

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: 325131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Spanish Trails Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1610 N Renaissance Blvd NE Albuquerque, NM 87107	
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 Based on record review and interview, the facility failed to complete a Significant Change (a major decline or improvement in a resident's physical or mental condition that is not self-limiting, affects more than one area of health status, and requires review and potential care plan revision) Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for 1 (R #3) of 1 (R #3) resident, when: R #3 began receiving hospice services while in the facility as ordered by a physician. This deficient practice could likely result in the residents not receiving the appropriate care and services they need. The findings are: A. Record review of R #3's face sheet revealed an admission date of 04/06/26 and a discharge date of 05/24/26, with the following diagnoses: Cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain). Intracranial hemorrhage (bleeding from a broken blood vessel within the brain). Nonpyogenic thrombosis of intracranial venous system (blood clots form in the brain's veins or venous sinuses without infection, potentially leading to increased intracranial pressure and neurological complications). Cortical blindness right side of brain (total or partial loss of vision). B. Record review of R #3's physician orders, dated 04/10/26, revealed an active order for hospice services. C. Record review of R #3's MDS assessments located in the electronic health record (EHR), revealed the following: Dated 04/09/26, R #3's admission and 5-day MDS assessment revealed staff documented the resident was not receiving hospice services. Dated 06/04/26, R #3's discharge MDS assessment revealed staff documented the resident was not receiving hospice services. Dated 04/09/26 through 06/04/26, a significant change MDS was not completed or available to indicate that R #3 was receiving hospice services. D. On 06/10/26 at 11:28 am, during an interview, the MDS Coordinator stated a resident who begins receiving hospice services should be reflected on a significant change MDS assessment. The MDS Coordinator stated a significant change MDS assessment should have been completed for R #3 because the resident was receiving hospice services while in the facility, but it was not.		

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