

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
NAME OF PROVIDER OR SUPPLIER Betty Dare Wellness & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 North Florida Avenue Alamogordo, NM 88310	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to ensure the MDS was accurate for 1 (R #18) of 3 (R #16, R #17, and R #18) residents reviewed for pneumonia treatment. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: A. Record review of the Resident Assessment Instrument (RAI, a comprehensive guidebook that provides instructions and coding guidelines needed to evaluate resident clinical status and develop individualized care plans) Process Policy, revised 08/22/24, revealed the facility will utilize the RAI to complete accurate assessments for each resident. B. 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 had a diagnosis of pneumonitis due to inhalation of food and vomit (a severe lung inflammation caused by breathing stomach contents or food particles into the airway). C. On 06/15/26 at 1:32 PM, an observation of R #18 in his room revealed he had his eyes closed and had not signs or symptoms of distress. D. Record review of R #18's quarterly MDS assessment, dated 04/16/26, revealed staff documented R #18 had pneumonia within the previous seven (7) days. E. Record review of R #18's provider progress note, dated 06/10/26, revealed R #18 had been admitted to the hospital on [DATE] due to aspiration pneumonia. F. On 06/16/26 at 10:59 AM, during an interview, the MDS Coordinator stated the following: 1. The pneumonia diagnosis automatically pulled into the quarterly MDS. 2. She believed the system documented R #18 had pneumonia due to his diagnosis of pneumonitis due to inhalation of food and vomit that was entered on 10/13/25. 3. She confirmed a diagnosis of pneumonia should not have been documented on R #18's quarterly MDS. G. On 06/16/26 at 12:06 PM, during an interview, the Medical Director confirmed the following: 1. R #18 had not had a diagnosis of pneumonia since October 2025. 2. R #18's diagnosis of pneumonitis due to inhalation of food and vomit should have been resolved after he was treated in October 2025. 3. R #18's quarterly MDS, dated [DATE], was inaccurate. 4. Staff should not have documented that R #18 had pneumonia within the previous seven (7) days of the MDS assessment.		

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 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, interview, and observation, the facility failed to ensure residents received quality treatment and care for 1 (R #17) of 3 (R #16, R #17, and R #18) residents reviewed for pneumonia care and treatment, when staff failed to: 1. Administer R #17's antibiotic as ordered. 2. Ensure R #17 received all doses of his ordered antibiotic. These deficient practices could likely lead to worsening of resident's medical conditions. The findings are: A. Record review of the Medication Administration Policy, no date, revealed staff were to administer medication per the order of the physician or licensed independent practitioner. B. 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 had a diagnosis of pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). C. On 06/15/26 at 12:17 PM, during an observation and interview with R #17, the following was revealed: 1. R #17 denied any respiratory concerns. 2. During observation, R #17 did not show signs of difficulty breathing. D. Record review of R #17's hospital discharge documents, dated 05/22/26, revealed the following: 1. R #17 had pneumonia in his right lung. 2. R #17 had an order for Amoxicillin-Pot Clavulanate (a broad-spectrum prescription antibiotic used to treat bacterial infections like pneumonia, sinusitis, and infections of the ear, skin, and urinary tract) 500-125 MG to be administered at bedtime for 5 days. E. Record review of R #17's physician's order, dated 05/22/26, revealed an order for Amoxicillin-Pot Clavulanate Oral Tablet 500-125 MG (Amoxicillin & Pot Clavulanate), Give 1 tablet by mouth one time a day for pneumonia until 05/27/26. F. Record review of R #17's MAR, dated May 2026, revealed staff documented the following for R #17's order for Amoxicillin-Pot Clavulanate Oral Tablet 500-125 MG: 1. On 05/22/26, staff documented code 9 (see nurse note). 2. On 05/23/26, staff documented code 9. 3. Staff documented administering the medication on 05/24/26, 05/25/26, 05/26/26, and 05/27/26 (4 doses). G. Record review of R #17's progress notes revealed the following: 1. On 05/22/26, staff did not document a note regarding why R #17's Amoxicillin-Pot Clavulanate was not administered. 2. On 05/23/26, staff documented, not in facility. H. Record review of R #17's entire medical record, no date, revealed staff did not document notifying the provider that R #17 did not receive all five (5) doses of Amoxicillin-Pot Clavulanate, or enter an order to extend R #17's Amoxicillin-Pot Clavulanate to ensure he received all five (5) ordered doses. I. Record review of the pharmacy medication manifest, dated 05/22/26, revealed five (5) tablets of Amoxicillin-Pot Clavulanate were delivered to the facility for R #17 on 05/23/26. J. On 06/15/26 at 1:33 PM, during an interview, LPN #16 and RN #16 stated the following: 1. R #17 was treated for pneumonia in May 2026. 2. They confirmed that staff documented see nurse note for R #17's Amoxicillin-Pot Clavulanate medication administration on 05/22/26 and 05/23/26. 3. If medications were not available, staff should check the medication dispensing system to see if the medication was available there. If not, they should notify the provider to see if they want to extend the order and document in the medical record. 4. R #17 received dialysis three times a week, and returned to the facility late in the evening. 5. Staff should have administered R #17's Amoxicillin-Pot Clavulanate when he returned from dialysis. K. On 06/15/26 at 1:44 PM, during an interview, the DON and Regional Nurse Consultant (RNC) confirmed the following: 1. R #17 did not receive his Amoxicillin-Pot Clavulanate on 05/22/26 or 05/23/26. 2. The Amoxicillin-Pot Clavulanate was delivered to the facility on [DATE]. 3. Staff should have administered R #17's Amoxicillin-Pot Clavulanate after he returned from dialysis on 05/23/26. 4. Staff were expected to notify the provider when an antibiotic was not administered and get an order to extend the medication so the resident received all ordered doses of the antibiotic.		

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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, interview, and observation, the facility failed to ensure medical records were complete and accurate for 1 (R #18) of 3 (R #16, R #17, and R #18) residents reviewed for pneumonia care and treatment when staff failed to document R #18's change in condition. This deficient practice could likely cause staff to not have the most accurate resident information and adversely impact the care staff provides. The findings are: A. Record review of the Change in Condition Policy, revised June 2020, revealed staff must document date, time, and pertinent details of the incident and the assessment in the nursing notes. Staff must also document the time the physician was notified, the method they were contacted, and whether or not orders were received. B. Record review of R #18's admission record, no date, revealed R #18 the following: 1. R #18 was admitted to the facility on [DATE]. 2. R #18 had the following diagnoses: a. Pneumonitis due to inhalation of food and vomit (a severe lung inflammation caused by breathing stomach contents or food particles into the airway). b. Chronic obstructive pulmonary disease (COPD, a progressive, incurable lung disease that blocks airflow and makes breathing difficult). c. Chronic respiratory failure with hypoxia (occurs when the lungs cannot adequately transfer oxygen into the bloodstream over a prolonged period). C. On 06/15/26 at 1:32 PM, an observation of R #18 in his room revealed he had his eyes closed and had not signs or symptoms of distress. D. Record review of R #18's physician's order, dated 12/19/25, revealed an order for azithromycin, give two tablets by mouth one time only for lung infection for one day and give one tablet by mouth one time a day for four days. E. Record review of R #18's progress notes, dated 12/19/25, revealed staff did not document that R #18 had a change in condition that required the provider to order antibiotics for a lung infection. F. On 06/16/26 at 10:06 AM, during an interview, LPN #16 stated the following: 1. He entered the order for azithromycin for R #18 on 12/19/25. 2. On 12/19/25, R #18 had a cough that wasn't normal for him. 3. He notified the Medical Director (MD) that R #18 had a cough during her rounds. 4. The MD assessed R #18 and gave him a verbal order for azithromycin. 5. He confirmed he did not document in the medical record that R #18 had a change in condition or that he notified the provider about R #18's change in condition. G. On 06/16/26 at 12:06 PM, during an interview, the MD stated the following: 1. On 12/19/25, LPN #16 notified her that R #18 had a cough. 2. She assessed R #18 and determined he had a lung infection. 3. She gave LPN #16 a verbal order for azithromycin for R #18. 4. She did not document in R #18's medical record that she had assessed R #18 on 12/19/25. 5. She usually writes a note with her assessment and plan for treatment in the medical record. 6. Staff were expected to document any change in condition and any provider communication in the resident medical record. H. On 06/16/26 at 12:58 PM, during an interview, the DON confirmed the following: 1. A newly developed cough would be considered a change in condition. 2. Staff were expected to complete a change in condition in the resident's medical record and notify the provider about any changes in the residents' health status. 3. Staff were expected to document any communication with the provider in the medical record. 4. The providers were expected to document all resident assessments and plans for treatment in the resident medical record.		