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	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Betty Dare	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on interview, record review, and facility policy review, the facility failed to provide care for one of 18 sample residents (Resident (R) 100) as requested which left R100 feeling undignified and upset. R100 requested a shower prior to a doctor's appointment which was not provided. Findings include: Review of R100's Admission document located under the Profile tab in the electronic medical record (EMR) revealed R100 was admitted on [DATE] with diagnosis that included acute and chronic respiratory failure with hypoxia. Review of the Progress Notes, located under the Progress Note tab in the EMR from 07/30/24 through 08/13/24 that R100 was alert and oriented to person, place, time, and situation. Review of the Care Plan, located in the EMR under the RAI tab, dated 08/13/24, noted R100 requires extensive assistance with bathing. During an interview on 08/14/24 at 9:20 AM, R100 stated, I didn't get a shower last night (Tuesday) or this morning (Wednesday) at 6:30 AM. I was told they only had one CNA (certified nursing assistant) to get me up and into the wheelchair. R100 began to cry and said, Someone screwed up. I was supposed to have a shower last night, but nobody gave me one. I was told it would be in the morning at 6:30 AM. No one came this morning to give me a shower. I was already dressed by 7:30 to 8:00AM, when they asked, and I said I can't do that now, my appointment is at 9:30 AM. R100 continued to cry. She stated I asked for a shower last night, before my doctor's appointment today. I wanted to be clean for my appointment. On 08/14/24 at 10:56 AM, CNA2 said, I came on at 6:00 AM. No one told me the resident was supposed to have a shower or I would have done it. When I found out after 8:00 AM, I couldn't get it done. I was passing trays. I got report from the night person on this hall, they didn't say nothing. Review of the bathing task sheet, located in the EMR under the task tab, a 30 day lookback, revealed only two notations both for 08/11/24 marked resident refused. There were no other entries on the record to show that a shower had been given, or bed bath offered, since admission on 07/30/24. R100 was to have a shower on Tuesday, Thursday, and Saturday on the day shift. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/14/24 at 3:00 PM with the day unit nurse, Licensed Practical Nurse (LPN)1 who was on duty from 6:00 AM to 6:00 PM, LPN1 stated, The day nurse was told the evening shift on Tuesday was to give the shower. LPN1 said she was not aware they had not given the shower until R100 told her when getting up for the day. LPN1 said, A shower was offered maybe at 8:00 AM, but the resident was already dressed and didn't want it. LPN1 confirmed that the resident wanted the shower before her doctor's appointment. LPN1 said, The resident said it was too hard for her to get undressed, shower, and redress again. On 08/15/24 at 11:13 AM, the Director of Nurses (DON) said, The resident is on the shower schedule for twice a week which is decided upon admission, how often they want a shower. The DON was not aware R100 had not been given a shower as requested. On 08/15/24 at 11:37 AM, the evening shift nurse (LPN3), on duty from 6:00 PM to 6:00 AM, said, The resident was supposed to have a shower, refused the first time, and they asked again. I just assumed they did it, I didn't know it didn't happen, she must have refused then. LPN3 did not know why the night CNA did not report to the next shift that the shower did not occur. On 08/15/24 at 4:30 PM, R100 and two family members (F2 and F3) were interviewed. R100 said she had been given only one shower since her admission. R100 denied being offered bed baths. R100 said, I think I'm getting stinky; I would like a bed bath. F2 and F3 confirmed that only one shower had been given and no bed baths. R100 said, F3 gives me a washcloth every day so I can wash my face. F3 stated, that's all I can do. On 08/15/24 at 4:40 PM, LPN1 said, I didn't think R100 liked bed baths, I don't know if they have been offered or not. Review of the facility's policy titled Resident Dignity, dated 11/16/23 indicated, Will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, record review, interviews, and facility policy review, the facility failed to assess one of one (Resident (R)3) resident for self-administration of medication in the sample of 18 residents. This had the potential to affect the residents' medication safety at the facility. Findings include: Review of R3's undated Admission Record in the Profile tab of the electronic medical record (EMR) revealed most recent admitted [DATE] and initial admitted [DATE]. The Admission Record revealed a diagnosis of myocardial infarction. Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/24/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 was cognitively intact. During an observation and interview on 08/12/24 at 8:12 AM, two white tablets in a medicine cup on top of R3's bedside table. R3 stated, Those are Tums. They bring them when they bring my morning medication, and I think I'm supposed to take them. Sometimes I chew them and get rid of them through the morning. During an observation on 08/12/24 at 08:25 AM, R3 was using her motorized wheelchair on 300 hall returning to her room. Two white tablets were in a medicine cup on R3's bedside table. Review of the EMR Physician Orders under the Orders tab revealed, Tablet (Calcium Carbonate (Antacid)) Give 1000 mg [milligram] by mouth in the morning for stomach upset related to GASTRO-ESOPHAGEAL REFLUX DISEASE dated 02/10/24. During an interview on 08/12/24 at 08:29 AM, Licensed Practical Nurse (LPN) 2 stated, The resident wants me to leave the Tums on her bedside table, because she takes them after she eats. Then I will go back and check on her after the breakfast trays are picked up, to see if she has taken them. She is cognizant enough to know what her medications are and what each of her medications are for. LPN2 reviewed R3's EMR and stated I don't see a doctor's order or anything on her care plan to keep medication at her bedside. We're not allowed to leave meds at the bedside, but the resident gets mad if we take them away. During an interview on 08/12/24 at 8:39 AM, the Minimum Data Set Coordinator (MDSC), stated, We absolutely do not leave medications at the bedside. Those looks like Tums in her medicine cup. She has no order to leave at bedside. During an interview on 08/15/24 at 10:13 AM, the Director of Nursing (DON) stated, I wasn't aware that resident kept medications at her bedside until they told me about the recent incident. The staff told me the daughter brings them in sometimes. I've always told my staff to never leave the resident without making sure they take all of their medicine first and if they find any that family bring it, to let nursing know. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Resident Self-Administration of Medication - R/S, LTC, revised on 10/30/23, indicated, under the section Procedure: 1. Complete the Resident Self-Administration of Medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do this safely. 7. A physician's order must be obtained prior to the resident self-administering medications. a. The order must be specific to the medications being self-administered. May be kept at bedside for self-administration or, May have all oral medications at bedside for self-administration). Update with new orders as needed. 8. The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of administration, if applicable .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 11599 Based on observation, interviews, and facility policy review, the facility failed to ensure a clean, environment for two of four hallways (hall one and hall leading to the dining room) and one resident (Resident (R) 31) room in the sample of 18 by heavily using disinfectant sprays. Findings include: 1. During the initial tour of the facility made on 08/12/24 at 10:15 AM, a strong smell of urine at the entrance to the 100 unit near the nurse's station. The facility was observed at this time to have carpet in the building in the day area, nurses station and 100/200 units. During an observation made on 08/12/24 at 3:00 PM, Housekeeper 2 (HSG2) was observed walking up and down the 100-hall spraying Lysol in the hallway and into the entrance of the residents' rooms. HSG2 was observed spraying the can of Lysol up into the air, and down onto the carpet from one end of the 100-hallway spraying from left to right. At this time, there were no residents observed in the hallway or sitting in the entrance of their rooms and the smell of Lysol was very strong and pungent. During an interview on 08/13/24 at 9:07 AM, HSG2 stated, We have a designated housekeeping person that uses a machine to clean the carpets every Tuesday and Thursday. To clean, we use a 73 Disinfecting Acid Bathroom cleaner, Windex, and a Bio-Enzymatic Odor Eliminator that I use in the rooms and hallways. During an interview on 08/13/24 at 9:22 AM, HSG1 stated, I clean the carpets on Tuesdays and Thursdays. During an interview on 08/14/24 at 7:57 AM, when HSG2 was asked why she was spraying Lysol up and down the 100 unit, she stated, I just wanted to sanitize everything. Everything like my cart, the doorknobs, just everything. When HSG2 was asked if she normally sprays Lysol up and down the units and into the entrance of the resident rooms, she stated, No, normally we don't use Lysol, but I did. I just wanted to go around and sanitize everything here. 2. During an observation on 08/13/24 at 12:18 PM, a facility van driver (driver) was observed vigorously spraying up and down the hall leading to the dining room. The driver was asked what was being sprayed and why. The driver stated, Lysol, because I thought I should for the odors. I saw others doing it [spraying Lysol], so I did. During an observation on 08/13/24 at 12:21 PM, Registered Nurse (RN2) was observed spraying a dark brown bottle at the ceiling near the nurse's station. RN2 was asked what was being sprayed and why. RN2 stated, good stuff [cologne] because it stinks in here. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 08/13/24 at 12:25 PM, HSG1 stated, this is what we're supposed to use, showing a bottle of Bio-Enzymatic Odor Eliminator. HSG1 proceeded to spray the bottle, at approximately four feet off the ground, around the carpeted lounge area and the nurse's station. A snack cart, a rolling metal cart with covered drinks and wrapped snacks, was in front of the nurse's station in proximity to the spray. On 08/13/24 at 1:15 PM, a family member (F1) stated when the staff spray, whatever they spray, in the resident's room it is overpowering, it's too much. On 08/13/24 at 2:36 PM, the Administrator and Director of Nurses (DON) stated, staff are not allowed to just spray anywhere. During an interview with R31 about sprays used in his room on 08/14/24 at 7:36 AM, R31 said yes, they spray, it's too strong, chokes me. On 08/15/24 at 10:05 AM, the Maintenance Director (MD), in charge of the housekeeping staff, stated, staff are not supposed to mask or cover up odors. The shampooer was used on the carpet and had old water in it which caused the odor. Review of the undated facility policy provided by the MD titled Managing Odors indicated, The primary method of controlling odors is to have a thorough and systematic cleaning program that addresses the material that causes malodors. Use of deodorizers (air fresheners) is not recommended to control odors due to their direct contribution to the indoor air contaminant load via the chemicals used to create the deodorizer.

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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** 20402 Based on observations, record review, interviews, facility policy review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to accurately code the Minimum Data Set (MDS) for two of two residents (Residents (R) 10 and R34) receiving hospice services and one of four residents (R17) receiving oxygen therapy of 18 sampled residents. By not ensuring the accuracy of the MDS these failures could potentially place the residents at risk for unmet care needs not being addressed. Findings include: Review of the MDS-3.0 RAI Manual-v1.17.1, October 2019, under Section J1400 Prognosis: indicated, Definition: Condition of chronic disease that may result in a life expectancy of less than 6 months; In the physician's judgement, the resident has a diagnosis or combination of clinical conditions that have advanced or will continue to advance to a point that the average resident with that level of illness would not be expected to survive more than 6 months. This judgement should be sustained by a physician note .Steps for Assessment: 1. Review the medical record for documentation by the physician that the resident's condition of chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record. 3. Review the medical record to determine whether the resident is receiving the hospice services. Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. Code 1, yes: if the medical record includes physician documentation: 1) that the patient is terminally ill; or 2) the resident is receiving hospice services . Section O0100K, Hospice Care, Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Further review of the RAI Manual indicated under Section O0100 Special Treatments, Procedures, and Programs: indicated, Steps for Assessment: 1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days. It indicated, O0100C, Oxygen therapy- code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item .This item may be coded if the resident places or removes his/her own oxygen mask, cannula. Review of the facility's policy titled, MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)-Rehab/Skilled & Therapy and Rehab, revised 07/01/24, indicated During the observation period each team member will review the EMR [electronic medical record] to determine if there is accurate documentation to support coding for the MDS. Validation verification must be completed after each discipline has coded and signed their section. The policy further indicated, Procedure: Significant Correction .2. A Significant error is an error in an assessment where: a. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the assessment; and b. the error has not been corrected via submission of a more recent assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Admission Criteria and Process, Hospice-Enterprise, revised 04/11/24, indicated Policy: Patients are admitted for Hospice care who have a terminal illness .The Medical Director considers the following information when reaching a decision to certify that a patient is terminally ill: Diagnosis of the terminal condition, other health conditions, either related to unrelated to the terminal illness, clinically relevant information supporting all diagnoses .Admission Criteria: The patient has a life-limiting illness with a life expectancy of 6 months or less, as certified by the hospice Medical Director and hospice attending physician, if any. 1. Review of R10's undated Profile page, under the Profile tab in R10's electronic medical record (EMR) indicated R10 was receiving hospice services. Review of Physician orders, dated 04/30/24, located in R10's EMR under the Orders tab, indicated, Resident admitted to [name of hospice company] on 04/30/24. Review of a Hospice Physician Order located in a red [name of hospice agency] hospice binder located at the nurse's station dated 05/01/24 and signed by the Hospice physician on 05/14/24, indicated, Terminal Dx [diagnosis] is Senile Degeneration of the Brain. The hospice physician order further indicated, I certify that the patient's prognosis is six months or less if the disease runs its normal course. Review of R10's quarterly MDS located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 07/31/24, revealed Section J and Section O of the MDS were completed by the MDS Coordinator (MDSC) on 08/06/24. Section J1400 of the MDS Prognosis was coded as No for R10 not having a terminal condition or chronic disease that may result in a life expectancy of less than 6 months. Hospice of the MDS was coded as While a resident at the facility R10 was also not receiving hospice services. The quarterly MDS was identified as being coded incorrectly as R10 had been continually receiving hospice services since 05/01/24. During an interview on 08/14/24 at 11:50 AM, regarding the coding of the MDS for R10, the MDSC stated R10 was admitted to hospice services 04/30/24. MDSC confirmed that she completed Section J1400 Prognosis and Hospice on the quarterly MDS for R10 on 08/06/24. The MDSC stated, I review the nurses notes, medications, diagnosis and I look through the hospice binder. When reviewing the inaccurate coding with the MDS Coordinator from the 07/31/24 quarterly MDS, she stated, I marked 'No' under the terminal prognosis and that must have been a typo on my part. For some reason, I marked it as no. I also marked 'No' for hospice and I don't know why. During an interview on 08/14/24 at 12:27 PM, the Director of Nursing (DON) stated, She [referring to R10] is on hospice. The MDSC is the one who completes the MDS assessments, and she does have access to the hospice binders. We have clinical meetings every day and if any changes arise, we talk about those. The DON confirmed that R10 has been receiving hospice services since 05/01/24. During a phone interview on 08/14/24 at 2:15 PM, Registered Nurse (RN)3 stated, [name of R10] went onto hospice services at the first of May 2024 and has been receiving hospice services ever since. 2. Review of R34's undated Admission Record in the Profile tab in the EMR revealed an admitted [DATE] revealed a diagnosis of Parkinson's disease without dyskinesia, without mention of fluctuations. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R34's quarterly MDS with an ARD of 06/11/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated R34 was moderately cognitively impaired. During an interview on 08/15/24 at 12:50 PM, the MDSC stated, Yes I missed coding it for hospice. During an interview on 08/15/24 at 1:10 PM, the DON stated, The MDSC is responsible for completing the MDS, then corporate double checks the MDS for accuracy, and sends an email of any errors. Hospice being coded must have been missed. 3. During an observation and interview on 08/12/24 at 1:00 PM, R17 was observed in her room lying in bed and an oxygen concentrator was next to R17's bed. During an interview R17 stated that she has been on oxygen since returning from the hospital and only prefers to wear it sometimes. Review of R17's medical diagnoses under the Med Diag tab located in R17's EMR indicated diagnoses to include chronic obstructive pulmonary disease and unspecified asthma with (acute) exacerbation. Review of the Physician Orders, dated 03/26/24, located in R17's EMR under the Orders tab indicated, Oxygen at 2LPM [liters per minute] per nasal cannula. Review of R17's quarterly MDS located in the EMR under the MDS tab, with an ARD date of 06/04/24, revealed the section of Oxygen of the MDS was completed by the MDSC on 06/07/24. Oxygen of the MDS was coded as While a resident at the facility, R17 was not receiving any oxygen therapy. The quarterly MDS was identified as being coded incorrectly as R17 was receiving oxygen therapy since being ordered on 03/26/24. During an interview on 08/14/24 at 12:36 PM, the MDSC stated that R17 was receiving oxygen therapy and confirmed that she completed the Oxygen portion of the quarterly MDS for R17 on 06/04/24. During the interview, the MDSC stated, I coded it as 'No' for receiving oxygen and I must have missed this one. I do see there is a continuous order for it too. I see the physician order in March, and I would have had that information when I completed the quarterly on 06/04/24. 43353

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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. 20402 Based on record review, interviews, and facility policy review, the facility failed to develop a person-centered comprehensive care plan with measurable goals, specific objectives, and interventions for one of two residents (Residents (R)10) receiving hospice services of 18 sampled residents. By not developing a person-centered care plan the resident may not be receiving the appropriate interventions to achieve the highest practicable well-being. Findings include: Review of the facility's policy titled, Care Plan-R/S, LTC, Therapy & Rehab, revised 11/01/23, indicated Purpose: To develop a comprehensive care plan using an interdisciplinary team approach .Definitions: Comprehensive Care Plan-includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Person-centered care-a focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life. The policy further indicated, Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. It further indicated, The comprehensive plan of care will be finalized during the interdisciplinary care team conference no later than seven days after completion of the comprehensive resident assessment .The plan of care will be modified to reflect the care currently required/provided for the resident. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services. Review of R10's undated Profile page, under the Profile tab in R10's electronic medical record (EMR) indicated R10 was receiving hospice services. Review of Physician orders dated 04/30/24, located in R10's EMR under the Orders tab, indicated, Resident admitted to [name of hospice company] on 04/30/24. Review of a Hospice Physician Order located in a red [name of hospice agency] hospice binder located at the nurse's station dated 05/10/24 and signed by the Hospice physician on 05/14/24, indicated Terminal Dx [diagnosis] is Senile Degeneration of the Brain. Review of a Hospice Certification and Plan of Care located in a red [name of hospice agency] hospice binder located at the nurse's station and signed by the physician on 05/14/24, indicated that the hospice Start of Care [SOC] date was 05/01/24. It further indicated R10's diagnoses, frequency of hospice visits to be made from hospice nurses, hospice social workers, hospice home health aides and chaplain. The Hospice Certification and Plan of Care further indicated R10's medications, specific goals, objectives, durable medical equipment (DME), functional limitations, safety measures, activities, nutritional requirements, mental status of R10 and specific duties of the hospice agency and nursing facility. (continued on next page)

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	325061	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Betty Dare	3101 North Florida Avenue Alamogordo, NM 88310

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an additional Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report located in a red [name of hospice agency] hospice binder located at the nurses station dated 06/11/24 with benefit period dates from 05/01/24 to 07/29/24, indicated information such as R10's diagnoses, frequency of hospice visits to be made from hospice nurses, hospice social worker, hospice home health aide, and chaplain. It further listed R10's medications, and hospice visits and specific duties of the hospice agency and nursing facility. Review of a facility Comprehensive Care Plan, revised on 05/09/24, and located in R10's EMR under the Care Plan tab, indicated Advanced Directive. It further indicated the [name of the hospice agency] and address. Interventions listed were: Staff will report any changes to hospice nurse, hospice comfort pack and hospice nurse and CNA to do rounds. There was no further documentation in the care plan to indicate the development of a person-centered care plan with measurable goals, objectives, and interventions for the care of R10 who was receiving hospice services. During an interview on 08/14/24 at 11:50 AM, the Minimum Data Set Coordinator (MDSC) stated, Once we find out a resident will be going onto hospice services and I start the care plan right away. The MDSC stated that R10 went onto hospice services on 04/30/24. The MDSC reviewed R10's Care Plan and stated, The care plan for hospice is under Advanced directives. There are no more specifics than that. She then indicated, Hospice would have their own care plan. During an interview on 08/14/24 at 12:27 PM, the Director of Nursing (DON) stated, We have the hospice care plan. Review of R10's Care Plan in the EMR, the DON stated, This is our care plan [referring to just the name of hospice company, and address under Advanced Directives] there is nothing further than that. We have talked about this in the past with our previous clinical consultant.

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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. 20402 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure oxygen (O2) concentrators had dust free filters, and were free of a buildup of heavy lint and dirt on the inlet where the air came into the machine for two of four residents (Residents (R) 21 and R25) receiving oxygen therapy out of a sample of 18 sampled residents. This deficient practice had the potential to allow an increased chance of infection and unnecessary respiratory treatment. Findings include: Review of the facility's policy titled Oxygen Administration, Safety, Mask Types-Rehab/Skilled, LTC, Therapy & Rehab revised 07/08/24 indicated, Purpose- To administer and store oxygen in a safe manner, to keep oxygen equipment clean and maintained in a good condition .,All oxygen therapy equipment will be clean, safe, and functional at all times .Document cleaning of concentrator and filters where appropriate . 1. During an observation on 08/12/24 at 11:44 AM, on 08/13/24 at 8:58 AM, and on 08/13/24 at 12:30 PM, R21's oxygen concentrator filter located on the right bottom side of the concentrator was observed to be very dirty, dusty, and brown. The filter was observed to be full of thick white lint. During an interview on 08/12/24 at 3:30 PM, R21 stated, I use oxygen at night with my CPAP [continuous positive airway pressure]. I'm on two liters. Review of the undated Medical Diagnosis located in R21's electronic medical record (EMR) under the Med Diag tab, indicated diagnoses to include, hypoxemia, sleep apnea, and dyspnea. Review of Physician Orders, dated 06/13/24 and located in R21's EMR under the Orders tab indicated Oxygen via nasal cannula at 2 liters per minute as needed for dyspnea, hypoxia or acute angina. During an interview on 08/13/24 at 12:44 PM, Registered Nurse (RN) 1 was asked who cleans the oxygen concentrator filters. RN1 stated, I honestly don't know. 2. During an observation made on 08/12/24 at 10:30 AM and on 08/13/24 at 9:00 AM, R25's grey oxygen concentrator filter that was located on the back of the concentrator revealed to have a very thick buildup of white lint on it. The heavy buildup of lint was stuck to the grey filter. During an interview on 08/12/24 at 2:48 PM, R25 stated, I only use my oxygen at night if I need it. Review of the undated Medical Diagnosis located in R25's EMR under the Med Diag tab, indicated diagnoses to include shortness of breath. Review of Physician Orders, dated 08/27/22 and located in R25's EMR under the Orders tab, indicated Oxygen at 2 LPM per nasal cannula, via 02 concentrator for oxygen saturation less than 88%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 08/13/24 at 3:19 PM, the DON was asked if R21 and R25's oxygen concentrator filters were being cleaned. The DON stated, No. During an observation in the presence of the DON of R21 and R25's oxygen concentrator filters, both had the same thick heavy buildup of dirt and lint on the filter. At this time, the DON stated, It's dirty. I never thought it should be something that we should be doing. I was not aware of it.

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	325061	A. Building B. Wing	08/15/2024

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 11599 Based on document review, interviews, and facility policy review, the facility failed to ensure Registered Nurse (RN) coverage was provided eight hours a day seven days a week. The failure created the potential for 48 residents, residing in the facility, not to receive appropriate care and oversight. Findings include: Review of the Fiscal Year Quarter 2 Payroll Based Journal (PBJ) of the Certification and Survey Provider Enhanced Reports (CASPER), submitted by the facility, identified no RN coverage on the following dates: 01/21/24, 02/17/24, 02/18/24, and 03/16/24. On 08/15/24 at 9:06 AM, the Infection Preventionist (IP), responsible for staffing, confirmed that there was no RN coverage, on 02/17/24 and 02/18/24. The IP provided Timecard Report to show RN coverage was provided on 01/21/24 and 03/16/24. On 08/15/24 at 1:02 PM, the Business Office Manager (BOM) confirmed that he submits the PBJ reports and that there was no RN coverage on 02/17/24 and 02/18/24. The resident census on 02/17/24 and 02/18/24 was 48 per the BOM records. On 08/15/24 at 12:43 PM, the Director of Nurses (DON) confirmed that there was no RN coverage on 02/17/24 and 02/18/24. The DON stated, It has been difficult to hire nurses in their community. Review of the facility policy titled Nursing Services Staff, dated 10/30/23 provided by the DON, read, Purpose: To provide appropriate staff for resident care in the nursing services department. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on record review, interviews, and policy review, the facility failed to provide documentation of behavior monitoring for the continued use of psychoactive medications for two of five residents (Resident (R) 7 and R19) reviewed for unnecessary medications. Failure to provide quantitative data regarding target behavior reduction/management has the potential to affect the resident receiving the lowest dose possible of a psychoactive medication. Findings include: 1. Review of R7's undated Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed a diagnosis of pneumonia, unspecified organism. Review of R7's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 was cognitively intact. Review of R7's August 2024 Medication Administration Record (MAR) under the report tab of the EMR revealed the following current psychotropic medication orders: Lamotrigine (mood stabilizer medication) 200 milligrams (MG) dated 06/20/2024 to be given in the morning for bipolar disorder. Seroquel (Antipsychotic medication), 200 mg dated 07/25/2024 to be given at bedtime for bipolar disorder Duloxetine (antidepression medication) delayed release 60 mg dated 06/19/2024 to be given in the morning and evening for depressive episodes Review of R7's EMR Physician's orders under the Orders tab revealed there was no order to monitor or document the resident's behaviors related to the use of her psychotropic medications. 2. Review of R19's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. The Admission Record revealed a diagnosis of other disorders of phosphorus metabolism. Review of R19's admission MDS with an ARD of 07/21/24, located in the EMR MDS tab, revealed a BIMS score of 99 out of 15 which indicated R19 was severely cognitively impaired. (continued on next page)

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	325061	A. Building B. Wing	08/15/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R19's August 2024 MAR under the report tab of the EMR revealed the following current psychotropic medication orders: Mirtazapine (antidepression medication) 15 mg dated 07/15/24 to be given at bedtime for agitation. Review of R19's EMR Physician's orders under the Orders tab revealed there was no order to monitor or document the resident's behaviors related to the use of her psychotropic medications. During an interview on 08/14/24 at 07:12 AM, Licensed Practical Nurse (LPN) 1 stated, We chart all the behaviors for the residents in the progress notes and it's only when they have them. During an interview on 08/15/24 at 01:10 PM, the Director of Nursing (DON) stated, Yes we have two residents that we never did behavior monitoring on. They were both planned to be short term only and were going to be discharged before now. Since they're still here and we don't know for how long now, we have to get the orders now and start documenting their behaviors. Review of the facility's policy titled, Psychotropic Medications - Rehab / Skilled revised on 12/06/23, indicated Policy: Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: without adequate monitoring. The facility's policy further indicated Procedure: 9. Throughout the administration of the psychotropic medications, the following must be completed: a. Mood and behavior documentation must continue in order to monitor the effect the medication has on the behavior; b. Monitor for side effects of the medication .; d. Monitor for effectiveness and potential adverse consequences .

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	325061	A. Building B. Wing	08/15/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, interviews, record review, review of facility policies and Centers for Disease Control and Prevention guidance, the facility failed 1. to ensure that staff wore appropriate Personal Protective Equipment (PPE) for three of twelve residents (Resident (R) 31, 200, and 41) reviewed for enhanced barrier precautions (EBP) when providing care, 2. to clean and disinfect patient equipment after use for one of eight residents (R15) reviewed for infection control 3. To follow hand hygiene practices during medication pass for one of five residents (R15) reviewed for medication administration. These failures could promote the spread of multi drug resistant organisms (MDROs) throughout the facility. Findings include: 1. Review of R31's undated Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed a diagnosis of chronic obstructive pulmonary disease. Review of R31's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/04/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R31 was moderately cognitively impaired. During an observation in doorway of R31 on 08/13/24 at 7:16 AM revealed, Licensed Practical Nurse (LPN) 1 cleaned the blood pressure cuff and let air dry prior to entering room. LPN1 performed hand hygiene and took R31's vital signs. She performed hand hygiene again after obtaining vitals. LPN1 did not wear a gown throughout patient care. R41 had a foley catheter requiring the use of EBP. A STOP EBP sign was on door frame and isolation cart was inside room. 2. Review of R200's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. The Admission Record revealed a diagnoses of infection following surgical procedure to the right toe and gas gangrene/acute osteomyelitis to the right ankle and foot. Review of R200's admission MDS with an ARD of 08/01/24, located in the EMR MDS tab, revealed a BIMS score of 15 out of 15 which indicated R200 was cognitively intact. During an observation in the doorway of R200 on 08/13/24 at 7:33 AM revealed LPN 1 cleaned the glucometer machine with a Sani-wipe, let it air dry for two minutes, then proceeded to knock and enter R200 room. R200 performed hand hygiene, donned gloves, checked her blood sugar using the glucometer machine, laid it on a clean paper towel, and performed hand hygiene. LPN1 picked up paper towel holding the dirty glucometer machine and set it on her medication cart. She used hand sanitizer, donned gloves, cleaned glucometer machine with a Sani-wipe, and set it on top of new paper towel on med cart to allow it to air dry. LPN1 performed hand hygiene again. LPN1 did not wear a gown throughout patient care. R200 had a recent partially right foot amputation requiring wound care treatments that required EBP. R200 had a STOP EBP sign on her door with an isolation cart inside her room. 3. Review of R41's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. The Admission Record revealed a diagnosis of Wernicke's encephalopathy. (continued on next page)

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	325061	A. Building B. Wing	08/15/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R41's quarterly MDS with an ARD of 08/01/24, located in the EMR MDS tab, revealed a BIMS score of seven out of 15 which indicated R41 was severely cognitively impaired. During observation of R 41 while lying in her bed on 08/13/24 at 9:52 AM, LPN 1 was observed disconnecting R41 tube feeding, flushing with water, administering medications via G-tube, and providing Flovent breathing treatment. LPN1 performed hand hygiene before patient care, changed gloves during patient care, and performed hand hygiene after patient care, but did not wear a gown care. R41 had a G-tube and Foley catheter requiring the use of EBP. A STOP EBP signage was on door frame and isolation cart was inside room. During an interview on 08/14/24 at 8:28 AM, R200 stated, I don't know what that EBP sign is on the door. The staff never wear gowns or masks. I don't know why the isolation cart is in our rooms. They said there is one in every room. During an interview on 08/14/24 10:52 AM, LPN1 stated, We only wear PPE according to what the sign on the door indicates. LPN1 stated that EBP isn't required when doing accuchecks or checking vital signs because they aren't on the list. During an interview on 08/14/24 11:25 AM, Infection Preventionist (IP) stated, I do training with my staff when I see there is something going on that needs corrected. I give documents out to staff and have them sign off that they read them and received them. First EBP training was done in April when it rolled out. On June 5th we hit the EBP hard. I can't tell you exactly what we covered. My expectation is EBP is required when they have an indwelling catheter, feeding tube, chronic wound and surgical wounds. We consider high contact any kind of touching and wound changing. The IP stated that PPE is not required when taking vitals or doing accuchecks. We refer to the CDC guidelines on the door signs as to when to use to PPE. During an interview on 08/15/24 01:10 PM, the DON stated, We follow EBP and use PPE according to the sign on the door only. Review of the facility's policy titled, Standard and Transmission-Based Precautions, All Service Lines-Enterprise, revised on 04/02/2024, indicated, under the section Policy/Procedure; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high- contact resident care activities that provide opportunities for transfer of MDROS [Multi-Drug Resistant Organisms] to staff hands and clothing Enhanced Barrier Precautions are needed for residents with chronic wounds (Pressure Ulcers, Diabetic Foot Ulcers, Unhealed surgical wounds, and venous statis ulcers) and Residents with Indwelling Medical devices (central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheotomies). Enhanced Barrier Precautions are Intended to be used for the duration of a resident's stay. EBP can be discontinued if a resident is on EBP solely due to an indwelling medical device or open wound and the device is removed, or the wound heals. Enhanced Barrier Precautions are also needed for residents with CDC-targeted and epidemiologically important (facility discretion) MDRO Infection and colonization, when contact precautions do not apply. See MDRO policy. High-contact Resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physician contact while assisting with transfers and mobility, changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy) and wound care . Review of the Centers for Disease Control and Prevention (CDC) website and Prevention (CDC) website https://www.cdc.gov/long-term-care-facilities/hcp/ prevent-mdro/PPE.html, titled, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multi-drug resistant Organisms, updated: 04/02/24 revealed, Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization . Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 4. Review of R15's undated Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. The Admission Record revealed a diagnosis of chronic obstructive pulmonary disease. Review of R15's Prospective Payment System (PPS) five-day scheduled assessment for a Medicare Part A Stay MDS with an ARD of 06/16/24, located in the EMR MDS tab, revealed a BIMS score of 13 out of 15 which indicated R15 was cognitively intact. During observation on 08/12/24 at 3:41 PM AM, R15 was seated in her wheelchair outside of doorway to her room. LPN2 retrieved the portable vital sign machine/equipment on wheels. LPN 2 attempted to apply the blue regular size blood pressure cuff on resident's upper left arm. The regular size cuff is too small and LPN2 removed it and returned it to the basket on the portable machine. She retrieved the gray larger size blood pressure cuff from the same basket and applied it to R15's upper left arm. The portable machine displayed error on attempt to obtain blood pressure reading. LPN2 removed the large blood pressure cuff from R31's arm and returned it to the basket. LPN2 stated that she was going to go get a stethoscope and manual blood pressure cuff. LPN2 returned and applied the manual cuff on R15's upper arm. She used the stethoscope and manually obtained blood pressure reading. LPN2 removed the manual cuff and put it in the basket on portable machine, along with the stethoscope. LPN2 performed hand hygiene but did not clean patient care equipment after use. During an observation on 08/12/24 at 3:58 PM, R15 returned to nurses' med cart and stated that she was ready for her medications now. LPN2 administered R15 her Symbicort inhaler. LPN2 picked up two cups off her medication cart with one containing a small amount of water and the other cup was empty. LPN2 asks R15 to swish the water from one cup and holds empty cup under R15's mouth asking her to spit it out. LPN2 was observed pouring contents of cups into sink in hallway used to wash hands. LPN2 did not perform hand hygiene. She continued to move onto the next resident preparing his medications. During an interview on 08/12/24 4:00 PM, LPN2 stated, Yes, I forgot to clean and disinfect the blood pressure cuffs. I always do it any other time. LPN2 stated that she didn't realize she forgot to do hand hygiene after R15 used the inhaler and had to swish and spit. During an interview on 08/14/24 11:25 AM, the IP stated, My expectation is that all patient care equipment be cleaned before and after and in between each use. My expectation is staff do hand hygiene every time and in between patient care and passing trays in between residents. I don't remember how many times they can sanitize before washing their hands to be honest. I think it's ten. But I know it's between five to ten times and always when they come out of the resident room. During an interview on 08/15/24 01:10 PM, the DON stated, My expectation is that staff always perform hand hygiene before and after care, in between residents, and whenever they touch a resident or their personal item. They are required to wash their hands after using hand sanitizer three times or when they're visibly soiled. (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	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Betty Dare	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Hand Hygiene - Enterprise, revised on 03/29/22, indicated, under the Policy section, All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering room [ROOM NUMBER]. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting room [ROOM NUMBER]. Zones: Patient zone and Health-care zone.