

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/29/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to submit a separate initial incident report and five-day follow-up investigation report within the required timeframe to the State Agency for 1 (R #16) of 1 (R #16) resident, after R #16 experienced two separate falls with injuries requiring hospitalization. If the facility does not submit the summary of its investigation to the State Agency, the State Agency cannot appropriately review the allegation for further investigation. The findings are: A. Record review of the facility's abuse, neglect, exploitation or misappropriation reporting and investigating policy, last revised August 2025, revealed the Administrator (or designee) was responsible for reporting reportable incidents to the appropriate state agencies. The policy stated the Administrator would submit a follow-up investigation report within five business days of the incident, and the report would describe the results of the investigation. B. Record review of R #16's face sheet revealed R #16 was originally admitted to the facility on [DATE] with the following diagnoses: Metabolic encephalopathy (a degenerative brain disease that alters brain function or structure). Traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain). Vascular dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). Vascular Parkinsonism (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination). Falls. Muscle Weakness. C. Record review of R #16's nursing progress notes revealed the following: Dated 05/02/26 at 6:24 am, R #16 experienced a witnessed fall in the facility's smoking area after bending down to retrieve a cigarette. R #16 sustained injuries to his mouth and nose and was transported to the hospital for evaluation. Dated 05/02/26 at 4:00 pm, R #16 returned from the hospital after experiencing a fall at the facility, which resulted in bruising below both eyes and a nasal fracture. Dated 05/05/26 at 4:52 am, R #16 experienced a second, separate unwitnessed fall in his room at 3:10 am, and was found near his bed with a bleeding forehead laceration (a wound produced by tearing) and a right-hand abrasion (scrape or scratch). The provider was notified, Emergency Medical Services (EMS) was contacted, and R #16 was transported to the hospital for evaluation. Dated 05/08/26 at 2:41 pm, R #16 returned to the facility from the hospital wearing a neck brace following a fall on 05/05/26. Hospital documentation identified injuries including a multicompartiment intracranial hemorrhage (bleeding that occurs in more than one distinct anatomical space within the skull), T12 compression fracture (a collapse of the 12th thoracic vertebra in the mid-to-lower back), and right pelvic fractures. D. Record review of the facility's incident report and five-day follow up reporting documentation for R #16's falls revealed the following: Dated 05/04/26 at 10:40 am, the facility submitted an incident report to the State Agency for R #16's fall with injury that occurred on 05/02/26. Dated 05/11/26 at 11:42 am, the facility submitted a five-day follow-up investigation report to the State Agency that combined R #16's falls with injuries from 05/02/26 and 05/05/26. The five-day follow-up investigation report for R #16's fall on 05/02/26 was not submitted to the State Agency until 05/11/26, and the facility did not complete or submit an initial incident report to the State Agency for R #16's unwitnessed fall with injury on 05/05/26. E. On (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 325045
		If continuation sheet Page 1 of 3

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/29/26 at 2:20 pm, during an interview, the Director of Nursing (DON) stated R #16 experienced an unwitnessed fall on 05/05/26 and was transported to the hospital, where he was later identified as having sustained a T12 fracture. The DON stated the facility did not submit a separate initial incident report to the State Agency for R #16's fall on 05/05/26 and should have. F. On 06/29/26 at 2:45 pm, during an interview, the Corporate Administrator stated her expectation was for R #16's second fall on 05/05/26 to be reported to the State Agency as a separate reportable incident, and for facility incident reports and five-day follow-up reports to be submitted within required timeframes.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain a safe and sanitary environment to prevent the transmission of infectious agents and communicable diseases for 1 (R #1) of 1 (R #1) resident, when the facility failed to prevent a Foley catheter (a thin, sterile tube inserted into the bladder to drain urine) drainage bag (also called a catheter collection bag; a device connected to the catheter tubing and collects urine) from touching the floor. This deficient practice has the potential to expose staff and other residents to infectious diseases. The findings are: A. Record review of the facility's catheter care and urinary policy, revised September 2024, revealed the purpose of the procedure was to prevent urinary catheter-associated complications, including urinary tract infections. The policy directed staff to use aseptic technique (a set of procedures used in healthcare to prevent the introduction of pathogens into a patient's body, thereby minimizing the risk of infection during medical procedures) when handling or manipulating the drainage system, ensure the catheter tubing and catheter drainage bag remained off the floor, and position the drainage bag below the level of the bladder to prevent urine from flowing back into the urinary bladder. B. Record review of R #1's face sheet revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: Hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (paralysis and weakness on the left side of the body following a stroke). Neuromuscular dysfunction of the bladder (the bladder does not empty properly due to a neurological condition). Obstructive and reflux uropathy (a condition in which urine flow is blocked or flows backward, affecting the urinary tract). C. Record review of R #1's active physician orders, dated 09/27/25, revealed orders for a Foley catheter, including routine catheter care, catheter output monitoring every shift, catheter irrigation as needed, and catheter drainage bag changes as needed. D. On 06/26/26 at 2:17 pm, during an observation, R #1 was lying in bed with the urinary catheter drainage bag resting on the floor. E. On 06/26/26 at 2:18 pm, during an interview, Registered Nurse (RN #1) stated R #1's urinary catheter drainage bag should not rest on the floor because this could increase the risk of contamination and infection or become dislodged if pulled when the resident moved. F. On 06/29/26 at 9:00 am, during an interview, the Unit Manager (UM #1) stated R #1's urinary catheter drainage bag should be secured to the hook on the side of the bed and should not rest on the floor. UM #1 stated placing the catheter drainage bag on the floor could increase the risk of contamination and infection. G. On 06/29/26 at 2:40 pm, during an interview, the Director of Nursing (DON) stated a urinary catheter drainage bag should not be left on the floor. The DON stated leaving the catheter drainage bag on the floor created an infection control concern and increased the risk of contamination.		