

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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.			
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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, and interview, the facility failed to ensure the results of the most recent state surveys were posted in areas of the facility that was readily accessible to residents and the public without having to ask for them. This could affect all 57 residents in the facility (residents were identified by the census report provided by the Administrator on 03/23/26). If residents, representatives, and/or visitors are unable to locate the most recent survey information, then they are unable to make informed decisions regarding residents' care. The findings are: A. On 03/25/26 at 2:00 PM, during an observation of the front lobby, revealed a survey results binder was located behind the receptionist desk in the front lobby area. The survey results binder was not readily accessible and visible for residents, family, or visitors. The survey results binder was in the middle of other binders. The survey results binder did not have any spine information on it to distinguish the binder from several other binders in the same area. B. On 03/25/26 at 1:54 PM, during an interview the Receptionist stated she was new working at the facility for about month and a half. She did not know if residents had access to the survey result binder. She stated that the survey results had been behind the reception desk since she had been working at the facility. C. On 03/26/26 at 3:52 PM, during an interview the Administrator stated that the survey result binder is located behind the receptionist's desk. The Administrator stated her expectation was that the survey result binder should be available to the residents, and the residents should know the location of the binder.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 A. Record review of R #8's admission Record, no date, revealed R #8 was admitted to the facility on [DATE]. 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. 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]. R #26 D. Record review of R #26's admission Record, no date, revealed R #26 was admitted to the facility on [DATE]. E. Record review of R #26's nursing progress notes revealed the following: 1. On 02/27/26, R #26 was transferred to the hospital for nausea, vomiting, and bleeding. 2. On 03/05/26, R #26 was readmitted from the hospital after an episode of vomiting with blood. F. Record review of R #26's medical record, no date, revealed the following: 1. 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]. 2. Staff did not document a written bed hold notification for her transfer to the hospital on [DATE]. R #43 (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of R #43's admission Record, no date, revealed R #43 was admitted to the facility on [DATE]. H. Record review of R #43's nursing progress notes revealed the following: 1. On 01/29/26, R #43 was transferred to the hospital after a fall with laceration to forehead. 2. On 03/17/26, R #43 was transferred to the hospital due to unresponsiveness. 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. J. On 03/27/26 at 10:12 AM, during an interview, the SSD stated the following: 1. Staff did not document a transfer notice or a bed hold notice for R #26's transfer to the hospital on [DATE]. 2. She does not notify the Ombudsman about transfers to the hospital. 3. She emails a list of all residents who were discharged from the facility to the Ombudsman monthly. 4. She does not send a written copy of the transfer or discharge notices to the Ombudsman.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plan revisions occurred for 4 (R #3, R #5, R #9, and R #14) of 10 (R #1, R #3, R #4, R #5, R #6, R #9, R #10, R #14, R #54, and R #64) residents reviewed for care plan accuracy, when staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #3 A. Record review of R #3's admission Record, no date, revealed the following: 1. R #3 was admitted to the facility on [DATE]. 2. R #3 had the following diagnoses: a. Alzheimer's Disease (a progressive, irreversible brain disorder that causes cognitive decline, memory loss, and behavior changes). b. Unsteadiness on feet (a lack of balance, stability, or coordination while standing or walking, often resulting in stumbling, staggering, or frequent falls). c. Repeat Falls d. Unspecified abnormalities of gait and mobility (general, undefined difficulties with walking or movement, such as unsteadiness or improper movement patterns). e. Unspecified lack of coordination (a general inability to control or coordinate muscle movements, that cannot be linked to a specific underlying diagnosis). B. On 03/24/26 at 1:48 PM, during an interview, R #3's Family Member (FM) stated that R #3 had fallen on 03/17/26. C. Record review of R #3's nursing progress note, dated 03/17/26, revealed R #3 was behind the secure unit door. R #3 fell when a staff member opened the door. D. Record review of R #3's IDT meeting note, dated 03/18/26, revealed the following: 1. R #3 fell due to an external force, causing R #3 to lose her balance. 2. The IDT recommended a referral for therapy to evaluate R #3. 3. Staff were to be mindful when entering and exiting the Secure Unit. 4. Staff were to redirect residents away from the doors. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 03/25/26 at 1:56 PM, during an interview, Physical Therapy Assistant (PTA) #16 stated the following: 1. R #3 was assessed by PT staff on 03/19/26 after she had fallen on 03/17/26. 2. After R #3 was assessed, she was started on PT services. 3. R #3 was not receiving PT services at the time of her fall on 03/17/26. F. Record review of R #3's care plan, revised 02/03/26, revealed staff did not revise R #3's care plan after R #3's fall on 03/17/26. G. On 03/25/26 at 1:12 PM, during an interview, the Regional Nurse Consultant (RNC) confirmed the following: 1. Staff did not revise R #3's care plan after her fall on 03/17/26. 2. Staff were expected to revise care plans when the IDT met and determined what interventions would be implemented to prevent future falls. R #5 H. Record review of R #5's admission record, no date, revealed R #5 was admitted to the facility on [DATE]. I. On 03/26/26 at 2:35 PM, during a random observation of the Secure Unit revealed R #5 was seated in the common area watching television. His lips were dry and chapped. J. On 03/26/26 at 2:47 PM, during an interview, R #5 stated he puts ChapStick on his lips all the time. He stated he knows they are dry, but it does not bother him. He does not need or want anything other than the Chapstick for his dry lips. He stated he thinks he drinks enough water because he drinks water all throughout the day. He stated that staff treat him well and remind him to drink water and use his Chapstick. K. On 03/26/26 at 2:51 PM, during an interview, CNA #1 stated R #5 does apply Chapstick to his dry lips throughout the day, however he is always licking or biting his lips therefore they stay dry and chapped. She stated R #5 does not complain about or report that his dry lips bother him. L. Record review of R #5's care plan dated 01/06/25 revealed R #5 is at risk for dehydration due to a diagnosis of traumatic brain injury. Care plan approaches included assessing R #5 for dehydration (.dry cracked lips.). Staff did not document revisions to R #5's care plan since 01/06/25. Staff did not document R #5's dry chapped lips. M. On 03/27/26 at 12:37 PM, during an interview, LPN #1 confirmed there was no documented review or revision for R #5's care plan related to dry, chapped lips since 01/06/25. R #9 N. Record review of R #9's admission Record, no date, revealed the following: (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #9 was readmitted to the facility on [DATE]. 2. R #9 had the following diagnoses: a. Unspecified dementia, unspecified severity, with agitation (a type of dementia characterized by cognitive decline and behavioral disturbances, including agitation, which can significantly impact daily functioning and quality of life. The specific type and cause of dementia have not been identified) b. Pathological fracture of the hip unspecified (when an unspecified bone in the hip breaks due to an underlying condition that weakens the bone, rather than from a traumatic injury). c. Unsteadiness on feet (lack of balance, stability, or coordination while standing or walking, often resulting in stumbling, staggering, or frequent falls). d. Repeated falls (when an individual experiences repeated falls in a specific time frame). e. Unspecified abnormalities of gait and mobility (general, undefined difficulties with walking or movement, such as unsteadiness or improper movement patterns). f. Unspecified lack of coordination (a general inability to control or coordinate muscle movements, that cannot be linked to a specific underlying diagnosis). O. Record review of R #9's nursing progress note, dated 03/09/26, revealed R #9 was found on the floor after reportedly falling out of bed. P. Record review of R #9's care plan revised on 02/11/26 revealed staff were to encourage R #9 to use environmental devices such as hand grips, handrails, etc. Q. On 03/27/26 at 12:37 PM, during an interview, LPN #2 confirmed the following: 1. R #9 fell on [DATE]. 2. Staff did not document that the IDT met to discuss R #9's fall. 3. R #9's care plan was not revised after her fall on 03/09/26. R #14 R. Record review of R #14's admission Record, no date, revealed the following: 1. R #14 was admitted to the facility on [DATE]. 2. R #14 had the diagnosis of unspecified systolic congestive heart failure (condition where the left ventricle of the heart [chamber that pumps oxygenated blood to the body] cannot pump blood effectively, leading to fluid buildup and reduced cardiac output [occurs when the heart cannot pump enough blood to meet the body's oxygen and nutrient demands]). S. Record review of R #14's physician's orders revealed an order dated 01/31/26: Lasix oral tablet (diuretic medication that helps eliminate fluid buildup) give 20 mg by mouth one time a day related to (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unspecified systolic congestive heart failure. T. Record review of R #14's care plan revealed the following: 1. The care plan for congestive heart failure was initiated on 12/14/25. 2. Staff did not document the use of Lasix for congestive heart failure. U. On 03/27/26 at 11:15 AM, during an interview, LPN #1 confirmed the following: 1. R #14 was taking Lasix for the diagnosis of congestive heart failure. 2. Staff did not revise R #14's care plan to include that R #14 was taking Lasix. 3. Staff should have revised R #14's care plan to include the high-risk medication Lasix and the interventions for monitoring potential side effects.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were treated with respect and dignity for 1 (R #54) of 2 (R #54, and R #64) residents sampled for dignity, when the facility failed to wake R #54 while asleep in the dining room and/or ask if R #54 wanted to join the activity that was taking place in the dining room. This deficient practice is likely to result in residents feeling unimportant, embarrassed, undervalued, and could diminish their self-worth. The findings are: A. Record Review of R #54's admission Record, no date, revealed resident was admitted on [DATE]. B. Record review of R #54's quarterly MDS dated [DATE] revealed a BIMS score of 12. C. On 03/24/26 at 2:32 PM - 2:54 PM, during an observation of the tea social activity in the resident dining room revealed the following: 1. R #54 was asleep in the center of the dining room surrounded by other residents. 2. There were four staff present (activity director, activity assistant, dietary aide, and a volunteer). 3. Staff did not attempt to wake R #54 up. 4. R #54 was not offered tea during this time of the social. D. On 03/24/26 at 2:54 PM, during an interview with the Activity Assistant (AA), AA was asked if she had attempted to wake R #54, she stated Oh, I will try right now. AA attempted to wake R #54. R #54 was not fully awakened. AA poured R #54 a cup of hot water. AA placed the cup on the table in front of R #54 and walked away. E. On 03/24/26 at 3:10 PM, during an observation of the tea social activity in the resident dining room revealed the following: 1. R #54 was still asleep. 2. AA observed Surveyor returning to the dining room, she attempted to wake R #54. AA shook R #54's shoulder. She stated, [Name of R #54], wake up, please make me look good. F. On 03/24/2026 at 4:07 PM, during an interview with R #54 he stated the staff don't care, and they won't do anything to assist. Sometimes there's good or bad depending on the staff. G. On 03/24/26 at 3:15 PM, during an interview the Activity Director (AD) stated when residents are sleeping during activities, staff are expected to attempt to wake residents to determine if they want to participate or go to their room. AD stated that it should not take staff thirty minutes to wake R #54.		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep residents free from involuntary seclusion (separation of a resident or patient from others, or from their room, against their will or the will of their legal representative) for 1 (R #7) of 1 (R #7) residents reviewed for physical restraints, when they failed to implement and document the following: 1. The clinical criteria (rules or standards on which a decision or judgment is made to determine medical necessity) R #7 met for placement in the secured/locked area by the resident's physician along with information provided by members of the interdisciplinary team. 2. Whether placement in the secured/locked area was the least restrictive approach that was reasonable to protect R #7 and assure her health and safety. 3. The IDT consideration of the impact and/or reaction of R #7, if any, regarding placement on the unit. 4. Ongoing review and revision of R #7's care plan as necessary, including whether she continues to meet the criteria for remaining in the secured/locked area, and if the interventions continue to meet the needs of R #7. These deficient practices could likely cause anxiety and depression due to residents being placed in an environment that restricts their freedom of movement throughout the facility. The findings are: A. On 03/24/26 at 4:38 PM, during an observation of the secured unit, it revealed R #7 was in the secured unit. B. Record review of R #7's admission record, no date, revealed an admission date of 06/25/24. C. Record review of R #7's Consent for Placement in Dementia Secure Unit form, revealed that R #7 signed on 02/13/26. D. Record review of R #7's Electronic Medical Record (EMR) revealed: 1. The physician and IDT did not document clinical rationale for R #7's placement in the secure unit. 2. Staff did not document that placement in secured unit was the least restrictive approach for R #7. 3. Staff did not document that the IDT assessed the impact or reaction of R #7 being placed in secured unit. 4. Staff did not document the ongoing review to indicate whether R #7 continued to meet the criteria to remain in the secured unit. 5. Staff did not document a diagnosis of dementia. E. Record review of R #7's quarterly MDS, dated [DATE], revealed a BIMS score of 6. F. Record review of R #7's NM Elopement Risk Evaluation, dated 02/06/26, revealed R #7 is no risk of elopement. G. On 03/26/26 at 5:27 PM, during an interview, R #7 stated she did not know why she was in the secured unit. H. On 03/26/26 at 10:34 AM, during an interview with the SSD, she confirmed that the required documentation for placement in the secured unit was not completed. I. Record review of the facility's Secure Unit Policy, revision date July 2024, revealed that the criteria for the secured unit is a cognitive deficit and a high risk for elopement.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation and interview, the facility failed to provide an ongoing program of activities designed to meet the interests of the residents for 2 (R #8 and R #43) of 3 (R #8, R #43, and R #54) residents reviewed for activities, when staff failed to provide meaningful activities based upon residents' interests. If residents are not provided or encouraged to attend/participate in activities that meet their interests, they are likely to experience an increase in boredom, isolation, and depression. The findings are: R #8A. On 03/24/26 at 10:17 AM, during an interview, R #8's Family Member stated he never sees residents doing any activities in the Secure Unit. B. On 03/24/26 at 3:08 PM, during an observation of the secured unit, there is an activity calendar posted in the commons area on the wall by the television. It was observed that the activity calendars are hanging in the resident's rooms also. C. On 03/24/26 at 2:18 PM, during an interview, CNA #8 stated activities are not scheduled in the Secured Unit. CNA #8 stated that the activities calendar posted was for the Main Unit. CNA #8 stated that at one time there was a table in the tv area for activities. CNA's were able to put out coloring sheets and other activities for the residents. CNA #8 stated that the table was removed about two months ago. She did not know why. R #43 D. On 03/24/26 at 2:43 PM, during an interview with R #43's Guardian, she stated the following: 1. She had not observed any activities in the Secured Unit. 2. R #43 has had a decline in health. 3. R #43 was unable to get out of bed. 4. She did not think staff were providing one-on-one visits or activities for R #43. E. On 03/25/26 at 4:51 PM, during an interview, the Activities Director (AD) confirmed the following: 1. The activities calendar posted in the Secured Unit was not for the Secured Unit. It was for residents in the main unit. 2. He did not have an activities calendar for the Secured Unit. 3. He does random non-scheduled activities throughout the day for the Secured Unit. 4. He did not have an activity aide until recently (AD did not give a specific time frame). 5. He had not been able to provide scheduled activities in the Secured Unit. 6. He could not leave things out for the residents in the Secured Unit because they disappear. 7. He currently does not have a consistent activity program for the Secured Unit.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide quality of care for 1 (R #3) of 1 (R #3) residents reviewed for hospice services when staff failed to: 1. Ensure care coordination occurred between hospice staff and facility staff. 2. Ensure R #3's visit notes from hospice were in her medical record. 3. Ensure R #3's orders from the hospice provider were in her medical record. These deficient practices are likely to result in staff not being aware of residents' care needs, staff not providing ordered medications, and worsening of the residents' medical conditions. The findings are: A. Record review of R #3's admission Record, no date, revealed R #3 was admitted to the facility on [DATE]. B. On 03/24/26 at 2:06 PM, during an interview, R #3's Family Member (FM) stated the following: 1. R #3 had fallen on 03/17/26. 2. The hospice provider had ordered R #3 scheduled pain medication for hip pain. 3. R #3 was diagnosed with pneumonia (a serious lung infection caused by bacteria, viruses, or fungi) and was started on antibiotics (powerful medications that treat bacterial infections by killing bacteria or preventing them from reproducing) on 03/19/26. C. Record review of R #3's hospice physician's orders, dated 03/19/26, revealed the following: 1. An order for doxycycline (antibiotic medication to treat infections) 100 mg twice a day for seven (7) days for upper respiratory infection (URI, a contagious viral or bacterial illness affecting the nose, throat, and sinuses, commonly causing cough, congestion, sore throat, and low-grade fever). 2. An order for prednisone (a potent synthetic corticosteroid used to treat severe inflammation, allergies, autoimmune diseases (like lupus and rheumatoid arthritis), asthma, and to prevent organ rejection) 20 mg daily for five (5) days for upper respiratory infection. 3. An order for acetaminophen (medication to treat mild-to-moderate pain and reduce fevers) 500 mg every eight (8) hours as needed for fever. D. Record review of R #3's physician's orders revealed the following: Record review of R #3's physician's orders revealed the following: 1. An order dated 03/19/26, for doxycycline 100 mg every 12 hours for infection (incorrect diagnosis, hospice order was for URI) until 03/28/26 at 11:59 PM (Order conflicts with the hospice order finding C. Seven days from 03/19/26 would have ended the morning of 03/26/26). 2. An order dated 03/19/26, for prednisone 5 mg (incorrect dose, hospice order was for 20 mg) once a day for pain (incorrect diagnosis, hospice order was for URI) with no end date (Order conflicts with the hospice order finding C. Hospice physicians ordered 20 mg for 5 days). 3. An order dated 03/19/26, for acetaminophen 500 mg every eight (8) hours as needed for pain (Order conflicts with the hospice order finding C. The hospice diagnosis was for fever). E. Record review of R #3's nursing progress notes revealed the following: 1. On 03/19/26 staff documented that R #3 had an elevated temperature of 100.8 degrees and had been looking ill since the morning. The hospice nurse assessed R #3 and medications were ordered. Acetaminophen 500 mg was administered to lower R #3's temperature. 2. On 03/23/26 staff documented hospice staff reported R #3 had pain to her left hip. R #3's hip appeared to be swollen. R #3's FM did not want diagnostic testing for R #3. R #3 was being treated for pneumonia. The hospice nurse was going to discuss R #3's pain regimen with the hospice provider to start R #3 on scheduled pain medication. F. Record review of R #3's medical record, no date, revealed no documentation of the following: 1. Hospice nurse's assessment of R #3 on 03/19/26. 2. Medication orders from the hospice provider on 03/19/26. G. Record review of R #3's hospice note, dated 03/23/26, revealed the following: 1. R #3 had moderate hip pain. 2. Hospice nurse discussed treatment options with R #3's FM. 3. R #3's FM decided on pain management for R #3. 4. R #3 was on antibiotics for pneumonia. 5. R #3 had a productive cough. 6. R #3 had crackles (a lung sound often heard through a stethoscope as clicking or rattling, typically signify underlying conditions like pneumonia, heart failure (pulmonary edema), or chronic lung diseases) in the base (lower part) of her left lung. H. On 03/25/26 at 2:32 PM, during an interview, Hospice Nurse (HN) #16 stated the following: 1. Another hospice nurse assessed R #3 on 03/19/26. R #3 had crackles in her lower lungs and pain in her hip. 2. She assessed R #3 on 03/23/26. R #3 had pain in her hip. R #3's FM did not (continued on next page)		

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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	want diagnostic testing but wanted to focus on pain management. 3. She said that she delivered Toradol (a powerful, non-opioid, non-steroidal anti-inflammatory drug (NSAID) used for short-term (maximum 5 days) treatment of moderate-to-severe acute pain) pills and an order from the hospice provider for Toradol to the DON on 03/24/26. 4. She stated that the DON signed a form when she delivered the Toradol. I. On 03/25/26 at 3:14 PM, during an interview, the DON stated the following:1. HN #16 dropped off medication with her on 03/24/26.2. HN #16 did not give her an order for the medication that she delivered on 03/24/26.3. She was not sure what medication HN #16 gave her or what resident the medication was for. 4. She thought the medications HN #16 gave her was a refill for a resident and didn't require a new order.5. She gave the medication to RN #16 to log in the controlled drug log. J. On 03/25/26 at 3:26 PM, during an interview, RN #16 stated the following: 1. He was the nurse working with R #3 on 03/23/26. 2. The HN #16 did not tell him on 03/23/26 that the hospice provider was going to order scheduled pain medication for R #3. 3. The HN #16 did not provide him with a visit note or any hospice orders for R #3 on 03/23/26.4. The DON gave him a bottle of Tramadol (a prescription-only synthetic opioid analgesic used to treat moderate to severe pain in adults) [This contradicts HN #16 statement that she gave Toradol to the DON] 50 mg on 03/24/26 for R #3. 5. The DON did not give him a physician's order for Tramadol 50 mg for R #3. 6. The label on the bottle of Tramadol 50 mg had directions to administer one tablet to R #3 every eight (8) hours as needed for pain (This contradicts HN #16 statement that the medication was ordered as a scheduled medication). 7. He confirmed that R #3 did not have an order in her medical record for Tramadol 50 mg. K. On 03/27/26 at 10:03 AM, during an interview, the Medical Records Clerk (MRC) stated the following:1. Hospice staff were expected to complete a note after each visit. They should leave a copy with the nurse and a copy for her to upload in the medical record.2. R #3's medical record did not have any notes or orders from hospice staff on 03/19/26.3. R #3's medical record did not have any hospice orders from 03/23/26 or 03/24/26.4. She did not have any documentation from hospice staff that needed to be uploaded into R #3's medical record. L. On 03/27/26 at 11:09 AM, during an interview, the DON confirmed the following: 1. Hospice staff were expected to communicate with the nurse caring for residents regarding their assessment of residents and any orders that needed to be added for residents.2. Hospice staff were expected to provide documentation of hospice physician's orders and visit notes to the nurse taking care of the resident. They should also give another copy of the order to the MRC to scan into the resident's medical record. 3. Facility staff were expected to review hospice visit notes and enter any orders that were received from the hospice staff. 4. The MRC was expected to scan all hospice visit notes and hospice orders into the residents' medical records. 5. She was unable to find documentation of the visit note from the hospice nurse who assessed R #3 on 03/19/26. 6. Facility staff were expected to verify there was an order from the hospice provider for any medication that was received from hospice staff. They should ensure the orders were accurately entered into the resident's medical record.		

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #3) of 3 (R #2, R #3, and R #14) residents reviewed for respiratory care when the staff failed to: 1. Order medications for the correct dose and the correct length of time for R #3's respiratory infection. 2. Assess vital signs and respiratory status after R #3 was diagnosed with an upper respiratory infection. These deficient practices are likely to result in staff not being aware of residents' respiratory status and worsening of their condition. The findings are: A. Record review of R #3's admission Record, no date, revealed R #3 was admitted to the facility on [DATE]. B. On 03/24/26 at 2:06 PM, during an interview, R #3's Family Member (FM) stated that R #3 was diagnosed with pneumonia (a serious lung infection caused by bacteria, viruses, or fungi) and was started on antibiotics (powerful medications that treat bacterial infections by killing bacteria or preventing them from reproducing) on 03/19/26. C. Record review of R #3's hospice physician's orders, dated 03/19/26, revealed the following: 1. An order for doxycycline (antibiotic medication to treat infections) 100 mg twice a day for seven (7) days for upper respiratory infection (URI, a contagious viral or bacterial illness affecting the nose, throat, and sinuses, commonly causing cough, congestion, sore throat, and low-grade fever). 2. An order for prednisone (a potent synthetic corticosteroid used to treat severe inflammation, allergies, autoimmune diseases, asthma, and to prevent organ rejection) 20 mg daily for five (5) days for upper respiratory infection. 3. An order for acetaminophen (medication to treat mild-to-moderate pain and reduce fevers) 500 mg every eight (8) hours as needed for fever. D. Record review of R #3's physician's orders revealed the following: 1. An order dated 03/19/26, for doxycycline 100 mg every 12 hours for infection until 03/28/26 at 11:59 PM (Order conflicts with the hospice order finding C. Seven days from 03/19/26 would have ended the morning of 03/26/26). 2. An order dated 03/19/26, for prednisone 5 mg once a day for pain with no end date (Order conflicts with the hospice order finding C. Hospice physicians ordered 20 mg for 5 days). 3. An order dated 03/19/26, for acetaminophen 500 mg every eight (8) hours as needed for pain. (Order conflicts with the hospice order finding C. The hospice diagnosis was for fever.) E. Record review of R #3's MAR, dated March 2026, revealed the following: 1. Staff documented doxycycline 100 mg was administered on the following dates and times: a. 03/19/26 at 8:00 PM b. 03/20/26 at 8:00 AM and 8:00 PM. c. 03/21/26 at 8:00 AM and 8:00 PM. d. 03/22/26 at 8:00 AM and 8:00 PM. e. 03/23/26 at 8:00 AM and 8:00 PM. f. 03/24/26 at 8:00 AM and 8:00 PM. g. 03/25/26 at 8:00 AM and 8:00 PM. h. 03/26/26 at 8:00 AM and 8:00 PM. i. 03/27/26 at 8:00 AM and 8:00 PM. j. 03/28/26 at 8:00 AM and 8:00 PM. 2. Staff documented prednisone 5 mg was administered on the following dates and times: a. 03/20/26 at 8:00 AM b. 03/21/26 at 8:00 AM c. 03/22/26 at 8:00 AM d. 03/23/26 at 8:00 AM e. 03/24/26 at 8:00 AM f. 03/25/26 at 8:00 AM g. 03/26/26 at 8:00 AM h. 03/27/26 at 8:00 AM i. 03/28/26 at 8:00 AM j. 03/29/26 at 8:00 AM k. 03/30/26 at 8:00 AM 3. Staff documented acetaminophen 500 mg was administered on the following dates: a. 03/20/26 b. 03/23/26 F. Record review of R #3's nursing progress notes revealed the following: 1. On 03/19/26 at 3:14 PM, staff documented that R #3 had an elevated temperature of 100.8* F. She had been looking ill since the morning. The hospice nurse assessed R #3 and medications were ordered. Acetaminophen 500 mg was administered to lower R #3's temperature. 2. On 03/19/26 at 3:28 PM, staff documented that R #3's temperature was rechecked and was 98.1* F. Staff would continue to closely monitor R #3. 3. On 03/23/26 staff documented that R #3 was being treated for pneumonia. G. Record review of R #3's hospice note, dated 03/23/26, revealed the following: 1. R #3 was on antibiotics for pneumonia. 2. R #3 had a productive cough. 3. R #3 had crackles (a lung sound often heard through a stethoscope as clicking or rattling, typically signify underlying conditions like pneumonia, heart failure (pulmonary edema), or chronic lung diseases) in the base (lower part) of her left lung. H. Record review of R #3's vital sign assessments, dated 03/01/26 to 03/30/26, revealed the following: 1. Staff did not document (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Los Alamos Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R #3's blood pressure, temperature, or pulse between 03/20/26 and 03/24/26.2. Staff did not document R #3's blood pressure, temperature, or pulse 3 between 03/26/26 and 03/30/26. I. Record review of R #3's medical record, no date, revealed facility staff did not document a respiratory assessment (evaluates a patient's breathing and lung function through a systematic approach: inspection, palpation, percussion, and auscultation. Key steps include observing breathing effort and rate, checking oxygen saturation, evaluating chest symmetry, and listening for lung sounds) after medications were ordered for R #3 on 03/19/26 for an upper respiratory infection. J. On 03/27/26 at 11:09 AM, during an interview, the DON confirmed the following: 1. R #3 was receiving doxycycline and prednisone for an upper respiratory infection since 03/19/26. 2. Facility staff (staff that worked at the nursing home) did not document assessing R #3's respiratory status between 03/19/26 and 03/27/26. 3. Facility staff were expected to assess residents' respiratory status including lung sounds and breathing effort at least every shift for residents who had a diagnosis or a suspected diagnosis of a respiratory infection or pneumonia. 4. Facility staff were expected to document the respiratory assessment in the residents' progress notes. 5. Facility staff documented that R #3 had a fever on 03/19/26 and administered acetaminophen for the fever.6. Facility staff did not document R #3's temperature between 03/20/26 and 03/24/26 or between 03/26/26 and 03/27/26.7. Facility staff were expected to assess all of the residents' vital signs at least every shift when they had an infection. K. On 03/31/26 at 11:18 AM, during an interview, the DON confirmed the following: 1. The hospice provider ordered doxycycline 100 mg to be administered to R #3 twice a day for 7 days, totaling 14 doses. 2. R #3 received 19 doses of doxycycline 100 mg. Five doses more than hospice provider had ordered. 3. The hospice provider ordered prednisone 20 mg to be administered to R #3 once a day for 5 days, totaling 5 doses. 4. The order in R #3's medical record was for prednisone 5 mg once a day and had no end date. 5. The order for prednisone 5 mg in R #3's medical record did not match the order for prednisone 20 mg that the hospice provider had ordered. 6. R #3 received 11 doses of prednisone 5 mg. R #3 should have received 5 doses of prednisone 20 mg.		

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to effectively manage pain (use of different techniques and medication to reduce and control the amount of pain a person experiences) for 1 (R #63) of 1 (R #63) residents reviewed for pain, when the facility failed to:Administer scheduled pain medications.Offer PRN pain medication. This deficient practice could likely result in residents experiencing unnecessary pain causing residents to experience a decline in physical and emotional health. The findings are:A. Record review of R #63's admission Record (no date) revealed the following:1. R #63 was admitted to the facility on [DATE]. 2. R #63 diagnoses included: a. Post-polio syndrome (condition that affects some individuals who have previously had polio, leading to muscle weakness, fatigue, joint pain and other symptoms many years after the initial infection). b. Polyneuropathy (condition in which multiple peripheral nerves throughout the body are damaged disrupting communication between the brain and the rest of the body leading to pain, numbness and weakness). c. Other chronic pain (pain that lasts over three months and can affect several parts of the body). B. On 03/24/26 at 10:06 AM, during an interview, R #63 stated the following:1. She has generalized pain (diffuse, persistent or recurring pain that can involve muscles, joints and soft tissue throughout the body) that comes and goes. 2. She had to go to the emergency room (ER) three days ago due to uncontrolled nerve pain (also known as neuropathic pain occurs due to damage or dysfunction of the nerves that send pain signals to the brain). 3. She was prescribed hydrocodone (narcotic medication used to treat severe pain) and another medication (R #63 was unsure of name of medication). 4. She had not received the other medication. 5. She was concerned that the pain would return. 6. She thought she was supposed to see the facility provider yesterday (03/23/26) to follow up on her pain and medications.7. She had not seen a provider as of that time. C. Record review of R #63's medical record revealed the following: 1. After hours call note, dated 03/21/26, revealed at approximately 1439 (2:39 PM) I received a request for this patient (R #63) to go to the emergency room. The patient has complained of generalized pain and states that she requires an ER visit when this happens. Other solutions in house were offered and the patient refused. She was sent to the emergency room. 2. R #63 was sent to the local ER on [DATE] due to uncontrolled pain. 3. R #63 was discharged from the ER and back at the facility at 9:30 PM. 4. The ER diagnosed R #63 with neuropathic pain. 5. The ER prescribed the following medications: a. Hydrocodone-Acetaminophen 5-325 mg oral tablet (prescription combination medication used to relieve moderate to severe pain, combining a narcotic analgesic with over-the-counter analgesic for enhanced pain control.), take 1 tablet by mouth every eight to twelve hours for three days as needed for pain. b. Amitriptyline (antidepressant medication primarily used to treat major depression and a variety of pain syndromes such as neuropathic pain) 25 mg oral tablet, take half-tablet by mouth at bedtime as needed for insomnia (common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and not being able to return to sleep). D. Record review of R #63's physician's orders revealed the following: 1. Order start date 03/21/26, Order end date 03/24/26: amitriptyline HCl oral tablet 25 mg, give 1 tablet by mouth every twenty-four hours as needed for insomnia. 2. An order dated 03/24/26: amitriptyline HCl oral tablet 10 mg, give 1 tablet by at bedtime for neuropathic pain for 14 days. 3. An order dated 03/21/26: hydrocodone-acetaminophen oral tablet 5-325 mg, give 1 tablet by mouth every 8 hours as needed for pain until 03/25/2026. E. On 03/25/26 at 10:35 AM, during an interview, R #63 stated the following: 1. She finally saw the facility provider on 03/24/26. 2. The facility provider prescribed the same medication the ER did for two weeks, and she was told that it should help control the pain fluctuations. 3. The provider told her that she would not have to ask for the medication. She would get it every night. 4. She did not receive the medication on 03/24/26. 5. She confirmed the medication that the provider ordered for her was amitriptyline but stated she could not remember the name until it was mentioned to her. 6. Her pain could be at zero then jump to eight (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Los Alamos Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 Sombrillo Court Los Alamos, NM 87544	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or nine (pain scale where zero is no pain and 10 is the most severe pain an individual has had). F. Record review of R #63's MAR for March 2026 revealed the following: 1. R #63 was not given any doses of her amitriptyline 25 mg PRN medication. 2. R #63 did not receive any doses of her amitriptyline 10 mg bedtime dose until 03/26/26 (two days after seeing the facility provider). G. On 03/25/26 at 4:19 PM, during an interview with the DON and LPN #3 the following was confirmed: 1. R #63 did not receive amitriptyline 25 mg PRN. 2. R #63 did not receive amitriptyline 10 mg at bedtime because the medication had not been received from the pharmacy yet.		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #3 and R #7) of 2 (R #3 and R #7) residents reviewed for accuracy of documentation, when staff failed to: 1. Ensure R #3's medications were ordered for the correct diagnoses or symptom. 2. Clarify what type of respiratory illness R #3 was being treated for. 3. Ensure that R #7's care plan documented accurate diagnosis. These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are: R #3 A. Record review of R #3's admission Record, no date, revealed the following: 1. R #3 was admitted to the facility on [DATE]. 2. R #3's diagnoses did not include a respiratory illness. B. On 03/24/26 at 2:06 PM, during an interview, R #3's Family Member (FM) stated that R #3 was diagnosed with pneumonia (a serious lung infection caused by bacteria, viruses, or fungi) and was started on antibiotics (powerful medications that treat bacterial infections by killing bacteria or preventing them from reproducing) on 03/19/26. C. Record review of R #3's hospice physician's orders, dated 03/19/26, revealed the following: 1. An order for doxycycline (antibiotic medication to treat infections) 100 mg twice a day for seven (7) days for upper respiratory infection (URI, a contagious viral or bacterial illness affecting the nose, throat, and sinuses, commonly causing cough, congestion, sore throat, and low-grade fever). 2. An order for prednisone (a potent synthetic corticosteroid used to treat severe inflammation, allergies, autoimmune diseases (like lupus and rheumatoid arthritis), asthma, and to prevent organ rejection) 20 mg daily for five (5) days for upper respiratory infection. 3. An order for acetaminophen (medication to treat mild-to-moderate pain and reduce fevers) 500 mg every eight (8) hours as needed for fever. D. Record review of R #3's physician's orders revealed the following: 1. An order dated 03/19/26, for doxycycline 100 mg every 12 hours for infection (incorrect diagnosis, hospice order was for URI) until 03/28/26 at 11:59 PM (Order conflicts with the hospice order finding C. Seven days from 03/19/26 would have ended the morning of 03/26/26). 2. An order dated 03/19/26, for prednisone 5 mg (incorrect dose, hospice order was for 20 mg) once a day for pain (incorrect diagnosis, hospice order was for URI) with no end date (Order conflicts with the hospice order finding C. Hospice physicians ordered 20 mg for 5 days). 3. An order dated 03/19/26, for acetaminophen 500 mg every eight (8) hours as needed for pain (Order conflicts with the hospice order finding C. The hospice diagnosis was for fever). E. Record review of R #3's hospice progress note, dated 03/23/26, revealed the following: (continued on next page)		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R #3 was on antibiotics for pneumonia. 2. R #3 had a productive cough. 3. R #3 had crackles (a lung sound often heard through a stethoscope as clicking or rattling, typically signify underlying conditions like pneumonia, heart failure (pulmonary edema), or chronic lung diseases) in the base (lower part) of her left lung. F. On 03/27/26 at 11:09 AM, during an interview, the DON confirmed the following: 1. R #3's hospice order for doxycycline 100 mg was for a diagnosis of URI. 2. Staff documented the order for doxycycline 100 mg was for a diagnosis of infection. 3. R #3's hospice order for prednisone 20 mg was for a diagnosis of URI. 4. Staff documented the order for prednisone 5 mg was for a diagnosis of pain. 5. R #3's hospice order for acetaminophen 500 mg was for fever. 6. Staff documented the order for acetaminophen 500 mg was for pain. 7. Staff were expected to ensure orders were entered in the medical record for the correct dose, the correct duration, and the correct diagnosis. 8. R #3's medical record was not revised to include a respiratory illness. 9. Staff were expected to update residents' diagnoses when a resident had a new diagnosis. R #7 G. Record review of R #7's care plan, dated 07/03/24, revealed that R #7 had bladder incontinence related to neurogenic disorder. H. Record review of R #7's medical record, no date, revealed R #7 staff did not document R #7 had a diagnosis of neurogenic disorder. I. On 03/27/26 at 9:25 AM, during an interview, the MDS Coordinator (MDSC) confirmed that R #7 did not have a diagnosis of neurogenic disorder. The MDSC stated that she must have entered the diagnosis of neurogenic disorder by mistake.		