

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

Printed: 10/09/2026
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 07/29/2026
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure a resident was free from abuse and neglect for 1 (R #1) of 1 (R #1) resident, when facility staff left R #1 outside in direct sunlight for an unknown period of time. This deficient practice could have resulted in R #1 being found unresponsive with severe sunburns. The findings are: A. Record review of the facility's Resident Safety Rounding policy, not dated, revealed the following:1. The facility is to provide routine resident safety rounding and observation to promote resident safety, identify unmet needs, and reduce the risk of accidents, injuries, and adverse events. 2. The frequency and type of monitoring is to be individualized based on resident condition, assessed safety risks, physician orders, behavioral or cognitive status, fall risk, care plan interventions, and changes in condition. 3. During rounds, facility staff are to assess safety, comfort, environmental concerns, and unmet care needs. B. Record review of the facility's Abuse, Neglect, and Exploitation policy, not dated, revealed the following: 1. Neglect is the failure of the facility, its employees, or service providers to provide goods and services that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 2. The facility is to provide ongoing oversight and supervision of staff to ensure that its policies are implemented as written. 3. All facility staff are to be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation and then annually. C. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/08/26, revealed the following:1. R #1 was admitted to the facility on [DATE].2. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 07, moderately impaired.3. R #1 required substantial or maximal assistance (helper does more than half the effort) to complete transfers.4. R #1 utilized a wheelchair for mobility and required partial or moderate assistance (helper lifts, holds, or supports but provides less than half the effort) to propel 50 feet with two turns or to propel 150 feet. 5. R #1 had the following diagnoses:-Unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), severe, with psychotic disturbance (a period of time during which an individual experiences a disconnection from reality, characterized by hallucinations and delusions),-Muscle weakness,-Lack of coordination,-Need for assistance with personal care,-Other abnormalities of gait and mobility,-Essential hypertension (HTN; high blood pressure),-Muscle spasm,-Coronary artery disease (heart disease). D. Record review of R #1's Care Plan Report revealed the following:1. Dated 03/05/26, Focus area for R #1 was at risk for impaired cognitive function or impaired thought processes due to dementia and a history of altered mental status. Interventions included facility staff to cue (a signal), reorient, and supervise R #1 as needed.3. Dated 03/06/26, Focus area for R #1 had a communication problem. Interventions included facility staff to anticipate and meet R #1's needs. E. (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 325044	Facility ID: 325044 If continuation sheet Page 1 of 5

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R #1's Occupational Therapy Progress Report, dated 07/02/26, R #1 demonstrated a decline in functional performance, reduced activity tolerance, impaired functional reach, and diminished coordination. R #1's performance fluctuated from session to session and required ongoing skilled verbal and tactile cueing, physical assistance, and compensatory strategy training. F. Record review of R #1's Medication Admin Audit Report, dated July 2026, revealed Registered Nurse (RN) #1 administered quetiapine fumarate (antipsychotic medication) to R #1 at 11:16 am. G. Record review of the Emergency Services Prehospital Patient Care Report, dated 07/19/26, revealed the following:-At 3:29 pm, Emergency Medical Services (EMS) was called to the facility for a resident found outside in the courtyard and was unresponsive. R #1 was found by another resident of the facility.-When EMS arrived at the facility, they were greeted at the front door by a facility nurse who said, This is not my patient. The nurse is in the room with the patient, but here is the paperwork.- The EMS personnel went to R #1's room and saw three facility staff members around R #1's bed. The facility staff held manual and electric blood pressure machines and stated they could not obtain a blood pressure.-When EMS personnel arrived at R #1's room, the nurse reported another resident found R #1 outside.- The facility staff could not say when they last saw R #1. The nurse later stated she remembered seeing R #1 at lunch.-R #1 lay in his bed with a pillow under his head.-R #1 did not respond to painful stimuli and had two ice packs, one under his neck and one in his right armpit.-EMS personnel could not start an intravenous line on R #1. H. Record review of R #1's emergency documentation from a local hospital, dated 07/19/26, revealed R #1 arrived at the emergency room at 3:55 pm on 07/19/26 with altered mental status (AMS) and hyperthermia (a medical condition in which the body's core rises above normal, 98.6 degrees). R #1 could not communicate with staff during the encounter. The facility staff reported another resident found R #1 outside and unresponsive after an unknown amount of time. R #1 had sunburns on both legs, both arms, and the top of his head. He appeared well-developed and well-nourished, but dehydrated, frail, listless (lacking energy), and unkempt. His neurological exam was limited due to his mental status. R #1 showed weakened grip strength and delayed responses when asked to stick out his tongue, smile, and squeeze hands. R #1's temperature measured 103 degrees, indicating hyperthermia. R #1's blood pressure was 74/54 (normal range, 90/60 mm/Hg to 120/80 mm/Hg), his heart rate was 101 beats per minute (bpm; normal is 60 to 100 bpm), his oxygen saturation (SpO2) was 87 percent (%) on room air (normal range 95 to 100%), and he breathed rapidly at 40 breaths per minute (BPM; normal range is 12 to 20 bpm). The hospital staff started cooling measures, including ice-pack application and cold IV fluids. I. Record review of the local weather forecast revealed the temperature measured 92 degrees, sunny without clouds, at 3:55 pm on 07/19/26. J. On 07/23/26 at 10:40 am, during an interview, RN #1 stated 07/19/26 was a busy day because she served as the floor nurse, medication technician, and wound care nurse. She stated she recalled seeing R #1 at lunchtime and later in the afternoon. She stated she could not remember the exact time she saw him in the afternoon. She stated a CNA told her R #1 was outside and was unresponsive. RN #1 stated she went to the courtyard, found R #1, and assisted two CNAs who brought him inside and to his room. She stated she and the two CNAs helped R #1 into his bed and began cooling him with cold wet washcloths and cold packs under his armpits and neck. She stated she observed R #1 was unresponsive and appeared sunburned. She stated another staff member called emergency services. RN #1 stated she was in R #1's room when paramedics arrived, and she told them another resident found R #1 unresponsive outside after an unknown amount of time. RN #1 stated two CNAs were assigned to R #1's hall and were responsible for his care. RN #1 stated she could not remember the names of the two CNAs. K. On 07/23/26 at 2:30 pm, during an observation, R #1 lay in bed and looked down at his blanket. The resident made eye contact but did not respond to (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	questions. A skin assessment showed the resident's upper thighs had blisters and peeling skin. The right and left forearms had ruptured blisters, and the top of his head had ruptured and intact blisters. L. On 07/24/26 at 12:14 pm, during an interview, the Activity Assistant (AA) #1 stated she first saw R #1 outside in the courtyard at approximately 1:30 pm on 07/19/26. She stated she spoke to R #1, but he declined assistance back into the building. She stated she finished the smoke break with other residents and then went back inside the facility. She stated she thought whoever took R #1 outside would return to get him. AA #1 stated R #2 approached her at about 3:30 pm and stated R #1 was outside and leaning over in his wheelchair. She stated she looked outside, saw R #1 leaning over, and went down the hall to speak to one of the CNAs assigned to R #1's hall (unnamed CNA and CNA #1). She stated she told a CNA that R #1 was outside and needed help. AA #1 stated she could not remember the CNA's name. AA #1 stated the CNA told her she would go get R #1 after she finished making his bed. AA #1 then returned to her activities with other residents. She stated a few moments later, she looked out the window again and saw R #1 twitching. She stated she saw CNA #1, who was also assigned to R #1's hall, near the front entrance of the building. She stated she went to CNA #1 and told her that R #1 was outside and needed help. She stated CNA #1 went outside with her and directed her to get a nurse, and she did. M. On 07/27/26 at 10:45 am, during an interview R #1 stated he could not recall when or how the sunburn occurred. He stated he wished he could remember but could not. N. On 07/28/26 at 7:48 am, during an interview, CNA #1 stated R #1 spent most days in bed, but at times he pushed himself in his wheelchair around the facility. She stated R #1 needed redirection when he became lost and looked for his room. CNA #1 stated R #1 rarely, if ever, went to the courtyard. CNA #1 stated on 07/19/26 she just returned from her lunch break when AA #1 approached her and said a resident needed help in the courtyard. CNA #1 stated she went to the courtyard with AA #1 and saw R #1 slumped over in his wheelchair, with one leg hanging off the side. She stated R #1 was not responsive, so she sent AA #1 to get the nurse. She stated the three staff members (RN #1, CNA #1, and AA #1) helped R #1 back to his room and into his bed. She stated she received education on heat-related illness during her CNA certification, but she did not receive any additional training since she began working at the facility. O. On 07/28/26 at 9:25 am, during an interview, the Director of Nursing (DON) stated she did not expect non-medical staff to take action if they saw a resident twitching and slumped over in a wheelchair because non-medical staff were not trained to respond. She stated if non-medical staff had concerns about a resident, she assume they would stop and help. She stated facility staff did not receive formal education on heat-related illnesses before this incident. She stated the facility did not have a policy for residents' use of the courtyard. Immediate Jeopardy was identified and the facility was notified on 07/28/26 at 3:15 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 07/29/26. The POR included the following: Corrective Action/Identification All residents residing in the facility have the potential to be affected by this alleged deficient practice. The following systematic measures were completed by 07/29/26.1. The facility took immediate measures to protect the residents from the identified risk related to resident supervision during periods of extreme heat and prevention of heat-related illness.2. Two additional hydration stations (a setup designed to provide convenient access to drinking water and other liquids to help residents stay hydrated) outside in the courtyard to improve resident access to fluids while outdoors.3. Two additional portable canopies were installed in the outdoor courtyard to provide increased shaded areas.4. The facility implemented courtyard monitoring to be completed hourly during the hours of 10:00 am and 7:00 pm. The courtyard monitoring includes hydration being offered to residents, observation of any signs or symptoms of heat-related illness, resident safety, and environmental conditions.5. The facility implemented a (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident Safety During Extreme Heat and Outdoor Activities policy which includes enhanced resident supervision, hydration practices, environmental monitoring, and interventions during periods of elevated temperatures. This policy established expectations for resident assessment, hydration, supervision, recognition of heat-related illness, and staff response.6. Facility-wide education completed on 07/28/26 or prior to the employee's next scheduled work shift on the following:-Resident safety during extreme heat and outdoor activities abuse and neglect prevention.-Recognition of heat-related illnesses,-Signs and symptoms of dehydration,-Resident supervision expectations,-Outdoor safety procedures,-Hydration requirements,-Immediate reporting of changes in resident conditions,-Abuse and neglect prevention and reporting responsibilities. 7. The facility ordered additional sun [NAME] (more permanent shade) for the courtyard. Implementation of the POR was verified onsite, and the IJ was removed on 07/29/26 at 9:45 am. The scope and severity were reduced from a K to a D. Implementation of the POR was verified by the following: 1. On 07/29/26 at 9:30 am, during an interview, Driver (DRV) #1 stated he received training on 07/28/26 on preventing, recognizing, and responding to heat-related illnesses. DRV #1 stated the training informed him the residents were at a higher risk for heat-related illnesses. He stated he knew to observe residents for signs of dehydration, changes in skin color, and alterations in their overall appearance because he was a CNA. 2. On 07/29/26 at 9:34 am, during an interview, Housekeeping (HK) #1 stated he received training on 07/28/26 on actions to take if he observed a resident of concern. HK #1 stated if he saw a resident in distress, then he would assist the resident with moving, if needed, and seek help from the nursing staff. 3. On 07/29/26 at 9:35 am, during an interview, Licensed Practical Nurse (LPN) #1 stated she knew how to prevent, recognize, and respond to heat-related illnesses as part of her nursing role, but the facility provided additional training on the topic on 07/28/26. She stated her first action as a nurse would be to assess the resident, followed by notifying the medical provider, and implementing any orders received.4. On 07/29/26 at 9:38 am, during an interview, R #6 stated the facility added shade and new hydration stations in the courtyard. R #6 further stated the added shade made the courtyard significantly cooler.5. On 07/29/26 at 9:42 am, during an interview, CNA #2 stated she received training on 07/28/26 on preventing heat-related illnesses and on immediately notifying a nurse if she became concerned about a resident.6. On 07/29/26 at 8:45 am, observation of the facility's outside courtyard revealed the following:1. Two hydration stations in the courtyard.2. Two portable canopies setup in the courtyard.7. Record review of the facility's training sign-in sheets for the heat-related illness education, dated 07/28/26 and 07/29/26, revealed all facility staff were trained in resident safety during outdoor activities, as well as on the prevention, recognition, and response to heat-related illnesses.8. Record review of the facility's courtyard monitoring sheets, dated 07/28/26, revealed a facility staff observed the courtyard hourly until 10:00 pm.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) accurately reflected residents' clinical status for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for assessments. If staff do not accurately assess residents, then the resident may not receive the care needed to obtain optimal health. The findings are: A. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/08/26, revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 07, moderately impaired. 3. Staff did not document R #1's diagnosis of Type 2 diabetes mellitus (DM2; a disease in which the body cannot make or properly use insulin). B. Record review of R #1's Medical Diagnosis list, not dated, revealed R #1 had a diagnosis of DM2 present on admission. C. On 07/23/26 at 12:59 pm, during an interview, R #1's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) stated R #1 has been diagnosed with DM2 for as long as she can remember. D. On 07/28/26 at 3:15 pm, during an interview, the MDS Coordinator (MDS) stated R #1's MDS assessment, dated 06/08/26 was not accurate, because the MDS assessment did not reflect R #1's diagnosis of DM2. The MDS Coordinator stated he expected each resident to have an MDS assessment that accurately reflected the resident's diagnoses.		