

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 11/21/2025
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.

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>Based on the record review and interview, the facility failed to ensure RN coverage was provided for 8 consecutive hours a day and for 7 days a week. This failure could potentially affect all 72 residents who lived in the facility (residents were identified by the Resident Matrix provided by the Administrator on 06/23/25. This deficient practice is likely to result in residents not receiving the services they require. The findings are: A. Record review of the Payroll Base Journal (PBJ) Staffing Data Report (report from the database of the federal agency overseeing certification for long term care facilities) dated Quarter #1 (October 1 through December 31) 2025 revealed no RN coverage for at least 8 consecutive hours on 10/06/24 and 12/31/24. B. On 11/21/25 at 2:38 PM during an interview, the administrator confirmed they were unable to provide proof of RN coverage for 10/06/24 and 12/31/24.</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #6) of 5 (R #3, R #5, R #6, R #39, and R #60) residents reviewed for unnecessary medications. If the residents or their representatives are not informed of the risks and benefits of the medication or treatment alternatives, they are not able to make informed decisions regarding residents' care. The findings are: A. Record review of R #6's physician's orders, dated 10/28/25, revealed an order for clonazepam (used to treat seizure disorders and panic disorder) 0.5 mg one time a day for insomnia. B. Record review of R #6's medical record, no date, revealed staff did not document consent for clonazepam. C. On 11/21/25 at 10:19 AM, during an interview, the DON confirmed that there was not a consent for R #6's clonazepam. The DON stated consents should be completed for psychotropic active medications.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless there was adequate monitoring for any adverse consequences resulting from the medication for 3 (R #5, R #6, and R #60) of 5 (R #3, R #5, R #6, R #39, and R #60) residents reviewed for unnecessary medications, when staff failed to: 1. Monitor R #5 for side effects of antidepressant (medication used to treat depression) medication. 2. Perform an AIMS (Abnormal Involuntary Movement Scale test used in medicine to assess side effects of antipsychotic medication) for R #6 and R #60. These deficient practices could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are:</p> <p>R #5</p> <p>A. Record review of R #5's admission documents, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. R #5 was admitted to the facility on [DATE]. 2. R #5 had a diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). <p>B. Record review of R #5's physician's order, dated 09/16/25, revealed an order for citalopram hydrobromide (antidepressant medication used for the treatment of depression) 20 mg, for depression.</p> <p>C. Record review of R #5's MAR, dated September 2025, revealed R #5 received Citalopram Hydrobromide as ordered from 09/17/25 to 09/30/25.</p> <p>D. Record review of R #5's MAR, dated October 2025, revealed R #5 received Citalopram Hydrobromide as ordered the entire month.</p> <p>E. Record review of R #5's MAR, dated November 2025, revealed R #5 received Citalopram Hydrobromide as ordered from 11/01/25 to 11/21/25.</p> <p>F. Record review of R #5's entire medical record, no date, revealed staff did not document assessing R #5 for side-effects (unwanted undesirable effects that are possibly related to a drug) of antidepressant medication.</p> <p>G. On 11/21/25 at 1:32 PM, during an interview, LPN #16 confirmed the following:</p> <ol style="list-style-type: none"> 1. R #5 had an order for citalopram hydrobromide. 2. Staff were not monitoring R #5 for side effects of antidepressant medications. 3. Staff were supposed to document monitoring for medication side effects on the Treatment Administration Record (TAR, a comprehensive, organized record of each treatment or monitoring of a patient). (continued on next page) 		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. On 11/21/25 at 1:36 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following:</p> <ol style="list-style-type: none"> R #5 had an order for an antidepressant medication. Staff were expected to monitor for side effects of antidepressants. <p>R#6</p> <p>I. Record review of R #6's admission record, no date, revealed the following:</p> <ol style="list-style-type: none"> R #6 was admitted to the facility on [DATE]. R #6 had psychiatric diagnosis of schizophrenia (severe mental disorder characterized by disturbances in thinking, perception, and behavior, including delusions, hallucinations, and disorganized speech). <p>J. Record review of R #6's physician's order dated 11/12/25, revealed an order for thioridazine (antipsychotic medication, historically used for schizophrenia and other psychotic disorders) 10 mg, give 1 tablet by mouth two times daily for schizophrenia.</p> <p>K. Record review of R #6's pharmacy recommendation dated 08/08/25, 09/05/25, and 10/03/25 revealed that R #6's antipsychotic medication can cause tardive dyskinesia (a neurological condition causing involuntary, repetitive body movements, often in the face (grimacing, tongue thrusting, lip-smacking), neck, limbs, or trunk) and other movement disorders and recommends a movement test within 30 days, and then every six months while R #6 is taking an antipsychotic medication.</p> <p>L. Record review of R #6's medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> No order or for AIMS, and No AIMS test had not been documented. <p>R #60</p> <p>M. Record review of R #60's admission record, no date, revealed the following:</p> <ol style="list-style-type: none"> R #60 was admitted to the facility on [DATE]. R #60 has a diagnosis of unspecified Dementia, unspecified severity, with other behavioral disturbance (is caused by damage to or loss of nerve cells and their connections in the brain with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety depending on patient). <p>N. Record review of R #60's physician's order dated 10/09/24, revealed an order for Mirtazapine (antidepressant medication, used to treat depression) 45 mg, give 1 tablet by mouth at bedtime for agitation related to restlessness and agitation.</p> <p>O. Record review of R #60's physician's order dated 05/06/25, revealed an order for Risperidone (antipsychotic medication used in elderly patients with dementia-related psychosis) 0.5 mg, give (continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>tablet by mouth one time a day for psychosis.</p> <p>P. Record review of R #60's pharmacy recommendation dated 09/01/25, and 09/05/25 revealed R #60's antipsychotic medication can cause tardive dyskinesia and other movement disorders and recommends a movement test within 30 days, and then every six months while R #6 is taking an antipsychotic medication.</p> <p>Q. Record review of R #60's medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. No order for AIMS, and 2. No AIMS test had not been documented. <p>R. On 11/21/25 at 10:19 AM, during an interview, the DON confirmed that there were pharmacy recommendations for a movement test for R #6 and R #60. RCN confirmed that an AIMS test has not been completed for R #6 and R #60. The DON stated that an AIMS test should have been done initially upon admission and that the recommendation should have been followed.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the required discharge or transfer information to the resident and the resident's representatives in writing for 4 (R #16, R #19, R #83, and R #85) of 4 (R #16, R #19, R #83, and R #85) residents sampled for hospitalizations or discharge when staff failed to: 1. Notify the residents and resident representative(s) of the resident's transfer to the hospital in writing and in a language and manner they understand for R #19 and R #85. 2. Send a written copy of the Discharge or Transfer Notices to the Ombudsman for R #16, R #19, R #83, and R #85. 3. Ensure residents or their representative received a written notice of the bed hold policy which indicated the duration the bed would be held for R #19 and R #83. 4. Complete a discharge summary for R #85. These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer or discharge, the location of the transfer or discharge, their rights to advocate and make informed decisions regarding the resident's healthcare, the services that the resident received while at the facility, the resident's current health status, or the resident's current medications leading to adverse outcomes for the resident. The findings are:</p> <p>R #16</p> <p>A. Record review of R #16's admission documents, no date, revealed R #16 was admitted to the facility on [DATE].</p> <p>B. Record review of R #16's progress note, dated 10/13/25, revealed R #16 fell and was transferred to the hospital for evaluation.</p> <p>C. Record review of R #16's transfer notice, dated 10/13/25, revealed R #16's was transferred to the hospital due to an unwitnessed fall.</p> <p>D. On 11/20/25 at 2:13 PM, during an interview, the social services worker (SSW) stated he did not send a copy of R #16's transfer notice, dated 10/13/25, to the Ombudsman.</p> <p>R #19</p> <p>E. Record review of R #19's admission documents, no date, revealed she was admitted to the facility on [DATE].</p> <p>F. On 11/17/25 at 3:44 PM, during an interview, R #19 stated the following:</p> <ol style="list-style-type: none"> 1. She was sent to the emergency room (ER) on 11/13/25 due to concerns about her surgical incisions. 2. She did not receive a written transfer notice for her transfer to the ER. 3. She did not receive a written bed hold notice. <p>G. Record review of R #19's entire medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. R #19's medical record did not contain a written transfer notification that included information (continued on next page) 		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>regarding how the resident or representative could appeal a transfer or how to contact the ombudsman for her transfer to the hospital on [DATE].</p> <p>2. R #19's medical record did not contain a written bed hold notification for her transfer to the hospital on [DATE].</p> <p>H. On 11/20/25 at 2:04 PM, during an interview, the administrator confirmed the following:</p> <ol style="list-style-type: none"> 1. Staff did not complete a written transfer notification for R #19's transfer to the hospital on [DATE]. 2. Staff did not complete a written bed hold notification. 3. Staff were expected to complete a transfer notice and bed hold notice and give a copy to the resident or resident representative at the time of transfer. 4. Staff were expected to send a copy of the transfer notice to the Ombudsman. <p>R #83</p> <p>I. Record review of R #83's admission Record (no date) revealed R #83 was admitted to the facility on [DATE].</p> <p>J. Record review of R #83's electronic medical record (EMR) revealed R #83 was transferred to the hospital on [DATE] due to changes of wound appearance and dehiscence (surgery complication where the incision reopens).</p> <p>K. Record review of R #83's EMR revealed R #83's medical record did not contain a written bed hold notification for the transfer to the hospital on [DATE].</p> <p>L. On 11/21/25 at 3:13 PM during an interview, the corporate nurse confirmed the following:</p> <ol style="list-style-type: none"> 1. Staff did not complete a written bed hold notification for R #83. 2. Staff were expected to send a copy of the transfer notices to the Ombudsman. <p>M. On 11/20/25 at 2:09 PM, during an interview, the SSW confirmed he did not send the Ombudsman copies of a written notice of transfers</p> <p>R #85</p> <p>O. Record review of R #85's medical record, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. R #85 was admitted to the facility on [DATE]. 2. R #85 was discharged from the facility AMA (Against Medical Advice when a person decides to leave the facility against a provider's advice) on 09/02/25. <p>P. Record review of R #85's progress note, dated 09/02/25, revealed the following: (continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. R #85 left the facility AMA with his family.</p> <p>2. R #85 was not given his medications and discharge paperwork.</p> <p>Q. Record review of R #85's entire medical record, no date, revealed staff did not document the following:</p> <p>1. A discharge notice for R #85's discharge from the facility on 09/02/25.</p> <p>2. A discharge summary for R #85 that included the following:</p> <p>a. A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>b. A final summary of the resident's status including an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another.</p> <p>c. A reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter)</p> <p>R. On 11/20/25 at 11:05 AM during an interview, the Social Service Coordinator confirmed the following:</p> <p>1. R #85 discharged AMA on 09/02/25 and refused to sign discharge paperwork.</p> <p>2. R #85's medical record did not contain documentation of a discharge summary, discharge notification, recapitulation of stay, or medication reconciliation.</p> <p>3. The facility did not send a written copy of a discharge notification for R #85 to the Ombudsman.</p> <p>4. R #85's medical record did not contain documentation of a report made to APS (Adult Protected Services) for R #85's discharge that Social Service Coordinator confirmed was reported to APS.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 2 (R #5, and R #39) of 7 (R #1, R #2, R #5, R #8, R #39, R #50, and R #60) residents reviewed for comprehensive care plans (plan that has measurable goals and timeframes to meet a resident's medical, nursing, mental health and psychosocial needs). This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are:</p> <p>R#5</p> <p>A. Record review of R #5's admission documents, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. R #5 was admitted to the facility on [DATE]. 2. R #5 had the following diagnoses: <ol style="list-style-type: none"> a. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). b. History of venous thrombosis (blood clot in veins), c. Embolism (obstruction of an artery). <p>B. Record review of R #5's admission MDS, dated [DATE], revealed staff documented that R #5 was taking antidepressant and anticoagulant medication.</p> <p>C. Record review of R #5's physician orders, multiple dates, revealed the following:</p> <ol style="list-style-type: none"> 1. An order dated 08/28/25 and discontinued on 09/16/25, for bupropion (antidepressant medication) 150 mg two (2) times a day for depression. 2. An order dated 09/16/25, for citalopram hydrobromide (antidepressant medication used for the treatment of depression) 20 mg, for depression. 3. An order dated 08/28/25 and discontinued on 09/16/25, for rivaroxaban (medication used to treat and prevent deep venous thrombosis (DVT), a condition in which harmful blood clots form in the blood vessels of the legs) 20 mg for DVT prevention. 4. An order dated 09/16/25, for rivaroxaban 10 mg once a day for anticoagulant (blood clot prevention). <p>D. Record review of R #5's care plan, revised on 10/23/25, revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document R #5's order for antidepressant medication in his care plan. 2. Staff did not document R #5's diagnosis of a history of venous thrombosis and embolisms and the order for anticoagulants. (continued on next page) 		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. On 11/21/25 at 1:36 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following:</p> <ol style="list-style-type: none"> 1. R #5 had an order for antidepressant medication. 2. R #5 had an order for anticoagulant medication, 3. R #5's care plan did not include that R #5 was taking antidepressant and anticoagulant medication. 4. Staff were expected to document orders for antidepressant and anticoagulant medications in resident care plans. <p>R #39</p> <p>F. Record review of R #39's admission record, no date, revealed an admission date of 11/04/25.</p> <p>G. Record review of R #39's physician orders revealed an order dated 11/17/25 for memantine (used to treat to treat memory loss) 5 mg give one tablet by mouth 2 times a day for cognitive decline.</p> <p>H. Record review of R #39's care plan dated 11/11/25 revealed R #39's care plan did not include R #39's psychotropic medication memantine and any interventions for the medication.</p> <p>I. On 11/21/25 at 1:58 PM, during an interview with the Regional Clinical Nurse (RCN), she confirmed that R #39's care plan did not document her memantine and the interventions for the medication. The RCN stated that all psychotropic medications should be care planned and that the interventions for the medication should be care planned.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**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 6 (R #2, R #5, R #6, R #19, R #56, and R #60) of 7 (R #2, R #5, R #6, R #16, R #19, R #56, and R #60) residents when the staff failed to: 1. Ensure the Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) members participated in a care plan meeting within 7 days of the completion of the MDS assessment for R #5, R #19, and R #56. 2. Revise the care plan with the most current resident information for R #2, R #5, R #6 and R #60. 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:</p> <p>Timing</p> <p>R #5</p> <p>A. Record review of R #5's admission documents, no date, revealed R #5 was admitted to the facility on [DATE].</p> <p>B. Record review of R #5's admission MDS, dated [DATE], revealed it was completed on 09/04/25.</p> <p>C. Record review of R #5's care conference note, dated 10/06/25, revealed the IDT members participated in a care plan meeting on 10/06/25 (not within 7 days of the completion of the admission MDS on 09/04/25).</p> <p>R #19</p> <p>D. Record review of R #19's admission documents, no date, revealed she was admitted to the facility on [DATE].</p> <p>E. Record review of R #19's admission MDS, dated [DATE], revealed it was completed on 11/13/25.</p> <p>F. Record review of R #19's entire medical record, no date, revealed that as of 11/21/25 the IDT members had not participated in a care plan meeting for R #19 (had not been completed within 7 days of the completion of the admission MDS on 11/13/25).</p> <p>R #56</p> <p>G. Record review of R #56's admission record, no date, revealed the resident was admitted to the facility on [DATE].</p> <p>H. Record review of R #56's admission MDS, dated [DATE], revealed it was completed on 09/19/25.</p> <p>I. Record review of R #56's care conference note, dated 10/08/25, revealed IDT members participated in a care plan meeting on 10/08/25 (not within 7 days of the completion of the admission MDS on (continued on next page)</p>		

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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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>09/19/25).</p> <p>J. On 11/20/25 at 2:15 PM, during an interview, the social services worker stated the following:</p> <ol style="list-style-type: none"> 1. He was unaware of when the IDT care conference needed to be completed in relation to the MDS assessments. 2. He confirmed that R #5, R #19, and R #56's care conferences were not held within 7 days of the completion of their admission MDS assessments. <p>Revision</p> <p>R #2</p> <p>K. Record review of R #2's admission Record (no date) revealed the following:</p> <p>R #2 was readmitted to the facility on [DATE].</p> <ol style="list-style-type: none"> 2. R #2 had a diagnosis of unspecified fall subsequent encounter (return to healthcare provider for ongoing care related to a previous fall). <p>L. Record review of R #2's nursing progress notes revealed R #2 sustained a fall on 11/04/25.</p> <p>M. Record review of R #2's care plan, dated 10/22/25, revealed the following:</p> <p>Staff documented that R #2 is at risk for falls.</p> <ol style="list-style-type: none"> 2. Staff did not revise the care plan with additional interventions (actions implemented by staff) after R #2's fall on 11/04/25. <p>N. On 11/21/25 at 3:32 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following:</p> <p>R #2 did sustain a fall on 11/04/25.</p> <p>An anti-roll back device (devices designed to secure wheelchairs in place when a user attempts to stand up, preventing accidental rolling that can lead to falls) for R #2's wheelchair was implemented after her fall on 11/04/25.</p> <ol style="list-style-type: none"> 3. Staff did not revise R #2's care plan with the changes. 4. Care plans should be revised to include changes in a resident's care. <p>R #5</p> <p>O. Record review of R #5's admission documents, no date, revealed R #5 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD, an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways). (continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>P. Record review of R #5's physician orders, dated 09/25/25, revealed an order for oxygen at three (3) liters per minute (LPM) continuously (all the time).</p> <p>Q. Record review of R #5's care plan, dated 09/03/25, revealed staff documented that R #5's oxygen settings were to be set at two (2) LPM as needed (PRN) for hypoxia (low oxygenation) (did not match the order that indicated 3 LPM continuously).</p> <p>R. On 11/21/25 at 1:13 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following:</p> <ol style="list-style-type: none"> 1. Staff were expected to have an IDT care plan conference within 7 days of the completion of the MDS assessment. 2. R 5's physician order was for R #5 to be on three (3) LPM of oxygen continuously. 3. R #5's care plan said he was supposed to be on two (2) LPM of oxygen as needed for hypoxia. 4. Staff did not revise R #5's care plan when his oxygen order changed. 5. Staff were expected to revise resident care plans when their orders changed. <p>R #6</p> <p>S. Record review of R #6's admission record, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. R #6 was admitted to the facility on [DATE]. 2. R #6 had psychiatric diagnosis of schizophrenia (severe mental disorder characterized by disturbances in thinking, perception, and behavior, including delusions, hallucinations, and disorganized speech). <p>T. Record review of R #6's physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. On 11/12/25, thioridazine (antipsychotic medication, historically used for schizophrenia and other psychotic disorders) 10 mg, give 1 tablet by mouth two times daily for schizophrenia. 2. On 10/20/25, a BMP (common blood test that checks electrolyte and blood sugar levels, kidney function, and acid-base balance) every three months due to use of antipsychotic meds. 3. On 10/02/25 to monitor mood and behavior related to psychotropic usage. Mood and behavior to be documented under progress notes. 4. On 10/20/25 for ECG (electrocardiogram, is a non-invasive test that records the heart's electrical activity to assess its rate, rhythm, and overall function) every 6 months due to chronic use of antipsychotic. <p>U. Record review of R #6's care plan dated 10/14/25, revealed that the orders for interventions for antipsychotic medications were not documented in the care plan. (continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>V. On 11/21/25 at 2:00PM, during an interview, the Regional Clinical Nurse (RCN) confirmed that the interventions for R #6's antipsychotic medication are not documented on her care plan. The RCN confirmed that the interventions should be care planned.</p> <p>R #60</p> <p>W. Record review of R #60's admission record, no date, revealed an admission date of 06/27/25.</p> <p>X. Record review of R #60's Activities Initial assessment dated [DATE] revealed R # 60's activity pursuits patterns for activities revealed the following was very important for R #60:</p> <ol style="list-style-type: none"> 1. Being around animals. 2. Keeping up with the news. 3. Groups with people. 4. Going outdoors. 5. Morning and afternoon activities. <p>Y. Record review of R #60's care plan dated 09/16/25 revealed R #60's care plan did not include her personal preferences from the initial MDS assessment dated [DATE] in the care plan section Approaches/Tasks.</p> <p>Z. On 11/20/25 at 9:45 AM during an interview, the Activities Director (AD) confirmed the following:</p> <ol style="list-style-type: none"> 1. R #60's care plan did not state how many times a week R #60 will attend activities. 2. R #60's care plan was not updated to include interest from the Activities Initial assessment dated [DATE]. 3. R #60's care plan should have R #60's interests and frequency of activities. 		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on record review, and interview, the facility failed to maintain acceptable parameters of nutritional status for 1 (R #70) of 3 (R #16, R #52 and R #70) residents reviewed for nutrition maintained acceptable parameters of nutritional status when staff failed to do the following: 1. Weigh R #70 once weekly for 4 weeks, and monthly thereafter 2. Ensure R #70 received his ordered nutritional supplement. These deficient practices could likely result in resident weight loss and adverse effects. The findings are: A. On 11/18/25 at 9:19 AM, during an interview, R #70's sister stated that the resident was having tooth pain and that she had lost weight because her tooth hurt when she ate. B. Record review of R #70's physicians orders revealed the following: 1. An order dated 10/16/25, R #70 is at risk for weight loss, weigh weekly for 4 weeks and monthly after that. 2. An order dated 10/27/25, house supplement two times a day for poor intake 4 oz. C. Record review of R #70's treatment administration record revealed the following: 1. House shake 4 oz was documented as given only twice, on 10/31/25, in October 2025. 2. Weight was only documented on 10/16/25 for the month of October 2025. D. On 11/20/25 at 1:50 PM, during an interview, the Regional Clinical Nurse (RCN), confirmed that R #70 was not being weighed as per the order. The RCN confirmed that there is no documentation that the house supplement was given to R #70 as ordered in October. The RCN stated that the physician's orders should be followed and that staff should document in the resident's record when the supplement is given to the resident.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and implemented by the physician and/or the physician provided documentation of a rationale (set of reasons or a logical basis for a course of action) for not following the consultant pharmacist's recommendation for 1 (R #6) of 5 (R #3, R #5, R #6, R #39, and R #60) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). The findings are: A. Record review of R #6's admission record, no date, revealed the following: 1. R #6 was admitted to the facility on [DATE]. 2. A diagnosis of dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. 3. A diagnosis of schizophrenia (a severe, chronic mental disorder characterized by a disconnection from reality, impacting thinking, emotions, and behavior, often involving hallucinations (seeing/hearing things not there) and delusions (false beliefs), unspecified. B. Record review of R #6's physician's orders revealed an order dated 08/11/25 for donepezil (a prescription medication used to treat symptoms of dementia caused by Alzheimer's disease) 10 mg give 1 tablet by mouth one time at bedtime related to schizophrenia, unspecified. C. Record review of R # 6's Medication Regimen Review (form provided to the facility with pharmacist recommendation) dated 09/05/25, revealed that a clarification for donepezil indication to be changed from schizophrenia to dementia. D. Record review of R #6's physician's orders dated 10/28/25 for donepezil 10 mg revealed the diagnosis was not updated to dementia until 10/28/25. E. On 11/21/25 at 10:19 AM, during an interview, the DON confirmed that the diagnosis for donepezil was not updated until 10/28/25. The DON stated that the diagnosis should have been updated within the month of the recommendation.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff adequately monitored medications for 1 (R #5) of 5 (R #3, R #5, R #6, R #39, and R #60) residents reviewed for unnecessary medications, when they failed to monitor R #5 for side effects (unwanted effects for medication) of anticoagulant (medicines that help prevent blood clots) medications. If the facility does not adequately monitor side effects of anticoagulant medication, the residents are likely to be at risk of bruising and severe bleeding. The findings are: A. Record review of R #5's admission documents, no date, revealed the following: 1. R #5 was admitted to the facility on [DATE]. 2. R #5 had a diagnosis of history of venous thrombosis (blood clot in veins) and embolism (obstruction of an artery). B. Record review of R #5's physician orders, multiple dates, revealed the following: 1. An order dated 08/28/25 and discontinued on 09/16/25, for rivaroxaban (medication used to treat and prevent deep venous thrombosis (DVT), a condition in which harmful blood clots form in the blood vessels of the legs) 20 mg for DVT prevention. 2. An order dated 09/16/25, for rivaroxaban 10 mg once a day for anticoagulant (blood clot prevention). C. Record review of R #5's pharmacist recommendation, dated 09/05/25, revealed the pharmacist recommended staff monitor R #5 for bleeding or thromboembolism (a circulating blood clot that gets stuck and causes an obstruction, possible side effects from anticoagulant medication). D. Record review of R #5's entire medical record, revealed staff did not document monitoring R #5 for side effects of anticoagulant medication. E. On 11/21/25 at 1:02 PM, during an interview, LPN #16 stated the following: 1. R #5 had an order for the anticoagulant rivaroxaban. 2. Nurses were supposed to monitor residents for side effects of anticoagulant medication. 3. Nurses were expected to document monitoring for side effects of anticoagulants in the MAR. 4. R #5's medical record did not contain any documentation that staff were monitoring him for side effects of anticoagulant medication. F. On 11/21/25 at 1:09 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. Staff were expected to monitor residents for side effects of anticoagulant medication. 2. On 09/05/25, the pharmacist recommended staff monitor R #5 for bleeding and thromboembolism. 3. R #5's medical record did not contain any documentation that staff were monitoring him for side effects of anticoagulant medication.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident received dental services for 1 (R #70) of 2 (R #6 and R #70) residents reviewed for dental care. This deficient practice could likely result in residents experiencing tooth decay, tooth pain, and difficulty chewing. The findings are: A. On 11/18/25 at 9:19 AM, during an interview with R #70's Power of Attorney (POA), she stated that R #70's teeth were hurting her, and she doesn't know if R #70 had been to see a dentist. B. Record review of R #70's progress note, dated 07/30/25, revealed R #70 had been to a dentist for an extraction of a tooth and there was decay under the gum. The progress note stated that the tooth broke and that R #70 needed to see an oral surgeon to extract the rest of the tooth. C. Record review of R #70's medical record, no date, revealed there was no documentation that R #70 had been to see an Oral Surgeon. D. On 11/19/25 at 5:25 PM, during an interview, Medical Records (MR) confirmed that R #70 had been to the dentist on 07/30/25 and that there was a referral to see an oral surgeon. MR stated that the resident had not seen an oral surgeon. E. On 11/20/25 at 9:42 AM, during an interview, R #70 stated that she was having tooth pain. R #70 stated that her teeth hurt when she drinks or eats anything cold. R #70 stated that if she eats on the side where the tooth is broken that it hurts. R #70 stated that she tries not to eat on the side where the tooth is broken. R #70 stated that she was supposed to see an oral surgeon but that the facility had not made an appointment yet. F. On 11/20/25 at 10:08 AM, during an interview, the DON confirmed that R #70 had not seen an oral surgeon. The DON stated that when there are referrals that they should be followed up with, and appointments should be made.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received dental services for 1 (R #6) of 2 (R #6 and R #70) residents reviewed for dental care. This deficient practice could likely result in residents experiencing tooth decay, tooth pain, and difficulty chewing. The findings are: A. On 11/18/25 at 10:08 AM, during an interview with R #6's son, he stated that R #6 had not been to a dentist since her admission at the facility. B. Record review of R #6's admission record, no date, revealed R #6 was admitted to the facility on [DATE]. C. Record review of a progress note, dated 01/28/25, revealed R #6 was scheduled for a routine dental exam but the dental office canceled the appointment because R #6's insurance was inactive. D. On 11/19/25 at 5:19 PM, during an interview, Medical Records (MR) confirmed that R #6 had an appointment to see the dentist on 01/28/25 but that at the time R #6's insurance was showing as inactive, so the appointment was canceled. MR stated that the dental office canceled the appointment. MR stated that the dental appointment for R #6 had not been rescheduled. E. On 11/20/25 at 9:42 AM, during an interview, the Regional Clinical Nurse (RCN) confirmed that a dental appointment has not been rescheduled for R #6.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure medical records were complete and accurate for 3 (R #10, R #24, and R #60) of 4 (R #10, R #24, R #50, and R 60) residents reviewed for documentation accuracy when staff failed to do the following: 1. Document R #24's blood sugar levels. 2. Document R #10 and R #60's activity participation. These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are:</p> <p>Blood sugar levels</p> <p>R#24</p> <p>A. Record review of R #24's physician's orders revealed an order dated 03/11/25 for blood glucose level monitoring twice a month on the first and 15th for type 2 diabetes mellitus without complications.</p> <p>B. Record review of R #24's TAR (treatment administration report) revealed the following:</p> <ol style="list-style-type: none"> 1. For the month of September 2025, R #24's blood sugar levels were not documented. 2. For the month of October 2025, R #24's blood sugar levels were not documented. 3. For the month of November 2025, R #24's blood sugar levels were not documented. <p>C. On 11/19/25 at 3:31 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed that the results of the blood glucose checks were not being documented in the resident's medical record. The RCN confirmed that the blood glucose levels should be documented in the resident's medical record at the time that they are checked.</p> <p>R #10</p> <p>D. Record review of R #10's admission Record (no date) revealed she was admitted to the facility on [DATE].</p> <p>E. Record review of R #10's Change in Condition (significant decline or improvement in the resident's condition) MDS dated [DATE] revealed the following:</p> <ol style="list-style-type: none"> 1. Section F: Preferences for Customary Routine and Activities the following were answered as very important to R #10: <ul style="list-style-type: none"> a. Being around animals such as pets. b. Going outside to get fresh air when the weather is good. c. Participation in religious services or practices. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. Record review of R #10's Care Plan dated 08/25/25 revealed the following:</p> <ol style="list-style-type: none"> Focus: Resident has limited interest in scheduled groups, resident prefers to spend time in her room watching TV and 1 on 1 activities. Outcome (goal of care plan): Resident participates in 1 on 1 activities and self-directed watching TV. Approaches/Tasks (actions taken by staff to help residents achieve care plan goals): <ol style="list-style-type: none"> Preferred activities are to watch TV and 1 on 1 activities. Remind R #10 that she may leave activities at any time and is not required to stay for entire activity. <p>G. Record review of R #10's Progress Notes from 08/25/25 through 11/18/2025 revealed the following:</p> <ol style="list-style-type: none"> Staff did not document that R #10 participated in any group activities. Staff documented that R #10 participated in 1 on 1 activities on 10/15/25. <p>R #60</p> <p>H. Record review of R #60's admission record, no date revealed the following:</p> <ol style="list-style-type: none"> R #60 was admitted to the facility on [DATE]. R #60 has a diagnosis of unspecified Dementia, unspecified severity, with other behavioral disturbance (is caused by damage to or loss of nerve cells and their connections in the brain with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety depending on patient). <p>I. Record review of R #60's Activities Initial assessment dated [DATE] revealed R # 60's activity pursuits patterns for activities revealed the following was very important for R #60:</p> <ol style="list-style-type: none"> Being around animals. Keeping up with the news. Groups with people. Going outdoors. Morning and afternoon activities. <p>J. Record review of R #60's care plan dated 09/16/25 revealed R #60's care plan did not include her personal preferences from the initial MDS assessment dated [DATE] in the care plan section Approaches/Tasks. (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>K. Record review of R #60's Activity Participation Record revealed the following:</p> <ol style="list-style-type: none"> 1. R #60 had no Activity Participation documentation in R #60's record for the month of September 2025. 2. R #60 had no Activity Participation documentation in R #60's record for the month of October 2025. <p>L. On 11/20/25 at 9:45 AM during an interview, the Activities Director (AD) confirmed the following:</p> <ol style="list-style-type: none"> 1. R #60 was involved in activities daily and one to one program. 2. No daily Activity Participation documentation in R #60's record for the following months: <ol style="list-style-type: none"> a. September 2025, b. October 2025, C. November 2025. 3. AD does not complete progress notes on residents' activity participation. 4. AD does not document daily in R #60's Activity Participation Record. 5. AD does not have a reason as to why there is missing documentation. 6. Care plan is not measured as to how many times R #60 should participate in activities weekly, and AD has not updated care plan for a year. <p>M. On 11/21/25 at 2:20 PM, during an interview with the Administrator she stated her expectation is that the AD documents and completes the activities documentation for the residents who participate in activities.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to have reasonable accommodations for 1 (R #16) of 3 (R #6, R #16, and R #24) residents sampled for accommodation of needs, when they failed to ensure R #16's water was within reach. This deficient practice could likely result in the residents being at risk of accidents and feeling like their preferences and requests are being ignored and lead to feeling like their needs do not matter. The findings are:</p> <p>A. Record review of R #16's admission documents, no date, revealed the following:</p> <ol style="list-style-type: none"> 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: <ol style="list-style-type: none"> a. Dementia; b. Muscle Weakness (weak muscles) c. Unspecified fall (fall with unknown cause) <p>B. On 11/17/25 at 1:27 PM, during an observation, R #16 laid down in her bed, revealed the following:</p> <ol style="list-style-type: none"> 1. R #16's bed was in lowest position. 2. R #16's drinking water was on the bedside table. 3. R #16's bedside table was positioned about two (2) feet from the bed and raised to a level that R #16 could not reach. <p>C. On 11/17/25 at 1:44 PM, during an interview, Nursing Aide #16 confirmed R #16's bedside table was out of R #16's reach and R #16 could not reach her water to drink.</p> <p>D. On 11/21/25 at 2:18 PM, during a joint interview, ADON and the Regional Clinical Nurse (RCN) confirmed staff were expected to ensure residents' bedside tables were within reach and that residents could reach their water and personal items.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS; federally mandated assessment instrument completed by facility staff) was accurate for 1 (R #16) of 2 (R #2 and R #16) residents reviewed for falls. 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 R #16's admission documents, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: a. Muscle Weakness (weak muscles); b. Unspecified fall (fall with unknown cause. B. Record review of R #16's progress note, dated 10/13/25, revealed R #16 fell and was transferred to the hospital for evaluation. C. Record review of R #16's admission MDS, dated [DATE], revealed staff documented that R #16 had no falls since admission. D. On 11/19/25 at 2:14 PM, during an interview, the MDS Coordinator confirmed the following: 1. R #16 fell on [DATE]. 2. R #16's admission MDS was dated on 10/14/25 and did not include R #16's fall on 10/13/25. 3. Staff should have documented R #16's fall on 10/13/25 on her admission MDS.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create a baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #83) of 3 (R #19, R #49 and R #83) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care upon admission and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition. The findings are: A. Record review of R #83's admission Record (no date) revealed the following: 1. R #83 was admitted into the facility on [DATE]. 2. R #83 had the following diagnoses: a. Encounter for orthopedic aftercare following surgical amputation (healthcare provided after a surgical removal of a limb or other body used to control pain or a disease process in the affected limb). b. Peripheral vascular disease (PVD; a blood circulation disorder that causes some blood vessels to narrow or block restricting blood flow to the arms, legs or other body parts). B. Record review of R #83's physician's orders revealed the following: 1. An order dated 08/30/25, wound care to left below knee amputation (BKA) cleanse with normal saline/wound cleanser, pat dry with gauze, apply skin prep (liquid that when applied to the skin forms a protective film or barrier) around wound edges, apply Bacitracin (antibiotic ointment used to prevent and treat skin infections) to wound bed (base or open area of a wound), apply Xeroform (sterile, nonstick gauze wound dressing that is impregnated with a mixture of petroleum jelly and an antimicrobial agent), and cover with abdominal pad (ABD, type of dressing used primarily for managing large wounds or those requiring high absorbency), wrap with Kerlix (bandage roll made from soft absorbent gauze that is designed to be wrapped around wounds), wrap with Ace bandage (elasticized bandage that applies compression and helps keep dressings in place). C. Record review of R #83's Care Plan, initiated 08/30/25, revealed the care plan did not contain a plan for R #83's BKA surgical site wound care. D. On 11/21/25 at 3:13 PM during an interview, the Regional Clinical Nurse (RCN) confirmed that R #83's care plan did not include a plan for R #83's BKA surgical site wound care.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide activities of daily living (ADL) assistance for 1 (R #24) of 1 (R #24) resident reviewed for ADL care when staff failed to: 1. Assist R #24 with nail care. 2. Assist R #24 back to his room after his meal. These deficient practices are likely to affect the dignity and health of the residents. The findings are: Nail Care A. Record review of R #24's admission record, no date revealed the following: 1. R #24 was admitted to the facility on [DATE]. 2. R #2 has a diagnosis of the following: a. Needing assistance with personal care. b. Legal blindness. c. Type 2 Diabetes Mellitus without complications B. On 11/18/25 at 1:01 PM, during an interview with R #24, he stated that his fingernails are too long and they get caught on things. R #24 stated that that he would like staff to cut his fingernails. C. On 11/18/25 at 1:02 PM, during an observation of R #24's fingernails, R #24's fingernails were long and some were jagged and broke. D. On 11/19/25 at 1:47 PM, during an interview, LPN #8 confirmed R #24 needs his fingernails cut by staff and that R #24 cannot cut his fingernails on his own. R #24 confirmed that R #24's nails are long and need to be cut. Transfer E. Record review of R #24's care plan dated 09/26/25 revealed the following: 1. R #24 has, nutritional problem or potential nutritional problem r/t Legally Blindness. Encourage [name of R #24] to go to the main dining room to get the assistance needed with meals. 2. R #24 has a Potential for falls/injuries r/t Impaired mobility. Assist with ADL's as needed. 3. R #24 requires assistance with ADLs. Mobility: utilizes wheelchair for mobility. Extent/type of assist may fluctuate within the day or day to day, depending on the level of strength, if in pain, mood, etc May require more staff assist or less Wheelchair mobility: Wheel 50 feet: Dependent Wheel 150 feet: Dependent. F. On 11/17/25 at 1:55 PM, during an observation of the dining room, R #24 sat at a table in the dining room by himself. He was whistling through his hands. R #24 appeared to be distressed. G. On 11/17/25 at 1:57 PM, during an interview with R #24, he stated that staff had forgotten him. R #24 stated that he had been trying to get someone's attention, but that no one had come for him. R #24 stated that he wanted to go back to his room and get out of his wheelchair. R #24 stated that he is blind and he can't hear and that he needs help to get back to his room. H. On 11/17/25 at 1:58 PM, during an interview with the Restorative Nurse Aide (RNA), she confirmed that R #24 was in the dining room. The RNA stated R #24 had been in the dining room since 11:30 AM. The RNA stated that she was coming back from lunch and saw R #24 was still in the dining room. The RNA stated that staff are supposed to stay in the dining area until all residents have left. The RNA confirmed that R #24 is blind and hard of hearing and that he needs assistance to get back to his room. I. On 11/17/25 at 3:06 PM, during an interview, the DON confirmed that there is supposed to be a nurse in the dining room until residents are done eating. The DON stated that staff should have assisted R #24 back to his room when he was done eating and that he should not have been left alone in the dining room</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure there was a system in place for the nursing staff to immediately determine code status [the residents choice as to whether or not they would like to be provided cardio- pulmonary resuscitation (CPR) in the event that they stopped breathing and/or their heart stopped] for 2 (R #16 and R #55) of 4 (R #16, R #39, R #55, and R #70) residents reviewed for code status. This deficient practice is likely to delay potentially lifesaving measures or cause residents to undergo CPR against their wishes, causing unnecessary suffering. The findings are: R #16 A. Record review of R #16's admission documents, no date, revealed R #16 was admitted to the facility on [DATE]. B. Record review of R #16's Medical Orders for Scope of Treatment (MOST, designed to ensure that seriously ill or frail patients can choose treatments they want or do not want and that their wishes are documented and honored), dated [DATE], revealed R #16 wanted staff to perform CPR in an emergency (Full Code). C. Record review of R #16's orders, no date, revealed staff did not document an order for R #16's code status. D. Record review of the nurse rounding tool, (paper nurses use to identify resident information quickly) no date, revealed R #16's code status was Do Not Resuscitate (DNR, a medical order to not resuscitate if heart or breathing stops, instructing providers not to do CPR, including chest compressions and intubation). E. On [DATE] at 9:16 AM, during an interview, LPN #16 stated the following: 1. Staff are expected to enter an order for resident code status upon admission. 2. MOST forms were supposed to be scanned into the resident's electronic medical record (EMR). 3. In an emergency, staff are expected to look in the computer for the resident's code status order. 4. Staff did not keep a copy of resident's MOST forms in the nurses' station in the skilled unit. 5. She confirmed R #16 did not have an order for code status. 6. If staff did not have access to the computer, staff were expected to look at the nurse rounding tool for the resident's code status. 7. She confirmed that R #16's MOST form indicated R #16 was a full code. 8. She confirmed that the nurse rounding tool indicated that R #16's code status was DNR and did not match R #16's MOST form. R #55 F. Record review of R #55's admission documents, no date, revealed she was admitted to the facility on [DATE]. G. Record review of R #55's MOST form, dated [DATE], revealed R #55 wanted her code status to be full code. H. Record review of R #55's physician's order, dated [DATE], revealed an order for R #55 to have CPR in an emergency. I. Record review of the nurse rounding tool, no date, revealed R #55's code status was DNR (did not match order or MOST). J. On [DATE] at 9:26 AM, during an interview, the DON confirmed the following: 1. Staff were expected to look at the resident's MOST forms to determine the resident code status. 2. There was a binder at the other nurses' station with MOST forms in it. 3. The binder with MOST forms was not readily available to staff in the skilled unit. 4. R #16's MOST form was not in the binder with the MOST forms. 5. She stated that the Social Services Worker (SSW) also had a binder with MOST forms that he kept in his office. 6. The SSW's binder with MOST forms included R #16's MOST form. 7. R #16's MOST form indicated she wanted to be a full code. 8. The nurse rounding tool indicated that R #16's code status was DNR and that did not match her MOST form. 9. R #55's MOST form indicated she wanted to be a full code. 10. The nurse rounding tool indicated that R #55's code status was DNR and that did not match her MOST form. K. On [DATE] at 9:44 AM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. Resident MOST forms should be readily available to staff at the nurses' station in case staff were unable to access the resident's EMR due to power outage or internet issues. 2. Nurse rounding tools should have the correct code status for each resident.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received proper treatment to maintain hearing for 1 (R #1) of 1 (R #1) resident reviewed for vision and hearing. This deficient practice could likely result in residents losing some independence if they cannot hear, which would compromise their quality of life. The findings are: A. On 11/18/25 at 9:25 AM, during an interview, R #1 said she had experienced hearing loss in her left ear. R #1 stated she has brought up the need to have a hearing evaluation completed but has not been scheduled. B. Record review of R #1's admission Record (no date) revealed R #1 was readmitted to the facility on [DATE]. C. Record review of R #1's Electronic Medical Record (EMR) revealed the following: 1. Care plan conference note dated 07/18/25 Hearing -An appointment is already scheduled. 2. Care plan conference note dated 10/18/25 Hearing - Needs an appointment. D. On 11/21/25 at 3:32 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. The care plan conference notes indicated that R #1 wanted a hearing evaluation. 2. R #1 has not been seen or scheduled for a hearing evaluation yet.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received restorative rehabilitation (focuses on maximizing an optimal level of functioning, enabling clients to regain/retain their independence following the debilitating effects of illness or injury) services as ordered by the physician for 1 (R #20) of 1 (R #20) resident reviewed for rehabilitation services. This deficient practice is likely to result in a decrease in residents' functional mobility. The findings are: A. Record review of R #20's admission record, no date revealed an admission date of 08/22/25. B. On 11/18/25 at 9:44 AM, during an interview, R #20 stated she was supposed to be walking daily with restorative nursing. R #20 stated the RNA (Restorative Nursing Aide) walked her yesterday for the first time in four months because state surveyors were in the building. C. Record review of R #20's physician's orders dated 09/16/25, revealed R #20 may participate in Restorative Nursing Program. Order did not specify directions as to how many times per week R #20 should be seen. D. Record review of R #20's quarterly MDS assessment dated [DATE], revealed the following number 0 (enter 0 if none or less than 15 minutes daily of days restorative program was performed for at least 15 minutes a day in the last 7 calendar days) number of days participated in Restorative Nursing Program E. Record review of R #20's physical therapy discharge note dated 09/24/25, revealed discharge recommendation to long term care with restorative nursing program for ambulation 2 times per day for at least 5 days a week with a front wheel walker with staff setup and supervision. F. On 11/19/25 at 3:59 PM, during an interview with RNA she stated on 11/17/25 the Restorative Nurse gave her a list with orders on what to do for residents in the restorative program. RNA stated on 11/17/25 was the first day restorative program was back in session, and she ambulated (to move from place to place) R #20. RNA stated R #20 should be ambulated daily, and she started ambulating her on 11/17/25 for the first time in a while because there was no restorative program. RNA stated R #20 told her she wants to get back to walking. RNA stated she does tell the residents when she is not available to ambulate them when she is assisting nursing to cover the floor as a CNA (certified nursing assistant) to provide direct care to residents. RNA stated she gets pulled to the floor to assist to provide direct care for residents often. RNA stated, on 11/18/25 and 11/19/25, R #20 was not ambulated because she was pulled to assist nursing on the floor to provide direct care to residents and help cover the shift. She worked her entire shift as a CNA not an RNA. G. On 11/19/25 at 3:38 PM, during an interview with Restorative nurse confirmed the following: 1. The Restorative Nursing Program started on 11/17/25. 2. R #20 was ordered to start the Restorative Nursing Program on 09/16/25 and did not begin till 11/17/25 due to staffing issue. 3. Residents were not told the Restorative Nursing Program was not active because CNA's on the unit were assisting residents with ambulating. 4. The expectation for the Restorative Nursing Program be followed by the order and completed by the RNA. H. On 11/19/25 at 3:38 PM, during an interview the Regional Nursing Consultant confirmed the following: 1. There was not an active Restorative Nursing Program in September 2025. 2. R #20 is on Restorative Nursing Program and should have been care planned, and the order should have stated how many days a week R #20 should be ambulating. 3. CNA's working the floor were getting refusals from R #20 and they are documenting refusal and non-applicable which indicated refused as well. 4. The expectation would be that the order would be written correctly and R #20 and other residents participating in the program would have a care plan for Restorative Nursing Program.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents with a diagnosis of urinary tract infection (UTI) received appropriate treatment for 1 (R #8) of 2 (R #8 and R #70) residents reviewed for urinary catheters (hollow, flexible tube that helps drain urine from the bladder) and UTI when they failed to ensure that a resident received antibiotic treatment for a UTI. This deficient practice could result in residents being susceptible to worsening infection or becoming septic (potentially life-threatening when the body responds to infection by damaging its own tissues) The findings are: A. On 11/17/25 at 3:30 PM, during an interview with R #8's son, he stated that R #8 has had a UTI twice since she was admitted . B. Record review of R #8's Electronic Medical Record (EMR) revealed the following: 1. R #8 was admitted to the facility on [DATE]. 2. R #8's diagnoses included the following: a. Urinary tract infection site not specified (diagnosis of UTI when the exact location within the urinary system has not been determined). b. Retention of urine unspecified (condition where the bladder does not empty completely or at all, which can lead to UTI). C. Record review of R #8's provider encounter note, dated 09/09/25, revealed the following: 1. History of present illness: R #8 complains of fatigue, generally not feeling well. Her urine in catheter has become progressively more cloudy. 2. Plan: complicated UTI (occurs in individuals with underlying health issues or conditions that make the infection more difficult to treat) pseudomonas (group of bacteria commonly found in the environment). Previous urine culture with multidrug resistant Pseudomonas (strain of bacteria that has become resistant to multiple antibiotics making it difficult to treat). Sensitive to cefepime (antibiotic with broad spectrum of antibacterial activity) and Zosyn (brand name combination antibiotic used to treat a variety of bacterial infections). Requested intravenous (IV; accessing a vein to give medication or fluid replacement) to be established- either peripherally inserted central catheter (PICC; invasive long-lasting [sometimes up to twelve months] tube that healthcare providers insert into a major vein that connects directly into the heart) or peripheral (tube placed into arm or hand for administration of medication or fluids that can last several days) as long as access can be maintained for 7 days. Plan on starting cefepime 1 gram IV every 12 hours as soon as IV is in place. D. Record review of R #8's progress notes revealed the progress notes did not contain any documentation regarding the outcome of R #8 obtaining IV access. E. Record review of R #8's physician's orders revealed the following: 1. An order dated 08/12/25 for cephalexin oral tablet (antibiotic used to treat various bacterial infections such as those affecting the urinary system) 250 MG, give 1 tablet by mouth one time a day for UTI suppression (prevention of recurrent UTI's). 2. No orders in place for cefepime as indicated on the provider encounter note dated 09/09/25. F. Record review of R #8's medication administration records (MAR; electronic form used by nursing staff to document administration of medication) dated August, September and October 2025 revealed the following: 1. R #8 received cephalexin once daily from August 13th, 2025, through October 10th, 2025. 2. R #8 did not receive any doses of IV cefepime. G. On 11/21/25 at 3:35 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. There is no documentation regarding R #8 going out for PICC or IV access. 2. R #8 did not receive any doses of IV cefepime as indicated on the provider encounter note.</p>		

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 11/21/2025
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**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 #5) of 1 (R #5) resident reviewed for respiratory care when the facility failed to: 1. Ensure R #5 wore their nasal cannula (a thin, flexible tube that wraps around your head, typically hooking around your ears) correctly. 2. Ensure staff followed the physician's order for oxygen use. These deficient practices are likely to result in residents receiving too much or not enough oxygen and can lead to worsening of their condition. The findings are: A. Record review of R #5's admission documents, no date, revealed the following: 1. R #5 was admitted to the facility on [DATE]. 2. R #5 had the following diagnoses: a. Chronic Obstructive Pulmonary Disease (COPD, an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways). b. Asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways, which makes it harder to breathe). B. Record review of R #5's physician's order, dated 09/25/25, revealed an order for 3 liters per minute (LPM, the flow rate of oxygen) continuously. C. On 11/17/25 at 2:00 PM, during an interview and observation of R #5 in his bed, the following was revealed: 1. R #5 had a nasal cannula on with the nasal prongs (two prongs that go inside your nostrils that deliver the oxygen) positioned on his left cheek. 2. R #5 stated that he needs oxygen because he has COPD. 3. R #5 stated that the nasal cannula won't stay in place and keeps slipping to his left cheek. 4. R #5 repositioned his nasal cannula, it moved back to his left cheek. 5. A sign was above R #5's bed indicating R #5 was supposed to be on 3 LPM of oxygen continuously. 6. R #5's oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) revealed it was set at 3.5 LPM of oxygen. D. On 11/17/25 at 2:06 PM, during an interview, LPN #16 confirmed the following: 1. R #5's nasal cannula was positioned on his left cheek and should be positioned in his nose. 2. R #5's order was for 3 LPM of oxygen. 3. R #5's oxygen concentrator was set at 3.5 LPM of oxygen. 4. Staff were not supposed to adjust resident's oxygen concentration without notifying the provider and getting an order. E. On 11/19/25 at 11:18 AM, during an observation of R #5 in his room, the following was revealed: 1. R #5 was not wearing his nasal cannula. 2. R #5's oxygen concentrator was set at 3 LPM. F. On 11/19/25 at 11:19 AM, during an interview, LPN #17 confirmed R #5 was not wearing his nasal cannula and was supposed to be wearing it continuously. G. On 11/21/25 at 1:13 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. If there was a situation where nursing staff needed to adjust oxygen, they should contact the provider for orders. 2. She confirmed that R #5's order was for 3 LPM of oxygen continuously. 3. She confirmed that there was no documentation of why R #5's oxygen was set at 3.5 LPM.</p>		

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 11/21/2025
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)		
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on interview and record review, the facility failed to complete performance reviews at least every 12 months for 1 (CNA #1) of 3 (CNA #1, CNA #2, and CNA #3), CNA's sampled for annual performance review. This deficient practice could likely result in staff being undertrained and providing inadequate care. The findings are: A. Record review of CNA #1's personnel records revealed the following: CNA #1's date of hire was 10/01/24. An annual performance evaluation was not completed for CNA #1 in October 2025. B. On 11/21/25 at 2:38 PM during an interview, the administrator confirmed that CNA #1's annual performance was not completed.</p>		