STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48645 Based on observation and interview the facility failed to provide a homelike environment for 2 (R #190 and R #37) out of 3 (R #190, R #37, and R #23) residents (residents were identified by the resident matrix provided by the Administrator on 04/21/24), when they failed to: 1) Repair damaged or missing drawer face from one resident's room. 2) Prevent or remove cockroaches inside a resident's continuous positive air pressure (CPAP; helps keep your airway open when asleep) humidifier tank. 3) Repair water leaks and damaged ceiling in the therapy room. If residents do not have a homelike environment, they may become depressed and anxious about things in disrepair. The findings are: Resident #190 A. On 04/22/2024 at 9:23 am, during observation of R #190's room, her closet drawer was missing the face and handle, which made it inoperable. B. On 04/22/2024 at 12:32 pm, during an interview with R #190, she stated her closet drawer face has been missing/broken for weeks. R #190 stated she cannot use the drawer because she cannot open it. She stated this made her feel like the facility did not care about her. R #190 stated she told multiple staff members (she cannot remember who) about the issue, but they have not fixed it yet. C. On 04/22/2024 at 1:16 pm, during an interview with the maintenance director, he stated he was not aware of R #190's broken drawer. The maintenance director stated he should have received a work order from the staff to fix the drawer, but he never received one. 49196 Resident #37 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 04/22/24 at 10:08 am during an interview, R #37 reported she sees roaches in her room on the walls, approximately once a week. She added once she found them in her bed and in her CPAP machine. She stated she had to get a new CPAP machine, because staff found roaches inside the CPAP water tank. R #37 stated she felt grossed out by the roaches in her room. E. Record review of R #37's Electronic Medical Record (EMR) revealed a progress note from Respiratory Therapist (RT) #1, dated 2/9/24. RT #1 documented the resident was awake and watched tv. RT #1 took the water tub from R #37's CPAP to rinse it out, and there were roaches in it. RT #1 cleaned the water tub and inspected the resident's CPAP machine. RT #1 documented there were more roaches inside the machine, and the resident refused the CPAP that night. RT #1 documented she informed the nurse and the evening supervisor. F. On 04/25/24 at 09:36 am during an interview with Nurse Unit Manager (UM) #1, she recalled the incident with R #37's CPAP and that R #37 reported roaches in her room. UM #1 stated the roaches in R #37's room may be due to the food R #37 stored in her room. G. On 04/25/24 at 2:22 PM during an interview with the RT Supervisor (RTS), she stated R #37's CPAP was replaced due to the incident with the roaches on 02/29/24, and she stated a CPAP machine should not be used after roaches were discovered inside of it. 40671 Water Leaks H. On 04/21/24 at 2:30 pm, an observation and interview revealed one resident received services in the therapy room. Further observation revealed four large trash bins, in the center of the therapy room, contained water and stood under an active leak from the ceiling, wet white bath towels lay on the floor in the same area as the trash bins, and a large section of the ceiling was missing tiles and exposed pipes. Observation also revealed water leaked on people who stood five to six feet away from the exposed leak. The administrator (ADM) stated there were two leaks. The ADM stated one was from the toilets in the resident rooms directly above the therapy room, and the other leak was from a sink. The ADM stated the leak started about a month ago. I. On 04/21/24 at 2:36 during an interview, the Maintenance Director (MD) stated there were two leaks, and the sink started leaking about two weeks ago. He stated he did some repairs to try to stop the leak, but it continued to leak and got worse. He stated they had plumbers come out to look at the leaks and give estimates on the repairs needed. J. Record review of a Job Proposal for repairs to the leaks revealed a date of 01/25/24. K. On 04/25/24 at 2:30 pm, an observation revealed one resident received therapy services in the therapy room while the ceiling tiles were missing and the exposed pipes leaked. L. On 04/25/24 at 2:31 pm during an interview with Physical Therapy Assistant (PTA), she stated she began employment at the facility in January 2024, and the leak was already happening. She stated the leaks could be a safety hazard for residents, because the floor was wet. She stated management kept saying they were working on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 04/25/24 at 2:37 pm during an interview, Restorative Aide (RA) stated the water leak was a safety hazard for residents, because was water on the floor. She stated there were also leaks in the restrooms, and they use one of the restrooms when they worked with the residents on how to utilize the restrooms safely. N. On 04/25/24 at 2:45 pm during an interview with Physical Therapist (PT), she stated the leak and exposed pipes was like that for about eight months. She stated she spoke to the Chief Executive Officer (CEO) and requested the repairs be made. The PT stated the CEO told her not to bring this issue up around the residents, and they would call a plumber. She stated the plumber came, told them this was an easy fix, and gave them an estimate of about five thousand dollars. The PT said the CEO told the MD to do the repairs himself. She stated the MD repaired the leaking pipe, but the leak continued to get worse. The PT said the facility replaced the ceiling tiles about every two days, because the tiles would get heavy, sag, and eventually fall. She stated this occurred while residents were participating in therapy sessions. The PT stated she felt like this was a safety hazard, because there was constantly water on the floor. She stated residents could trip or slip. The PT further stated the leak also affected the front desk reception area. O. On 04/25/24 at 3:00 pm, an observation revealed the two restrooms in the therapy room had signs of significant water damage to the ceilings. The ceiling had discolored tiles, exposed water pipes, missing ceiling tiles, and a musty stale odor. P. On 04/25/24 at 3:03 pm an observation of ceiling tiles above the front reception desk revealed water damage to the ceiling tiles. The ceiling tiles were discolored and wrinkled. Residents were in the area around the front desk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49196 Based on interview, observation, and record review, the facility failed to ensure the comprehensive care plan was accurate for 1 (R #202) of 1 (R #202) residents reviewed for care plan accuracy. This deficient practice could likely result in staff not understanding and implementing the most appropriate interventions and treatments for the resident. The findings are: A. On 04/22/24 at 9:57 AM during an observation, R #202 wore a catheter bag for an indwelling (left in place) urinary catheter. B. Record review of R #202's current physician order summary revealed an order to change the resident's catheter monthly and as needed for blockage or leaking. C. Record review of R #202's care plan revised on 02/14/24 revealed the resident had an intermittent catheter (catheter inserted several times a day to drain the bladder then removed) related to a neurogenic bladder (lack of bladder control due to brain, spinal cord, or nerve impairment.) D. On 04/25/24 at 9:36 AM during an interview with Nurse Unit Manger (UM) #1 and the Director of Nursing (DON), UM #1 stated R #202's care plan incorrectly documented R #202 used an intermittent catheter. They stated the resident was admitted with and still used an indwelling catheter. The DON stated the care plan should accurately reflect that the resident used an indwelling catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 47899 Based on observation, record review, and interview, the facility failed to meet professional standards of quality for 2 (R #26 and R # 87) of 2 (R #26 and R #87) residents reviewed by when staff failed to administer medications per recommend guidelines. If the facility is not administering medications in accordance with physician orders and accepted professional practices, then residents are likely to not get the therapeutic results needed. The findings are: Findings for R #26 A. On 04/21/24 at 12:36 pm, during an observation of the 500 south medication cart, Licensed Practical Nurse (LPN) #5 opened the top drawer of the medication cart to reveal two small medication cups that held medications. One of the cups belonged to R #26 and had the resident's room number written on the outside of the cup. B. Record review of R #26's care plan, dated 02/25/24, revealed the care plan did not contain instructions for staff to hide medications in R #26's food without knowledge of the resident. C. Record review of R #26's electronic medical records revealed the records did not contain documentation to show the resident or the resident's responsible party gave consent for staff to administer R #26's medications hidden in food. Findings for R #87 D. On 04/21 at 12:39 pm, during an observation of the 500 south medication cart LPN #5 opened the top drawer of the medication cart to reveal two small medication cups that held medications. One of the cups belonged to R #87 and had the resident's room number was written on the outside of the cup. E. Record review of R #87's care plan, dated 2/17/24, revealed the care plan did not contain instructions for staff to hide medications in R #87's food without knowledge of the resident. F. Record review of R #87's electronic medical records revealed the records did not contain documentation to show the resident or the resident's responsible party gave consent for staff to administer R #26's medications hidden in food. C. On 04/21/24 at 12:39 pm, during an interview, LPN #5 confirmed she prepared the medications for R #26 and R #87. She stated she stored the medications in the drawer so she could hide the medications in some food. LPN #5 stated R #26 and R #87 did not know the medications were in the food, but it was the only way they could get the residents to take their medications. D. On 04/25/24 at 2:34 pm, during an interview, the Director of Nursing (DON) stated the residents did not have an order for staff to administer the medications without the resident's knowledge. The DON confirmed residents' record did not contain documentation to show the Power of Attorney (POA) gave permission for staff to hide the resident's medication in food and give it without the resident's knowledge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on observation, interview, and record review, the facility failed to maintain records of controlled substances (drugs subject to strict government control because they may cause addiction) on the 400 north, 500 south, and 600 front medication carts. This deficient practice could likely cause controlled substances to be diverted (the transfer of any legal prescribed controlled substance from the individual for whom it was prescribed to another person for any illegal use). The findings are: A. Record review of the facility's policy titled Controlled Substances, revised date December 2012, revealed nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse [NAME] off duty must make the count together. They must document and report any discrepancies to the Director of Nursing. B. On 04/21/24 at 12:16 pm, an observation of the 500 south medication cart revealed staff failed to sign the narcotic book [a book used to manually track inventories of prescribed medications, tracks the resident's prescriptions administration, and records when the facility received the medication for Schedule 2 controlled substance (medication with a high potential for abuse and/ or addiction) from the pharmacy] to show they counted the medication blister cards (cards that contain individually sealed medication tablets in which the medication must be pushed through the foil in order to take the medication. The cards have the medication name, pill information, and expiration dates and allows one to count the number of pills remaining) and compared them to the residents' medication sheets for the following dates: 1. On 04/12/24 for the 3:00 pm to 11:00 pm shift; 2. On 04/12/24 for the 11:00 pm to 7:00 am shift; 3. On 04/13/24 for the 7:00 am to 3:00 pm shift. C. On 04/21/24 at 12:17 pm, during an interview, Licensed Practical Nurse (LPN) #5 stated it was important to complete a narcotic count to verify the narcotic count was correct and to sign the narcotic sheet before the nurse who was on shift left and the nurse who was coming onto shift took the keys to the medication cart. D. On 04/21/2024 at 12:21 pm, an observation of the 600 hall front medication cart narcotics book revealed staff failed to sign the narcotic book to show they counted the medication blister cards and compared them to the residents' medication sheets for 04/20/2024. E. On 04/21/24 at 12:25 pm, during an interview with LPN #1, she stated the narcotics book should be signed by the outgoing and incoming nurse at each shift change. F. On 04/21/24 at 12:37 pm, an observation of the 400 north medication cart revealed staff failed to sign the narcotic book to show they counted the medication blister cards and compared them to the residents' medication sheets for the following dates: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 04/05/24 for the 3:00 pm to 11:00 pm shift; 2. On 04/12/24 for the 3:00 pm to 11:00 pm shift. G. On 04/21/24 at 12:40 pm, during an interview with LPN #6, she confirmed the findings for the 400 north, 500 south, and 600 front medication carts and stated the nurses should sign the narcotic book. H. On 04/25/24 at 2:33 pm, during an interview with the Director of Nursing (DON), she confirmed the nurses should sign the narcotic sheets when they are going off shift and coming on shift. the DON stated this was to ensure the narcotic count was correct and that the offgoing nurse handed the keys to the oncoming nurse. 48645

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48645 Based on record review, observation, and interviews the facility failed to: 1. Ensure eye drops were disposed of within 30 days of opening. 2. Ensure all expired supplies were not kept with unexpired supplies. 3. Ensure medications are kept in original package. 4. Ensure all expired medications were not kept with unexpired supplies. These deficient practices are likely to result in all 261 residents', identified on the census list provided by the Executive Director (ED) on 04/21/24, medications that were pre-poured (put into unmarked cups, without patient identifiers), to receive expired medications or supplies that have lost either their potency or effectiveness, or to receive medication or vaccines that have lost either their potency or effectiveness. The findings are: Ensure eye drops are disposed of within 30 days of opening. A. Record review of a National Institute of Health, peer reviewed article titled, Shelf Life and Efficacy Eye Drops, dated October 2018, revealed it was recommended to discard ophthalmic drugs 30 days after opening. B. On 04/21/24 at 11:46 am, during an observation, 300 unit medication cart contained eye drops (xalantan; used to treat high pressure in the eyes) with an open date of 03/13/2024. C. On 04/21/24 at 12:08 pm, during an observation, the 200 unit medication cart contained eye drops (moxivloxacin; used to treat eye infections) with an open date of 02/01/2024. D. On 04/22/24 at 10:21 am, during an interview the Director of Nursing (DON), she stated staff should dispose of all eye drops within 30 days of opening. Ensure all expired supplies were not kept with unexpired supplies. E. On 04/21/24 at 11:54 am, during an observation of the 300 unit medication storage room, one safety syringe, 3 milliliter liter (ml), 20 gauge (size of the needle) with an expiration date of 02/2019. F. On 04/21/24/ at 12:59 pm, during an observation of 400 unit medication storage room, two shielded intravenous (IV) straight catheter hub (one handed needle retraction for safety) with an expiration date of 06/30/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	G. On 04/22/24 at 10:25 am, during an interview with the DON, she stated expired supplies should not be kept with non-expired supplies in the medication storage rooms. 47899 Ensure medications are kept in original package. H. On 04/21/24 at 12:01 pm, an observation of the 500 south hall medication cart revealed two cups of pre-poured medications (medications unknown) in the top drawer. Each cup had a room number written on them. The cups of medication belonged to R #26 and R #87. I. On 04/21/24 at 12:03 pm, during an interview with LPN #5, she stated she had to pre-pour the medication cups, because the residents refused to take the medication. She stated she would hide the medication in the residents' food. J. On 04/21/24 at 12:39 pm, an observation of the 400 north side medication cart revealed one green capsule (medication unknown) at the bottom of medication cart. K. On 04/21/24 at 12:40 pm, during an interview with LPN #6, she confirmed the green capsule should not have been out of its blister pack (pre-packaged medications allowing nurse staff to pop out one pill at a time). L. On 04/25/24 at 2:34 pm, during an interview with the DON, she confirmed nursing staff should go into the residents' room before removing pills from their original containers. She stated the nursing staff should not pre-pour medications. The DON stated if nursing staff pre-pour medications then they need to discard those medications if the residents were not in their rooms. The DON stated nursing staff should keep their carts clean of loose medications. Ensure expired medications are kept separate from unexpired medications. M. On 04/21/24 at 12:25 pm, an observation of the 500 unit medication storage room revealed six enoxaparin (medication that prevents blood clots), 120 milligrams (MG) per 0.8 milliliters (ML) with an expiration date of 10/2023. Further observation showed the expired enoxaparin were stored with unexpired medications. N. On 04/21/24 at 12:59 pm, an observation of the 400 medication storage room revealed one bottle of tubersol [tuberculosis infection (TB)], 5 units per 0.1 ml with an open date of 03/20/24. Further observation revealed the tubersol was house stock (used on any new admissions), approximately 1/4 full, and stored with unexpired medications. O. Record review of the tubersol manufacturer's instructions revealed, A vial of tubersol which has been entered (opened) and in use for 30 days should be discarded. (The 30th day for the open tubersol, dated 03/20/24, was 04/19/24.) P. On 04/21/24 at 1:00 pm, during an interview with House Supervisor, she confirmed the open date on the on the vial of tubersol to be, 03/20/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Q. On 04/25/24 at 2:34 pm, during an interview with the DON, she stated staff went through the medication storage rooms and carts weekly to clean them out and check for expired items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40795 Based on record review and interview, the facility failed to document weekly wound assessments for 1 (R #7) of 1 (R #7) residents reviewed for wound care. This deficient practice could likely result in a resident's wound progression not being evaluated on a weekly basis. A. Record review of R #7's face sheet revealed R #7 was admitted to the facility on [DATE] with the pertinent diagnoses of: metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), cerebral infarction (an ischemic stroke- caused by disrupted blood flow to the brain due to problems with the blood vessels that supply it), and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). B. Record review of physician orders revealed the following: 1. Physician order, dated 02/01/24, Clean open area [stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed)] to left buttock with wound cleanser. Pat dry apply zinc paste/barrier cream and cover with optifoam dressing. Change every day (QD) and as needed (PRN) until resolved. Every evening shift. 2. Physician order, dated 03/23/24, for wound care. Clean open area (stage 2 pressure ulcer) to left buttock with wound cleanser. Pat dry, apply zinc paste/barrier cream, and cover with optifoam dressing. Change QD and PRN until resolved. C. Record review of R #7's Electronic Health Record (EHR), revealed R #7 did not have weekly wound assessments on file (documentation of wound measurements, appearance, and reaction to treatment). D. On 04/25/24 at 11:56 am, during an interview with the facility's Director of Nursing (DON), she stated staff monitored R #7's wound and treated it. She stated the wound was resolved as of 04/25/24; however, staff did not document weekly wound assessments. She stated staff should document weekly wound assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47899 Based on observation, record review, and interview the facility failed to maintain proper infection prevention measures when staff failed to: 1. Ensure safe transport of soiled laundry from resident room to laundry chute. 2. Ensure staff members wore appropriate personal protective equipment (PPE; gloves, face mask, eye protection, and a gown) while sorting contaminated laundry in the laundry room. Failure to adhere to an infection control program could likely cause the spread of infections and illness to all 261 residents listed on the census provided by the Administrator on 04/21/24. The findings are: Ensure staff members wore appropriate personal protective equipment while sorting contaminated laundry in the laundry room. D. On 04/24/24 at 2:31 pm, during an observation and interview, Housekeeper (HK) #1 wore gloves and sorted dirty laundry from the laundry chute. HK #31 stated she used gloves but should also use a yellow gown, face mask, and eye wear while going through the soiled clothes. HK #1 knew where the PPE items were kept. HK #1 stated she did not have it on all the time, because it was hard to breathe. E. On 04/25/24 at 2:25 pm, during an interview, the [NAME] President of Clinical Services (VPCS) stated HK #1 should wear PPE, to include gloves, gown, mask, and eye wear when sorting laundry so they are protected against what the soiled laundry might have on it. The VPCS went into the soiled laundry room and observed where HK #1 was standing and sorting. The VPCS stated HK #1 should have worn PPE. Ensure safe transport of soiled laundry from resident room to laundry chute. A. On 04/23/24 at 9:38 am, during an observation in R #150's room, the roommate's bedding was changed, and the dirty soiled linen sat in a chair unbagged, with nothing covering the chair. Certified Nursing Assistant (CNA) #5 came into the room and grabbed the soiled linen off the chair. CNA #5 did not sanitize the resident's chair after removing the soiled laundry. CNA #5 did not use a bag to carry the soiled linens and allowed the soiled linens to touch her scrubs. CNA #5 carried the soiled linen to a laundry bucket which sat outside of the room and placed it into the laundry bucket. B. On 04/23/24 at 9:38 am, during an interview with CNA #5, she stated she was not allowed to place the soiled linens on the floor when she stripped the beds, and that was why she sat the soiled linens on a chair. CNA #5 stated if there were not bags available to transport the soiled linen, then they put the soiled linen in the chair until they came back with the laundry baskets to pick them up. CNA #5 felt this was acceptable if there were not any bags for the soiled linen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. On 04/25/24 at 10:33 am, during an interview, the Director of Nursing (DON) confirmed staff should place the soiled linen in a plastic bag when the linen was removed from the residents' bed. The DON stated staff should use the plastic bag to carry the dirty linens to the laundry basket, and staff should never allow soiled linen to touch their clothing.