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	11/17/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was free from physical restraints for 1(R #10) of 1(R #10) resident when staff held a resident down to give him an injection of Haldol (anti-psychotic medication) for his behaviors. This deficient practice could likely cause harm to the resident from being restrained, fear to the resident if he does not understand what is going on, and does not promote a safe, secure environment. The findings are: A. Record review of R #10's face sheet revealed he was admitted on [DATE] with severe dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation and suicidal ideation. B. Record review of R #10's physician order, dated 08/14/25, indicated an order for Haldol (antipsychotic medication) injection 5 milligram (mg). Inject one vial intramuscularly (IM; administered in the muscle) every eight hours for extreme agitation until 08/27/25. C. Record review of R #10's Medication Administration Record (MAR) indicated staff administered a Haldol injection 5 milligram (mg) to the resident on 08/13/25, 08/14/25, 08/15/25, 08/16/25, 08/17/25, 08/20/25, 08/24/25, and 09/09/25. D. Record review of R #10's care plan, dated 08/12/25, indicated the following:- Focus: R #10 had a behavior problem, was angry with placement, resisted care, wandered and wanted to leave, and was exit seeking.- Interventions: Administer medications as ordered. Monitor and document for side effects and effectiveness. Anticipate and meet R #10's needs. Psychiatric referral sent 08/12/25. E. Record review R #10's nursing progress notes revealed the following:- Dated 08/16/25 at 10:05 pm, a struck through the note to indicate incorrect documentation. Further review of the struck through note revealed staff documented the resident lay in his bed, refused to eat his breakfast, and refused to take his scheduled medications. R #10 kept talking about going back to Santa Fe over and over until he became agitated. R #10 then became verbally and physical abusive. Three staff members held the resident's arms and legs, because he refused to get an IM Haldol. R #10 spat on the staff's face twice while they administered the injection. - Dated 08/16/25 at 10:05 pm, staff documented the resident lay in his bed, refused to eat his breakfast, and refused to take his scheduled medications. He kept talking about going back to Santa Fe, over and over, until he became agitated. The resident became verbally and physically abusive. Staff administered the Haldol intramuscularly. The resident spat on the staff's face twice while they administered the injection. Resident spat on another staff during dinner time later the same day. F. On 09/11/25 at 9:05 am, during an interview, the Unit Manager (UM) of Floor 200 stated R #10 was fairly new to the facility, and he did not want to be there. The UM stated R #10 became physically aggressive at times. She stated R #10 did not always require medication to calm him down. She stated R #10 liked cokes, so she would bargain with him using a coke. The UM stated she talked to the nurse who wrote the progress note on 08/16/25 at 10:05 pm. The UM stated she told the nurse the facility staff did not have a right to hold someone down and restrain them to give them medication. She stated her expectation was for staff to try other interventions first. She stated if nothing was working, then staff should leave R #10 alone for five minutes and go back to try again. She stated the medication should not be the first choice. The UM stated she had Nurse #4 strike out the note, because the charting was not appropriate. The UM stated a training with all staff about physically restraining residents needs to be done. She stated sometimes agency staff worked at the facility, and they thought restraints were okay to use. G. On 09/11/25 at 9:24 am, during an interview, Nurse #4 stated she worked at the facility for one year. She stated R #10 could be unpredictable, and he spat on her before. She stated R #10 was very difficult when he first came to the facility. She stated they only gave the injection when he was physically aggressive. She stated the resident fought her and spat at her the day she gave the injection to him. She stated he really needed the medication. Nurse #4 stated the UM spoke with her about not holding a resident down to give medication. She stated the UM told her holding R #10 down to give an injection for his behavior was not appropriate. H. On 09/11/25 at 12:00 pm, during an interview, Certified Nursing Assistant (CNA) #3 stated the nurse gave R #10 the injection on 08/16/25, and she held R #10 down while they gave the medication. She stated R #10 fought and spat on them. She stated they were not aggressive when they held R #10 down. I. On 09/11/25 at 12:30 pm, during an interview, the Director of Nursing (DON) stated she was familiar with R #10. The DON stated R #10 had a hard adjustment to the facility, and they were continuing to adjust his medications. The DON stated physically holding a resident down to give medication was not okay. She stated she would expect staff to re-direct and talk the resident through it. She stated she would not expect staff to hold the resident down. She stated if the

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident was free from chemical restraints for 1(R #10) of 1(R #10) resident when staff administered Haldol (antipsychotic medication) injection, 5 milligram (mg), multiple times without a qualifying diagnosis and without attempting other interventions first. This deficient practice could likely create an environment of fear for the resident and does not promote a safe, secure environment. The findings are:A. Record review of R #10's face sheet revealed he was admitted on [DATE] with severe dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation and suicidal ideation. B. Record review of R #10's care plan, dated 08/12/25, indicated the following: - Focus: R #10 had a behavior problem, was angry with placement, resisted care, wandered and wanted to leave, and was exit seeking. - Interventions: Administer medications as ordered. Monitor document for side effects and effectiveness. Anticipate and meet R #10's needs. Psychiatric referral sent 08/12/25. C. Record review of R #10's psychological evaluation, completed 08/13/25, indicated the following:- R #10 stated he did not want to be at the facility. He did not like his roommate, because he believed the roommate stole his clothes. R #10 made a comment that if he had a gun, then all these people would be dead. R #10 stated they were a bunch of crazy idiots. R #10 wanted to go back to Santa Fe.- Diagnoses attached to the encounter: R #10 was diagnosed with suicidal ideation, unspecified dementia with unspecified severity with agitation, and moderate major depressive disorder.- Plan: Resident was deemed safe to stay in the facility. The resident did not have a plan or a means to harm himself or others. Risperidone (anti-psychotic) medication was discontinued, and sertraline (used for depression) was increased. D. Record review of R #10's physician order, dated 08/14/25, indicated an order for Haldol (antipsychotic medication) injection 5 milligram (mg). Inject one vial intramuscularly (IM; administered in the muscle) every 8 hours for extreme agitation until 08/27/25. E. Record review of R #10's Medication Administration Record (MAR) indicated staff administered a Haldol injection 5 milligram (mg) to the resident on 08/13/25, 08/14/25, 08/15/25, 08/16/25, 08/17/25, 08/20/25, 08/24/25, and 09/09/25. F. Record review of R #10's nursing progress notes indicated the following notes:- Dated 8/13/25 at 11:14 am, R #10 was at the nurse's station asking to go back to the hospital in Santa Fe. The nurse told R #10 he had been discharged from the hospital to the facility. R #10 stated if he could not leave this facility to go back to Santa Fe, then he would kill everybody and himself. Provider and Unit Manager (UM) notified. Haldol 5 mg intramuscularly given to left upper arm.- Dated 8/13/25 at 12:05 pm, the Psychiatric Provider saw R #10, and the resident verbalized he would get a gun and shoot everyone. R #10 had a history of suicidal ideation. The Psychiatric Provider cleared the resident, and one on one care was not initiated.- Dated 8/14/25at 10:27 pm, R #10 was given a Haldol 5 mg intramuscularly this morning when resident became agitated, yelling, screaming, and calling names. Re-assessed after 30 minutes, and the medication was effective. R #10 became calm and quiet while in the day room.-Staff did not document a nursing progress note on 08/15/25 to indicate why staff administered a Haldol injection to R #10. - Dated 8/16/25 at 10:05 pm, R #10 lay in bed, refused to eat breakfast, refused to take scheduled medications. He kept talking about going back to Santa Fe over and over until he became agitated. Resident became verbally and physically abusive. Haldol IM given. Resident spat on the staff's face twice while they gave the injection. Resident also spat on another staff during dinner time.- Dated 8/17/25 at 10: 06 pm, R #10 was agitated earlier in the shift, shouting he wanted to go look for his dog. R #10 was given redirection and medication, but it did not change R #10's behavior. Staff administered a Haldol injection to the resident. The medication took time to kick in, but it eventually helped as the patient went to sleep.- Dated 8/20/25 at 11:09 pm, staff administered Haldol 5 mg intramuscularly to the resident during the morning when the resident started screaming and acting upset. R #10 stayed in his room all day, and he decided to go to the nurse's station in the evening to look for his dog.- Dated 8/24/25 at 8:15 am, staff heard R #10 yelling in hallway and trying to hit hall monitor. He held onto the Hall Monitor's right forearm tightly. The Hall Monitor reported R #10 grabbed a spray bottle with chemicals from housekeepers' cart and tried to spray another resident with it. The Hall Monitor immediately reacted and took the spray bottle away from R #10. R #10 became very angry and began yelling and cussing at th eHall Monitor. The resident grabbed the Hall Monitor and tried to hit him. Staff assisted the Hall Monitor and redirected R #10 away from the Hall Monitor.- Dated 8/24/25 at 8:20 am, R #10 was redirected to his room and stated that man hated him and wanted to hurt him. R #10 was given Haldol 5 mg injection, and he

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews and record reviews, the facility failed to demonstrate its measures to minimize the risk of Legionella (bacteria naturally found in water that can cause a severe type of lung infection called legionnaires' disease when people inhale tiny water droplets containing the bacteria) in the building's water system, when the Legionella Water Management Program (LWMP) team failed to develop and implement an adequate LWMP. This failure had the potential to affect all residents in the facility. This deficient practice is likely to lead to outbreaks of legionellosis (legionnaires' disease and Pontiac fever, a milder flu-like illness). The findings are:A. Record review of the facility's LWMP, last revised in August 2024, showed the following: - The policy did not have a procedure on how to use the control measures to control the introduction and/or spread of Legionella in the building water system. - The policy did not include control limits (the maximum value, minimum value, or range of values that are acceptable for the control measures that you are monitoring to reduce the risk for legionella growth and spread) and parameters.- The policy did not have monitoring procedures to include:a. Specified and documented testing protocols for legionella.b. Established control limits acceptable for the control measures the facility monitored to reduce the risk for Legionella growth and spread.- The policy did not have established ways to intervene when control limits were not met or when there was a case of healthcare-associated legionellosis in the facility. B. On 09/10/25 at 10:00 am, during an interview with the facility's Administrator, Regional Corporate Nurse, Director of Nursing, Maintenance Director, and Environmental Services Manager, they stated they were not aware the LWMP was inadequate to prevent the growth and spread of legionella in the building water system. They stated they were not aware the plan was missing procedures to explain how to use the control measures, acceptable control limits and parameters, monitoring procedures, and established ways to intervene when control limits were not met or when there was a case of healthcare-associated legionellosis in the facility.