STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/16/2026

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

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a written Notice of Medicare Non-Coverage (NOMNC) to 1 (R #16) of 3 (R #16, R #17, and R #18) residents reviewed for beneficiary notices. If residents or their representatives are not provided with the beneficiary notices, then they may not make an informed decision about the services provided to them and could likely result in a decline in health and function. The findings are: A. Record review of R #16's admission Record, no date, revealed R #16 was admitted to the facility on [DATE]. B. On 02/13/26 at 1:22 PM, during an interview, R #16's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) stated she did not receive a NOMNC informing her of when R #16's last day of Medicare Part A (Medicare hospital insurance that covers inpatient hospital stays, skilled nursing facility care, hospice, and limited home health services) coverage was. C. Record review of R #16's End of Part A MDS assessment (an assessment that is required when a resident's Medicare Part A stay ends but they remain in the facility) revealed R #16's end date for her most recent Medicare stay was 01/09/26. D. On 02/13/26 at 2:16 PM, during an interview, the Administrator confirmed the following: 1. Staff did not give R #16 or her POA a NOMNC. 2. Staff were expected to give residents or their representatives a copy of the NOMNC at least three (3) to five (5) days prior to the end of their Medicare Part A coverage so they can make informed decisions regarding the residents' care.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F627 S/S E, HB Based on record review and interview, the facility failed to implement an effective discharge planning process for 3 (R #16, R #17, and R #18) of 3 (R #16, R #17, and R #18) residents reviewed for discharge planning, when staff failed to: 1. Conduct discharge planning for R #16 and R #18. 2. Update comprehensive care plans and discharge plans with treatment preferences and needs for R #16, R #17, and R #18. These failures have the potential for unsafe discharge and an increased risk of resident harm. The findings are: R #16 A. Record review of R #16's admission Record, no date, revealed R #16 was admitted to the facility on [DATE]. B. On 02/13/26 at 1:22 PM, during an interview, R #16's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) stated the following: 1. R #16 planned to discharge to an assisted living facility in the community. 2. The facility had not had any meetings with her to talk about what interventions were being implemented to assist R #16 with reaching her goal to discharge to an assisted living facility. C. Record review of R #16's care plan, dated 02/07/26, revealed the following: 1. Staff documented R #16's goal was to discharge to an assisted living facility. 2. Staff did not document specific interventions that were in place to assist R #16 with meeting her discharge goal. D. Record review of R #16's medical record, no date, revealed staff did not document discharge planning meetings with the IDT team, R #16, or R #16's representative. R #17 E. Record review of R #17's admission Record, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 was discharged from the facility on 02/10/26. F. Record review of R #17's care plan, dated 02/06/26, revealed the following: 1. R #17's discharge plan was to go home with home health services. 2. Staff did not document specific interventions that were in place to assist R #17 with meeting her discharge goal. R #18 G. Record review of R #18's admission Record, no date, revealed the following: 1. R #18 was admitted to the facility on [DATE]. 2. R #18 was discharged from the facility on 12/28/25. H. On 02/16/26 at 10:08 AM, during an interview, R #18's Family Member (FM) stated the following: 1. She received a call on 12/26/25 from the Social Services Clerk (SSC) stating that R #18's last day of Medicare Part A coverage (Medicare hospital insurance that covers inpatient hospital stays, skilled nursing facility care, hospice, and limited home health services) was 12/28/25. The SSC told her that if R #18 stayed at the facility after 12/28/25, they would be charged $308 per day. 2. A staff member (she was unsure of title) looked in R #18's medical record and told her that R #18 had to leave the facility by 12:00 PM on 12/28/25 so they would not be charged. 3. During R #18's stay, staff did not have a meeting with her or R #18 to discuss R #18's discharge or discuss what interventions were in place to help R #18 discharge home safely. 4. Staff did not discharge R #18 home with any medical equipment, medications, information for home health agencies, information about community providers, or information about follow-up appointments. I. Record review of R #18's care plan, dated 11/05/25, revealed the following: 1. R #18's discharge plan was to go home with home health services. 2. Staff did not document specific interventions that were in place to assist R #18 with meeting his discharge goal. J. Record review of R #18's NMNOC, dated 12/26/25, revealed R #18's last date of coverage was 12/28/25. K. Record review of R #18's nursing progress notes, revealed the following: 1. On 12/28/25, staff documented Resident left the facility with no medications. Wife helped transfer the resident into his wheelchair and transferred into a private vehicle. Per his wife he needed to leave as they are unable to pay for the stay at the facility. 2. On 12/29/25, staff documented: a. R #18 left against medical advice on 12/29/25 (see finding K:1, R #18 left on 12/28/25). b. Prior to the scheduled discharge, the interdisciplinary team had been working to coordinate (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharge planning, including the arrangement of durable medical equipment (DME, doctor-prescribed, in-home medical devices intended for long-term due to illness or injury, such as wheelchairs, oxygen tanks, hospital beds, and walkers) and home health services to support a safe transition. c. At the time of departure, the resident left without ordered DME and without home health services in place. The resident verbalized concern that he would be financially responsible for continued stay at the facility, which contributed to his decision to leave prior to completion of discharge planning. L. Record review of R #18's medical record, no date, revealed staff did not: 1. Document discharge planning. 2. Staff did not document attempts to obtain home health services or durable medical equipment (DME) for residents to safely discharge home. 3. Staff did not document what home health services or DME the resident would need to discharge home. 4. Staff did not document a post-discharge plan of care indicating: a. Where the resident will live after leaving the facility. b. Follow-up care the residents will receive from other providers, and the provider's contact information. c. Needed medical and non-medical services. d. Community care and support services, if needed. e. When and how to contact the continuing care provider. M. On 02/16/26 at 2:28 PM, during an interview, the Administrator confirmed the following: 1. She was unable to determine if the IDT team had discharge planning meetings for R #16 and R #18. 2. Staff did not update R #16, R #17, and R #18's care plans with interventions specific to assisting each resident meet their discharge goals. 3. Discharge planning was expected to begin at admission. 4. The IDT team was expected to meet with residents and their representatives to discuss discharge planning and interventions that were needed to help residents meet their discharge goals. 5. Staff were expected to document discharge planning meetings in the resident's medical record. 6. Staff were expected to update resident care plans with interventions to help the residents meet their discharge goals. 7. R #18's NOMNC indicated that R #18's last day of coverage was on 12/28/25. 8. She stated that staff planned for R #18 to be discharged on 12/29/25. 9. She was unable to determine if anyone discussed this discharge plan with R #18 or his FM. 10. She was unsure what staff member told R #18's FM that R #18 needed to leave the facility by 12:00 PM on 12/28/25.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 in writing for 1 (R #24) of 3 (R #24, R #25 and R #26) residents sampled for hospitalizations when staff failed to: 1. Send a written copy of the Transfer Notice to the Ombudsman (is a government official who investigates and tries to resolve complaints). 2. Ensure resident or their representative received 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 representative not knowing the reason for the transfer, the location of the transfer or discharge, their rights to advocate and make informed decisions regarding the residents' healthcare. The findings are: A. Record review of R #24's admission Record revealed he was admitted to the facility on [DATE]. B. Record of R #24's nursing progress note dated 02/14/26 revealed resident was sent to the hospital due to shortness of breath. C. Record review of R #24's Bed Hold Notice Agreement dated 02/14/26, revealed staff did not document the number of days for R #24's bed hold when R #24 was transferred to the hospital on [DATE]. D. On 02/16/26 at 11:14 AM, during an interview, the Social Service Clerk (SSC) stated R #24 was sent to the hospital. SSC stated that she does not send notification to the ombudsman to inform the ombudsman when R #24 was discharged from the facility. E. On 02/16/26 at 12:54 PM, during an interview, RN #27 stated that the process for Discharge/Transfer and bed hold is given to the residents when they are leaving facility. RN #27 stated she puts three days on Bed Hold for residents' and management will change because she doesn't know how many Bed Hold days residents have. F. On 02/16/26 at 1:03 PM, during an interview, the DON stated that nurses initiate the Bed Hold process, and then BOM will follow up with the number of days the residents have. Each nurse has a check list of what needs to get done so that nothing is missed. This will make sure the Discharge/Transfers and Bed Hold process is completed for each resident that goes out. G. On 02/16/26 at 1:46 PM, during an interview, the Business Office Manager (BOM) stated nursing initiates the discharge/transfer for residents. BOM stated Nursing does not know how many days residents have. The BOM completes the Bed Hold process by reaching out to family on how many days are left for the residents. The BOM informs the family and follows up with the Bed Hold process typically the next day. H. On 02/16/26 at 2:07 PM, during an interview, the Administrator stated the Social Service department is the one that sends the notifications of discharges to the Ombudsman. The Administrator stated the Ombudsman told her that monthly notifications were okay to do. The Administrator stated she sent an email notification out on 01/20/26 for the following dates 01/12/26-01/20/26. The Administrator's expectation is that SSC would send out the Ombudsman notification of resident discharges monthly by email. I. Record review of an email from the Ombudsman on 02/16/26 at 3:16 PM, revealed that the Administrator was sending the Ombudsman notifications, however; it was to the incorrect email address. J. Record review of the facility's Transfer and Discharge policy, dated 10/24/22, revealed the facility must ensure documentation is complete, involve the physician in the decision, notify the residents and/or their representative, issue a written notice, and assist with safe and appropriate discharge planning. The policy also stated residents must be informed of their right to appeal, and staff must notify the Ombudsman.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive MDS assessment was completed within 14 calendar days after admission for 1 (R #17) of 3 (R #16, R #17, and R #18) residents reviewed for discharge planning. This deficient practice could likely result in residents' needs not being met. The findings are: A. Record review of R #17's admission Record, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 was discharged from the facility on 02/10/26. B. Record review of R #17's medical record, no date, revealed staff did not document a comprehensive MDS assessment during R #17's stay at the facility. C. On 12/13/26 at 1:41 PM, during an interview, the MDS coordinator confirmed the following: 1. R #17 was readmitted to the facility on [DATE]. 2. Staff did not document an admission MDS for R #17. 3. Staff were expected to complete an admission MDS on all residents within 14 days of admission to the facility. 4. Staff should have completed an admission MDS for R #17 by 02/05/26.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview, the facility failed to complete a Significant Change (major decline or improvement in the patient's health status) MDS assessment within 14 days after the facility determined a significant change in the resident's physical condition had occurred for 1 (R #20) of 2 (R #19 and R #20) residents reviewed for hospice services. This deficient practice could likely result in residents not receiving the appropriate care and services they need. The findings are:A. Record review of R #20's admission record, no date, revealed R #20 was admitted to the facility 11/07/25. B. Record review of R #20's physician's orders, revealed the following: 1. An order dated 01/16/26 to refer R #20 to hospice. 2. An order dated 01/22/26 to admit R #20 to hospice. C. Record review of R #20's Hospice admission Agreement, dated 01/17/26, revealed R #20 was signed by R #20's family member on 01/17/26. D. Record review of R #20's hospice visit note, dated 01/17/26, revealed R #20 was seen by a hospice nurse on 01/17/26 for R #20's start of hospice care. E. Record review of R #20's medical record, no date, revealed staff did not document a change in condition MDS assessment within 14 days after staff identified that R #20 conditioned had declined and he required hospice services. F. On 02/16/26 at 2:21 PM, during an interview, the MDS Coordinator and Regional MDS Coordinator confirmed the following: 1. R #20 was placed on hospice services on 01/17/26. 2. Staff did not document a change in condition MDS assessment for R #20 after his condition declined and he was placed on hospice services. 3. Staff were expected to complete a change in condition MDS assessment within 14 days after staff identified that a resident had a change in condition. 4. Staff should have completed a change in condition MDS assessment within 14 days after R #20 was admitted to hospice services.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete and transmit a MDS assessment within 14 days of the assessment reference date (ARD; last day of the resident observation period for the MDS assessment) for 1 (R #3) of 3 (R #1, R #2 and R #3) residents reviewed for MDS assessments. This failed practice could lead to the facility not reporting information in a timely manner (within 14 days) to the Centers for Medicare & Medicaid Services (CMS). The findings are: A. Record review of R #3's Quarterly MDS dated [DATE] revealed the following: 1. The ARD was 01/14/26. 2. The RN signed the assessment completion date on 02/10/26. B. On 02/16/26 at 4:50 PM, during an interview, the MDS Coordinator confirmed that R #3's MDS was not completed and transmitted within 14 days.

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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 and care plan meeting requirements occurred for 3 (R #1, R #16, and R #18) of 9 (R #1, R #2, R #3, R #16, R #17, R #18, R #19, R #20, and R #22) residents when staff failed to: 1. Ensure the IDT members participated in a care plan meeting within 7 days of the completion of the MDS assessment for R #16 and R #18. 2. Revise the care plan with the most current resident information for R #1. These deficient practices 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: Timing R #16 A. Record review of R #16's admission Record, no date, revealed R #16 was admitted to the facility on [DATE]. B. On 02/13/26 at 1:22 PM, during an interview, R #16's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) stated that staff had not had a meeting with her to discuss R #16's care plan. C. Record review of R #16's admission MDS, dated [DATE], revealed staff completed R #16's admission MDS on 12/15/25. D. Record review of R #16's medical record, no date, revealed staff did not document having an IDT care plan meeting for R #16. R #18 E. Record review of R #18's admission Record, no date, revealed R #18 was admitted to the facility on [DATE]. F. On 02/16/26 at 10:08 AM, during an interview, R #18's family member (FM) stated that staff did not meet with R #18 or her to discuss R #18's care plan. G. Record review of R #18's admission MDS, dated [DATE], revealed staff completed R #18's admission MDS on 11/18/25. H. Record review of R #18's medical record, no date, revealed staff did not document having an IDT care plan meeting for R #18. I. On 02/16/26 at 2:28 PM, during an interview, the Administrator confirmed the following: 1. IDT care plan meetings were not held for R #16 and R #18 since admission. 2. IDT care plan meetings were expected to occur quarterly based on the residents' MDS assessment (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dates. Care Plan Revision R #1 J. Record review of R #1's admission Record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 diagnoses included hypokalemia (low blood potassium levels) and dementia. K. Record review of R #1's Provider Progress note dated 11/10/25 revealed the following: 1. Plan: Essential hypertension (abnormally high blood pressure that is not the result of a medical condition), Patient's blood pressure ranged from 121/71 to 162/79 (force of blood pushing against the walls of the arteries as the heart pumps it throughout the body and is measured using two numbers) on losartan (medication used to treat high blood pressure) 50 mg daily, consider titration for persistent elevated blood pressures. L. Record review of R #1's care plan dated 11/06/25 revealed staff did not update the care plan to include essential hypertension diagnosis. M. On 02/16/26 at 4:05 PM, during an interview, the DON confirmed R #1's care plan was not revised with the diagnosis of essential hypertension.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received quality treatment and care for 4 (R #1, R #19, R #20, and R #22) of 7 (R #1, R #2, R #3, R #17, R #19, R #20, and R #22) residents reviewed for care and treatment, when staff failed to: 1. Ensure staff monitored R #1's blood pressure. 2. Ensure orders for hospice services (specialized, team-based care for individuals with a terminal illness focusing on comfort, pain management, and quality of life rather than curing the illness) were entered timely for R #19 and R #20. 3. Ensure orders for therapy services were discontinued when hospice services were started for R #19 and R #20. 4. Ensure orders were entered correctly into R #22's medical record. These deficient practices could likely lead to resident's needs not being met and/or a worsening of their medical condition and prognosis. The findings are: Blood Pressure Monitoring R #1 A. Record review of R #1's admission Record, no date, revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 diagnoses included hypokalemia (low blood potassium levels) and dementia. B. Record review of R #1's Provider Progress Note dated 11/10/25 revealed the following: 1. Plan: Essential hypertension (abnormally high blood pressure that is not the result of a medical condition), Patient's blood pressure ranged from 121/71 to 162/79 (force of blood pushing against the walls of the arteries as the heart pumps it throughout the body and is measured using two numbers) On losartan (medication used to treat high blood pressure) 50 mg daily, consider titration (process of gradually adjusting the dose of a medication to find the optimal amount that is effective while minimizing side effects) for persistent elevated blood pressures. C. Record review of R #1's Physician's orders revealed the following: 1. Order date 11/24/25, order discontinue date 12/08/25: Losartan tablet 50 mg, give one tablet by mouth one time a day (scheduled to be given every morning) for hypertension. 2. Order date 12/08/25, order discontinue date 01/12/26: Losartan tablet 50 mg, give one and a half tablets by mouth one time a day (scheduled to be given every morning) for hypertension, hold for SBP (top number of blood pressure reading) less than 110. D. Record review of R #1's MAR dated December 2025 revealed staff did not document checking R #1's blood pressure prior to the administration of Losartan on the mornings of December 9th through December 30th. E. Record review of R #1's MAR dated January 2026 revealed staff did not document checking R #1's blood pressure prior to the administration of Losartan on the mornings of January 1st through January 12th. F. Record review of R #1's blood pressure readings for December 2025 revealed staff did not document checking R #1's blood pressure on the mornings of December 9th, 11th, 12th, 14th, 16th, 17th, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18th, 20th, 21st, 22nd, 23rd, 25th, 28th, 30th, and 31st. G. Record review of R #1's blood pressure readings for January 2026 revealed staff did not document checking R #1's blood pressure on the mornings of January 1st, 3rd, 8th, 11th and 12th. H. On 02/16/26 at 4:16 PM, during an interview, the DON confirmed the following: 1. R #1's blood pressure was not checked every morning from December 9, 2025, through January 12, 2026. 2. It is unclear if R #1's physician's orders to hold Losartan if SBP is less than 110 were being followed. 3. Staff are expected to check and document blood pressures prior to giving medication to ensure specific parameters (specific measurements used to assess a person's health and determine effectiveness of medication) in the physician's orders are being followed. Hospice I. Record review of R #19's admission Record, no date, revealed R #19 was readmitted to the facility on [DATE]. J. Record review of R #19's physician's orders, revealed the following: 1. An order dated 12/16/25, to admit R #19 to the Skilled Nursing Facility (SNF, a licensed, 24-hour healthcare facility providing short-term, intensive rehabilitation and medical care to patients transitioning from hospital to home). 2.An order dated 01/22/26, to admit R #19 to hospice on 01/15/26. 3. An order dated 12/18/25, for speech and language pathology (SLP, a rehabilitation service that treats communication, language, cognitive, and swallowing disorders) three (3) times a week for eight (8) weeks. 4. An order dated 12/18/25, for physical therapy (PT, a healthcare specialty focused on restoring, maintaining, and improving movement, strength, and function) five (5) times a week for eight (8) weeks. 5. An order dated 12/17/25, for occupational therapy (OT, a treatment that helps people overcome physical, emotional and social challenges) five (5) times a week for 60 days. K. Record review of R #19's hospice visit note, dated 01/15/26, revealed R #19 was seen by a hospice nurse on 01/15/26 for R #19's start of hospice care. L. Record review of R #20's admission Record, no date, revealed the following: 1. R #20 was admitted to the facility on [DATE]. 2. R #20 was discharged from the facility on 02/01/26. (continued on next page)

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	02/16/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. Record review of R #20's physician's orders, revealed the following: 1. An order dated 01/22/26 to admit R #20 to hospice. 2. An order dated 12/08/25 and discontinued on 01/24/26, for PT four (4) times a week for 60 days. N. Record review of R #20's Hospice admission Agreement, dated 01/17/26, revealed it was signed by R #20's family member on 01/17/26. O. Record review of R #20's hospice visit note, dated 01/17/26, revealed R #20 was seen by a hospice nurse on 01/17/26 for R #20's start of hospice care. P. On 02/16/26 at 11:45 AM, during a joint interview, the Speech and Language Pathologist and the Physical Therapist, revealed the following: 1. When a resident is started on hospice services, they cannot receive SLP, PT, or OT services. 2. They confirmed that R #19 had been placed on hospice services on 01/15/26. 3. They confirmed that R #19 still had active orders in her medical record for SLP, PT, and OT. 4. They confirmed that R #20 was admitted to hospice on 01/17/26. 5. They confirmed that R #20's order for hospice admission was not entered into his medical record until 01/22/26. 6. They confirmed that after R #20 was admitted to hospice services, his order for PT was not discontinued until 01/24/26. 7. They stated that staff don't always communicate with the therapy team when a resident is admitted to hospice. 8. They stated that sometimes they go to do therapy with residents and staff tell them the resident is on hospice. They stated that when they look in the resident's medical record, they don't have any orders indicating that the residents have been placed on hospice. Q. On 02/16/26 at 2:55 PM, during an interview, the DON confirmed the following: 1. R #19 was receiving hospice services since 01/15/26. 2. Staff did not enter R #19's order to admit to hospice in her medical record until 01/22/26. 3. R #19 had an active order (an authorized, current directive written by a qualified healthcare provider) to be admitted to SNF. 4. R #19 had active orders for PT, OT, and SLP. 5. R #20 was admitted to hospice services on 01/17/26. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/16/2026
NAME OF PROVIDER OR SUPPLIER Betty Dare Wellness & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 North Florida Avenue Alamogordo, NM 88310	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Staff did not enter R #20's order to admit to hospice services in his medical record until 01/22/26. 7. Staff did not discontinue R #20's PT order until 01/24/26. 8. Staff were expected to enter hospice admission orders in the medical record as soon as the resident was admitted to hospice. 9. Residents cannot continue receiving PT, OT, and SLP services after being admitted to hospice. 10. Staff were expected to discontinue SNF admission orders as soon as a resident was admitted to hospice. 11. Staff were expected to discontinue PT, OT, and SLP orders as soon as a resident was admitted to hospice. Correct Orders R #22 R. Record review of R #22's admission Record, no date, revealed R #22 was admitted to the facility on [DATE]. S. Record review of R #22's convalescent care orders (CCO's, physician-signed, temporary, medically necessary orders to admit a patient to a skilled nursing facility), dated 02/13/26, revealed the following: 1. An order for weight bearing as tolerated (placing as much weight as is comfortable on an injured or operated leg or arm, ranging from minimal pressure to full weight-bearing) for R #22's right leg. 2. An order for partial weight bearing (involves placing a specific, limited percentage of body weight (e.g., 20%, 50%) on an injured leg, typically using crutches, a walker, or a cane to reduce pressure) for R #22's left leg. T. Record review of R #22's orders, dated 02/14/26, revealed the following: 1. Weight bearing as tolerated. 2. Staff did not document that the order for weight bearing as tolerated was for R #22's right leg. 3. Staff did not document the order for partial weight bearing on R #22's left leg. U. On 02/16/26 at 1:41 PM, during an interview, LPN #17 confirmed the following: 1. R #22's CCO's had an order for weight bearing as tolerated on R #22's right leg and partial weight bearing on R #22's left leg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #22's order in the medical record was for weight bearing as tolerated. 3. R #22's order in the medical record did not specify that R #22 was supposed to be weight bearing as tolerated on R #22's right leg. 4. Staff did not document an order in R #22's medical record for partial weight bearing on R #22's left leg. 5. Staff were expected to enter all CCO's as ordered into the medical record. 6. R #22 could get hurt if he puts too much weight on his left leg. V. On 02/16/26 at 2:55 PM, during an interview, the DON confirmed that staff were expected to review and enter all CCO's into the medical record correctly at the time of admission.

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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 observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #3) of 2 (R #3 and R #22) resident reviewed for implementation of orders when the facility failed to: 1. Ensure staff entered convalescent care orders (CCO's, physician-signed, temporary, medically necessary orders to admit a patient to a skilled nursing facility) for oxygen use into R #3's medical record. 2. Ensure staff followed R #3's physician's order for oxygen use. These deficient practices are likely to result in residents not receiving enough oxygen and can lead to worsening of their condition. The findings are: A. Record review of R #3's admission Record, no date, revealed R #3 was readmitted to the facility on [DATE]. B. Record review of R #3's CCO's, dated 02/13/26, revealed an order for R #3 to receive oxygen at a rate of 2.5 liters per minute (LPM, flow rate of oxygen). C. Record review of R #3's orders, no date, revealed staff did not document the physician's order for oxygen in R #3's medical record. D. On 12/16/26 at 12:24 PM, during an observation of R #3's room revealed there was not an oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) or any oxygen delivery equipment (devices, including nasal cannulas, masks, and catheters, supply supplemental oxygen to individuals with respiratory needs by delivering specific concentrations of oxygen) in her room. E. On 12/16/26 at 12:29 PM, during an observation of R #3 in the dining room, revealed R #3 did not have an oxygen tank (a container with oxygen inside it, used for helping people to breathe) on her wheelchair or a nasal cannula (a lightweight, flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen) on her face. F. On 02/16/26 at 1:57 PM, during an interview, LPN #16 confirmed the following: 1. R #3 did not have an order for oxygen in the medical record. 2. R #3's convalescent care orders dated 02/13/26 had an order for R #3 to be on 2.5 LPM of oxygen. 3. R #3 had not been placed on oxygen after returning from the hospital on [DATE]. 4. Staff were expected to enter all convalescent care orders into the medical record when a resident returns from the hospital. G. On 02/16/26 at 2:55 PM, during an interview, the DON confirmed the following: 1. Staff were expected to review all convalescent care orders and enter the orders into the resident's medical record. 2. Staff were expected to ensure all orders were implemented.