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	07/30/2024

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on record review and interview, the facility failed to notify the Power of Attorney (POA; a health care power of attorney grants, in writing, a particular agent the power to make healthcare decisions on another's behalf) when R#2 wandered into another resident's room and sustained an injury from an unknown resident, for 1 (R #2) of 1 (R #2) resident reviewed. If the facility is not notifying the resident's POA when the resident has a change of condition, then the POA is unable to make decisions related to treatment and advocate for the resident's care. The findings are: A. Record review of R #2's face sheet dated 07/24/24 revealed the following: - admitted [DATE]. - Dementia, with other behavioral disturbance (a chronic disease that causes a progressive decline in memory, judgment, including poor decision making). - Muscle wasting and atrophy (loss of muscle tone and lack of movement). - Emergency contact #1 and POA - relationship daughter B. Record review of R #2's progress notes revealed the following: - Dated 07/05/24, Certified Nursing Aide (CNA) #1 found R #2 outside R #3's room with a scratch to the right side of his face, and his lips were red in color. - The record did not contain documentation on 07/05/24 to show staff notified the resident's POA of the incident. - Dated 07/06/24, R #2's POA notified Licensed Practical Nurse (LPN) #1 that R#2 appeared injured. When LPN #1 entered R #2's room she noticed R #2 had bruising on his face. The resident's eyes and cheek were red, purple, with black round circles around the eyes. The resident was not able to state what happened. LPN #1 questioned the RN #1 from previous evening shift, 07/05/24, and she stated, The resident walked into R #3's room, and CNA #1 found the resident with scratches. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. On 07/29/24 at 11:45 am, during an interview with the Director of Nursing (DON), she stated the facility did not call R #2's POA to inform them of the incident that occurred on 07/05/24, but they should have.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on observation and interview, the facility failed to provide a safe, clean, and comfortable environment for and R #13 and all residents who utilized the courtyard and the 600 unit hallway. This deficient practice is likely to cause all residents in this facility to be exposed to environmental hazards and not to feel comfortable, which could affect their psychosocial well-being. The findings are: A. On 07/29/24 at 1:02 pm, an observation revealed the following: -The patio of the resident courtyard smoking area and grass edge were littered with cigarette butts. -The floors down the 600-unit hallway were visibly stained and unkempt. B. On 07/27/24 at 1:15 pm, an observation of resident occupied rooms revealed the following: - room [ROOM NUMBER]: The closet door was falling off the hinges. - room [ROOM NUMBER]: The closet door was falling off the hinges. - room [ROOM NUMBER]: The closet door was falling off the hinges. C. On 07/30/24 at 10:34 am, during an interview and observation, R #11 stated the floors were always dirty, and his hands got dirty when he propelled himself in his wheelchair down the hallway. The resident stated he did not need to wear gloves, because this was where he lived. R #11 propelled himself in his wheelchair down the hall, and his hands were visibly dirty. D. On 07/30/24 at 10:36 am, during an interview with R #12, she stated the floors in the facility were filthy and having people come to see her was embarrassing. E. On 07/30/24 at 10:38 am, during an interview, R #13 stated that the hallways smelled of bowel movement due to unchanged residents. He stated he had a heightened sense of smell, because he was blind, which made his living conditions difficult. F. On 07/30/24 at 10:38 am, an observation revealed the hallway smelled of bowel movement.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on interview and record review, the facility failed to keep residents free from abuse and neglect for 1 (R #1) of (R #1) residents sampled for abuse when staff failed to: 1. Provide line of sight supervision for R #1 after she requested a one on one or to be sent to the hospital. This deficient practice could likely result in physical harm to residents, and/or psychosocial distress (unpleasant emotions associated with a highly stressful situation), or worsening of current mental health conditions for the residents who were subject to this behavior. The findings are: R #1 A. Record review of the face sheet for R #1 indicated the following: R #1 was admitted to the facility on [DATE]. She had the following diagnoses: - Anoxic brain damage (lack of oxygen to the brain), - Acute respiratory failure with hypoxia (lungs cannot deliver enough oxygen or remove enough carbon dioxide from your blood), - Cardiac arrest (heart suddenly and unexpectedly stops beating), - Tracheostomy (surgical opening in the neck allowing air to flow), - Dysarthia (difficulty in speech due to weakness of speech muscles), - Anarthria (severe motor speech disorder that prevents someone from articulating speech at all), - Depression. B. Record review of R #1's care plan initiated on 05/30/24. indicated the resident had a communication problem and was not able to verbalize words. The interventions were R #1 would maintain current level of communication function by making sounds, using appropriate gestures, responding to yes/no questions appropriately, and using a sheet to spell out words. C. Record review of R #1's Subjective Objective Assessment and Plan (SOAP) note, dated 05/17/24, indicated R #1 had a communication barrier due to brain injury and tracheostomy. The resident could communicate with spelling out words and nodding yes or no. R #1 was frustrated with her inability to communicate and her over all condition, and she lashed out. D. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/30/24, indicated the resident had a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 5, severely impaired. The MDS did not reveal any suicidal thoughts or behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E. Record review of a social services progress note for R #1, dated 07/22/24 at 1:33 pm, indicated the following: Social Services Assistant (SSA) #2 went to see R #1. R #1 had tears in her eyes and stated that she needed to go to the hospital. The resident stated that she wanted to just die, and she was not worth anything now. SSA #2 asked R #1 if she had a plan, and the resident said she wanted one-on-one (one person in line of sight of the resident) or to go to the hospital. R #1 got more upset. SSA #2 spoke to the nurse and the Director of Nursing (DON), and she said to send the resident for a psychiatric evaluation (clinical interview that helps diagnose mental health conditions), and staff were to do frequent checks on R #1. SSA #2 let the nurse know for the staff to do the frequent checks, and SSA #2 would work on getting her sent out for a psychiatric evaluation. F. On 07/26/24 at 11:30 am, during an interview with Nurse #4, she stated R #1 could be difficult sometimes. She stated R #1 was lonely, sad, and angry. Nurse #4 stated she was aware the resident spoke with the SSA #2 on 07/22/24 and wanted to go to the hospital. Nurse #4 stated R #1 told SSA #2 that she wanted to die. Nurse #4 stated SSA #2 came and told her what R #1 said. Nurse #4 stated R #1 was up at the nurses station with her after she finished talking with SSA #2. Nurse #4 stated she went to assist another resident who needed her help, and when she went back to the nurses station, R #1 was not there. Nurse #4 stated she did not go to R #1's room to look for the resident. She stated shortly after got back to the nurses station, R #1 came out of her room and said she swallowed razor blades. Nurse #4 went into R #1's room and saw the broken razor on her bed. Nurse #4 stated she called 911. G. Record review of the nursing progress notes for R #1, dated 07/22/24 at 2:06 pm, indicated R #1 went to Nurse #3 and claimed she (R #1) swallowed a blade from the razor. Nurse #3 immediately went to her room and found the broken razor, Q-tips, and tissue paper. Staff called 911 and checked the resident's vitals, which were normal. Resident sent to the emergency room . H. Record review of the hospital gastroenterology (a branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines) consultation note, dated 07/22/24, revealed the reason for the consultation was razor blades due to suicide attempt. Patient with suicide attempt with reportedly swallowing two razor blades, one of which was visualized on imaging. One razor blade surgically removed, and the other was not visualized on the x-ray. I. On 07/29/24 at 10:00 am, during an interview with SSA #2, she stated R #1 really did not want to be at the facility. She stated the resident was on the secured locked unit, because the resident did not make safe choices and wanted to leave the facility. She stated R #1 had anxiety and did not want to be at the facility. SSA #2 stated R #1 did not express she wanted to kill herself before 07/22/24. SSA #2 stated she saw R #1 on 07/22/24, and R #1 was crying and sad. She stated R #1 told her she did not want to live and asked for one-on-one and wanted to go to hospital. SSA #2 stated she told the nurse what R #1 said to her. She stated a one-on-one was not implemented for the resident. SSA #2 stated she went down stairs to chart the conversation, and the next thing she knew, she received a phone call that R #1 swallowed razor blades. R #1 was sent out to the hospital immediately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	J. On 07/29/24 at 10:30 am, during an interview with the Director of Nursing (DON), she stated a staff member told her R #1 did not want to be at the facility and did not want to live. The DON stated that she was notified after R #1 told the SSA #2 that she wanted to go out to the hospital or have a one to one. The DON stated she asked the staff member if R #1 had a plan to hurt or kill herself, and the staff member stated no. She said since R #1 did not have a plan, she told the staff who worked on the 200 unit to do frequent checks on the resident. The DON stated that shortly afterwards, she received a call from Nurse #4 who reported R #1 swallowed razor blades. She stated they sent the resident out to the hospital. K. On 07/26/24 at 12:25 pm, during an interview with Power of Attorney (POA)/daughter, she stated her mother did not like it at the facility and was not used to having so many restrictions. The POA stated R #1 was confused a lot and made up things in the past to get out of situations. POA stated she put a camera in R #1's room, but R #1 would take it down. POA asked for it to be put back up when R #1 went to the memory care unit. She stated her mother would make allegations that people hurt her or abused her. The daughter stated that she never believed her mother. She stated this was not the first time her mother tried to hurt herself. The POA stated she watched on the video recording (after she found out about the suicide attempt) her mother take apart the razor. She said R #1 took the razor apart at 1:48 pm and at 1:53 pm she swallowed it. She stated immediately after swallowing the razor blade, R #1 left her room and told the nurse what she did. She stated she did not think her mother tried to kill herself. The daughter stated her mother was just trying to get out of the facility. L. Record review of the facility's Suicide Threats Policy, revised date 2007, indicated a staff member shall remain with the resident until the nurse supervisor/charge nurse arrived to evaluate the resident. Based on interview and record review, Immediate Jeopardy (IJ) was identified on 07/29/24 at 2:45 pm to the Administrator and the Director of Nursing, in person. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 07/30/24 at 10:05 am. Implementation of the POR was verified onsite on 07/30/24 with ongoing trainings for staff around resident suicide threat policy, and a full sweep of all residents was completed to identify any other resident who maybe suicidal. After verification of POR on 07/30/24 at 2:45 pm, the scope and severity was reduced to D. Plan of removal: 1. The facility will identify any residents who have expressed a suicidal comment within the past sixty (60) days. 2. Social Services will interview any residents identified within the past sixty (60) days to evaluate the mental condition of the resident in reference to any suicidal thoughts. Social Services Director will begin resident interviews on 07/30/2024 and complete on 07/30/2024. The facility will immediately implement any measures per the facility's Suicide Threats Policy which are required to be initiated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Education of staff, which includes Administration, Direct Care Staff on the facility. Policy and procedures for suicide threats voiced by a resident will begin on July 29, 2024. 4. Staff will report any resident threats of suicide immediately to the Nurse Supervisor, Charge Nurse, DON/designee, and Physician. 5. A staff member will remain with the resident until appropriate direction is provided by the physician. 6. Any resident who expresses a suicide threat will be transferred to the hospital for evaluation. 7. A psychiatric consultation will be initiated. 8. Facility will initiate a facility wide sweep of all residents to determine if any residents exhibit suicide ideation. The facility will follow the following procedures: a. A standard format of questions will be utilized. b. The format will include the resident's name, person who is conducting the interview, and date of interview. c. Resident interviews will be initiated on 07/30/2024 and completed by 07/30/2024 9. Any residents identified at Risk for Suicide Ideation during facility-wide screening, Suicide Threat Policy will be initiated. 48645 Surveyor: [NAME], [NAME]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on record review and interview, the facility failed to prevent an accident for 1 (R#2) of 2 (R#2 and R #3) when the facility failed to implement interventions to prevent R #2 from walking into other residents' rooms without permission and potentially putting himself at risk for harm. This deficient practice could likely result in physical harm to residents, physical harm and/or psychosocial distress (unpleasant emotions associated with a highly stressful situation), or worsening of current mental health conditions for the residents who were subject to this behavior. The findings are: R #2 A. Record review of R #2's medical record revealed he was admitted on [DATE] with the following diagnoses: 1. Benign intracranial hypertension (high pressure around the brain causes symptoms like vision changes and headaches). 2. Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) in other diseases classified elsewhere, unspecified severity, with other behavioral disturbances (disturbance, mood disturbance, and anxiety.) B. Record review of R #2's comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/23/24, revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 4, severe cognitive impairment. C. Record review of R #2's progress notes revealed the following: - Dated 07/05/24 at 5:20 pm, Certified Nursing Aide (CNA) #1 documented he found R #2 in the doorway of R #3's room, while R #3 was pushing R #2 out of his room. CNA #1 saw scratches and redness on the right side of R #2's face. - Dated 07/06/24 at 11:45 am, Licensed Practical Nurse (LPN) #1 documented she noticed R #2 had bruising on his face, and his eyes and cheeks were red and purple, with black circles around his eyes. LPN #1 documented R #2 could not state what happened. LPN #1 documented she asked CNA #1 what happened. The CNA stated R #2 walked into R #3's room, and he found R #2 with scratches. - Dated 07/09/24 at 11:51 pm, LPN #2 documented she found R #2 in another resident's room. - Dated 07/12/24 at 1:32 pm, an intervention was added to R #2's care plan to check on him frequently every shift to ensure his location was safe and to redirect if needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. On 07/29/24 at 11:45 am, during an interview with the Director of Nursing (DON), she stated, since his admission, R #2 has wandered into other resident's rooms and sometimes lay down in their beds. She stated they did not care plan R #2's wandering or put in place any interventions to monitor his movements until 07/12/2024. The DON did state she filed a facility initiated report and completed the 5 day follow up for the incident. E. On 07/29/24 at 12:03 pm, during an interview with Registered Nurse (RN) #1, she stated she was approached by CNA #1 around dinner time on 07/05/24, who advised her that he found R #2 outside of R #3's room with some scratches and redness to his face. RN #1 stated R #2 was known to wander into other resident's rooms, since he was admitted . She further stated she and CNA #1 did not witness the altercation between R #2 and R #3 on 07/05/24. RN #1 stated R #2's injuries, on the night of 07/05/24, were as CNA #1 described, redness and minor scratch to R #2's face. When asked RN #1 stated she was not sure when she had last seen R #2 before the incident. F. On 07/29/24 at 1:07 pm, during an interview with CNA #1, he stated on 07/05/24 around dinner time, he saw R #2 visibly shaking in the doorway of R #3's room, and it appeared to him that something happened. CNA #1 stated he did not see the incident. CNA #1 stated he approached the residents in R #3's room, and everyone said nothing happened. The CNA stated he could see some red marks near R #2's left eye and face. CNA #1 stated he separated the residents and took R #2 to his room. He stated he told the RN #1 about the incident and started to keep a closer eye on R #2. He said the resident was known to wander the floor, walk into other resident's rooms, and sometimes even lay down on their beds. G. On 07/29/24 at 1:20 pm, during an interview with R #3 in his room, he stated he did not remember the incident with R #2 and shrugged his shoulders. He would not answer anymore questions. H. On 07/29/24 at 1:30 pm, during an interview with R #2 in his room, he stated he did not remember the incident.