admission MDS, dated [DATE], revealed the following:1. Staff documented a BIMS score of 2.2. Staff documented R #43 is frequently incontinent of urine.3. Staff documented R #43 is always incontinent of bowel movements.2. Staff documented that R #43 requires substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene. J. Record review of R #43's nursing progress notes revealed the following: a. On 01/29/26 at 7:44 PM, R #43 was sent to the ER for evaluation after a fall. b. On 01/30/26 at 9:30 AM, R #43 returned from the hospital. K. Record review of R #43's medical record, no date, revealed R #43 was not discharged from the facility on 01/29/26. L. Record review of hospital discharge instructions, dated [DATE], revealed R #43 was discharged from the hospital at 10:16 PM. M. On 03/26/26 at 3:31 PM, during an interview, the Administrator confirmed that R #43 was transferred to the hospital on [DATE]. The Administrator stated that she was notified that R #43 was discharged on 01/29/26 at approximately 10:30 PM. The Administrator stated the facility always attempts to pick up residents as soon as possible after discharge from the hospital. The Administrator stated that the facility does not have 24-hour transportation. The Administrator confirmed that R #43 was not picked up from the hospital until 01/30/26 at approximately 9:00 AM. The Administrator stated that the hospital is responsible for the residents until the facility can pick them up, even after they have been discharged from the hospital. N. On 03/26/26 at 4:04 PM, during an interview with the ERN, she stated that R #43 arrived at the hospital on [DATE] at approximately 7:30 PM. She stated that R #43 was discharged at approximately 10:16 PM on 01/29/26. ERN stated she made several calls to the facility. The calls went to voicemail. The ERN stated that she was finally able to reach the Administrator on the Administrator's cell phone. The Administrator assured the ERN facility staff was on their way to pick R #43 up. The ERN stated that she talked to the Administrator approximately 3 more times after the initial contact. The ERN stated the Administrator stopped answering calls. Facility staff did not pick R #43 up until 01/30/26 at approximately 9:00 AM. The ERN stated that through the 11 hour wait, R #43 was confused and was trying to get up out of bed. The ERN stated that R #43 became more confused as the night progressed.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to provide the required transfer information for 3 (R #8, R #26, and R #43) of 4 (R #8, R #26, R #43, and R #59) residents reviewed for hospitalizations when staff failed to: 1. Notify R #8, R #26, R #43, and their representative(s) of the residents' transfer to the hospital in writing and in a language and manner they understand. 2. Ensure the transfer notices for R #8, R #26, and R #43 included: a. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. b. The name, phone number, and address (mailing and email) of the Office of the State Long-Term Care Ombudsman (an advocate for residents in nursing homes and assisted living facilities).3. Send a written copy of R #8, R #26, and R #43 transfer notices to the Ombudsman. 4. Ensure R #8, R #26, and R #43 and their representative(s) receive a written notice of the bed hold policy which indicated the duration the bed would be held. These deficient practices could likely result in the residents and/or their representatives not knowing the reason for the transfer, the location of the transfer, and their rights to advocate and make informed decisions regarding the residents' healthcare. The findings are: R #8</p> <p>A. Record review of R #8's admission Record, no date, revealed R #8 was admitted to the facility on [DATE].</p> <p>B. Record review of R #8's nursing progress note, dated 01/31/26, revealed R #8 was transferred to the hospital following a fall.</p> <p>C. Record review of R #8's medical record, no date, revealed staff did not document a written transfer notice or written bed hold notice for R #8's transfer to the hospital on [DATE].</p> <p>R #26</p> <p>D. Record review of R #26's admission Record, no date, revealed R #26 was admitted to the facility on [DATE].</p> <p>E. Record review of R #26's nursing progress notes revealed the following:</p> <ol style="list-style-type: none"> <li>On 02/27/26, R #26 was transferred to the hospital for nausea, vomiting, and bleeding.</li> <li>On 03/05/26, R #26 was readmitted from the hospital after an episode of vomiting with blood.</li> </ol> <p>F. Record review of R #26's medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> <li>Staff did not document a written transfer notification that included information regarding how R #26 or her representative could appeal a transfer or how to contact the Ombudsman for her transfer to the hospital on [DATE].</li> <li>Staff did not document a written bed hold notification for her transfer to the hospital on [DATE].</li> </ol> <p>R #43 (continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. Record review of R #43's admission Record, no date, revealed R #43 was admitted to the facility on [DATE].</p> <p>H. Record review of R #43's nursing progress notes revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/29/26, R #43 was transferred to the hospital after a fall with laceration to forehead.</li> <li>2. On 03/17/26, R #43 was transferred to the hospital due to unresponsiveness.</li> </ol> <p>I. Record review of R #43's medical record, no date, revealed staff did not document a written transfer notice or written bed hold notice for her transfers to the hospital on [DATE] or 03/17/26.</p> <p>J. On 03/27/26 at 10:12 AM, during an interview, the SSD stated the following:</p> <ol style="list-style-type: none"> <li>1. Staff did not document a transfer notice or a bed hold notice for R #26's transfer to the hospital on [DATE].</li> <li>2. She does not notify the Ombudsman about transfers to the hospital.</li> <li>3. She emails a list of all residents who were discharged from the facility to the Ombudsman monthly.</li> <li>4. She does not send a written copy of the transfer or discharge notices to the Ombudsman.</li> </ol>