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

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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)

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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.

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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** 47899 Based on interview and record review the facility failed to help maintain acceptable parameters of nutritional status, such as usual body weight, for 1 (R #409) of 3 (R # 26, R # 87, and R # 40) residents sampled for nutrition, when they failed to put a plan into place for R #409 who had weight loss. This deficient practice could likely result in the residents losing weight, causing physical and mental health issues. The findings are: A. Record review of R 409's face sheet revealed an admitted [DATE] with the following diagnoses: -Parkinson's disease (a progressive disorder that affects the nervous system and causes tremors, stiffness and slow movement) with dyskinesia with out mention of fluctuations (uncontrolled, involuntary movements of the face, arms or legs). -Major depressive disorder (a mental disorder with at least two weeks of low mood, low self esteem, and loss of interest or pleasure of normal things). -Chronic kidney disease, stage 3 (mild to moderate damage to the kidneys and can be treated with diet, medications, and lifestyle changes). B. Record review of R # 409's Physicians orders revealed the following: 1. An order for weekly weights, for four weeks. Once a day on Monday. Start date 12/23/23, end date of 01/10/24. 2. Mirtazapine (an antidepressant used to treat depression. A side effect is increased appetite) tablet, 15 milligrams (MG). Administer one tablet orally for depression once a day. Start date 12/20/23, end date 02/08/23. 3. Mirtazapine tablet, 30 MG. Administer one tablet at bedtime for depression. Start date 02/08/24. 4. Physicians orders showed the record did not contain follow-up orders for monthly weights. C. Record review of R #409's weights revealed she had a weight loss of 7% in less than one month. 1. On 12/21/23, the resident weighed 112.9 pounds. 2. On 12/22/23, the resident weighed 111.5 pounds. 3. On 12/25/23, the resident weighed 113.0 pounds. 4. On 01/01/24, the resident weighed 111.4 pounds. 5. On 01/08/24, the resident weighed 105.0 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. The record did not contain any other weights for the resident. D. Record review of R #409's Electronic Medication Administration Record (EMAR) revealed the record did not contain an order for nutritional shakes (a drink filled with nutrients with higher calories) or med pass (fortified nutrition shake.) E. On 04/25/24 at 2:42 pm, during an interview, the Director of Nursing (DON) stated the resident was started on mirtazapine 15 MG for loss of appetite. The DON stated the resident did not live in the facility long enough for staff to hold a quarterly meeting (a meeting in which the interdisciplinary team gets together and talks about the resident and any needs they may need), and that is why they have not done anything for the resident's weight loss.