

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 04/06/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an accurate, comprehensive care plan for 5 (R #3, R #9, R #10, R #12, and R #44) of 8 (R #2, R #3, R #5, R, #9, R #10, R #12, R #14, R and #44) residents reviewed for care plans when staff failed to:1. Develop and implement a care plan with interventions for R #3's oxygen therapy,2. Develop and implement a care plan with interventions for R #10's use of mobility bars and glasses,3. Develop and implement a care plan with interventions for placement in the secure/locked unit for R #9, R #12, and R #44.This deficient practice could likely result in proper care not being provided to residents.The findings are: R #3 A. Record review of R #3's admission record revealed R #3 was admitted into the facility on [DATE]. B. On 03/22/26 at 10:41 am, a random observation of R #3 in her room, revealed R #3 was lying in bed and had her oxygen on via nasal canula (a small, flexible tube that delivers oxygen to the nose through soft prongs). C. Record review of R #3's physician orders, revealed an order for oxygen three liters per minute (lpm), continuously via nasal canula. D. Record review of R #3's care plan, last revised on 02/25/26, revealed no care plan or interventions for R #3's use of oxygen therapy. E. On 03/22/26 at 2:37 pm, during an interview with Licensed Practical Nurse (LPN) #2, she confirmed R #3 does wear oxygen and should have a care plan with interventions for the use of oxygen. R #10 F. Record review of R #10's admission record revealed R #10 was admitted into the facility on [DATE]. G. On 03/22/26 at 2:13 pm, a random observation of R #10 in her room, revealed R #10 was lying in bed and had a quarter-sized bed rail (adjustable metal or rigid plastic bars that attach to the sides of a bed) located on the left upper bed. H. Record review of R #10's care plan, last revised on 03/18/26, revealed no care plan was developed or implemented for the use of quarter-sized bed rails. (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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #10's medical orders revealed an order for quarter-sized bed rails as an enabler for turning and repositioning in bed. J. On 03/22/26 at 2:37 pm, during an interview with LPN #1, she confirmed R #10 does utilize quarter-sized bed rails for positioning in bed and should have a care plan in place. R #9 K. Record review of R #9's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen and nutrients) with psychotic disturbance (a severe mental state characterized by a loss of contact with reality, often featuring delusions, hallucinations, and disorganized thinking or behavior). 2. Gastro-Esophageal Reflux Disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining), 3. Fibromyalgia (chronic muscle pain), 4. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol), 5. Psychosis (a symptom, involving a loss of contact with reality, where a person experiences the world differently from others) not due to substance or known condition. L. Record review of R #9's care plan dated 05/27/25 revealed no care plan to include interventions for secured/locked unit placement. M. On 04/06/26 at 11:27 am, during an interview with the Director of Nursing (DON) she confirmed R #9 was admitted directly to the secured/locked unit and does not have a care plan that was implemented and reviewed to include whether she continues to meet the criteria for remaining in the secured/locked area, and if the interventions continued to meet her needs. R #12 N. Record review of R #12's admission Record revealed R #12 was admitted to the facility on [DATE] with the following diagnoses: 1. End stage renal disease (ESRD; chronic irreversible kidney failure), 2. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar), 3. Insomnia (sleep disorder that can make it hard to fall asleep or stay asleep), 4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). O. Record review of R #12's care plan dated 09/11/24 revealed no care plan to include interventions for secured/locked unit placement. P. On 04/06/26 at 11:27 am, during an interview with the DON she confirmed R #12 was admitted directly to the secured/locked unit and does not have a care plan that was implemented and reviewed to include whether he continues to meet the criteria for remaining in the secured/locked area, and if the interventions continued to meet his needs. R #44 Q. Record review of R #44's admission Record revealed R #44 was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), 3. Muscle wasting atrophy (the loss of muscle tissue) in right and left legs, 4. Dementia with agitation, R. Record review of R #44's care plan dated 10/20/24 revealed no care plan to include interventions for secured/locked unit placement. S. On 04/06/26 at 11:27 am, during an interview with the DON she confirmed R #44 was admitted directly to the secured/locked unit and does not have a care plan that was implemented and reviewed to include whether he continues to meet the criteria for remaining in the secured/locked area, and if the interventions continued to meet his needs.		

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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. Based on record review and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 (R #1, R #27, and R #42) of 3 (R #1, R #27, and R #42) residents when staff failed to:1. Remove gloves and sanitize hands before touching surroundings.2. Sanitize blood pressure cuff in between residents after use.3. Sanitize hands before and after medication administration.4. Use proper handling techniques of drinks and bowls while distributing meals to residents in the dining room.If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illness. The findings are:R #1A. On 03/25/26 at 3:22 pm, during an observation of activities of daily living (ADL) care for R #1,1. Licensed Practical Nurse (LPN) #4 donned (put on) clean gloves and a gown.2. LPN #4 performed peri-care (cleaning from the front of the hips, between the legs and buttocks, and the back of the hips) for R #1.3. LPN #4 retrieved R #1's phone charger and handed it to her while wearing soiled gloves.4. LPN #4 moved a bedside table to within the resident's reach while continuing to wear soiled gloves.B. Record review of Centers for Disease Control (CDC) handwashing guidelines indicated that if gloves become soiled with blood or body fluids after task, the gloves should be removed, hands are to be sanitized and then put on clean gloves. Centers for Disease Control and Prevention. (2024, February 27). Clinical safety: Hand hygiene for healthcare workers. CDC. https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. R #42C. On 03/23/26 at 9:04 pm during an observation of medication administration Registered Nurse (RN) #1 did not sanitize the blood pressure cuff before using it for R #42 and did not cleanse after using it for R #42.D. Record review of the recommendations by the Centers for Disease Control (CDC) state that in long-term care facilities, blood pressure cuffs should be sanitized after use or between residents, using approved sanitizing cleanser. [Centers for Disease Control and Prevention. (n.d.). CDC~Centers for Disease Control and Prevention. https://www.cdc.gov].E. On 03/23/26 at 9:06 am, during an observation of medication administration, RN# 1 failed to sanitize hands prior to preparing medications for R #42 and RN # 1 failed to sanitize hands after administration of medications to R #42.F. Record review of the Medication Administration policy dated 12/01/25, revised 12/02/25, revealed staff will wash hands prior to and after medication administration. R #27G. On 03/21/26 at 12:23 pm, an observation of the lunch dining services revealed License Practical Nurse (LPN) #2, touched R #27's leg, placed his leg on the foot rest of his wheelchair, grabbed the back of R #27's wheelchair and moved him closer to the table, and then touched R #27's plate without washing or sanitizing her hands.H. On 03/21/26 at 12:37 pm during an interview with LPN #2, 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 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 5 (R #6, R #30, R #39, R #54, and R #100) of 6 (R #2, R #6, R #30, R #39, R #54, and R #100) 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 03/21/26 at 9:36 am, an observation and interview of the facility revealed the following: 1. R #39 was lying on her bed, and the call light was on the floor, underneath the bed. 2. Certified Medical Assistant (CMA) #1 confirmed the call light was not within reach and should have been. B. On 03/21/26 at 9:47 am, an observation and interview of the facility revealed the following: 1. R #6 was lying in her bed, and the call light was on the floor, at the head of the bed. 2. Certified Nurse Aide (CNA) #1 confirmed the call light was not within reach and should have been. C. On 03/21/26 at 9:53 am, an observation and interview of the facility revealed the following: 1. R #30 was lying in his bed, and the call light was on the floor, next to the bed. 2. R #100 was lying in his bed, and the call light was on the floor, next to the bed. D. Certified Nurse Aide (CNA) #1 confirmed the call lights for R #30 and R #100 were not within reach and should have been. R #54 E. On 03/21/26 at 10:54 am, a random observation of the facility revealed: 1. R #54 was lying in the recliner next to her bed and the call light was on the floor, underneath the bed. 2. Certified Nurse Aide (CNA) #2, confirmed the call light was not within reach and should have been.		

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to allow 1 (R #7) of 2 (R #7 and R #39) residents reviewed for hospice and pressure ulcers to choose the attending physician when they refused to accept medical orders for R #7's pressure ulcers from her hospice physician, instead sending R #7 to appointments at a wound clinic to obtain medical orders and care for pressure ulcers. If the facility does not allow residents to choose the physicians that are responsible for their care, then residents could experience feelings of frustration and depression. The findings are: A. Record review of R #7's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Osteomyelitis (inflammation of bone and bone marrow), 2. Extended spectrum beta lactamase resistance (ESBL; a condition that makes infections harder to treat), 3. 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], 4. Pressure ulcer of sacral region, stage 4 (a deep wound that may impact muscle, tendons, ligaments, and bone), 5. Hypertensive heart disease without heart failure (a condition where chronic high blood pressure causes changes in the heart without the development of heart failure), 6. Cutaneous abscess (a painful, swollen lump on skin caused by a bacterial infection) of buttock, 7. Attention and concentration deficit (a condition characterized by persistent difficulties in focusing, sustaining attention, and maintaining concentration that affects a person's daily functioning). B. On 03/22/26 at 1:58 pm, during an interview with R #7's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care), he stated the facility is making his mom go to appointments at a wound clinic in a neighboring town because they won't accept the medical orders from her hospice physician. R #7's POA stated that they chose the hospice doctor to manage R #7's care but the facility is preventing that from happening. R #7's POA stated that hospice was chosen so the hospice physician should oversee her care instead the facility is not allowing them to choose the physician they want. C. On 03/23/26 at 11:00 am, during an interview with Hospice Executive Director ([NAME]) she stated the facility contacted her to obtain permission for R #7 to go to a wound clinic to get care for her pressure ulcers because they did not have anyone in house to provide the care. The [NAME] stated facility nurses are responsible for providing continuous wound care with a hospice nurse providing the wound care and taking measurements once weekly. The [NAME] stated the facility is still sending R #7 to appointments at the wound clinic even though she is on hospice. D. On 04/06/26 at 11:13 am, during an interview with the Assistant Director of Nursing (ADON) she stated that R #7 is going to the wound care clinic in a neighboring town because the facility does not have a wound care nurse. E. Record review of R #7's current physician order revealed an order dated 12/03/25 to admit R #7 to hospice care starting on 10/10/25. F. Record review of R #7's progress notes revealed progress notes dated 01/20/26, 01/21/26, 01/22/26, 01/26/26, 01/27/26, 01/28/26, 01/29/26, and 02/02/26 where R #7 had an appointment out of town at the wound clinic.		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review and interview, the facility failed to notify residents and their representatives in writing with explanation of why the move is required for 1 (R #7) of 1 (R #7) resident reviewed for room change notifications. If the facility fails to notify the resident and their representative(s) in writing, the resident and/or their representative(s) could experience confusion and frustration. The findings are: A. Record review of the facility's communication form for room change notification for R #7 dated 02/02/26 revealed R #7 and her representative were not informed prior to the room change.B. On 03/24/26 at 1:47 pm, during an interview with R #7's representative, he stated the facility did not notify him prior to moving R #7 to a new room. R #7's representative stated that when he came to visit R #7, he went to her old room and found she was no longer there and had to ask facility staff where she was.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the facility failed to ensure the PASARR (Preadmission Screening and Resident Review) Level I Identification Screen accurately reflected the resident's diagnosis or need for secondary screening for 1 (R #72) of 1 (R #72) resident reviewed for accuracy of PASARR screening. If the facility does not ensure PASARR screenings are completed accurately, then residents with serious mental illness may not receive required evaluations or specialized services, placing them at risk for unmet mental health needs and a decline in psychosocial well-being. The findings are: A. Record review of R #72's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra), 2. Surgical aftercare (the management of a patient's health immediately after a procedure and during their recovery), 3. Hypothyroidism (the thyroid is not making enough thyroid hormone), 4. Hypertension (HTN; high blood pressure), 5. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), 6. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol). B. Record review of R #72's PASARR dated 03/04/26 revealed R #72 did not have a diagnosis or suspected mental illness. C. On 04/01/26 at 12:21 pm, during an interview with the administrator, she confirmed R #72 does have a diagnosis of mental illness and the PASSAR is incorrect.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain acceptable parameters of nutritional status for 1 (R #7) of 2 (R #7 and R #106) residents reviewed for nutrition when staff failed to follow the diet order and nutritional recommendations allowing R #7 to have a 22 pound or 22.2% weight loss. This deficient practice is likely to lead to residents suffering from unplanned weight loss and malnutrition which could worsen medical conditions. The findings are: A. Record review of R #7's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Osteomyelitis (inflammation of bone and bone marrow), 2. Extended spectrum beta lactamase resistance (ESBL; a condition that makes infections harder to treat), 3. 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], 4. Pressure ulcer of sacral region, stage 4 (a deep wound that may impact muscle, tendons, ligaments, and bone), 5. Hypertensive heart disease without heart failure (a condition where chronic high blood pressure causes changes in the heart without the development of heart failure), 6. Cutaneous abscess (a painful, swollen lump on skin caused by a bacterial infection) of buttock, 7. Attention and concentration deficit (a condition characterized by persistent difficulties in focusing, sustaining attention, and maintaining concentration that affects a person's daily functioning). B. On 03/22/26 at 1:58 pm, during an interview with R #7's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care), he stated that R #7 has lost about thirty pounds in the last few months. C. Record review of R #7's weight log revealed the following: 1. On 09/22/25, R #7 weighed 100.8 pounds. 2. On 12/23/25, R #7 weighed 94 pounds. 3. On 03/23/26, R #7 weighed 78.6 pounds. 4. R #7 had a weight loss of 22.02% (percent) in six months. D. Record review of R #7's care plan revised on 01/08/26 revealed staff are to: (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Assist R #7 with meals using verbal and/or physical assistance. 2. Encourage R #7 to come out of her room for meals. 3. Monitor intake at all meals, offer alternative choices as needed. 4. Offer alternate food choices if 50% of meal is not consumed. D. Record review of R #7's Nutrition & Amount Eaten log dated 02/24/26 to 03/25/26 revealed fourteen days where R #7 did not eat more than 50% of any meal that day. E. Record review of R #7's electronic health record revealed no alternative meal choices offered to R #7 on the days when she ate less than 50% of her food. F. On 03/25/26 at 9:06 am, an observation and interview of R #7 in her room revealed the following: 1. R #7 received her food tray that consisted of a glass of milk, a glass of orange juice, hashbrowns, gravy with what appeared to be small bits of meat, and oatmeal that appeared watery. 2. R #7 is eating without assistance and only ate a small portion of her meal. 3. At 9:45 am, R #7's meal tray was picked up by facility staff. Staff did not ask R #7 if she was still hungry or if she wanted an alternative food option.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to effectively manage pain (use of different techniques and medication to reduce and control the amount of pain a person experiences) for 1 (R #8) of 4 (R #2, R #8, R #9, and R #72) residents reviewed for pain when the facility failed to administer medications as per physician's orders. This deficient practice could likely result in residents experiencing unnecessary pain and could compromise their quality of life. The findings are: A. Record review of R #8's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. End stage renal disease (ESRD; chronic irreversible kidney failure), 2. Dependence on renal dialysis (treatment due to the inability of the kidneys to filter waste from the blood), 3. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar), 4. Pressure ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) of left buttock, stage 3 (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone), 5. Chronic respiratory failure with hypoxia (a condition where the lungs fail to exchange gases leading to low oxygen levels in the blood), 6. Epilepsy (a seizure disorder), 7. Generalized anxiety (feelings of fear or apprehension) disorder, 8. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 9. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). B. Record review of R #8's progress notes revealed a progress note dated 03/08/26 where R #8 fell while walking with her walker. R #8 was sent to a local emergency department for evaluation after complaining of excruciating (severe) pain in her hip. C. Record review of R #8's discharge paperwork from a local hospital dated 03/08/26 revealed R #8 sustained a closed fracture (broken bone where the skin remains intact) of right inferior pubic ramus (the flat bony structure located at the lower part of the hip bone) and a closed fracture of sacrum (a large flat bone in the lower part of the spine, forming the rear section of the pelvis). D. On 03/22/26 at 9:34 am, during an interview with R #8, she stated that she was in pain because she hasn't been given her pain pill for the past three days. E. Record review of R #8's medication administration record (MAR) for the month of March 2026 revealed the following: 1. An order dated 03/09/26 for R #8 to have ten milligrams (mg) of oxycodone (a pain medication) every four hours as needed for moderate pain for ten days. 2. R #8 received ten mg of oxycodone on 03/18/26 at 4:41 pm. 3. R #8 did not receive this medication on 03/19/26. 4. R #8 did not have an order for this pain medication on 03/20/26. 5. An order dated 03/21/26 for R #8 to have five mg of oxycodone every six hours as needed for pain for fourteen days. 6. R #8 did not receive this medication on 03/21/26. F. On 03/22/26 at 11:15 am, during an interview with Licensed Practical Nurse (LPN) #1 she stated that she hasn't been able to access the oxycodone for R #8 over the past few days so the other nurse on shift will be pulling it from the pyxis (a medication dispensing cabinet). LPN #1 stated that she did not report it to anyone because R #8 got the rest of her pain medication.		

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 04/06/2026
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident preferences were honored for 1 (R #106) of 1 (R #106) residents reviewed when:- Alternative meals were not offered,- Meal did not contain adequate protein,-Facility meal ticket did not match the menu.This deficient practice is likely to result in residents being unable to make informed meal choices and not receiving meals consistent with their preferences.The findings are:R #106A. Record review of admission Record revealed R #106 was admitted to the facility on [DATE] with the following diagnoses:1. Chronic obstructive pulmonary disease (COPD; lung disease),2. Morbid obesity (severely overweight),3. Fluid overload (is a medical condition where the body retains an excessive amount of fluid, affecting tissues and organs),4. Shortness of breath,5. Type 2 diabetes (DM2, a condition results from insufficient production of insulin, causing high blood sugar).6. Heart Failure.B. On 03/25/26 at 9:02 am during an observation and interview, R #106 received her breakfast tray which consisted of oatmeal, hashbrowns, a small portion of egg, milk and juice. She stated that the menu she had been given listed biscuits with sausage and gravy and she didn't get any of that. R #106 stated that they are not asked about preferences, they just eat what is served and the menu rarely matches what is served.C. Record review of the menu dated March 2026 that was provided to R #106 revealed biscuit with sausage gravy as the main course.		

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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	
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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, record review and interview, the facility failed to provide assistive devices for 1 (R #106) of 5 (R #4, R #5, R #7, R #72, and R #106) residents reviewed during dining observation. If residents are not provided with special eating equipment as needed, then residents might be unable to consume their meals and beverages and is likely to result in weight loss, malnutrition, and dehydration. The findings are:A. On 03/25/26 at 9:25 am, an observation and interview with R #106 revealed:1. R #106 was observed trying to eat oatmeal with a weighted fork.2. No other utensils were available to R #106.3. R #106 stated she rarely gets a weighted spoon unless she asks for one.B. Record review of physician orders dated 01/26/26 revealed an order for R #106 to use a weighted utensil during meals.		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post nurse staffing data on a daily basis 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:1. Registered nurses.2. Licensed practical nurses.3. Certified nurse aides.4. Resident census.This deficient practice has the potential to affect all 110 residents as identified by the census provided by the Director of Nursing on 03/21/26 and could likely result in residents and visitors not having the staffing information readily available. The findings are:A. On 03/21/26 at 10:57 am, an observation of the main entrance revealed the nurse staffing data sheet was dated 03/20/26.B. On 03/21/26 at 10:58 am during an interview with the Human Resources Director (HRD), he confirmed the nursing staffing data sheet should be posted daily and it was not.		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interviews, the facility failed to ensure the nutritional needs and preferences were met for all 110 residents listed on the facility census provided by the Director of Nursing (DON) on 03/21/26, when staff failed to updated and post the correct menu. These deficient practices are likely to lead to residents experiencing frustration, depression, and weight loss due to not knowing what food is being served or being able to choose what they eat. The findings are: Menu A. On 03/21/26 at 12:11 pm, a random observation of the dining room revealed no lunch menu posted. B. On 03/21/26 at 12:18 pm during an interview with the Dietary Manager (DM), she confirmed the lunch menu was not posted.		