

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Spring River Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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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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. Based on observation and interview, the facility failed to ensure residents were treated with respect and dignity for 1 (R #15) of 1 (R #15) resident sampled for dignity, when staff failed to cover the resident's urine bag (medical device used to drain and collect urine when a person cannot urinate normally). This deficient practice could likely to result in residents feeling embarrassed and angry, and that their feelings and preferences are unimportant to the facility staff. The findings are: A. On 02/03/26 at 11:43 am, a random observation of the facility revealed R #15 in his wheelchair going down the North hallway of the facility, across the lobby area, up the South hallway of the facility, and into the activity area. R #15's urine bag was approximately a quarter full of urine and was not covered. B. On 02/03/26 at 11:56 am, during an interview with the Social Services Director (SSD), she confirmed R #15's urine bag was not covered, and it should be.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report incidents involving allegations of abuse and allegations that resulted in serious bodily injury to the State Agency, no later than two hours for 2 (R #13 and R #14) of 5 (R #12, R #13, R #14, R #15 and R #16) residents reviewed for abuse and neglect. If the facility fails to report allegations of abuse and neglect to the State Agency, then the State Agency is unable to ensure residents are free from abuse and neglect. The findings are: R #13A. Record review of R #13's facility incident report dated 01/12/26 revealed the following:1. An incident resulting in serious bodily injury. R #13 had a fall resulting in a compression fracture (a break or crack in a vertebra that causes the bone to collapse) of L2 (location of the fracture; lower back). 2. The report was submitted to the State Survey Agency 01/21/26, approximately nine days after the incident. R #14B. Record review of R #14's facility incident report dated 12/28/25 revealed the following:1. An incident resulting in serious bodily injury. R #14 had a fall resulting in a rib fracture. 2. The report was submitted to the State Survey Agency 01/09/26, approximately 12 days after the incident. C. On 02/04/26 at 2:15 pm during an interview with the Director of Operations (DOO), she stated that the Director of Nursing completes the reporting process for this facility and thought it was being done correctly.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to report the results of all investigations to the State Survey Agency within five working days of an incident for 5 (R #12, R #13, R #14, R #15 and R #16) of 5 (R #12, R #13, R #14, R #15 and R #16) residents reviewed for abuse or neglect. If the facility is not submitting the summary of the facility's investigation to the State Survey Agency, then the State Survey Agency is unable to appropriately triage (review) the allegation for further investigation. R #12A. Record review of the facility's list of reportable incidents (list of events the facility reported to the State Survey Agency) revealed reportable incidents for R #12 on the following dates:1. 12/04/25,2. 12/22/25,3. 01/07/26,4. 01/11/26.B. Record review of the facility's five-day reports revealed the following:1. The investigations were completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency.R #13C. Record review of the facility's list of reportable incidents revealed a reportable incident for R #13 on 01/12/26.D. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency.R #14E. Record review of the facility's list of reportable incidents revealed a reportable incident for R #14 dated 12/28/25.F. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency.R #15G. Record review of the facility's list of reportable incidents revealed a reportable incident for R #16 dated 01/15/26.H. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency.R #16I. Record review of the facility's list of reportable incidents revealed a reportable incident for R #16 dated 12/07/25.J. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency.K. On 02/04/26 at 2:18 pm, during an interview with the Director of Operations (DOO), she confirmed it is the facility's responsibility to submit a five-day follow-up report with the results of the investigation to the state survey agency. She could not confirm the results of the investigations had been submitted to the State Survey Agency for the following:1. Incidents for R #12 dated:-12/04/25,-12/22/25,-01/07/26,-01/11/26.2. An Incident for R #13 dated 01/12/26,3. An incident for R #14 dated 12/28/25,4. An incident for R #15 dated 01/15/26,5. An incident for R #16 dated 12/07/25.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide quality of care for 2 (R #1 and R #2) of 3 (R #1, R #2, and R #3) residents reviewed when staff failed:1. To assist R #1 with fluid during mealtimes.2. To provide timely assistance for R #2's toileting needs. These deficient practices could likely cause residents to feel unimportant and frustrated. The findings are: R #1A. Record review of R #1's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Acute and chronic respiratory failure with hypoxia (a condition where there is not enough oxygen in the blood),2. Emphysema (a respiratory disorder that results in the reduction of air intake),3. Heart failure (impaired heart function), unspecified,4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).B. On 12/31/25 at 12:06 pm, a random dining observation revealed R #1 sat at a table in the dining room near the main entrance with two other individuals. R #1 was served her lunch meal which consisted of chicken, potatoes, a green vegetable, and a dinner roll at 12:10 pm by Certified Nurse Aide (CNA) #3. R #1 asked CNA #3 for a drink when her meal was placed on the table. R #1 asked CNA #1 for something to drink at 12:19 pm. CNA #1 walked by and started serving other residents without giving R #1 something to drink.C. Record review of R #1's care plan dated 09/04/25 revealed the following:1. R #1 exhibits or is at risk for fluid volume deficits as evidence by insufficient intake.2. R #1 is to be encouraged to consume all fluids during meals.3. R #1 is to be offered and encouraged to fluids of choice.D. Record review of R #1's current medical orders revealed an order dated 12/03/25 for R #1 to increase fluids as tolerated.E. On 12/31/25 at 12:45 pm, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed R #1 was not served a drink with her meal and had finished her meal without having a drink available. LPN #1 stated she expects every resident to be served a drink with each meal unless there is a medical order against it. LPN #1 confirmed this resident does not have any orders that would restrict her ability to have a drink with meals.R #2 F. Record review of R #2's admission record revealed R #2 was admitted into the facility on [DATE] with the following diagnoses:1. Wedge compression fracture of fourth lumbar vertebra (spinal injury that can cause significant pain and mobility issues),2. Wedge compression fracture of fifth lumbar vertebra (spinal injury that causes significant pain and mobility issues),3. Age-related osteoporosis (condition where bone density decreases as people age, leading to fragile bones),4. Morbid (Severe) obesity due to excess calories,5. Muscle Weakness,6. Reduced mobility (limits a person's ability to move freely and easily, impacting on daily activities and overall well-being),7. Need for assistance with personal care,8. Abnormalities of gait and mobility (unusual walking patterns that can arise from various medical conditions, injuries, or environmental factors).G. Record review of R #2's quarterly Minimum Data Set assessment (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/23/25, revealed the following:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 12, moderately impaired.2. R #2 is dependent and requires the assistance of staff to complete toileting and hygiene tasks.H. Record review of R #2's care plan dated 10/20/25 revealed R #2 is at risk for decreased ability to perform ADL's (activities of daily living) in transfer, bed mobility and toileting.I. Record review of R #2's progress notes dated 11/10/25 revealed an incident where R #2 was assisted to the restroom and placed on the toilet where he was left for an undetermined and extended period of time. The nurse's evaluation showed that due to R #2 staying on the toilet too long, he was experiencing pain. The nurse failed to document the location of R #2's pain. J. On 12/30/25 at 11:15 am during an interview with the Director of Operations (DOO), she indicated she was unable to produce R #2's record in its entirety. She stated the previous owners are not providing complete access to residents' records who were in the facility prior to 12/01/25 [change of ownership occurred on this day] therefore she could not answer as to why R #2 was left on the toilet or provide any details as to the investigation of this incident. The ADM stated that a resident should never be left on the toilet for an extended period of time.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide podiatry (the medical care and treatment of the human foot) services for 1(R #3) of 5 (R #3, R #8, R #9, R #10, and R #11) residents reviewed for toenail care. This deficient practice could likely result in functional decline, pain, and infections. The findings are: A. Record review of R #3's face sheet revealed she was admitted on [DATE] with the following diagnoses:1. Osteomyelitis, (inflammation of bone and bone marrow),2. Pressure ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) of right heel, unstageable [a wound that has full thickness tissue loss but is covered with slough (dead tissue) or eschar (dark scab or falling away of dead skin) so that the true depth of the wound cannot be determined],3. Pressure ulcer of sacral (the portion of the spine between the lower back and the tailbone) region, stage 4 (a deep wound that may impact muscle, tendons, ligaments, and bone),4. Wedge compression fracture (The fracture forms on the front of the vertebra. The broken bone collapses and takes on a wedge shape) of first thoracic vertebra (group of twelve small bones that form the upper spine forming the rib cage),5. Cognitive (relating to the process of acquiring knowledge and understanding through thought, experience, and the senses) communication Deficit.B. Record review of R #3's physician orders dated 09/23/25, 10/09/25, and 12/03/25 revealed an order for podiatry for wound care and toenail care.C. Record review of a photo dated 11/17/25 revealed R # 3's toenails are long and overgrown.D. Record review of R #3's Electronic Health Record (EHR) revealed the EHR did not contain any podiatry notes/visits.E. On 12/31/25 at 10:00 am, during an interview, Licensed Vocational Nurse (LVN) #1 stated staff can do nail care when needed unless the nails are too thick and hard, if they are too hard, they will request that residents be sent to podiatry for nailcare. She was unable to confirm when R #3's nails were trimmed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #1) of 1 (R #1) resident reviewed for respiratory care when staff failed to follow the physician's order for oxygen use. This deficient practice is likely to result in residents experiencing worsening of their medical conditions. The findings are: A. Record review of R #1's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Acute and chronic respiratory failure with hypoxia (a condition where there is not enough oxygen in the blood),2. Emphysema (a respiratory disorder that results in the reduction of air intake),3. Heart failure (impaired heart function), unspecified,4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).B. Record review of R #1's Minimum Data Set assessment (MDS; a federally mandated assessment instrument completed by facility staff) dated 10/28/25, revealed the following:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 09, moderately impaired.2. R #1 utilizes oxygen therapy (the administration of oxygen to people that have low blood oxygen levels). C. Record review of R #1's care plan dated 09/04/25 revealed the following interventions (items listed in the interventions column of the care plan):1. Cue/remind her to wear her oxygen as she frequently forgets to keep it in.2. Oxygen as ordered. 5 L/Minute (liters per minute) per nasal cannula. D. Record review of R #1's medical orders revealed an order dated 12/03/25 for R #1 to use continuous oxygen at five liters per minute, using a nasal cannula.E. On 12/31/25 at 12:05 pm during a random observation in the dining room, R #1 sat in her wheelchair, at a table near the main entrance. R #1 did not have an oxygen tank or concentrator in her immediate area and was not wearing a nasal cannula.F. On 12/31/25 at 12:27 pm, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed R #1 did not have access to any type of supplemental oxygen with her in the dining room and R #1 does have an order to wear continuous oxygen.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide a sufficient number of nursing personnel to meet the individualized care needs of its residents and failed to maintain accurate PPD (Person Per Day) to demonstrate compliance with federal staffing standards. This deficient practice has the potential to affect all 87 residents care residing in the facility. The findings are: A. Record review of the facility's PPD documentation dated 06/01/25 to 12/29/25 revealed the following:1. The facility failed to provide PPD documentation for 06/01/25 to 11/30/25 [change of ownership occurred on 12/01/25].2. Documentation for 12/03/25 revealed two Registered Nurses (RN) were scheduled to work two twelve-hour shifts for a total of 24 hours but 36 hours was reported.3. Documentation for 12/10/25 revealed two RN were scheduled to work two twelve-hour shifts for a total of 24 hours but 36 hours was reported.B. Record review of the facility's schedules and timecards revealed no documentation prior to 12/01/25 [change of ownership occurred on this day].C. On 12/30/25 at 11:15 am during an interview with the Director of Operations (DOO), she confirmed she cannot provide copies of the PPD, schedules, or timecards prior to 12/01/25 when the current company completed a Change in Ownership. The ADM confirmed she is not able to verify the facility had sufficient nurse staffing because the documentation prior to 12/01/25 is not available to her.D. On 12/31/25 at 10:36 am during an interview with the Director of Nursing (DON), she confirmed the PPD staffing totals that were reported for 12/03/25 and 12/10/25 were not accurate. The DON stated she had no PPD documentation prior to 12/01/25 [change in ownership occurred on this day].E. On 02/04/26 at 10:10 am, the DOO confirmed she is still not able to provide any copies of the PPD, schedules or timecards prior to 12/01/25 when Change in Ownership occurred.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility failed to post nurse staffing data daily, at the beginning of the shift that included the following: 1. Facility name. 2. The current date. 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: -Registered nurses. -Licensed practical nurses. -Certified nurse aides. -Resident census. This deficient practice could likely result in residents and visitors not having the staffing information readily available. The findings are: A. On 12/31/25 at 9:02 am, an observation of the main entrance revealed the nurse staffing data sheet was dated 12/30/25. B. On 12/31/25 at 9:21 am during an interview with the facility's receptionist, she confirmed the nursing staffing data sheet should be posted daily and it was not.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure staff administered and secured medications for 1 (R #17) of 1 (R #17) resident reviewed for medications when staff left a pre-poured (the practice of preparing and storing medications in advance of their scheduled administration) medication on the resident's dresser in his room. This deficient practice could likely result in residents not getting the medications they need. The findings are: A. On 02/03/26 at 10:00 am, a random observation of the facility revealed a medicine cup approximately halfway full of a white powder. B. On 02/03/26 at 10:23 am, during an interview with Licensed Practical Nurse (LPN) #1, she stated the white powder in the medicine cup is Nystatin powder (a medication used to treat skin infections). LPN #1 stated the medication should not have been left on the resident's dresser.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to serve food under sanitary conditions when staff failed to use proper handling techniques of drinks and bowls while distributing meals to residents in the dining room. This deficient practice is likely to affect all 87 residents listed on the census provided by the Director of Operations (DOO) on 12/30/25 and could likely cause an increase in illnesses if safe food handling practices are not followed. The findings are: A. On 12/31/25 at 12:00 pm, an observation of the lunch dining services revealed the following:1. Certified Nurse Aide (CNA) #1 moved a chair from one table to another, moved the table over approximately two feet, touched a different chair at another table and then served drinks to all residents in the dining room without washing or sanitizing her hands.2. CNA #2 touched R #4's right arm and chair while assisting R #4 to sit down. CNA #2 served R #5 his lunch without sanitizing or washing her hands. CNA #2 touched R #5's cup and bowl by the top of the rim (cupping) when placing them on the table.3. CNA #3 pushed R #6's sleeve up her arm and then served R #1 her lunch without washing or sanitizing her hands. CNA #3 touched R #1's bowl by the top rim when placing it on the table.B. On 12/31/25 at 12:37 pm during an interview with the Dietary Supervisor (DS), she confirmed that staff should be sanitizing or washing their hands after touching dirty surfaces and handling food items and trays.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview, the facility's Director of Operations (DOO) and Administrator (ADM) failed to manage the facility when they knew/should have known and prevented the following deficient practices which occurred in the facility: 1. Not ensuring incidents of abuse and significant injuries were reported to the State Survey Agency by the required time.2. Not ensuring or knowing if the follow-up reports were submitted to the State Survey Agency.3. Not ensuring or knowing notification to State Licensing Office is needed for the ADM's leave of absence.4. Not ensuring an interim ADM is available to manage the facility.5. Not ensuring or knowing and attempting to stop the State Survey Agency from completing survey-related tasks required to identify noncompliance when onsite at the facility. These deficient practices are likely to affect all 87 residents residing in the facility according to the daily census provided by the Director of operations on 12/30/25 and could lead to residents not maintaining their highest practicable physical, mental, and social well-being. The findings are: Not ensuring incidents of abuse and significant injuries were reported to the State Survey Agency by the required time. R #13A. Record review of R #13's facility incident report dated 01/12/26 revealed an incident resulting in serious bodily injury. The report was submitted to the State Survey Agency 01/21/26, approximately nine days after the incident. R #14B. Record review of R #14's facility incident report dated 12/28/25 revealed an incident resulting in serious bodily injury. The report was submitted to the State Survey Agency 01/09/26, approximately 12 days after the incident. C. On 02/04/26 at 2:15 pm during an interview with the Director of Operations (DOO), she stated that the Director of Nursing completes the reporting process for this facility and thought it was being done correctly. Not ensuring or knowing if the follow-up reports were submitted to the State Survey Agency. R #12D. Record review of the facility's list of reportable incidents (list of events the facility reported to the State Survey Agency) revealed reportable incidents for R #12 on the following dates:1. 12/04/25,2. 12/22/25,3. 01/07/26,4. 01/11/26.E. Record review of the facility's five-day reports revealed the following:1. The investigations were completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency. R #13F. Record review of the facility's list of reportable incidents revealed a reportable incident for R #13 on 01/12/26. G. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency. R #14H. Record review of the facility's list of reportable incidents revealed a reportable incident for R #14 dated 12/28/25. I. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency. R #15J. Record review of the facility's list of reportable incidents revealed a reportable incident for R #16 dated 01/15/26. K. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency. R #16L. Record review of the facility's list of reportable incidents revealed a reportable incident for R #16 dated 12/07/25. M. Record review of the facility's five-day report revealed the following:1. The investigation was completed.2. There was no evidence that the results of the investigation were submitted to the State Survey Agency.N. On 02/04/26 at 2:18 pm, during an interview with the Director of Operations (DOO), she confirmed it is the facility's responsibility to submit a five-day follow-up report with the results of the investigation to the state survey agency. She could not confirm if the results of the investigations had been submitted to the State Survey Agency and was not sure how the reports are supposed to be submitted. Not ensuring or knowing to provide notification to licensing office of the ADM leave of absence. O. On 02/03/26 at 10:27 am, during an interview with the DOO, she confirmed she had not contacted the state licensing office to notify the State Agency that the ADM is on an extended leave of absence. The DOO stated she has contacted the state in order to get a license as an administrator for the state but was not aware the (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Spring River Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility needed to notify the licensing office. Not ensuring an interim ADM is available to manage the facility. P. On 02/03/26 at 10:13 am during an interview with the DOO, she confirmed1. The ADM has not been acting in the capacity of his administrator role due to being on leave of absence.2. There is not a current interim administrator at the facility. Not ensuring or knowing and attempting to stop the State Survey Agency from completing survey-related tasks required to identify noncompliance when onsite at the facility. Q. On 02/03/26 at 10:05 am, during a random observation of the facility, the DOO had a facility staff member search for and bring the State Agency surveyors to the conference room claiming the surveyors do not have authority to walk through the facility.R. On 02/03/26 at 10:07 am during an interview with the DOO, she stated the state surveyors did not have the authority to walk through the facility or review resident's charts unless it is related to the original complaints that the State Survey Agency entered the facility for on 12/30/25. The DOO stated that even though the facility was not able to provide surveyors access to view any documents related to the complaint and had to reenter the facility to conduct a thorough investigation, the surveyors are only allowed to view items pertaining to the original complaint.		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observation and interviews, the facility failed to ensure the governing body appointed an administrator who is responsible for the management of the facility. This deficiency can result in the facility not having an administrator to ensure the residents' day-to-day needs are met. A. On 12/30/25 at 10:31 am, a random observation of the facility revealed a license for the listed Administrator (ADM) hanging on the wall behind the reception area. B. On 12/30/25 at 10:37 am during an interview with the Director of Operations (DOO), she stated the administrator was on vacation and not available. C. On 01/28/26 at 12:02 pm during an interview with the DOO, she confirmed the administrator is not available and that she was the person handling things. She did not state why he was not available. D. On 02/03/26 at 10:03 am, during an interview with Certified Nurse Aide (CNA) #4, she stated the Administrator is the DOO. CNA #4 confirmed she has not seen any other person acting in an administrative capacity in the building since before the Change in Ownership occurred on 12/01/25. E. On 02/03/26 at 10:13 am during an interview with the DOO, she confirmed the following:1. She is not and has not been the acting administrator.2. The ADM has not been acting in the capacity of his administrator role due to being on leave of absence.3. There is not a current interim administrator at the facility.4. She is not licensed as an administrator in this state.		

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NAME OF PROVIDER OR SUPPLIER Spring River Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure medical records were readily accessible for 1 (R #7) of 1 (R #7) resident reviewed for documentation accuracy when staff failed to provide timely access to the State Agency (SA) to the entire Electronic Health Record (EHR) for R #7. This deficient practice prevented a thorough investigation of R #7's history and has the potential to negatively impact the care staff provide to meet residents' needs due to state surveyors not being able to complete an unannounced investigation.A. Record Review of R #7's EHR, revealed that the complete EHR was unavailable and inaccessible.B. On 12/30/25 at 3:17 pm, during an interview with the Director of Operations (DOO), she indicated she was unable to produce R #7's record in its entirety. She stated the previous owners are not providing complete access to residents' records who were in facility prior to 12/01/25 [change of ownership occurred on this day].C. On 02/03/26 at 10:45 am, during an interview with the DOO, she confirmed the facility is now able to and did provide access for the State Agency to view R #7's EHR (thirty-six days after the State Agency initially requested access to the record).		

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NAME OF PROVIDER OR SUPPLIER Spring River Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure call lights were within reach of the residents while in the room for 4 (R #17, R #18, R #19, and R #20) of 6 (R #2, R #5, R #17, R #18, R #19, and R #20) residents reviewed for call lights. This deficient practice could likely result in residents being unable to notify staff when they need assistance. The findings are: A. On 02/03/26 at 10:00 am, a random observation of the facility revealed R #17 was lying in bed, and the call light was hanging on the light fixture that is attached to the wall near to the ceiling. B. On 02/03/26 at 10:03 am, a random observation of the facility revealed R #18 was lying in bed, and the call light was hanging on the light fixture that is attached to the wall near to the ceiling. C. On 02/03/26 at 10:05 am, a random observation of the facility revealed R #19 was lying in bed, and the call light was hanging on the light fixture that is attached to the wall near the ceiling. D. On 02/03/26 at 10:08 am, a random observation of the facility revealed R #20 was lying in bed, and the call light was hanging on the light fixture that is attached to the wall near the ceiling. E. On 02/03/26 at 10:10 am, a random observation of the facility revealed R #21 was lying in bed, and her call light was wrapped around the bed rail (adjustable metal or rigid plastic bars that attach to the sides of a bed) several times and rested approximately two inches from the floor. F. On 02/03/26 at 10:23 am, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that it does not meet her expectations for residents not to have their call lights accessible.		