STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325044	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring River Rehabilitation and Care Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a Significant Change (major decline or improvement in the patient's health status) Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) within 14 days of a resident beginning hospice care for 1 (R #1) of 2 (R #1 and R #2) residents. Failure to complete a Significant Change MDS according within the required timelines may result in inaccurate or outdated care plans, missed identification of new or changing needs, or inadequate communication among interdisciplinary team members, which may lead to compromised resident safety and care. The findings are: A. Record review of R #1's admission Record revealed R #2 was admitted to the facility on [DATE] with the following diagnoses:1. Multiple Sclerosis (MS; a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue), 2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Chronic Kidney Disease (CKD; impaired kidney function). B. Record review of R #1's Hospice Election Form, dated 03/26/26, revealed R #1's hospice care began 03/27/26. C. Record review of R #1's most recent MDS assessment dated [DATE] revealed R #1 is not on hospice. D. On 05/14/26 at 4:10 pm during an interview with the Director of Nursing, she stated the following:1. R #1 was admitted to hospice on 03/27/26.2. R #1 did not have a significant change MDS to reflect hospice care.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to administer medication according to physician orders for 1 (R #3) of 5 (R #1, R #2, R #3, R #4, and R #5) residents when staff administered a blood pressure medication outside of the parameters defined by the physician. This deficient practice could likely lead to the resident having adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication. The findings are:A. Record review of R #3's admission Record revealed R #1 was admitted to the facility on [DATE] with hypertensive heart disease with heart failure (the result of unmanaged high blood pressure that weakens or stiffens the heart preventing it from pumping blood efficiently). B. Record review of R #3's physician order, dated 03/24/26, revealed an order for diltiazem (high blood pressure medication) 120 milligrams (mg) to be administered once daily. The medication should be held if systolic blood pressure (SBP; the top number in a blood pressure reading) was less than 110, diastolic blood pressure (DBP; the bottom number in a blood pressure reading) was less than 60, or the heart rate was less than 60. C. Record review of R #3's monthly Medication Administration Record (MAR; a tool used to document the administration of medications), dated May 2026, revealed staff administered diltiazem to R #3 on 05/10/26, and the resident's blood pressure measured 127/50 and her heart rate was 52. D. On 05/13/26 at 5:51 pm during an interview, the Director of Nursing stated staff did not follow the physician' s order when they administered diltiazem to R #3 on 05/10/26. She stated it was expected staff would not administer the medication when R #3's blood pressure and heart rate were outside the parameters.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide necessary care and services to prevent the worsening of a pressure ulcer (injury to skin and underlying tissue from prolonged pressure) for 1 (R #1) of 5 (R #1, R #2, R #3, R #4, and R #5) residents reviewed for pressure ulcers/skin impairment. Specifically, the facility failed to accurately identify, assess, measure, stage, monitor, document, report, and adjust care for R #1's coccyx/sacral pressure ulcer. This deficient practice resulted in R #1's pressure ulcer progressing to an infected Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed bone, tendon, ligament, cartilage, or muscle), with exposed bone, purulent drainage (pus), cellulitis (skin infection), osteomyelitis (bone infection), hypotension (low blood pressure), tachycardia (fast heart rate), and systemic infection concerns (signs infection may have spread through the body). The findings are:Cross Reference: F-641, F-657, F-726, F-880 A. Record review of the facility's Wound Treatment Management policy, dated 12/01/25, revealed the following:1. Purpose: to promote wound healing and to provide treatments in accordance with current standards of practice and physician orders.2. Wound treatments will be provided in accordance with physician orders.3. Treatment decisions will be based on they type of wound and the characteristics of the wound.4. The effectiveness of the treatments will be monitored through ongoing assessment of the wound.5. Considerations for treatment modifications include lack of progress towards healing, changes in the characteristics of the wound, and changes in the resident's goals and preferences, such as end-of-life or resident rights. B. Record review of R #1's admission Record revealed R #1 was admitted to the facility on [DATE] with the following diagnoses:1. Multiple sclerosis (MS; a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue), 2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Protein-calorie malnutrition (PCM; a form of undernutrition caused by inadequate intake or absorption of protein, calories, or both),4. Stage 2 pressure ulcer (PU; partial thickness loss of skin presenting as a shallow, open ulcer with a red pink wound bed, may be an intact or a ruptured blister) to the sacrum (a large flat bone in the lower part of the spine, forming the rear section of the pelvis). C. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessments revealed the following:1. admission MDS dated [DATE] revealed:- A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 13, cognitively intact.- R #1 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene activities, showering or bathing, and personal hygiene activities.- R #1 is at risk of developing pressure ulcers.2. Quarterly MDS dated [DATE] revealed:- A BIMS score of 08, moderately impaired.-R #1 required substantial/maximal assistance for toileting hygiene activities and was dependent (helper does all the effort) in showering or bathing and personal hygiene activities.- R #1 did not have any pressure ulcers.- R #1 was at risk for developing pressure ulcers. D. Record review of R #1's care plan revealed the following:1. admission date 12/1/25.2. Dated 12/18/25 and last revised on 03/26/26, resident had a self-care deficit and needed assistance with self-care task, to include transfers, bed mobility, toilet use, and ambulation. Resident required the assistance of one staff for ADLs and two staff for transfers.3. Dated 12/18/25 with no revisions, resident had bowel incontinence related to multiple sclerosis. Staff to provide pericare after each incontinent episode. 4. Dated 03/27/26 and last revised on 04/02/26, resident elected to receive hospice services.5. Dated 12/22/25 and last revised on 04/01/26, resident was at risk for skin impairment related to advanced age, fragile skin, history of skin impairment, incontinence, and poor mobility. Interventions included cushion around and under boney prominences, pressure relieving device to bed, staff to keep skin clean and dry, low air loss mattress, staff to observe for abnormal skin issues and notify nurse of any impairments, pressure (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	reducing cushion to wheelchair, staff to reposition the resident frequently, and licensed nurse to conduct weekly skin checks. E. Record review of R #1's progress notes revealed the following: 1. Skin check (weekly review of a resident's skin performed by staff), dated 12/18/25, R #1 had a Stage 2 pressure ulcer to his sacrum with partial thickness skin loss and exposed dermis (middle layer of skin). Wound was present on admission.2. Skin issue (weekly review of an identified skin impairment performed by the Wound Care Nurse), dated 12/26/25, R #1 had a pressure ulcer to his sacrum that was resolved. Wound was healed and closed.3. Skin check, dated 01/21/26, R #1 had an abrasion (a scrape; only affects the outer most layers of the skin) wound to his coccyx (tailbone) that was acquired in house (at the facility).4. Skin check, dated 01/23/26, R #1's skin issue to his coccyx was resolved.5. Skin check, dated 01/28/26, R #1 had a pressure ulcer located on his coccyx. Measurements are not documented as part of this assessment.wound nurse to measure.6. Skin check, dated 01/30/26, R #1 had an excoriation (superficial skin injury caused by scraping, scratching or picking, removes top layer of skin) wound to his coccyx, acquired in-house. It is unknown how long the wound has been present.7. Skin check, dated 02/04/26, R #1 had an excoriation wound to his coccyx, acquired in-house. It is unknown how long the wound has been present.8. Skin check, dated 02/06/26, R #1 had an excoriation wound to his coccyx, acquired in-house. It is unknown how long the wound has been present. R #1 has redness to penis and bilateral [both] buttocks.9. Skin check, dated 02/13/26, revealed R #1 had an excoriation wound to his coccyx, acquired in-house. It is unknown how long the wound has been present.10. Skin issue, dated 02/13/26, R #1 had an excoriation wound to his coccyx, acquired in-house. Overall wound characteristics improved and It is unknown how long the wound has been present.11. Skin check, dated 02/20/26, R #1 had an excoriation wound to his coccyx that was stable in progress and was previously deteriorating.12. Skin check, dated 02/27/26, R #1 had an excoriation wound to his coccyx, acquired in-house.13. Skin check, dated 02/27/26, R #1 had an excoriation wound to his coccyx that was stable in progress and was previously deteriorating.14. Skin check, dated 03/05/26, R #1 had an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.15. Skin check, dated 03/06/26, R #1 had and an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present. Redness noted on coccyx area.16. Skin check, dated 03/13/26, R #1 had an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.17. Skin check, dated 03/19/26, R #1 had an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.18. Skin issue, dated 03/25/26, R #1 had an excoriation and small opening wound to his coccyx, It is unknown how long the wound has been present.19. Skin check, dated 03/26/26, R #1 had and excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.20. Skin check, dated 04/02/26, R #1 had an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.21. Skin issue, dated 04/03/26, R #1 had an excoriation and small opening wound to his coccyx, that was stable in progress and was previously deteriorating. Staff documented, It is unknown how long the wound has been present. The wound measured 3.5 cm in length, 5.5 cm in width, 50% epithelial (indicates the outermost layer of tissue was half-closed), and had light exudate (weeping or oozing) of clear watery fluid. Odor was not present after cleansing.22. Skin check, dated 04/09/26, R #1 had a Stage 4 pressure ulcer with full thickness skin (a deep wound which extended entirely through the outermost, thinnest layer of skin, the thick middle layer of skin, and exposed fat, muscle, or bone) and tissue loss to the coccyx. F. Record review of R #1's physician orders revealed the following: 1. An order dated 12/18/25, wound care to the sacrum to cleanse with wound cleanser, pat dry, apply collagen (wound care solutions), cover with dry dressing every Monday, Wednesday and Friday and as needed for soiling or dislodgement. Stop date 12/26/25.2. An order dated 01/30/26, Calmoseptine (moisture barrier skin ointment) apply to sacrum every day and night for incontinence care. Stop date 03/25/26.3. An order dated 03/02/26, low air loss mattress (an air mattress to help prevent skin breakdown) due to reduced mobility and history of skin impairment.4. An order dated (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	03/15/26, wound care to the sacrum to cleanse with wound cleanser, pat dry, apply collagen particles (medical-grade, sterile powders designed for advanced wound care) mixed in Calmoseptine. Stop date 03/25/26.5. An order dated 03/25/26, wound care to the sacrum to cleanse with Vashe (wound cleanser), pat dry, apply alginate ag (a highly absorbent, seaweed-derived wound care product infused with silver), cover with dry dressing daily and as needed for soiling or dislodgement.6. An order dated 3/25/26, a referral to a local wound clinic for sacral wound.7. An order dated 03/26/26, R #1 to be evaluated and treated by a local hospice agency. G. Record review of R #1's Medication Administration Record (MAR; a staff tool used to document when medications are administered), dated January, February, and March 2026, revealed staff administered Calmoseptine ointment to R #1 as ordered from 01/31/26 through 03/25/26. H. Record review of R #1's Treatment Administration Record (TAR; a staff tool used to document when treatments are administered) revealed the following:1. Dated December 2025, staff administered wound care to the sacrum three times weekly, as ordered.2. Dated January, February, and March 2026, Calmoseptine was administered as ordered.3. Dated March 2026, a low air loss mattress was used on R #1's bed. Wound care to the sacrum was administered as ordered. I. Record review of R #1's hospice nurse progress note, dated 03/27/26, revealed the following:1. Dated 03/27/26, diagnosis multiple sclerosis and dementia, with related hypertension and chronic kidney disease. Resident was alert and oriented times 3 (person, place, and time) with intermittent confusion. Resident had a wound that progressively deteriorated to a Stage 3 pressure ulcer. Resident had increased pain due to pressure ulcer to sacrum. Resident refused facility staff attempts to turn him or to bathe him.2. Dated 03/27/26, admission note. Resident was completely bedbound and maximum assist with all ADLs. Resident incontinent of bowel and bladder. Resident had a large Stage 3 pressure ulcer to sacrum. Wound looked infected. Doctor notified and ordered Bactrim twice a day for 7 days. During wound care, the resident complained of pain. Resident stated laying on his bottom makes it hurt. He often refused for facility staff to turn and reposition him. Educated resident on allowing staff to turn and reposition him. Orders for oxycodone 5 milligram (mg) every four hours, as needed, and reposition resident every two hours.3. Dated 03/30/26, routine visit. Staff nurse reported the facility did not receive the resident's pain medications yet. Nurse stated she would call the pharmacy. Resident had urine soaked through his brief and onto his bedding. Wound care provided. Hospice nurse rolled resident to his right side and propped him with pillows.4. Dated 04/01/26, routine visit. Facility staff nurse stated they did not receive the resident's pain medication. The nurse was unsure if any called the facility over the last two days.5. Dated 04/03/26, routine visit. The resident lay in bed with a cup of water. The resident's blanket and sheet were wet. Wound care provided and bedding changed.5. Dated 04/06/26, routine visit. Nurse was informed to clean the resident's wound, because it had been a few days. Resident had a bowel movement. Brief changed and dirty dressing removed from wound. Wound care provided.6. Dated 04/08/26, routine visit. Removed resident's dirty brief and dirty wound dressings. Wound care provided. J. Record review of R #1's hospice Wound Assessment Tool Report revealed the following:1. Dated 03/27/26, wound to sacrum was a Stage 3 pressure ulcer and measured 6 cm long, 5 cm wide, and 1 cm deep. Surface area 30 square centimeters (sq. cm.) Depth full thickness; no granulation tissue (a type of connective tissue that forms on the surface of a wound during the healing process) present; edges none clearly visible; exudate (body fluid discharged by the body in response to tissue damage and wound healing) type purulent (a thick, opaque, yellow, green, or brown fluid composed of pus and indicating infection at the wound site); exudate amount small; epithelialization (a thin, continuous layer of cells) less than 25% of wound covered; necrotic (dead) tissue type yellow slough (yellow stringy tissue adhered to wound bed); necrotic tissue amount between 50% to 75% of wound covered; skin color surrounding wound white; no peripheral tissue edema (swelling); no undermining (significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface); faint odor. Follow up comments: None.2. Dated 03/30/26, wound to sacrum was a Stage 3 pressure ulcer and measured 10 cm long, 10 cm wide, and 1 cm deep. Surface area 100 sq. cm. Depth (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	full thickness; no granulation tissue present; edges distinct; exudate type purulent; exudate amount small; epithelialization less than 25% of wound covered; no necrotic tissue present; skin color surrounding wound normal; no peripheral tissue edema; no undermining; faint odor. Follow up comments: New low air loss mattress ordered due to wound.3. Dated 04/06/26, wound to sacrum was a Stage 3 pressure ulcer and measured 6 cm long, 6 cm wide, and 2 cm deep. Surface area 36 sq. cm. No change in status. Depth description full thickness; no granulation tissue present; edges distinct; exudate type bloody; exudate amount small; epithelialization less than 25% of wound covered; no necrotic tissue present; skin color surrounding wound normal; no peripheral tissue edema; no undermining; no odor. Follow up comments: Wound decreasing in size and showing improvement.4. Dated 04/08/26, wound to sacrum was a Stage 3 pressure ulcer and measured 7 cm long, 8 cm wide, and 0 cm deep. Surface area 56 sq. cm. Depth full thickness, granulation tissue bright, beefy red with 25% to 75% of wound bed filled; edges distinct; exudate type purulent; exudate amount small; epithelialization less than 25% of wound covered; no necrotic tissue present; skin color surrounding wound bright red or blanches to touch; no peripheral tissue edema; faint odor. Undermining in all quadrants and measured between 1 to 3 cm. Follow up comments: None. K. Record review of R #1's physician notes from a local wound care clinic, dated 04/09/26, revealed the following:1. An initial visit for evaluation and management of a non-healing wound to the sacral (sacrum) area.2. A Stage 4 pressure ulcer measured 5.7 cm in length, 10 cm in width, and 2.7 cm in depth with active draining, foul smelling, and associated with exposed bone. The surrounding tissue was warm to touch and appeared cellulitic (bacterial skin infection).3. Wound Care Clinic sent R #1 to local emergency department for treatment. L. Record review of R #1's emergency room discharge paperwork, dated 04/09/26, revealed the following:1. R #1 presented with a Stage 4 decubitus ulcer (pressure ulcer) to the sacrum, purulent drainage present, foul-smelling, exposed bone, erythema present. Concerns for deep soft tissue infection and possible osteomyelitis. The resident was tachycardic (abnormally fast resting heart rate) and hypotensive (abnormally low blood pressure), which raised concerns for systemic infection.2. Resident had high white blood cell count, likely due to infected Stage 4 pressure ulcer which involved the sacrum. Osteomyelitis (inflammation of bone and bone marrow) present.3. The resident was administered the following medications in emergency department: Ketorolac (anti-inflammatory), ondansetron (nausea medication), fentanyl injection (pain medication), vancomycin (a powerful antibiotic), and Zosyn (antibiotic).4. The POA understood the resident was not a surgical candidate to remove the infected decubitus ulcer. The POA understood that outpatient treatment would be attempted but it was not a definitive treatment and the resident may succumb to this infection.5. The physician ordered Bactrim and frequent repositioning, and the resident would return to the nursing facility. M. On 05/12/26 at 2:00 pm, an observation of R #1's wound care and interview with Registered Nurse (RN) #1 revealed the following:1. RN #1 used a clean paper ruler to measure R #1's pressure ulcer to his sacrum which measured 3 inches in length and 2.5 inches in width.2. RN #1 was unable to give measurements of the wound in centimeters.3. RN #1 stated she could not obtain measurements for depth, because she does not know how. N. On 05/13/26 at 9:15 am during interview, R #1's Power of Attorney (POA) stated she e felt the facility was not caring for R #1's pressure ulcer and chose to put the resident on hospice. The POA was aware R #1 had a pressure ulcer but was not aware of the extent of the wound. The POA stated she was notified by the local emergency room physician that R #1 could pass away from this infection. O. On 05/13/26 at 12:06 pm during an interview, the Hospice Nurse (HRN) stated the Hospice Physician ordered antibiotics (medication) on 03/27/26 due to R #1's infected Stage 3 pressure ulcer to the sacrum. She stated the wound measured 6 cm length by 5 cm width by 1 cm depth, and it had a foul odor. P. On 05/13/26 at 4:10 pm during an interview, the Director of Nursing (DON) stated the following:1. The facility did not identify or document any characteristics of the wound prior to the hospital physician diagnosing R #1 with an infected, Stage 4 pressure ulcer, on 04/09/26.2. Skin checks were routine examinations of resident's skin, and the floor nurses completed the skin checks weekly. 3. Skin (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	issues were routine examinations of an identified issue, and the Wound Care Nurse completed the skin issue examinations weekly. 4. The facility employed one full-time Wound Care Nurse, but the Wound Care Nurse left the faciity on [DATE].5. The facility hired the current Wound Care Nurse on 05/6/26.6. The current Wound Care Nurse was not available for interview.7. The DON would be responsible for completing skin issues if the Wound Care Nurse was not available.8. She did not observe R #1's wound, and she could not confirm if the skin check and skin issues records were accurate. 9. She did not know if staff notified the physician of the progression of R #1's wound, and the facility did not have any documented evidence to show staff notified the physician of the progression of the wound.10. It was her expectation for staff to follow facility policies and physician orders.11. The documented skin issues for R #1 did not meet her expectations for identifying wound characteristics, measurements, and staging of wound. 12. The facility's documentation of the wound did not show progressive deterioration. 13. The facility did not have any documentation to include characteristics of R #1 having a stageable pressure ulcer until the emergency room physician diagnosed it as a Stage 4, infected pressure ulcer. Q. The Medical Director was unavailable for interview during the survey. Attempt to contact the Medical Director was made on 05/13/26, but the Medical Director did not return the call. Immediate Jeopardy was identified and the facility was notified on 05/14/26 at 11:45 am. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 05/19/26 at 12:00 pm. The POR included the following:Corrective Action/IdentificationAll residents have the potential to be affected by this alleged deficient practice. The following measures and monitoring were completed by 05/19/2026.The resident's wound was immediately assessed, and documentation was clarified to reflect consistent anatomical location.The attending provider reviewed, clarified the anatomical location, and confirmed current wound staging and treatment plan. A skin assessment was completed on every resident in the facility where five new skin issues were identified. The facility ensured accurate classification, consistent anatomical documentation, and appropriate treatments and interventions were in place.Documentation was completed and added to the wound tracker.All responsible parties including the physician and POA were notified.Education was provided to all licensed nursing staff on:Documentation of findings from weekly skin checks.Wound identification and reporting.Consistent anatomical documentation.Documentation of care provided, refusals, and reapproaches.The facility has hired a new Infection Prevention/Wound Care Nurse that is trained and certified.Education was provided to the Administrator and Director of Nursing as well as all facility staff on identifying and reporting suspected abuse and neglect.Systemic MeasuresA standardized wound documentation process has been implemented to ensure consistency in anatomical identification and staging.Risk management reports will be completed for all new or worsening skin issues to ensure timely notification to the provider.Floor nurses will complete weekly skin checks, and the treatment nurse will complete weekly wound assessments on residents with identified skin issues.Wound audits will be conducted by the Director of Nursing three times per week for two weeks, then weekly for four weeks to ensure:Consistent documentationAccurate stagingAppropriate treatment implementationDocumentation of refusalsAn audit was conducted to ensure all residents requiring evidence based protocols (EBP) for skin integrity were identified and interventions were implemented. Implementation of the POR was verified onsite, and the IJ was removed on 05/19/26 at 12:00 pm. The scope and severity were reduced from a K to E. Implementation of the POR was verified by the following:1. Record review of R #1's progress notes revealed the following:A. Skin Issue, dated 05/14/26 revealed R #1: -Had a Stage 4 pressure ulcer with full thickness and tissue loss, -The pressure ulcer was acquired in-house, -The pressure ulcer measured 6 cm in length by 9 cm deep and tunnels from three to six o'clock.B. Record review of R #1's physician's progress note, dated 05/15/26, revealed the physician stated the following: -The pressure ulcer extends from the sacrum to the coccyx, -The plan of care is comfort based and unlikely to heal, -Since no bone was visible, the staging is Stage 3 but has been Stage 3-4 inthe past.2. Record review of R #1's physician orders (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325044	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring River Rehabilitation and Care Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	revealed an order dated 05/14/26, for wound care to the sacrum. Staff are to cleanse the wound with wound cleanser, pat dry, apply alginate AG, cover with a dry dressing daily and as needed for soiling or dislodgement.3. Record review of the facility's skin assessments, last one dated 05/19/26, revealed the following: -Five new skin issues were assessed and treated. -Interventions were put in place for monitoring and treatment for the identified skin issues. - Physician orders were in place for the five identified skin issues.4. Record review of the facility's care plan audit revealed it was completed prior to 05/19/26.5. Record review of the wound tracker revealed all new skin issues were included in the tracking.6. Random observations of the facility revealed enhanced barrier precautions (EBP) were in place for all residents with open wounds.7. Record review of the facility's education logs dated 05/15/26 revealed education was provided to all licensed nursing staff on documentation of findings from weekly skin checks, wound identification and reporting, consistent anatomical documentation, and documentation of care provided, refusals, and reapproaches.8. Record review of the facility's education logs dated 05/15/26 revealed education was provided to all facility staff including the Administrator and Director of Nursing on identifying and reporting suspected abuse and neglect.9. On 05/19/26 at 1:36 pm, during an interview, Certified Nurse Aide (CNA) #3 stated she was recently trained on identifying skin issues and reporting them to the nurse on shift as soon as possible.10. On 05/19/26 at 2:05 pm, during an interview, CNA #4 stated the facility retrained them on identifying and reporting new skin issues.11. On 05/19/26 at 2:06 pm, during an interview, Registered Nurse (RN) #1 stated she was to report all new skin issues to the Wound Care Nurse who would measure and stage the wound.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective, comprehensive Infection Prevention and Control Program for 3 (R #1, R #5, and R #6) of 6 (R #1, R #2, R #3, R #4, R #5 and R #6) residents reviewed for infection control when the facility failed to:1. Post required Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) signage for R #1, R #5 and R #6,2. Include R #1 in the facility's Antibiotic Stewardship monitoring program (tracking tool designed to ensure antibiotics are used only when necessary),3. Track R #1 within the facility's overall infection control program (ongoing process to collecting, analyzing and interpreting data to track, prevent and control the spread of infections).4. Ensure staff utilized appropriate Personal Protective Equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) when providing care for R #5 and R #6, These deficiencies are likely to place residents at risk for the development and transmission of communicable diseases.R #1A. Record review of R #1's admission Record revealed R #2 was admitted to the facility on [DATE]. B. Record review of R #1's progress notes revealed:1. Skin Check on 02/04/26, R #1 has an excoriation wound to his coccyx acquired in-house. It is unknown how long the wound has been present.2. Skin check on 02/27/26, R #1 has an excoriation wound to his coccyx that is stable in progress and was previously deteriorating.3. Skin check on 03/05/27, R #1 has an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.4. Skin check on 03/26/26, R #1 has an excoriation and small opening wound to his coccyx. It is unknown how long the wound has been present.5. Skin check on 04/09/26, R #1 has a stage four pressure ulcer/injury with full thickness skin (extends entirely through the outermost, thinnest layer of skin and the thick middle layer of skin and through the subcutaneous (under the skin) fat exposing fat, muscle or bone) and tissue loss. C. Record review of R #1's physician orders revealed1. An order dated 3/27/26 for Bactrim (antibiotic medication) 800 milligrams (mg) to be given two times a day for wound to the sacrum area for seven days.2. An order dated 04/10/26, for Doxycycline (antibiotic medication) 100 mg to be given by mouth two times a day for sacral wound for 10 Days. D. Record review of Antibiotic stewardship program revealed R #1 was not on antibiotics in [NAME] 2026 or April 2026. E. Record review of the facilities infection program revealed R #1 did not have any wounds and did not have enhanced barrier precautions in place for the months of February 2026, March 2026, and April 2026. F. On 05/13/26 at 11:56 am, during an observation and interview with Certified Nurse Aide (CNA) #2, she confirmed R #1 did not have an EBP sign posted on his door. G. On 05/13/26 at 5:49 pm, during an interview with the Director of Nursing (DON) she confirmed:1. R #1 was not included in the antibiotic stewardship program for March 2026 and should have been because he was taking Bactrim.2. R #1 was not included in the antibiotic stewardship program for April 2026 and should have been because he was administered Bactrim and Doxycycline.3. R #1 is not included in the facility's Infection Control Program for the months of February 2026, Marh 2026, and April 2026 and should have been for tracking of wound and EBP. R #5H. Record review of R #5's admission Record revealed R #5 was admitted to the facility on [DATE] with the following diagnoses:1. Sepsis (a serious condition in which the body responds improperly to an infection),2. Pressure ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral region, Stage 4 (a deep wound that may impact muscle, tendons, ligaments, and bone),3. Need for assistance with personal care. I. Record review of R #5's physician orders revealed:1. An order dated 4/30/26 to clean the urinary catheter with soap and water ever shift and as needed.2. An order dated 4/30/26 to change wound vac (a medical device used to delever negative pressure wound therapy) canister when dressing change is done and as needed if three quarters full. J. On 05/14/26 at 3:02 pm during an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation and interview with Occupational Therapist (OT) #1 she confirmed:1. R #5 did not have an EBP sign posted.2. OT #1 was providing high contact care (transfers) to R #5 and was not wearing PPE. R #6 K. Record review of R #6's admission Record revealed R #6 was admitted to the facility on [DATE] with the following diagnoses:1. Extended spectrum beta lactamase (ESBL; enzymes produced by certain bacteria) resistance,2. Unspecified (the cause of an infection elsewhere in the body, without specifying the exact strain or subtype) Escherichia coli (E-coli; bacterium that normally lives in the gut), L. Record review of R #6's physician record dated 05/08/26 revealed an order for enhanced barrier precautions due to ESBL and E-coli. Ensure sign in placed on door/in room and gown and gloves to be worn for all high contact care. M. On 05/12/26 at 10:03 am during an observation and interview with Certified Nurse Aide (CNA) #2, she confirmed:1. R #6 did not have an EBP sign on the door.2. CNA #2 preformed high contact care (brief change) and did not wear PPE.