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	08/06/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the failed to ensure home health services were in place prior to discharge for 1 (R #1) of 4 (R #1, R #2, R #3, and R #4) residents reviewed for discharge. If the facility does not ensure the home health agency receives and accepts the resident, a delay in health care can potentially lead to negative outcomes including:1. Worsening wounds if they are not cared for,2. Worsening in mobility due to lack of physical therapy or occupational therapy.The findings are:A. Record review of R #1's face sheet indicated R #1 was admitted on [DATE] with the following diagnoses:1. Paraplegia (impairment in motor or sensory function of lower portions of the body),2. Cellulitis of left lower limb (cellulitis; deep inflammation of the tissues just under the skin; caused by infection),3. Type 2 diabetes (DM2, a condition results from insufficient production of insulin, causing high blood sugar),4. Need for assistance with personal care.B. Record review of R #1's Electronic Health record (EHR) revealed the resident was discharged from facility on 04/08/25.C. Record review of R #1's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 03/22/25 section Q, indicated the resident's primary goal was to discharge back to the community.D. Record review of R #1's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15; cognitively intact E. Record review of R #1's care plan dated 03/20/25 revealed a plan to discharge back to community.F. Record review of R #1's physician note dated 04/08/25 revealed, R#1 was to have home health upon discharge.G. Record review of the facility documentation that the physician orders and the fax cover sheet dated 04/08/25, indicated that the orders for home health were faxed on 04/08/25 to the home health agency (HHA). H. Record review of R #1's progress notes, R #1 was discharged on 04/08/25. The physician's note and orders were also dated 04/08/25. The referral to HHA also occurred on 04/08/25.I. On 08/05/25 at 1:00 pm, during an interview with Social Services (SS), she stated R #1 initiated the discharge the day prior to discharge date of 04/08/25. The SS stated R #1 had told the SS he wanted to go home. The SS stated, she encouraged R #1 to stay at least one more day. This would allow the SS to set up home health services, other physician appointments and treatments in which R #1 had agreed. The SS confirmed she was unable to provide confirmation that the fax to HHA had ever been sent to or received by HHA.J. On 08/05/25 at 1:05 pm, during an interview with HHA representative along with the SS stated the HHA staff indicated she had no records that R #1 was admitted to their services or that they had ever received orders for R #1.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a functioning call light system for 2 (R #1 and R #2) of 2 (R #1 and R #2) residents reviewed for call lights. If the facility fails to have call lights that are not functioning, residents cannot call staff in case of an emergency or get their needs met by the facility. The findings are:R#1A. Record review of R #1's admission Record revealed R #1 was admitted to the facility on [DATE], with the following diagnoses:1. Acute and chronic respiratory failure with hypoxia (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning), 2. Major depressive disorder, recurrent, moderate (causes a persistent feeling of sadness and loss of interest),3. Epilepsy, unspecified, not intractable, without status epilepticus (brain disease where nerve cells don't signal properly, which causes seizures),4. Generalized anxiety disorder (group of mental health conditions characterized by excessive fear, worry, and anxiety that interfere with daily life),5. Need for assistance with personal care,6. Overactive bladder (collection of symptoms that may affect how often you pee and your urgency),7. Other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain (condition characterized by the breakdown (degeneration) of one or more of the discs that separate the bones of the spine (vertebrae), causing pain in the back or neck and frequently in the legs and arms).B. Record review of R #1's quarterly/annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated [DATE], revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 14 (cognitively intact).C. On [DATE] at 12:56 pm during an interview and observation with R#1 she stated, it takes staff a long time to answer call lights. R #1's call light was activated by R #1 and the light outside of R #1's room did not light up. There were not any other visible signs that the call light was activated.D. On [DATE] at 1:05 pm, during an interview and observation with Certified Nursing Assistant (CNA) #1 of R#1's room, the call light was activated by CNA #1 and the light outside of R #1's room did not light up. CNA #1 confirmed the call light was not functioning, and it should be. R#2A. Record review of R #2's admission Record revealed R #2 was admitted to the facility on [DATE], with the following diagnoses:1. Alzheimer's disease, unspecified (causes brain cells die over time and the brain to shrink),2. Dysphagia, oropharyngeal phase (disorder or impairment in initiating a swallow.)3. Leiomyoma of uterus, unspecified (common growths of the uterus),4. Obstructive and reflux uropathy, unspecified (when your urine can't flow (either partially or completely) through your ureter, bladder, or urethra due to some type of obstruction).B. Record review of R #1's quarterly/annual Minimum Data Se dated [DATE], revealed a Brief Interview for Mental Status score of zero (significant impairment).C. On [DATE] at 1:08 pm during an observation of CNA #1 revealed CNA #1 activated R #2's call light. R #2's call light did not activate, and CNA #1 stated, I am going to go make a note in both of their charts and report it.D. Record review of the facility's NSG101 Call light Center Nursing Policy dated [DATE] revealed Patient's will have a call light or alternative communication device at each patient's bedside, toilet and bathing room to allow patients to call for assistance when unattended. Staff will respond to call lights and communication devices promptly. Staff will report problems with a call light or call system immediately to the supervisor and/or Maintenance Director and will provide immediate or alternative solutions until the problem can be remedied. (examples include replacing call light, providing a bell or whistle, increasing frequency of rounding, etc.).