STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325061	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Betty Dare Wellness & Rehabilitation LLC	3101 North Florida Avenue Alamogordo, NM 88310

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create a baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) that include all necessary information for providing care for 1 (R #17) of 3 (R #16, R #17 and R #18) residents reviewed for treatment of wounds. This deficient practice could likely result in residents not receiving the appropriate care upon admission and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition. The findings are: A. Record review of R #17's admission documents, no date, revealed the following:1. R #17 was admitted to the facility on [DATE].2. R #17 had a diagnosis of a fracture (broken bone) of the left femur (upper leg bone), subsequent encounter for closed fracture with routine healing (refers to a specific phase in fracture recovery, indicating a follow-up visit for routine care like cast checks, X-rays to monitor healing, or medication adjustments after active treatment, not the initial injury or complex complications). B. On 12/29/25 at 11:57 AM, during an interview, R #17 stated the following:1. Staff were completing wound care on her left hip.2. She was going to the doctor that day to remove the staples from her surgical incision (a clean cut or opening made in the body, typically by a surgeon, to access tissues for an operation) and see how her hip was healing. C. Record review of R #17's physician order, dated 12/22/25, revealed an order to clean incision and ensure dressing was in place each shift until staples were removed. D. Record review of R #17's base line care plan, dated 12/20/25, revealed staff did not document that R #17 had a surgical wound or any interventions in place to treat her incision. E. On 12/30/25 at 1:03 PM, during an interview, the DON confirmed the following:1. R #17 had an incision on her left hip that still had staples.2. R #17 had orders for wound care for her incision.3. Staff did not document on R #17's baseline care plan that she had an incision on her left hip that required wound care.4. Staff were expected to document all wounds and interventions in place to treat wounds in resident baseline care plans.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 1 (R #16) of 3 (R #16, R #17 and R #18) residents reviewed for treatment of wounds. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: A. Record review of R #16's admission documents, no date, revealed the following:1. R #16 was admitted to the facility on [DATE].2. R #16 had a diagnosis of a fracture (broken bone) of the left fibula (lower leg bone), subsequent encounter for open fracture type 1 or 2 (indicating a small wound with minimal contamination) with routine healing (the fracture is progressing as expected, without complications like delayed healing or nonunion). B. Record review of R #16's physician orders, dated 11/11/25, revealed the following:1. An order for Surgical Incision (surgical cut made in skin) care for R #16's left inner ankle.2. An order for Surgical Incision care for R #16's left knee. C. Record review of R #16's admission MDS assessment, dated 11/12/25, revealed staff documented that R #16 had a surgical wound. D. Record review of R #16's care plan, dated 12/16/25, revealed staff did not document the ordered interventions to treat the wounds on R #16's left leg. E. On 12/30/25 at 12:55 PM, during an interview, the DON confirmed the following: 1. R #16 had wounds on his left shin (front of the leg below the knee) and left ankle. 2. R #16 had orders for wound care to his left knee and left ankle. 3. Staff documented on R #16's care plan that he had wounds on his left knee and left ankle. 4. Staff did not document interventions in place to heal R #16's wounds on his left knee or left ankle. 5. Staff were expected to document all interventions in place to heal wounds on resident care plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet professional standards of practice (established guidelines and expectations that ensure the delivery of high-quality care to residents) for 1 (R #16) of 3 (R #16, R #17 and R #18) residents reviewed for treatment of wounds when staff failed to follow physician's orders. If the facility is not providing care per physician's orders, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: A. Record review of R #16's admission documents, no date, revealed the following:1. R #16 was admitted to the facility on [DATE].2. R #16 had a diagnosis of a fracture (broken bone) of the left fibula (lower leg bone), subsequent encounter for open fracture type 1 or 2 (indicating a small wound with minimal contamination) with routine healing (the fracture is progressing as expected, without complications like delayed healing or nonunion). B. Record review of R #16's physician order, dated 12/03/25, revealed an order to remove R #16's sutures (sterile threads, also called stitches, used to hold tissues together after injury or surgery) and staples from his left leg. C. Record review of R #16's wound clinic documents (from outside clinic), dated 12/23/25, revealed the wound care clinic removed sutures and staples from R #16's left leg on 12/23/25 (staff had not removed R #16's sutures and staples as ordered on 12/03/25). D. On 12/30/25 at 12:55 PM, during an interview, the DON confirmed the following: 1. R #16 had an order to remove R #16's sutures and staples from his left leg on 12/03/25. 2. Staff had not removed R #16's sutures or staples from his left leg until the wound clinic removed the sutures on 12/23/25. 3. Staff were expected to follow physician's orders. 4. Staff should have removed R #16's sutures and staples.

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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 1 (R #16) of 3 (R #16, R #17 and R #18) residents reviewed for treatment of wounds when staff failed to accurately document in the resident's medical record. This deficient practice has the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are: A. Record review of R #16's admission documents, no date, revealed the following:1. R #16 was admitted to the facility on [DATE].2. R #16 had a diagnosis of a fracture (broken bone) of the left fibula (lower leg bone), subsequent encounter for open fracture type 1 or 2 (indicating a small wound with minimal contamination) with routine healing (the fracture is progressing as expected, without complications like delayed healing or nonunion). B. Record review of R #16's physician order, dated 12/03/25, revealed an order to remove R #16's sutures (sterile threads, also called stitches, used to hold tissues together after injury or surgery) and staples from his left leg. C. Record review of R #16's Treatment Administration Record (TAR, documentation of treatments that have been provided to residents), dated December 2025, revealed on 12/04/25, staff documented removing R #16's sutures and staples. D. Record review of R #16's wound photographs, dated 12/09/25, revealed the following: 1. Four (4) sutures were visible on R #16's knee. 2. Six (6) staples were visible on R #16's inner left leg near the knee. E. Record review of R #16's wound clinic documents (from outside clinic), dated 12/23/25, revealed the wound care clinic removed sutures and staples from R #16's left leg on 12/23/25 (staff had not removed R #16's sutures and staples as ordered on 12/03/25). D. On 12/30/25 at 12:55 PM, during an interview, the DON confirmed the following: 1. R #16 had an order for staff to remove R #16's sutures and staples from his left leg on 12/03/25. 2. On 12/04/25, staff documented that they had removed R #16's sutures and staples as ordered.3. Staff did not removed R #16's sutures or staples from his left leg. 4. Staff should not have documented that they removed R #16's sutures and staples when they did not remove them.