

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Princeton Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</p> <p>Based on record review and interview, the facility failed to complete and document a thorough investigation, implement measures to prevent further incidents, and implement corrective actions regarding allegations of neglect (failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness), abuse (knowingly causing physical or mental harm or failing to provide goods and services necessary to avoid physical or mental harm), and injury of unknown origin for 3 (R #4, #5, and #6) of 3 (R #4, #5, and #6) residents reviewed for abuse and neglect allegations when staff failed to complete and submit thorough follow-up reports for R #4, #5, and #6.</p> <p>If facilities do not submit follow up reports then the SA cannot assure the residents are safe and free of abuse.</p> <p>R #4</p> <p>A. Record review of R #4's face sheet, undated, revealed R #4 was admitted into the facility 10/03/24.</p> <p>B. Record review of the Facility Reported Incident report, dated 10/14/24, revealed the following:</p> <ul style="list-style-type: none"> - Staff found R #4 on the floor of his room and helped him back to bed. Staff completed skin and pain assessment and noted a laceration (skin tear) to the back of R #4's head that was bleeding. Staff contacted the physician and received an order to send R #4 to the emergency room (ER). - The State Agency (SA) received the incident report from the facility on 10/16/24. - The facility did not submit a five-day follow-up report (a report sent to the State Survey Agency which includes the results of the facility's investigation into alleged violations) to the SA within the five day period. <p>C. Record review of the facility's incident records, dated November 2024 through February 2025, revealed staff did not investigate R #4's abuse allegations.</p> <p>D. On 02/20/25 at 1:52 pm, during an interview, the Administrator (ADM) verified staff did not complete an investigation and did not submit a five-day follow-up report to the SA.</p> <p>R #5</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. Record review of R #5's face sheet, undated, revealed R #5 was admitted into the facility 11/22/23.</p> <p>F. Record review of the Facility Reported Incident report, dated 11/23/24, revealed the following:</p> <ul style="list-style-type: none"> - Nursing staff heard someone yelling for help and went to check on the noise. Staff found R #5 in the hallway on the floor, with both knees extended and her back resting against the wall. - Nursing immediately assessed R #5 for injuries, but they did not note any visible injuries. R #5 complained of right knee pain of 10 out of 10 (pain scale 1 through 10; ten being the worst pain.) Staff notified the on-call physician who ordered an immediate x-ray to the resident's right knee. <p>G. Record review of the facilities five-day follow-up report revealed it was received by the SA on 12/01/24 [three days late].</p> <p>H. Record review of the facility's Letter of Non-Compliance, dated 2/14/25, revealed the SA notified the facility administrator that an addendum to the five-day follow-up was required, in order to address what preventions were put in place. [The SA has not yet received the addendum.]</p> <p>I. On 02/20/25 at 1:52 pm, during an interview, the ADM stated he was not sure why the facility staff did not respond to the SA with an addendum to the five-day follow-up report for R #5 .</p> <p>R #6</p> <p>J. Record review of R #6's face sheet, undated, revealed R #6 was admitted into the facility on [DATE].</p> <p>K. Record review of the Facility Reported Incident report, dated 11/22/24, revealed the following:</p> <ul style="list-style-type: none"> - R #6 grabbed another resident by the arm and scratched the other resident. - The SA received the incident report from the facility on 11/23/24. - The facility did not submit a five-day follow-up report to the SA. <p>L. Record review of the facility's incident records, dated November 2024 through February 2025, revealed staff did not conduct a thorough investigation of R #6's incident that occurred on 11/22/24.</p> <p>M. On 02/20/25 at 1:52 pm, during an interview, the ADM verified staff did not complete the investigation and did not submit the five-day follow-up report to the SA for R #6 .</p>		