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	03/27/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to ensure residents were free from neglect for 2 (R #20 and R #24) of 3 (R #20, #22 and #24) residents reviewed, when:The facility's nursing staff did not assess or change R #20's wound dressing for several hours after R #20 requested assistance.The facility's nursing staff did not assist R #24 as required, which caused R #24 to become upset.If the facility fails to assist residents as required or requested, then residents are likely to experience physical injury and psychological harm, including fear or distress related to staff interactions. The findings are:ˆR #20:A. Record review of R #20's face sheet revealed an admission date of 01/30/26 with the following diagnoses:Cerebral infarction due to embolism (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain),Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly). B. Record review of R #20's Kardex (documentation system that enables nurses to write, organize, and easily reference key patient information) located in the electronic health record (EHR), dated 01/30/26, revealed R #20 required the assistance of one staff member for toileting, showering/bathing, hygiene, bed mobility and dressing. R #20 requires the assistance of two staff members and a mechanical lift for transferring from the bed to a wheelchair. C. Record review of R #20's nursing progress notes, dated 03/02/26, revealed a change in condition (CIC; a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) was completed when R #20 stated Certified Nursing Assistant (CNA) #5 was rude to him and would not assist him as he requested. D. On 03/26/26 at 9:00 am, during an interview, R #20 stated CNA #5 was mocking (making fun of someone or something in a cruel way) him and the nurse did not change his wound dressing for several hours after his request. R #20 was unable to recall any other details about the incident. E. On 03/26/26 at 9:52 am, during an interview, the Social Services Assistant (SSA) stated R #20 stated CNA #5 was mean to him during care. The SSA stated she reported it to the Administrator immediately. F. On 03/26/26 at 10:01 am, during an interview, the Administrator (ADM) stated she was told R #20 did not receive care during the morning on 03/02/26. The Administrator stated CNA #5 was observed going into R #20's room at 2:30 am, but no other staff entered R #20's room until a nurse entered R #20's room at 5:00 am. During the Administrators investigation, CNA #5 stated she changed R #20's brief, and he requested his wound dressing to be changed. The Administer stated CNA #5 reported that she told the nurse R #20's request for the dressing change. The Administrator stated the nurse told her that she entered R #20's room right away, but after watching the unit video footage, the Administrator confirmed the nurse did not go into R #20's room until 5:00 am. The Administrator stated R #20's wound dressing should have been addressed sooner than several hours after the request was made by R #20. G. On 03/26/26 at 2:33 pm, during an interview, the Director of Nursing (DON) stated R #20 filed a grievance on 03/02/26 indicating CNA #5 was rude to him and he did not get proper care. The DON stated R #20 told her that he wanted his wound dressing changed and it did not get changed until hours after he requested the wound dressing be changed. The DON stated CNA #5 went into R #20's room at 2:30 am on 03/02/26, (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but the nurse did not go into R #20's room to change the wound dressing until 5:00 am. The DON stated the nurse should have assessed and/or changed R #20's wound dressing sooner than 5:00 am. R #24:H. Record review of R #24's face sheet revealed R #24 was admitted into the facility on [DATE] with the following diagnoses:Fracture of the right femur (long bone that connects the hip to the knee),Type II diabetes (a disease in which the body cannot make or properly use insulin),Repeated falls. I. Record review of R #24's Kardex located in the EHR, dated 02/24/26, revealed R #24 required the assistance of one staff member for dressing, hygiene, showering/bathing, and bed mobility. R #24 was able to toilet herself with assistance in transferring, and R #24 required the assistance of one staff member when transferring from the bed to a wheelchair. J. Record review of R #24's nursing progress notes, dated 03/02/26, revealed an alleged abuse incident occurred on 03/02/26 involving R #24 when R #24 stated CNA #5 was rude and refused to help her. R #24 stated CNA #5 told her she can do some care areas herself and without staff assistance. K. Record review of R #24's abuse questionnaire, dated 03/02/26, revealed an answer of Yes to the question of Have you had any interactions or experiences in which you felt uncomfortable or felt negative while at the facility? In the explanation of what occurred, R #24 stated CNA #5 made her feel like she was not trying with her own recovery. L. On 03/26/26 at 10:03 am, during an interview, the Administrator (ADM) stated facility nursing staff should help residents as required. The Administrator stated due to the allegations made by R #24 regarding CNA #5 and the nurse, she terminated the employment of both employees. M. On 03/26/26 at 2:36 pm, during an interview, the Director of Nursing (DON) stated encouragement from nursing staff to residents is ok, but it must be encouragement and not making a resident feel bad about needing assistance. She stated since there were two incidents with residents having a grievance about CNA #5, they decided to terminate the employment of both CNA #5 and the nurse, which led to the allegations of neglect being confirmed.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff revised the care plan for 1 (R #5) of 1 (R #5) residents reviewed, when:Facility staff failed to update R #5's plan of care to include substance use (the intake of various substances, including alcohol, tobacco products, and drugs, which can be consumed, inhaled, injected, or otherwise absorbed into the body). This deficient practice is likely to result in residents' care and needs not being addressed if care plans are not updated.ˆ The findings are: A. Record review of R #5's face sheet revealed R #5 was originally admitted into the facility on [DATE] with the diagnosis of opioid dependence (physical and behavioral dependence on opioids, prescription or illicit). B. Record review of R #5's nursing notes revealed the following:Dated 02/01/26: Staff observed R #5 discarding an empty packet of Suboxone (a medication used to treat opioid dependence) in the trash. R #5 denied taking any, and R #5 was not prescribed Suboxone. Staff notified the on-call provider, who ordered monitoring for adverse reactions. Nursing staff and security conducted a room search and found no additional contraband (goods that have been imported or exported illegally). C. Record review of R #5's Care Plan revealed the following:Dated 01/21/26: R #5 resides on a secure unit related to polysubstance abuse disorder (a mental health condition involving the use of two or more substances in a pattern that negatively affects health, functioning, and quality of life). Interventions: perform safety risk evaluation on admission, as needed, and upon changes in condition.Dated 01/21/26: R #5 at risk for substance use disorder related to polysubstance abuse disorder. Interventions: monitor for signs or symptoms of substance abuse.R #5's care plan was not updated after the Suboxone incident on 02/01/26. D. On 03/27/26 at 12:23 pm, during an interview, the Director of Nursing (DON) stated she was aware of the 02/01/26 incident in which R #5 was found with an empty Suboxone packet. She confirmed the facility did not update R #5 ?s care plan following the incident. E. On 03/27/26 at 1:50 pm, during an interview, the Administrator (ADM) stated her expectation was when a new risk or behavior was identified, the facility would discuss it, and nursing would be responsible for updating the care plan. The ADM stated she would expect R #5's care plan to be updated to address the identified risk.