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	12/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the provider timely of any skin condition changes for 1 (R #1) of 1 (R #1) resident reviewed when the facility's treatment nurse (TN) did not notify the provider of the worsening wound and lack of healing progress. This deficient practice is likely to result in a delay in treatment or inadequate treatment. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] and discharged to the emergency room [DATE]. B. Record review of R #1's medical diagnoses on face sheet dated 10/14/25 revealed the following (including but not limited to): -Muscle wasting and atrophy (waste away), not elsewhere classified, multiple sites. -Morbid (SEVERE) obesity (substantial accumulation of body fat) due to excess calories. -Developmental disorder of scholastic skills (a persons ability to learn core academic skills).-Disorder of adrenal (endocrine gland located on top of each kidney) gland.-Hypopituitary (condition where pituitary gland does not produce one or more of its hormones)-Mild cognitive impairment C. Record review of nursing note dated revealed: 06/10/25 revealed R #1, stated that she had bumped her lower left leg on the door. RN (Registered Nurse) assessed and finding were top fine layer [skin] was broken and somewhat rolled up. Nurse did unroll what was able but steri-strips were applied area cleaned with NS (normal saline) and Optifoam adhesive applied wound measured 3.2cm by 2.6cm (cm=centimeters). 06/20/25 revealed, wound dressing changed done on LLE, wound sited cleansed with NS and povidone. Redness of skin surrounding the wound was noted no purulent smell or drainage was observed ABD pad applied over wound and securely wrap with kerlix. 06/26/26 revealed, wound to lower left leg, cleanse with normal saline or wound cleanser, pat dry, apply Santyl ointment to wound and cover with ABD pad. Chief complaint/cellulitis of left lower leg.No other notes from 06/28/26 to 08/14/26 identify that the physician was notified of wound progress. D. Record review of Care plan dated 06/10/26 and revised on 07/16/25 revealed, [name of R #1] has a non healing skin tear. Goal [name of R #1]'s skin tear will be healed by review dated. Target date 07/21/25. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or had surface. E. Record review of R #1's Weekly Skin Checks dated 06/05/25 through 09/03/25 revealed the following: ?- 06/05/25: No wounds identified. ?- 06/10/25: Left lower leg (front) Skin tear 3.6x (by) 2.8 centimeters (cm) superficial (on the surface). ?- 06/17/25: Left lower leg (front) skin tear. No measurement provided. ?- 07/10/25 through 08/29/25: Left lower leg (front) open lesion (damaged tissue on the body) to mid front LLE, 5+PITTING EDEMA. No measurements of the wound were available during this time.?F. Record review of R #1's wound report dated 06/07/25 through 09/01/25 revealed the following: - 06/07/25 - 06/14/25 = Date Identified 06/10/25 left lower leg front, Length (L) = N/A, Width (W) = N/A, Depth (D) = N/A). - 06/15/25 - 06/22/25 = (No weekly skin assessment documentation found) - 07/01/25 - 07/02/25 = (No weekly skin assessment documentation found) - (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/19/25 - 07/20/25 = (No weekly skin assessment documentation found) - 07/21/25 - 08/02/25 = Last assessed: 08/02/25 = Skin Tear left lower leg front, L=4.00 cm, W=4.50 cm, D=0.10 cm - 08/03/25 - 08/11/25 = (No weekly skin assessment documentation found) - 08/12/25 - 08/25/25 = Last assessed: 08/14/25 = Skin Tear left lower leg front, L=3.70 cm, W=5.00 cm, D=0.10 cm G. Record review of R #1's physician orders revealed the following:? ?- 06/10/25: Clean LLE skin tear with NS (normal saline, a solution for cleaning skin) and top with optifoam (a specialty dressing brand) adhesive, one time a day for skin tear.?Order discontinued on 06/11/25.? ?- 06/23/25: Wound care: Monitor steri-strips (thin sticky bandages) on LLE for placement and S&S (signs and symptoms) of infection. Apply NAD (a specialty dressing use for wounds) over steri-strips and until drainage has decreased, apply abd (a type of dressing) pad over NAD. Wrap with Kerlix (type of bandage).?Order discontinued on 06/25/25. ?- 06/27/25: Wound care to Left lower leg: Cleanse with NS or wound cleanser, pat dry, apply xeroform (a type of dressing) and cover with ABD pad and wrap with kerlix every day shift for skin tear.?Order discontinued on 06/28/25. ?- 06/28/25: Wound care to left lower leg: cleanse with NS or wound cleanser, pat dry. apply Santyl (a topical medication) ointment, to wound, cover with ABD pad and wrap with kerlix. Ever yday shift for wound change dressing as needed if soiled, dislodged, and if resident persistence, of dressing change.?Order discontinued on 08/14/25. ?- 08/14/25: Wound care to left lower leg: cleanse with NS or wound cleanser, pat dry. apply Santyl ointment to wound bed, apply collagen (a topical medication) to wound, cover with ABD (a type of dressing) pad and wrap with kerlix, everyday shift for wound change dressing as needed if soiled, dislodged, and if resident persistence, of dressing change.?Order discontinued on 08/29/25. H. On 10/15/25 at 1:40 PM, during an interview with the Director of Nursing (DON), she stated all changes in wound status should be addressed immediately by notifying the provider to request any new orders. She confirmed the wound on R #1's left leg was not improving and was at a standstill and that the provider should have been notified by the facility nurses that the wound was not improving. She confirmed that there were no change in treatment order from 06/28/25 to 08/14/25 and that should be brought up to the provider's attention. She also confirmed that the treatment nurse and the provider did not have any communication regarding the wound on R #1's leg between 06/28/25 to 08/14/25. I. On 10/15/25 at 2:34 PM, during an interview with the Nurse Practitioner (NP), she stated, [name of R #1] will not let me look at her leg, so I rely on the nurses to tell her about the condition of her skin. She stated that she did not know R #1's leg wound was not improving and had not been informed by the facility of any changes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview the facility failed to ensure the wound was monitored weekly and order to refer to wound clinic was followed for 1(R #1) of 4(R #1-4) residents reviewed for wounds. This deficient practice likely resulted in the worsening of the wound. The findings are:Cross reference to findings in F580 A. Record review of R #1's wound report dated 06/07/25 through 09/01/25 revealed the following: - 06/07/25 - 06/14/25 = Date Identified 06/10/25 left lower leg front, Length (L) = N/A, Width (W) = N/A, Depth (D) = N/A). - 06/15/25 - 06/22/25 = (No weekly skin assessment documentation found) - 07/01/25 - 07/02/25 = (No weekly skin assessment documentation found) - 07/19/25 - 07/20/25 = (No weekly skin assessment documentation found) - 07/21/25 - 08/02/25 = Last assessed: 08/02/25 = Skin Tear left lower leg front, L=4.00 cm, W=4.50 cm, D=0.10 cm - 08/03/25 - 08/11/25 = (No weekly skin assessment documentation found) - 08/12/25 - 08/25/25 = Last assessed: 08/14/25 = Skin Tear left lower leg front, L=3.70 cm, W=5.00 cm, D=0.10 cm B. Record review of R #1's physician orders dated 07/23/25 revealed REFER RESIDENT TO (name of hospital) WOUND CARE CLINIC FOR FRONT LEFT LOWER EXTREMITY WOUND one time only for LLE WOUND for 7 Days. C. Record review of R #1's physician's order revealed an order dated 07/23/25 refer resident to [name of hospital] wound care clinic for front left lower extremity wound was placed by Licensed Practical Nurse (LPN) #1. D. Record review of R #1's progress notes revealed the following: ?- On 08/09/25 at 1:00 am, Nurse Practitioner (NP) made a referral to [name of hospital] wound clinic. ?- On 08/15/25 at 1:00 am, Medical Director (MD) made a referral to [name of hospital] wound clinic. E. On 10/15/25 at 1:40 pm, during an interview with the Director of Nursing (DON) she stated she oversees the entire nursing staff and that includes wound treatments. She expects the nurses to give a copy of any referrals and appointments to their scheduler/medical records personnel (MR). F. Record review of progress notes from July 2025 through October 2025 did not identify that an appointment for the wound clinic was made of that R #1 attended any wound clinic appointments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 10/15/25 at 2:34 pm, during an interview, the NP revealed she made a referral for R #1 to go to the [name of hospital] Wound Care Clinic. She stated she gave a verbal order to LPN #1 on 08/09/25. She stated her expectations is that the facility would set up appointments and transportation. H. On 10/15/25 at 4:27 pm, during an interview, MR stated she never received this referral, and the resident was not seen for wound care at [name of Wound Care Clinic] as ordered. She stated nurses are expected to give her a copy of any referrals including any pertinent documents. She stated that once she has all of the information she can then proceed with faxing and calling the third party and getting a date for that referral or appointment. She stated she processes those referrals and appointments within hours of receipt of the referral.? I. On 10/15/25 at 4:12 PM, during an interview with the DON, she confirmed that they [nurses] missed four weekly skin assessments (including description and measurements) for R #1. DON further stated that thorough skin assessments of wounds are used to monitor the wounds and assessments are expected to be completed and documented weekly.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation and interviews, the facility?failed to?ensure residents received the necessary treatment?and services to prevent the development?and worsening of?pressure wounds?(damage which results from unrelieved pressure on the body)?for??2?(R?#s?2 and 4) of 4 (R #s 1, 2, 3 and 4) residents?reviewed for wounds when staff?failed to:? Follow Physician treatment orders for R #2 and 4.Document and?monitor?wound progress (that includes measurements; to track effectiveness of wound care treatments and to prevent the progression of pressure ulcers) for R #2.? These deficient practices likely resulted in the worsening of R #2's and R #4's pressure wounds. The findings are: R #2: A. Record review of R #2's admission assessment revealed R #2 was admitted into the facility on [DATE] from the local hospital with stage 2 (some of the outer surface of the skin is damaged) pressure ulcer to his coccyx (tailbone) measuring 2.3x4.2 centimeters. B. Record review of R #2's face sheet medical diagnoses revealed the following (including but not limited to): -Type 2 diabetes mellitus (condition when the body cannot use insulin correctly and sugar build up in the blood), onset: 09/03/25. -Pressure ulcer (Bedsores are injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time) of other site, unstageable (Unstageable pressure ulcers are wounds characterized by obscured depth due to the presence of necrotic tissue or eschar), onset: 09/03/25. -Muscle wasting and atrophy (loss of muscle mass), not elsewhere classified, multiple sites, onset 09/03/25. -Unspecified severe protein-calorie malnutrition (as a condition characterized by a weight loss of more than 10% within the past 6 months), onset 08/25/25. C. Record review of R #2's nursing admission evaluation dated 09/04/25 revealed: Integrity (part of admission documentation that verifies skin condition present on admission to the facility R #2 has a sacral pressure 11 (sacral pressure sore stage 2, when clarified by Registered Nurse (RN) #2 2.3 cm (centimeter) x 4.2 cm. One-person physical assist for bed mobility, dressing and personal hygiene. Two person assist with transfers, Toilet use, bathing. Wheelchair use for mobility. Full weight bearing D. Record review of R #2's weekly wound report (tracking system the facility utilizes to tract and trend all residents skin concerns) dated 09/03/25 through 10/15/25 revealed the following: ?- 09/03/25 - 09/10/25 = Date last assessed 09/05/25 Coccyx, Deep Tissue Pressure Injury, Length (L) = 6.00, Width (W) = 6.60, Depth (D) = 0.00, Deep Maroon=75%, Bright Beefy Red=25%. ?- 09/11/25 - 09/17/25 = No weekly skin assessment documentation found. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	?- 09/17/25 - 09/24/25 = Date last assessed: 09/23/25 Coccyx, Unstageable (wound with full thickness tissue loss), L = 7.00, W = 7.00, D = N/A, Deep Maroon=25%, Bright Beefy Red=50%, slough (dead tissue that separates from the living tissue) white fibrinous (layer of tissue on its surface) =25%, Scant Exudate (fluid that drains from the wound) - serosanguineous (fluid that contains both clear water fluid and blood). ?- 09/24/25 - 10/01/25 = last assessed: 10/01/25 Coccyx, Unstageable, L = 7.00, W = 7.00, D = N/A, Bright Beefy Red=75%, slough white fibrinous=25%, Erythema (redness of the skin), Scant Exudate - serosanguineous. ?- 10/01/25 - 10/08/25 = No weekly skin assessment documentation found. - 10/08/25 - 10/15/25 = Date last assessed: 10/10/25 Coccyx, Unstageable, L = 7.00, W = 2.00, D = N/A, slough white fibrinous=100%, Erythema, moderate Exudate - serosanguineous. E. Record review of Care plan dated 09/03/25 revealed: [name of R #2] has 1 pressure ulcer or potential for pressure ulcer development r/t (related to) immobility. Approach- Administer treatments as ordered and monitor for effectiveness. Educate [name of R #2]/family/caregivers as to causes of skin breakdown, including, transfer/positioning/requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Inform [name of R #2]/family/caregivers of any new area of skin breakdown. The care plan did not identify any order for pressure relieving mattress, wheelchair cushion or requirement for staff to reposition the resident. F. Record review of R #2's physician orders revealed the ?- 09-05-25: stage 2 Pressure ulcer (localized damage to the skin typically occurs over bony prominent area) to coccyx (tailbone area): cleanse with wound cleanser or NS (Normal following: Saline, a solution used to clean wounds), pat dry, apply collagen (a type of special dressing) to wound bed, cover with bordered gauze QD (once daily) and PRN (as needed) Discontinued 09/06/25 ?- 09-06-25: SKIN TRAUMA (damage to skin and underlying tissue fur to mechanical force) to coccyx: cleanse with wound cleanser or NS, pat dry, apply collagen to wound bed, cover with bordered gauze?QD?and PRN Discontinued 09/26/25 ?- 09-24-25: Moisture barrier cream to peri area (part of the body that involves the genitals and anal area) and coccyx ?- 09-26-25: Unstageable to coccyx: cleanse with wound cleanser or ns, pat dry, apply calcium alginate (a topical medication) to wound bed, cover with bordered gauze?qd (every day)?and PRN Discontinue 10/10/25 ?- 10-06-25: Refer to wound care clinic to eval and treat as indicated ?- 10-10-25: Unstageable to coccyx: cleanse with wound cleanser or ns, pat dry, apply?medi?honey (a topical medication), apply calcium alginate to wound bed, cover with bordered gauze?qd?and PRN everyday shift AND as needed every day shift AND as needed every day shift AND as needed every day shift AND as needed. Wound Clinic Appointment 10-15-25. G. Record review of Treatment Administration Records revealed orders: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Cleanse with wound cleanser or ns, pat dry, apply collagen to wound bed, cover with bordered gauze qd (each day) and PRN (as needed) every day shift dated 09/06/25 to 09/26/25 did not identify wound care was provided 09/15/25, 09/16/25, 09/17/25 and 09/24/25. Moisture barrier cream to peri area and coccyx every shift dated 09/04/25 to 09/24/25 was documented as conducted twice daily. H. On 10/14/25 at 2:51 PM, during an interview with Licensed Practical Nurse (LPN) #2, she stated R #2 wound is getting worse everyday (not improving). She confirmed that the previous wound treatment nurse was providing wound care treatments without an order from a provider (using wound treatment not ordered by the physician). I. On 11/18/25 at 12:57 pm during an interview with DON #2 she stated that on 09/25/25 LPN # 1 did a dressing change for R #2 that was not appropriate she put a dressing on that was not according to the order. J. Record review of corrective action memo dated 09/25/25 revealed: on 09/23/25 during wound rounds it was noted that [initial for R #2]'s dressing was not the ordered dressing for the wound. [initial for R #2] informed nurse that his dressing had been changed earlier and was told by [Initial of LPN #1] that she was going to change his dressing to one that only had to be changed every 3 days. This nurse removed dressing that had [Initial of LPN #1] initials dated 09/23/25 and observed a declination [worsening] in the state of the wound. Which presented 20% slough, 20% DTI and 60% beefy red tissue. K. On 10/15/25 at 11:10 am during an interview with Family (FM) #1, she stated that R #2 has a wound to his bottom, and LPN #2 told them that the wound is really bad and suggested we take him to the hospital. R #2 was admitted to the facility with the wound on his bottom it was the size of a quarter and it was getting bigger and blue all around the open sore and at the time he went to the hospital it was now the size of a business card. R #2 was transferred to [name of hospital in another city] the wound care team saw R #2 on 10/14/25 and they were told that they wanted to take all the dead skin off the wound. He complained of a lot of pain to his bottom. FM #1 further stated that the Treatment Nurse at the facility told her (FM#1) that the dressing orders had been changed and that they would not have to change the dressing as often and it would be done every 3 days so changing it less often would help with R #2 not having so much pain when it was not changed. L. Record review of R #2'sMinimum Data Set (MDS) assessment dated [DATE] revealed that R #2 is partial/moderate assistance (helper does less than half the effort) with Activities of Daily Living (ADL's dressing, transfers, bathing). M. On 10/15/25 at 2:52 during an interview with Nurse Practitioner, she stated that when she saw the wound it was unstageable, redness around the wound, small wound opening and she relied on treatment nurse's judgement to give an update on a regular basis. She stated she would expect that her orders were followed and that she would be notified of changes to the wound. NP confirmed that she had not been notified of R #2's worsening wound and would have liked to be notified as soon as there was any change to the wound, N. Record review of R #2's nursing note dated 10/12/25 revealed R #2 was discharged from facility to the hospital per family request due to R #2's unstageable wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	O. Record review of [name of local hospital] admission assessment dated [DATE] revealed: large Sacral (tailbone) decubitus ulcer, stage III or IV (three or four) Patient (R #2] was noted to have worsening of the sacral decubitus ulcer.When he [R #2] left the hospital in September, the wound was documented as stage II and the size of a quarter. R #4 P. Record review of R #4' face sheet revealed admission date of 01/29/24. Q. Record review of care plan initiated 10/29/24 reveals [name of R #4] has pressure ulcer or potential for pressure ulcer development r/t (related to) Hx (history) of ulcers. No additional updates to the care plan related to wound or treatment interventions as of 11/18/25. R. Record review of progress note dated 10/23/25 revealed Redness coccyx. S. Record review of R #4 progress note dated 11/04/25 revealed pressure ulcer stage 3 (full thickness tissue loss) wound that is measured at 1cm x 1cm x 0.1 cm located on the upper coccyx. T. Record review of Treatment Administration Record dated 09/29/25 through 10/16/25 revealed Stage 2 to coccyx, Cleanse with NS (normal saline), pat dry, apply duoderm q (every) 3 days and prn (as needed) every day shift every 3 days. U. Record review of R #4's provider orders dated 11/05/25 revealed an order remove the dressing, clean with normal saline or wound wash, place collagen sheet over the wound then cover the wound with dry dressing. Dressing is to be changed daily and as needed. V. Record review of R #4's Treatment Administration Record (TAR) revealed order Wounds care to stage 2 PI (pressure injury) to coccyx: Cleanse with wound cleanser or NS, pat dry, apply collagen sheet, cover with dry dressing. Change daily and PRN for dislodgment and soiling. Every day shift dated 11/05/25 to 11/19/25. Wound care was documented as being completed, 11/05/25, 11/07/25, 11/10/25 and 11/12/25 through 11/19/25. W. On 11/18/25 at 11:50 am during an observation of R #4's wound care treatment and an interview with DON #2, she confirmed the date on the dressing was 11/12/25, she confirmed the dressing was 6 days old and this would indicate R #4 had not been provided wound care since 11/12/25. DON #2 further stated that the documentation of wound care being completed on the TAR from 11/13/25 through 11/17/25 would be false documentation by RN #4. X. On 11/18/25 at 2:20 pm during interview with Medical Director, he stated if a wound does not improve then he would expect to be notified and he would consider changes to his wound care orders. MD confirmed that he had not been notified that the wound was not improving. MD confirmed that he would expect the nursing staff to keep him informed of all changes so that he could monitor and direct wound care. He stated the facility had a wound care nurse and this nurse should have noted any changes and concerns and then notified him of those changes and concerns. On 11/18/25 at approximately 6:15 pm the facility was notified of a finding of Immediate Jeopardy (IJ). On 11/19/25 at 2:24 pm an acceptable plan of removal was submitted with the following evidence: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Plan of Removal 1. Immediate Actions Resident #2 is no longer a resident of the facility. Resident #4 wound was assessed and treated on 11/18/2025 by interim DON. Woundpresents in an improving condition. MD was notified of inaccurate documentation. Charge nurse alleged falsifying documentation suspended pending investigation on11/18/25. Interim DON completed an audit of all residents with wounds to ensure all orders werecarried out correctly on 11/18/2025. All other dressings were found to be dated correctlywith correct ordered treatment in place.2. System CorrectionsRe-educate all licensed nurses on:Wound care policyIdentification of wound progression: Proper wound assessment and monitoringtechniques to recognize signs of wound decline or wound not progressing.How to document completed wound care correctly.When and how to notify the provider related to change in worsening wound status toensure any new orders are provided as needed.Completing wound treatments exactly as ordered.Zero-tolerance policy for falsifying documentation.Nurses to complete competency related to completing wound dressing correctly.Nurse re-education and competency to be completed by interim DON or appropriatedesignee prior to completing any wound care for residents. Re-education/competencyobservation began on 11/18/25. Agency nurses will be educated prior to their shiftbeginning by interim DON/designee.Facility will consult with wound provider for consenting residents.3. Monitoring / QA Interim DON or designee will conduct weekly wound audits of current residents withwounds for two weeks, including wound assessment, documentation, notifications, andtreatments. Thereafter, 5 random residents will be selected to be reviewed weekly.4. Completion Date: 11/21/2025 The Plan of Removal was approved on 11/19/25. The Immediate Jeopardy was removed as of 11/19/25 and the scope and severity was reduced from J to D. The POR was verified as follows: Record review confirmed full house audit of all residents to identify any wounds. On 11/05/25 at 3:30 pm the Plan of Removal was verified when LPN #1, 2, 3 and Registered Nurse (RN) #1 each interviewed and stated they had been provided training on 11/18/25 which included reviewing all orders for all residents, verifying the orders with the facility provider, and entering the orders in each resident's EMR. All four nurses confirmed their training included monitoring all residents for daily wound care orders completing wound care orders and then documenting wound care. The Interim DON reported she had been provided training on 11/18/25 to monitor all residents with wounds review all resident's wound care orders and document all wound care provided. The facility administrator was interviewed and confirmed that the plan of removal had been reviewed by the facility Quality Assurance and Performance Improvement (QAPI) (a group of facility leaders who review the performance of the facility and staff and determine areas that could be improved) team on 11/18/25 and the changes were now included in the QAPI review.

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	12/19/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to: ensure medications were stored properly, medication carts were locked and secured when not in use. This deficient practice is likely to result in resident injury, through dosing with medications that have been improperly stored, having access to medications not prescribed for them, and possible overdose. A. On 11/18/25 at 2:00 pm, during random observation of the memory care unit and interview the medication cart was unlocked. Medication cart was in the back of the unit and standing next to the medication cart was R #5 and walking back and forth was R #6. Medication cart was unlocked from 2:00 pm to 2:33. Housekeeping Director was asked medication cart should be left unlocked and he stated No and proceeded to go look for Director of Nursing (DON) #2, and left cart unlocked. Certified Nurse Aide (CNA) #1 was asked if medication cart should be unlocked, she stated it should not be she also walked away to look for the Nurse. CNA #1 came back a few minutes later and locked the medication cart. B. On 11/18/25 at 2:32 pm, during an interview with the Director of Nursing she confirmed the medication cart was unlocked and she stated that the medication carts should be locked when not in use.

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	12/19/2025

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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 - Some	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, observation and interview, the facility failed to ensure medical records were accurate for 2(R #2 and 4) of 4(R #104) residents reviewed. If the facility is not ensuring accurate medical records, then residents are likely at risk of not receiving the care needed to achieve optimal wellness. The findings are:R #2:A. Record review of R #2's admission assessment revealed R #2 was admitted into the facility on [DATE] from the local hospital with stage 2 (some of the outer surface of the skin is damaged) pressure ulcer to his coccyx (tailbone) measuring 2.3x4.2 centimeters. B. Record review of R #2's weekly wound report (tracking system the facility utilizes to tract and trend all residents skin concerns) dated 09/03/25 through 10/15/25 revealed the following: ?- 09/03/25 - 09/10/25 = Date last assessed 09/05/25 Coccyx, Deep Tissue Pressure Injury, Length (L) = 6.00, Width (W) = 6.60, Depth (D) = 0.00, Deep Maroon=75%, Bright Beefy Red=25%. ?- 09/11/25 - 09/17/25 = No weekly skin assessment documentation found. ?- 09/17/25 - 09/24/25 = Date last assessed: 09/23/25 Coccyx, Unstageable (wound with full thickness tissue loss), L = 7.00, W = 7.00, D = N/A, Deep Maroon=25%, Bright Beefy Red=50%, slough (dead tissue that separates from the living tissue) white fibrinous (layer of tissue on its surface) =25%, Scant Exudate (fluid that drains from the wound) - serosanguineous (fluid that contains both clear water fluid and blood). ?- 09/24/25 - 10/01/25 = last assessed: 10/01/25 Coccyx, Unstageable, L = 7.00, W = 7.00, D = N/A, Bright Beefy Red=75%, slough white fibrinous=25%, Erythema (redness of the skin), Scant Exudate - serosanguineous. C. Record review of Weekly Skin Check for R #2 dated 09/29/25 revealed No is response to question Does the resident have any skin impairment? The assessment also identified The assessment was completed using direct observation and communication with the resident, as well as communication with licensed and non licensed direct care staff member. R #4D. Record review of R #4' face sheet revealed admission date of 01/29/24. E. Record review of care plan initiated 10/29/24 reveals [name of R #4] has pressure ulcer or potential for pressure ulcer development r/t (related to) Hx (history) of ulcers. No additional updates to the care plan related to wound or treatment interventions as of 11/18/25. F. Record review of R #4's Treatment Administration Record (TAR) revealed order Wounds care to stage 2 PI (pressure injury) to coccyx: Cleanse with wound cleanser or NS, pat dry, apply collagen sheet, cover with dry dressing. Change daily and PRN for dislodgment and soiling. Every day shift dated 11/05/25 to 11/19/25. Wound care was documented as being completed, 11/05/25, 11/07/25, 11/10/25 and 11/12/25 through 11/19/25. G. On 11/18/25 at 11:50 am during an observation of R #4's wound care treatment and an interview with DON #2, she confirmed the date on the dressing was 11/12/25, she confirmed the dressing was 6 days old and this would indicate R #4 had not been provided wound care since 11/12/25. DON #2 further stated that the documentation of wound care being completed on the TAR from 11/13/25 through 11/17/25 would be false documentation by RN #4.