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	11/21/2024

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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35632 Based on observation, record review, and interview, the facility failed to ensure staff did not leave medications on the bedside table for 1 (R #13) of 1 (R #13) resident. This deficient practice could likely result in residents misplacing or not taking medications which could cause the resident to be pain. The findings are: A. On 11/20/24 at 1:54 pm, observation of R #13's room revealed a small cup with two pills sat on the bedside table. B. On 11/20/24 at 1:54 pm, during an interview with R #13, she stated the medications were not there that long. She stated she did not take them when the nurse brought them to her, because she was waiting for staff to change her brief. C. On 11/20/24 at 2:07 pm, during an interview with Register Nurse (RN) #1, she stated she left the pills in R #13's room on her bedside table. She stated R #13 was ready for her medications, but she was waiting to be changed. The RN stated R #13 did not want to sit up in bed. She stated she knew better then to leave the medications on the resident's bedside table. She said she should have brought the medication back to the medication cart and disposed of them. She stated she should have kept the medications in the cart until R #13 was ready to take them. She stated the medications in the cup were baclofen (muscle relaxant) and gabapentin (used for nerve pain). D. Record review of R #13's physician orders indicated the following orders: - Baclofen 20 milligrams (mg), four times per day for spasticity. - Gabapentin 300 mg, three times per day for chronic pain.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50752 Based on observation and interview, the facility failed to ensure medication carts were locked when unattended. This deficient practice is likely to negatively impact the health of residents on the 600 unit if they were to ingest (swallow) medications not intended for them. The findings are: A. On 11/21/24 at 7:47 am, during an observation of the 600-unit medication cart, the medication cart was unattended and unlocked. B. On 11/21/24 at 7:47 am, during an interview with Registered Nurse (RN) #1, she confirmed that medication carts should be locked and secured at all times when left unattended.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50752 Based on observation and interview, the facility failed to ensure residents had a safe and functional environment when the facility failed to ensure flooring was flat, smooth, and level for 1 (R #1) of 1 (R #1) residents reviewed. This deficient practice could likely result in residents living in an unsafe environment and could increase their risk for injuries and decrease their quality of life. The findings are: A. On 11/20/24 at 8:37 am, during observation of the R #1's room, the floor was uneven, and multiple tiles were missing near the window. An unoccupied bed sat over the missing tiles near the window. Further observation revealed a floor tile was missing near the toilet in the resident's bathroom. B. On 11/20/24 at 8:40 am, during an interview with R #1, he stated the floors in the bathroom and the bedroom were gross, and he told the facility four times to fix it. He stated he reported this to the nurses and the maintenance man. C. On 11/21/24 at 10:20 am during an interview with the Maintenance Director (MD), he stated that the air conditioning unit was causing some condensation (water vapors in the air is changed into liquid form) during the warmer months of August and September 2024, and the floor raised and became uneven. He stated they put a bed over the affected spot since the resident was still residing in the room, while they waited to repair it. He stated that the floor tile in the bathroom needed to be replaced.