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	07/25/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record reviews, the facility failed to protect the residents from the potential for accidents and hazards when the facility:- Permitted residents, with independent smoking privileges, to keep smoking materials, to include lighters and cigarettes, in their possession and to take them to their rooms.- Failed to ensure residents who utilized supplemental oxygen did not take their oxygen tanks into the designated smoking area.These failures had the potential to affect all residents. If residents have smoking materials in their possession, then there is the potential to light cigarettes or start fires in the facility. If this occurred around supplemental oxygen, then the oxygen could ignite and feed the fire. This puts residents at risk of serious injury, serious harm, and possibly death. The findings are:A. Record review of the facility's Smoking Policy - Residents, dated August 2024, revealed residents, who had independent smoking privileges were permitted to keep cigarettes, electronic cigarette pipes, tobacco, and other smoking items in their possession. B. Record review of the facility's list of residents who smoke, dated July 2025, revealed the facility had 53 residents with independent smoking privileges. C. Record review of the facility's Oxygen Administration Policy, dated September 2024, revealed the policy did not address safety precautions for the use of supplemental oxygen. D. Review of National Fire Protection Association (NFPA) 99, Health Care Facilities Code, 2012 edition, revealed the following:- Chapter 11 Gas Equipment- 11.5 Administration- 11.5.1.1 Elimination of Sources of Ignition. - 11.5.1.1.1 Smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, tobacco in any form) shall be removed from patients receiving respiratory [breathing] therapy [to include supplemental oxygen]. - 11.5.1.1.2* No sources of open flame shall be permitted in the area of oxygen administration. E. On 07/23/25 during the recertification survey, observation revealed the following:- Multiple residents throughout the facility received supplemental oxygen. - At 10:15 am, R #269 sat in her wheelchair in the designated smoking area. The resident wore a nasal cannula connected to an ambulatory liquid oxygen cylinder which hung on the back of her wheel chair, and she held a pack of cigarettes and a lighter. The resident's ambulatory oxygen cylinder contained a sticker which stated No Smoking. Further observation revealed R #31 sat in a wheelchair next to the resident and held a lit cigarette. F. On 07/23/25 at 10:16 am, during an interview and observation, R #269 stated she forgot to remove her oxygen cylinder prior to entering the designated smoking area. She stated she was aware she should not wear it in the smoking area. The resident propelled herself past multiple residents who were actively smoking and into the facility. G. On 07/23/25 at 10:20 am, during an interview, the Maintenance Director stated staff should be stationed at the facility exit to the designated smoking area to remind residents to remove their oxygen before entering the smoking area. He stated the staff was not present today (07/23/25). The Maintenance Director stated oxygen cylinders should not be brought into the designated smoking area because it was a fire hazard. H. On 07/23/25 at 10:25 am, observation revealed the exit from the facility to the designated smoking area did not have a designated staff present to remind residents to remove their oxygen tanks before entering the smoking area. I. On 07/23/25 at 10:35 am, during an interview, the Corporate Nurse and the Respiratory therapist stated the facility's policy was to educate the independent smokers. They stated the independent smokers were alert and oriented, so (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

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	07/25/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	they educated them not to take their oxygen outside. The Corporate Nurse and the Respiratory therapist stated education was the facility's only precaution to prevent oxygen use in the designated smoking area, and they did not have any other systems in place. They stated the independent smokers were aware they should not take their oxygen tanks into the designated smoking areas. J. On 07/23/25 at 1:00 pm, during and interview, the Administrator, the DON, and the ADON stated independent smokers, to include independent smokers who utilized supplemental oxygen, could keep their smoking materials on them, to include cigarettes and lighters. He said some independent smokers kept their smoking materials in their room and others kept their smoking materials with the Receptionist. The Administrator stated the independent smokers were allowed to carry their smoking materials through the facility to the outside designated smoking area. He stated residents who utilize supplemental oxygen were allowed to be in the same space as the independent smokers with their smoking materials. Based on observations, interviews, and record review, an Immediate Jeopardy (IJ) was identified on 07/23/25 at 1:30 pm, and the facility Administrator was notified in person. The facility took corrective action by providing an acceptable Plan of Removal (POR). The Plan of Removal was approved on 07/23/2025 at 5:40 pm. - Facility staff will always be present during smoking hours, 7:00 am to 9:30 pm, in the designated smoking areas to monitor residents to ensure oxygen equipment (portable oxygen equipment, e-tanks, or concentrators) are not present in the smoking area, which may harm a resident who was present in the smoking area. - On 07/23/25, all staff education on the facility's smoking policy was initiated. The facility's smoking policy was updated and sent to all staff via the employee messaging system on 07/23/25. All staff education on the updated smoking policy will be completed on 07/27/25. - The smoking attendant who was present in the hallway close to the designated smoking area will receive disciplinary action for not being present in the designated smoking area.- Any smoking material, to include cigarettes and lighters, will be maintained by the facility in a secured cart and will be dispersed by facility personnel in the designated smoking area. The smoking cart will be located in the proximity of the designated smoking areas. The smoking cart will be under the supervision of the smoking attendant. This will become effective on 07/23/25 and will be completed by 07/23/25. - The facility resident smoking policy will be revised. The facility smoking policy will be revised to include independent smoking procedures. It will also include updated policy of smoking material storage. - Independent residents who wish to smoke between the hours of 9:30 pm and 7:00 am will be allowed to smoke under the facility staff's supervision. - Facility smoking sweep/audit of current smokers in the facility was completed on 07/23/25. All smokers identified were educated on the new procedures regarding smoking policy and management of smoking materials. All smoking materials were confiscated and placed in a secured smoking cart on 07/23/25. K. On 07/24/25 at 10:59 am, during an observation and interview, R #2 had his cigarettes and lighter. The resident stated he was going to refuse to give his smoking materials up when staff asked for them, but the staff did not ask him for his smoking materials. L. On 07/24/25 at 10:08 am, observation revealed R #144 walked through the 600 unit with two unlit cigarettes in his hands. The resident approached the smoking attendant and said he was leaving the building. The smoking attendant gave R #144 his pack of cigarettes. The resident walked away from the smoking area to the elevator, he boarded the elevator and went to another floor of the building with his smoking materials. M. On 07/24/25 at 10:23 am, observation revealed R #288 entered the building from the smoking area. The resident held his cigarettes and lighter, propelled himself past the smoking attendant, and told the attendant, I will be back. The smoking attendant did not stop the resident and did not collect the resident's smoking materials. The resident propelled themself through the building. N. On 07/24/25 at 10:23 am, during an interview, the smoking attendant stated she completed the training on the new smoking policy the morning of 07/24/25. She stated she was supposed to collect all smoking supplies from the residents when they entered the building from the smoking area. The smoking attendant stated she did not collect R #288's smoking materials because she had a lot going on. She stated she trusted the resident and knew he would return. The smoking attendant stated she was not supposed (continued on next page)

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	07/25/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	to allow residents to take their smoking materials past her, per her training that morning on the new smoking policy. She stated she was not going to argue with R #288 because she considered that abuse. The smoking attendant stated she gave R #144 his smoking materials, because he said he was leaving the facility. She stated she did not know if the resident left or when he was leaving. Implementation of the POR was verified onsite on 07/25/25, and the IJ was removed on 07/25/25 at 3:00 pm. The scope and severity was reduced from a L to an F. Implementation of the POR was verified by the following: - Record review of the facility's In-Service Attendance Sheets, dated 07/23/25, revealed the following: - Topic: All smoking materials must be kept in the smoking cart. The smoking attendant must be present at the smoking cart in the smoking area at all times. - Facilitators: The Director of Nursing and the Assistant Director of Nursing. - Staff signed they received the training, to include dietary, maintenance, nursing, administrative, laundry, activities, social services, security, and housekeeping staff.- Record review of the facility's audit of residents who smoked, dated 07/25/25, revealed the following: - Staff met with all residents with supervised smoking privileges to ensure they did not have any smoking materials on themselves or in their room. - Staff met with all residents with independent smoking privileges provided education on the new smoking policy and took their smoking materials to the smoking cart near the designated smoking area.- On 07/24/25 at 2:00 pm, record review and observation revealed staff conducted an education for all resident smokers. Topics covered included: review of the facility smoking policy, safety guidelines related to smoking, proper process for oxygen usage, proper process for smoking in designated areas, proper storage and keepsake of personal smoking items. Residents signed an attendance record. - Record review of the facility's updated Smoking Policy, dated July 2025, revealed residents with or without independent smoking privileges may not have or keep any smoking items, including cigarettes and tobacco, on their person. All smoking items must be kept and stored in the designated smoking cart. The facility maintains the right to confiscate smoking items found in violation of the smoking policies. - On 07/25/25 at 1:53 pm, during an interview, Registered Nurse (RN) #1 stated she completed the new oxygen training online, and residents could not keep their smoking materials with them in the facility. She stated staff confiscated all the resident smoking materials. - On 07/25/25 at 1:54 pm, during an interview, LPN #1 stated she completed the online training on 07/24/25, and the residents had a meeting on 07/24/25 to be informed of the changes. She stated if staff saw or suspected smoking materials with a resident, then they are to confiscate the smoking materials right away. - On 07/25/25 at 2:00 pm, during an interview, Smoking Attendant (SA) #1 stated worked during the resident smoking hours, 7:00 am to 9:30 pm. She stated residents were not allowed to have their cigarettes with them inside the facility. She stated she gave the residents two cigarettes each. She stated residents with supplemental oxygen had to leave their oxygen at the atrium door or she would not give them their two cigarettes. She stated if residents refused to return smoking materials to the cart when they reentered the facility, then she would call security to come and speak with the resident. - On 07/25/25 at 2:25 pm, during an interview, Therapist #1 stated she completed an online training regarding smoking materials and oxygen. She stated residents were not allowed to take their oxygen containers outside any longer. She stated residents also could not carry smoking materials on their person through the facility any longer. - On 07/25/25 at 2:29 pm, during an interview, the Front Receptionist stated all smoking materials were kept in a cart by the atrium door, and staff brought the cart to the front area for observation by security during the night. She stated oxygen was not allowed outside near the residents who smoked. The receptionist stated security locked the atrium door after smoking hours. She stated if a resident wanted to smoke after hours, then the night supervisor supervised the resident outside. She stated if staff saw a resident with smoking materials in the building, then they would call a CNA or other health staff to confiscate the items. - On 07/25/25 at 2:30 pm, during an interview, R #50 stated she got the smoking policy update by word of mouth in the courtyard from other smokers. She stated smoking near the doors and going outside with oxygen was no longer permitted. - On 07/25/25 at 2:45 pm, (continued on next page)

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	07/25/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	during an interview, R #78 stated he got the updated rules about oxygen and smoking materials. He stated he could not have his smoking materials in his room or carry them anymore. He stated he had to leave his oxygen at the door now and always sign out his cigarettes with the attendant.

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	07/25/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure resident was assessed for risk of entrapment (state of being stuck or caught on bed rail) from bed rails for 2 (R #123 and R #296) of 3 (R #101, R #123 and R #296) resident reviewed for accidents. This deficient practice has the potential to cause serious injury by becoming trapped between the mattress and bed rail. The findings are: R #123 A. On 07/22/25 at 8:29 am during an observation of R #123's room, there was a quarter size rail (rails that take up a quarter part of the bed) on each upper side of R #123's bed. B. Record review of R #123's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Fracture of Neck of Left Femur (a break in the bone of the upper thigh, specifically within the region just below the hip joint ball), 2. Repeated Falls, 2. Muscle Wasting and Atrophy (decrease in muscle mass and strength), 3. Lack of Coordination, 4. Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, not a specific disease), 5. Schizophrenia (a chronic and severe mental health disorder that affects how a person thinks, feels, and behaves), 6. Disorder of bone density and structure (conditions where bones become weaker, more fragile, and susceptible to fractures due to changes in bone mass and/or structural integrity). C. Record review of R #123's the Electronic Health Record (EHR) revealed: 1. the record did not contain any physician orders for the use of bedrails. 2. the record did not contain a bed rail assessment for the safe usage of bedrails. D. On 07/22/25 at 8:30 am during an interview with R #123, he stated he uses the bed rails for bed mobility and repositioning. R #123 could not remember how long he has the bed rails but did not recall having them upon admission. E. On 07/24/25 at 10:58 am, during an interview with the 2nd floor unit manager (UM2), she stated she did not know if R #123 had bed rails upon admission as he was on a previous floor before arriving to her unit. She confirmed R #123 did not have orders for use of bed rails nor a completed assessment (continued on next page)

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	07/25/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and should have. R #296 E. Record review of R #296's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Chronic systolic congestive heart failure (CHF; impaired heart function), 2. Moderate Persistent Asthma (condition where the airway becomes inflamed, narrow, and swell, and produces extra mucus which makes it difficult to breathe), 3. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 4. Essential Primary Hypertension HTN; high blood pressure), 5. Hyperthyroidism (the thyroid is not making enough thyroid hormone). F. On 07/22/2025 at10:25 AM, during an observation of R #296 laid in bed in an upright position with bilateral (both sides) half side rails up on both sides of the bed. G. Record review of R #296's the Electronic Health Record (EHR) revealed the record did not contain any physician orders for the use of bedrails and did not indicate a bed rail assessment had not been completed for the safe usage of bedrails.

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	07/25/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by ensuring adequate indication of use based off of the residents' conditions for 3 (R #2, R #123, and R #282) of 4 (R #2, R #44, R #123, and R #282) residents reviewed for unnecessary medications. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The Findings are: R #2 A. Record review of R #2's physician's orders revealed the following: 1. Topiramate Oral Tablet (an anticonvulsant medication that is used to treat seizures and prevent migraine headaches.) 50 milligrams (MG). Give 1 tablet by mouth one time a day for Seizures (a sudden, abnormal surge of electrical activity in the brain that can cause a variety of symptoms, including changes in behavior, movement, sensation, and awareness). Start Date: 04/12/25 2. Trazodone HCl Oral Tablet (an antidepressant medication primarily used to treat depression, anxiety, and insomnia) 100 MG (Trazodone HCl) Give 2 tablet by mouth at bedtime for insomnia (difficulty falling asleep, staying asleep, or experiencing non-restorative sleep, leading to daytime impairment). Start Date: 04/11/25 B. Record review of R #2's face sheet revealed R #2 was admitted to the facility on [DATE] and does not have the following diagnosis: 1. Seizures 2. Insomnia R #123 A. Record review of R #123's physician's orders revealed the following: 1. Atorvastatin Calcium Oral Tablet (a medication belonging to the statin class, commonly prescribed to lower cholesterol and triglyceride levels and reduce the risk of cardiovascular disease) 40 milligrams (MG). Give 0.5 tablet by mouth one time a day for hyperlipidemia (a condition in which there are high levels of fats (lipids) in the blood). Start date: 05/22/25 2. Benztropine Mesylate Oral Tablet (anticholinergic: it works by blocking the action of a neurotransmitter in the central nervous system) 2 Milligrams (MG). Give 1 tablet by mouth two times a day for Parkinsons (a progressive brain disorder that results from the death of dopamine-producing cells, leading to problems with movement, coordination, and other symptoms like tremor, rigidity, and slow movement). Start Date: 06/13/25. 3. Aspirin Oral Tablet (blood thinner and non-steroidal anti-inflammatory drug) 81 milligrams (MG). Give 1 tablet by mouth at bedtime for coronary artery disease (occurs when arteries supplying blood to the heart become narrowed by plaque buildup (atherosclerosis), reducing blood flow and potentially causing chest pain, shortness of breath, or a heart attack). Start Date: 04/21/25. B. Record review of R #123's face sheet revealed R #123 was admitted to the facility on [DATE] and does not have the following diagnoses: 1. Hyperlipidemia (a condition where there are abnormally high levels of lipids (fats) in the blood). 2. Parkinson's (a progressive neurodegenerative disorder that primarily affects movement). 3. Coronary Artery disease (occurs when the coronary arteries, which supply blood to the heart, narrow or become blocked). R #282 A. Record review of R #282's physician's orders revealed the following: 1. Valproic Acid oral solution (anticonvulsant; medication used to treat seizure activity), 250 milligrams (MG)/5 milliliters (ML). Give 5ML by mouth three times a day for seizure disorder. Start date 04/18/25. B. Record review of R #282's face sheet revealed R #123 was admitted to the facility on [DATE] and does not have a diagnosis of seizure disorder. C. On 07/24/25 at 10:58 AM, during an interview with the 2nd floor unit manager (UM2), confirmed the indications of use for medications should match residents' diagnoses. UM2 confirmed the indications of use for medication did not match diagnosis for R #2, R#123 and R#282.

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	07/25/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received routine dental services (an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures) were provided dental visits annually for 2 (R #1 and R #14) of 2 (R# 1 and R #14) residents reviewed for routine dental services. This deficient practice is likely to negatively impact residents through pain, mood, and state of well-being if dental conditions have not been addressed in a timely manner. R #1 A. Record review of R #1's Electronic Health Record (EHR), R #1 was admitted on [DATE] with the following diagnoses: 1. Muscle wasting and atrophy (the decrease in size or wasting away of a cell, tissue, organ, or muscle), 2. Muscle Weakness, 3. Adult Failure to Thrive (decline in physical and cognitive function, accompanied by weight loss, decreased appetite, and inactivity), 4. Acute Respiratory Failure with Hypoxia (inadequate supply of oxygen to the tissues), 5. Gastro-Esophageal Reflux Disease (GERD; stomach acid frequently flows back into the esophagus, causing irritation). B. On 07/22/2025 at 9:06 AM, during an interview with R #1, she stated she needed bottom dentures and has been asking the nurses and social services for an appointment to get them, but nothing has happened. R #1 stated it is difficult to eat without lower teeth. C. On 7/24/25 at 3:45 pm, during an interview with the director of social services (DOSS), she confirmed that R #1 should have had a dental appointment scheduled and has not. R #14 D. Record review of R #14's face sheet on 05/14/25, was admitted with the following diagnoses: Paranoid Schizophrenia (a serious mental disorder (affects the brain and mood) 1. Other cerebral infarction due to occlusion or stenosis of the small artery (an area of dead tissue in the brain, 2. Leukemoid Reaction (very large short-term increase in your white blood cell count that can be mistaken for leukemia), 3. Rhabdomyolysis (serious condition caused by muscle injury or breakdown), 5. Primary insomnia (difficulty falling asleep, staying asleep, or experiencing non-restorative (not resting or restoring the body) sleep), 4. Dysphagia, oral phase (difficulty in swallowing or as a symptom of disease). E. On 07/21/25 at 12:54 pm, during an interview with R #14, she stated she has not had a dentist come into the facility and look at her teeth. F. Record review of R #14's progress notes dated 04/14/25 through 07/23/25 revealed the progress notes did not contain any documentation of dental service (a diagnostic, preventive, or corrective procedure furnished by or under the supervision of a dentist) visits for R #14. G. Record review of R #14's medication orders revealed an order dated 06/04/25 for Depakote, an anticonvulsant that has a side effect of causing enlargement of the gums. H. Record review of R #14's care plan dated 05/21/25 revealed she is to be monitored for side effects of this medication, and she has not been seen by a dentist for routine dental/gum care of the teeth and gums. I. On 07/21/25 at 1:06 pm, during an interview with Unit Manager (UM) #3, she stated dental evaluations are not performed annually for residents. Dental appointments are made through social services when the facility is informed of dental problems for a resident. She was not aware of any issues that R #14 is experiencing. J. On 07/21/23 at 1:29 pm during an interview with Social Services Staff (SS) #1, she stated she does not arrange resident transportation for dental appointments and is unsure how often routine dental care needs to be arranged per facility policy; but does know that resident dental visits are made by referral only and not performed annually (every year) for residents. K. Record review of the facility's Dental Services Policy obtained from SS #1, and dated December 2022, revealed the following: 1. Routine and emergency dental services are available to meet the resident's oral health services (the health of the teeth, gums, and the entire oral-facial system that allows us to smile, speak, and chew) in accordance with the resident's assessment and plan of care. 2. Social Services representatives will assist residents with appointments, transportation arrangements and reimbursement (repayment) of dental services under the state plan, (continued on next page)

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	07/25/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if eligible (meeting criteria). 3. All dental services are recorded (documented) in the residents' medical record.

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	07/25/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to maintain proper infection prevention measures by: 1. Not disinfecting direct patient care equipment after use. 2. Not adhering to Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities), 3. Not adhering to contact precautions (used for individuals with infections that can spread through direct or indirect contact with the patient or their environment). These deficient practices have the potential to affect all 291 residents residing in the facility according to the census provided by the Administrator (ADM) on 07/21/25 by experiencing an increase of infections leading to further health concerns. The findings are: Equipment A On 07/24/25 at 9:58 AM during an observation of the medication pass for R #75, Registered Nurse (RN) #32 took R #75 blood pressure with portable blood pressure cuff. Upon completion of blood pressure measurement RN placed cuff on her medication cart workspace and continued to work with another resident. She then put the cuff back into her pocket without cleansing. B. On 07/24/25 at 10:00 am during an interview with RN #32, she stated she should have cleaned the blood pressure cuff with disinfectants after use. C. On 7/25/25 at 11:39 am, during an interview with the IP (Infection Preventionist), she confirmed that all equipment used for residents should be clean before and after use. Contact Precautions D. On 07/21/25 at 09:25 am, during an observation, housekeeping (HK) #13 entered a resident's room without proper personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection), as directed by the Contact precaution sign posted on the outside of R #75's door. E. On 07/21/25 at 9:30 am, during an interview with HK #1, she stated she should have been wearing the proper PPE. F. On 07/21/25 at 9:42 am during an observation, Licensed Practical Nurse (LPN) #73 entered R #75's room without PPE. G. On 07/21/25 at 9:47 am, during an interview LPN #73 stated you only must use a gown if touching a resident even with contact isolation, she stated that the policy states should be gown and gloves when doing direct patient care. Enhanced Barrier Precautions H. On 07/25/25 at 10:30 am, during an observation of R #125 room had EPB signage outside the door to his room. I. On 07/25/25 at 10:35 am, during an observation of peri-care (cleaning from the front of the hips, between the legs and buttocks, and the back of the hips) and urinary catheter care. RN #32 and Certified Nurse's Aide (CNA) #77 entered room without putting on the appropriate PPE as directed by the sign on the door. J. On 07/25/25 at 10:42 am, during an interview with RN #32, she confirmed gown, and gloves should be worn during catheter care and infection control signs should be followed. K. On 07/25/25 at 10:47 am, during an interview with CNA # 77, she stated she should have worn gown and gloves according to the sign that was posted. L. On 7/25/25 at 11:39 am, during an interview with the Infection Control Nurse (ICN) with she stated the infection control signage is there for a reason and staff are expected to read the signs and follow directions accordingly. She stated her expectation is that staff should have worn PPE prior to entering the EBP during high contact interaction with resident and should have worn PPE prior to entering a room with contact precautions whether they were interacting with resident or not. She also stated that LPN #73 is incorrect about the current policy on contact isolation policies.

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	07/25/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and interview, the facility failed to maintain an effective pest control program for 3 (R #2, R #52, and R #172) of 3 (R #2, R #52, and R #172) residents reviewed by allowing insects and their waste in their living space. If the facility does not maintain an effective pest control program, then residents are at a greater risk of contracting certain diseases and may feel disgusted or embarrassed about their living space. The findings are: R #2 A. On 07/22/25 at 12:42 pm, an interview and observation with R #2 revealed the following: 1. R #2 stated the facility has a big bug problem and feels like they could do more to control it. R #2 stated his sister has to purchase bug traps (traps and kills insects) to keep in his room. 2. Two bug traps were located on the floor of the restroom in R #2's room. 3. Duct tape running along the border of the wall that R #2 stated he put there because bugs would come out of the wall there. 4. R #2 stated he has talked with the facility's staff several times regarding the pest infestation but nothing happens. R #52 and R #172 B. On 07/25/25 at 9:16 am, an observation of R #52's room revealed a corner of the wall where black spots appeared to form a larger black spot, approximately six inches by 10 inches. The black spots appear to be insects, larva (young insects), and insect eggs. C. On 07/25/25 at 9:37 am during an interview with the 5th floor unit manager, she stated she has not been told anything about a pest infestation in R #2's room or R #52 and R #172's room. The 5th floor unit manager confirmed the black spots in R #52 and R #172's room does appear to be an insect infestation.

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	07/25/2025

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of 12 hours per year for 3 (CNA #3, CNA #4, and CNA #5) of 5 (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5) CNAs reviewed for required in-service training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents. The findings are: CNA #3 A. Record review of CNA #3's personnel file revealed CNA #3 was hired on 05/06/24. B. Record review of CNA #3's in-service training Transcript Report revealed CNA #3 did not complete any of the required trainings. CNA #4 C. Record review of CNA #4's personnel file revealed CNA #4 was hired on 11/29/23. D. Record review of CNA #4's in-service training Transcript Report revealed CNA #4 did not complete the 12 hours of training as required per year. CNA #5 E. Record review of CNA #5's personnel file revealed CNA #5 was hired on 07/26/23. F. Record review of CNA #5's in-service training Transcript Report revealed CNA #5 d did not complete the 12 hours of training as required per year. G. On 07/24/25 at 3:09 pm, during an interview with the Human Resources Director (HRD), she confirmed the following: 1. CNA #3 has not completed any training during his employment at the facility. 2. CNA #3 continues to work shifts providing care for residents in the facility even though he has completed no trainings. 3. CNA #4 has not completed 12 hours of training annually. 4. CNA #4 continues to work shifts providing care for residents in the facility even though she has not completed all required trainings. 5. CNA #5 has not completed 12 hours of training annually. 6. CNA #5 continues to work shifts providing care for residents in the facility even though she has not completed all required trainings. The HRD further stated she expected all CNAs to complete at least 12 hours of training per year.

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	07/25/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #282) of 3 (R #2, R #123, and R #282) residents reviewed for unnecessary medications. If the residents or their representatives are not informed of the risks and benefits of the medication or treatment alternatives, they are not able to make informed decisions regarding residents' care. The findings are: A. Record review of R #282's physician's orders revealed the following: - An order for Gabapentin capsule (anticonvulsant; medication used to treat seizure activity), 100 milligrams (mg). Give one capsule by mouth three times a day for intrusive agitation (unwanted thoughts that enter one's mind despite efforts to avoid them, and agitation, a state of being unable to remain still or calm, characterized by motor hyperactivity, restlessness, emotional tension, and sometimes verbal aggression. Start date: 03/14/25. - An order for Trazadone oral tablet (antidepressant; medications used to treat depression and other mental health conditions), 100 milligrams (mg) Give one tablet by mouth at bedtime for sleep. Start date: 07/21/25. B. Record review of R #282's medical record revealed staff did not document the consent for Gabapentin and Trazadone. C. On 07/24/25 at 10:58 AM, during an interview with the 2nd floor unit manager (UM2) confirmed the indications of use for gabapentin and trazadone are considered psychotropic (psychotropic medication; any drug that affects brain activities associated with mental processes and behavior) use and require consent. She confirmed staff did not obtain the consent form for the Gabapentin and Trazadone for R #282. The UM2 confirmed staff are expected to complete the psychotropic medication consent form prior to the resident starting psychotropic medications.

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	07/25/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update/revise the advance directive for 1 (R #6) of 1 (R #6) resident reviewed for advanced directives. This deficient practice could likely result in residents' declination of treatment such as refusals of artificial nutrition (a medical treatment for a person to receive nutrition when they are no longer able to) or intravenous (IV; into the vein) hydration as well as life saving measures such as attempting cardiopulmonary resuscitation (CPR; full code, an emergency procedure that combines chest compression with artificial ventilation) against resident's wishes. The findings are: A. Record review of R #6's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: - End stage renal disease (ESRD; chronic irreversible kidney failure). - Dependence on renal dialysis (a medical procedure that removes excess water, solutes, and toxins from the blood when the kidneys are no longer able to do so), - Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar), - Obesity (overweight), - Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). B. Record review of R #6's New Mexico Medical Orders for Scope of Treatment (MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form dated [DATE] revealed R #6 chose to put a do not resuscitate (DNR; lifesaving measures are not desired) order in place. C. Record review of R #6's current physician orders revealed an order dated [DATE] indicated R #6 is a full code (attempt CPR). D. Record review of R #6's care plan initiated on [DATE] revealed R #6 has an advanced directive of full code in place. No further evidence of a more recent care plan was located. E. On [DATE] at 10:22 am during an interview with R #6, he stated that he does not want lifesaving measures such as CPR attempted, that is why he signed the DNR form. F. On [DATE] at 1:51 pm during an interview with 5th floor unit manager, she stated that in an emergency situation, the order showing in the resident's chart is what would be followed and since R #4's chart says he is full code, CPR would be performed.

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	07/25/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a comfortable and homelike environment by ensuring safe temperature levels (between 71 degrees to 81 degrees) for residents ensuring and a clean, comfortable, and safe environment. These deficient practices could affect all 291 residents as identified by the Daily Census provided by the Administrator (ADM) on 07/21/25. If the facility does not ensure safe temperature levels, clean and safe environment then the residents could be at risk causing additional or increased adverse health conditions and uncomfortable living conditions for the residents. The findings are: A. On 07/22/25 at 8:00 am observation revealed the following: - Blue painter's tape was hanging off two windows at the front face of the facility. - There were more than 10 cigarette butts on the ground at the front entrance to the facility. - The Physical Therapy room was missing a ceiling tile at the pillar in the room, and above the women's restroom sink. - The atrium had a spot on a west wall which previously housed a water fountain. The wall was not repaired following removal, which resulted in discoloration and seven round penetrations (six 0.5 inch (in.) circles, and one 3 in. opening). - There was a water fountain with broken (pushed in up into the water fountain face) and missing push bars, which left sharp edges and a disassembled appearance. B. On 07/23/25 at 8:00 am during an interview, the MD stated the stains on ceiling tiles in the facility were probably caused by rain leaks, or past toilet and sink issues. He stated the stained tiles were not homelike, should not be in the current state, and he would put in work orders for all tiles that surveyors found. C. On 07/23/25 during the Life Safety Code tour the following observations were made: - The northwest side of the building had trash consisting of hospital beds, two bikes, more than three pallets of wood, a 6 foot (ft.) x 8 ft shelving unit, three cardboard boxes, more than two broken tables, two intravenous (IV) poles (an apparatus used to administer a fluid (as of medication, blood, or nutrients), the seat of a recliner, medication carts, trash bins, and other items, which were visible from the resident courtyard. - The shed at the north fence located in the resident courtyard had various paper trash lining the exterior. It was visible from resident room windows, and the resident courtyard. - The resident courtyard was littered with cigarette butts throughout the grounds from fence to fence. Three Ashtrays were missing their components to properly close, and cigarette waste was not exclusively disposed of inside the provided fire-safe trash can. - There were ashtrays overfilled with combustible trash and cigarette waste which prevented the components from closing as designed. (continued on next page)

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	07/25/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Two open and disassembled tower-type ashtrays were outside the atrium doors full o. - There were two open 96-gallon trash cans which contained combustible trash and cigarette waste outside the atrium doors. - The Unit 600 Manager's office had a missing ceiling tile in a Central supply closet that houses extra supplies. - The dry pantry in the kitchen had three missing ceiling tiles, and the dishwashing sink had a peeling ceiling tile. - The Elevator #2 had a portion of exposed flooring with nail heads visible, and felt soft upon step. - The Unit 200 Supply room had two missing ceiling tiles. - Resident room [ROOM NUMBER] was missing half of the ceiling tiles on the left side, and multiple spots of a black substance between 1 in. and 4 in. were on the walls above the ceiling threshold. The insulation and ducts were exposed and had a yellow and brown stained color. - The bathroom wall baseboard plastic strip in Resident room [ROOM NUMBER] was corroded and falling off below the shower and a black substance was present lining the wet opening. - Resident room [ROOM NUMBER] had a missing ceiling tile in bathroom. - The bathroom wall baseboard plastic strip in Resident room [ROOM NUMBER] was corroded and falling off below the shower, and a black substance was present lining the opening. - The Unit 400 Janitor's closet had uneven, falling ceiling tiles. - The bathroom at the Unit 400 nurses' station was missing a ceiling tile. - One drooping ceiling tile was outside of the medication supply room - Resident room [ROOM NUMBER] had a flooded bathroom with two buckets under the sink to catch leaking water from the sink. - Resident room [ROOM NUMBER] had a flooded bathroom with two buckets under the sink to catch leaking water from the sink. - The dayroom in Unit 400 had a hanging iron window barrier, located inside next to the resident seating area. D. On 07/23/25 at 10:00 am during an interview, the Maintenance Director (MD) stated the storage shed exterior was not homelike. He also stated that the items on the north side of the building were all trash, and there was a third-party company the facility must call to come and remove the waste once it gets full throughout the year. He stated it was not homelike to store the items at this location. Temperature (continued on next page)

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	07/25/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 07/21/25 at 12:26 pm during a dinning observation, the wall temperature thermostat was at 82 degrees. F. On 07/21/25 at 12:30 pm during an interview with Registered Nurse (RN) #1 confirmed the temperature thermostat was at 82 degrees. G. On 07/21/25 at 12:26 pm during an interview with R #279, she stated she is very hot in the dining room. Safe Clean Environment 2nd Floor H. On 07/23/25 at 12:00 pm, during observation of the second-floor nursing unit revealed the following: - The ceiling tiles outside of room [ROOM NUMBER]-202, near the exit sign, had brown circular stains and pieces were chipped off. - Outside room [ROOM NUMBER], just inside the door the paint was peeled. - The Activities room the railing near the window was loose and pulled away from the wall. 3rd Floor I. On 07/23/25 at 10:26 am, during observation of the third-floor nursing unit revealed the following: - The entry door had chipped sheet rock and paint, - room [ROOM NUMBER] had a missing name plate covered with paper, - room [ROOM NUMBER] no name plate, plain piece of paper hanging in its place, - Pillar near nurse's station the paint was peeled, and the sheetrock was chipped and damaged, - The corridor rail just outside room [ROOM NUMBER] had a large hole along the rail and had rough edges, - The entry door of room [ROOM NUMBER] was damaged at the bottom, wood had splinted, and the paint was peeled off. - The main entry/exit door had a loose door handle, and the covering was coming off exposed the screws that secure handle to the door. J. On 07/23/25 at 10:44 AM during an interview, Certified Nurses Aid (CNA) #22 confirmed the loose door handle is not safe and should be repaired. K. On 07/23/25 at 10:45 during interview, Registered Nurse (RN) #2 confirmed the environment in it's current state is not homelike and expects repairs to be completed when needed. (continued on next page)

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	07/25/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4th Floor L. On 07/21/25 at 9:00 am, during an observation of the fourth-floor nursing unit revealed the following: -The carpet was visibly soiled and sticky, - There was a musty odor (an unclean and stale odor) throughout the entire unit. M. On 07/23/25 at 12:09 pm, during an observation of the fourth floor revealed the following: -Chipped paint along walls and side rails, -Chipped and peeled paint on the wall and desk of nurse's station. -Dining area, the floors were extremely sticky and appeared soiled. -The railing near the windows in the dining area was loose with missing drywall and paint chipped off. 5th Floor N. On 07/23/25 at 9:55 am during an observation of the fifth-floor nursing unit revealed the following: -The carpet down both hallways were visibly soiled, and unit had a musty smell (an unclean and stale odor). -The dining area railing along the window had missing screws from the bottom and was loose. -In the dining area there was a dark substance of what appeared to be ketchup or spaghetti sauce on the ceiling, the walls were visibly soiled with food particles, and the shades covering the windows had dried food on them. O. On 7/23/25 at 10:08 am, during an interview, Housekeeping (HK) # 12 confirmed the fifth-floor dining area should be cleaned thoroughly including the walls, shades and the ceiling tiles should be replaced if dirty. 6th floor P. On 07/23/25 at 9:55 am, during observation of the sixth-floor nursing unit revealed the following: -Both hallways, the carpet was visibly soiled, and the unit had a musty smell (an unclean and stale odor). -Multiple areas throughout the unit had chipped and missing paint and/or sheetrock. -The activities room railing near windows was pulled away from the wall and a loose bolt was hanging loose. -The biohazard room near the entrance door and nurses' station was easily accessible. The door was (continued on next page)

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	07/25/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	labeled biohazard and the door had keypad entry but was malfunctioning and entry could be made into the room without using the keypad. The room was tidy but had a red biohazard trash can inside with on full bundle of bagged trash and on the floor by the red biohazard trash were two full sharps containers that were locked. Also, the room contained a gray trash bin that had waste inside. Q. On 07/23/25 at 9:56 am, during an interview with Registered Nurse (RN) #27, he confirmed the door should be shut and locked, confirmed the door opened without using the keypad lock. He wasn't aware it did not function properly. He also stated the room does contain biohazard trash. R. On 7/23/25 at 9:59 am, during an interview with CNA #27, she confirmed the biohazard door lock did not function correctly.

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	07/25/2025

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to complete the quarterly review Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment within 92 days for 1 (R #179) of 2 (R #179 and R #294) residents reviewed for resident MDS assessments. This deficient practice could likely result in residents not receiving the care and assistance needed. The findings are:A. Record review of R #179?s face sheet revealed she was originally admitted to the facility on [DATE]. B. Record review of R #179's most recent quarterly MDS was completed on 02/19/25. C. On 07/25/25 at 9:36 am during an interview with MDS Coordinator, she confirmed R #179 should have had a quarterly MDS completed in May2025. She confirmed the quarterly MDS was not completed and should have been.

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	07/25/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated comprehensive assessment of a resident's functional, medical, psychosocial and cognitive assessment completed by facility staff) was accurate for 1 (R #282) of 3 (R #2, R #101, and R #282) residents reviewed for MDS assessments. This deficient practice could result in a failure to provide adequate care and treatment of the resident's needs. The findings are: A. Record review of R #282's face sheet revealed he was admitted on [DATE]. B. Record review of R #282's physician's orders revealed the following: - An order for Gabapentin capsule (anticonvulsant; medication used to treat seizure activity), 100 milligrams (mg). Give one capsule by mouth three times a day for intrusive agitation. Start date: 03/14/25. - An order for Valproic Acid oral solution (anticonvulsant; medication used to treat seizure activity), 250 milligrams (MG)/5 milliliters (ML). Give 5ML by mouth three times a day for seizure disorder. Start date 04/18/25. C. Record review of R #282's quarterly MDS dated [DATE] revealed R #282 does not take anticonvulsants. D. On 07/25/25 at 9:36 am during an interview with the MDS Coordinator, she confirmed R #282's quarterly MDS dated [DATE] should indicate the use of anticonvulsants and does not. She confirmed the quarterly MDS was not completed accurately and should have been.

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	07/25/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 2 (R #44 and R #123) of 5 (R #2, R #44, R #55, R #123 and R #321) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: R #44 A. Record review of R #44's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Epilepsy (a seizure disorder), 3. Heart failure (a condition where the heart muscle cannot pump enough blood), B. Unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), 5. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety), C. Record review of R #44's baseline care plan dated 04/18/25 revealed the baseline care plan did not contain any goals or interventions for R #44's diagnosis of dementia. D. On 07/23/25 at 1:51 pm during an interview with the 5th floor unit manager, she confirmed R #44's care plan does not include goals or interventions for R #44's diagnosis of dementia. R #123 E. Record review of R #123's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, not a specific disease), 2. Schizophrenia (a chronic and severe mental health disorder that affects how a person thinks, feels, and behaves), 3. Cognitive Communication Deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive functions, rather than problems with speech or language itself) F. Record review of R #123's baseline care plan dated 04/21/25 revealed the baseline care plan did not contain any goals or interventions for R #123's diagnosis of schizophrenia. G. On 07/24/25 at 10:58 AM, during an interview with the 2nd floor unit manager (UM2) confirmed R #123's care plan does not include goals or intervention for R #123's diagnoses of schizophrenia.

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	07/25/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a comprehensive care plan for 4 (R #2, R #44, R #56, and R #123) of 5 (R #2, R #44, R #55, R #56 and R #123) residents reviewed when staff failed to: 1. Develop a care plan for R #2's anticonvulsant medication and seizure disorder. 2. Develop a care plan for R #44's diagnosis of dementia. 3. Develop a care plan for R #56's use of a trapeze bar (a device suspended above a bed to assist with transferring or repositioning). 4. Develop a care plan for R #123's diagnosis of schizophrenia. This deficient practice is likely to result in staff not being aware of the residents' care needs and preferences, and residents not receiving the needed care. The findings are: R #2 A. Record review of R #2's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Acute kidney failure (kidneys no longer function well), 2. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly), 3. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 4. Gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining). B. Record review of R #2's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 05/30/25, revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. C. Record review of R #2's current physician orders revealed an order dated 04/11/25 for Topiramate (an anticonvulsant medication used to treat and prevent seizures in people with epilepsy) to be given for seizures. D. Record review of R #2's care plan dated 03/07/25 revealed the care plan did not contain any goals and interventions in place for anticonvulsant medications or seizure disorder. R #44 E. Record review of R #44's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Epilepsy (a seizure disorder), 3. Heart Failure (a condition where the heart cannot pump enough blood to meet the body's needs), 4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), with agitation, 5. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety). F. Record review of R #44's quarterly Minimum Data Set, dated [DATE], revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 13, cognitively intact. G. Record review of R #44's comprehensive care plan dated 04/18/25 revealed the care plan did not contain any goals or interventions in place for R #44's dementia. R #56 H. Record review of R #56's Minimum Data Set (MDS) dated [DATE] revealed he was admitted on [DATE]. Admitting diagnosis included: 1. Acute Embolism and thrombosis of Iliac Vein, Bilateral (blood clot forms in the iliac vein, obstructing blood flow). 2. Unspecified inflammatory spondylopathy, lumbar region (forms arthritis that usually strike the bones in your spine and nearby joints. 3. Low back pain, unspecified, 4. Other chronic pain (pain that lasts for over three months), 5. Hemiplegia (the severe paralysis or loss of motor function on one side of the body, resulting from brain damage, often from a stroke, traumatic brain injury, or brain tumor) and Hemiparesis (weakness on one side of the body, affecting the arm, leg, and sometimes the face, caused by brain damage or injury to the spinal cord) following unspecified cerebrovascular diseases affecting left non-dominate side (complete paralysis of one side of the body partial weakness), 6. Spinal Stenosis, site unspecified (pressure on the spinal cord and nerves that travel through the spine), 7. Muscle wasting and atrophy, not elsewhere Classified, other site (wasting or thinning of muscle mass), 8. Other cervical disc degeneration, Unspecified Cervical Region (wear and tear affecting the spinal disks in your neck), 9.Other intervertebral disc degeneration, lumbar region (breakdown of discs that cushion the vertebrae in the lower back). I. Record review of R #56's care plan dated 03/29/24 revealed R (continued on next page)

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	07/25/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#56's is totally dependent on staff for repositioning/turn in bed. The care plan does not include goals or interventions regarding R #56's use of a trapeze bar. J. Record review of R #56's electronic health record (EHR) revealed did not contain any evidence of an assessment for trapeze bar. K. Record review of R #56's current medical orders revealed R #56 did not have an order for use of a trapeze bar. L. On 07/22/25 at 10:55 am during an interview with R #56, he stated he is able to reposition himself while he is in bed using the trapeze bar. M. On 07/23/25 at 11:34 am during an interview with the Director of Nursing (DON), she confirmed there are no goals or interventions in place for R #56's use of a trapeze bar and confirmed that there should be a care plan for trapeze bars for every resident that utilizes one. R #123 N. Record review of R #123's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, not a specific disease), 2. Schizophrenia (a chronic and severe mental health disorder that affects how a person thinks, feels, and behaves), 3. Cognitive Communication Deficit (difficulties in communication arising from impairments in cognitive functions like attention, memory, and executive functions, rather than problems with speech or language itself). O. Record review of R #123's quarterly Minimum Data Set, dated [DATE], revealed a Brief Interview for Mental Status score of 06, significantly impaired. P. Record review of R #123's current physician orders revealed an order date 04/21/25 for Quetiapine Fumarate (antipsychotic medication) to be given for schizophrenia agitation. Q. Record review of R #123's care plan dated 04/21/25 revealed the care plan did not contain any goals or interventions for R #123's diagnosis of schizophrenia. R. On 07/24/25 at 10:58 AM, during an interview with the 2nd floor unit manager (UM2) confirmed R #123's care plan does not include goals or intervention for R #123's diagnoses of schizophrenia.

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	07/25/2025

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 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 observation, record review, and interview, the facility failed to ensure staff revised the care plan for 3 (R #101, R #123 and R #200) of 3 (R #101, R #123 and R #200) residents reviewed when staff failed to -update R #101's, and R #123'scare plan to include use of bed rails. -update R #200's care plan to include interventions for pain management These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #101 A. On 07/24/25 at 10:43 am, an observation of R #101's room revealed a half-sized bed rail (a bed rail that is designed to be installed on the side of the bed) on the left side of her bed. B. Record review of R #101's admission Record revealed she was originally admitted to the facility on [DATE] with the following diagnoses: 1. Fracture of Left Patella (a bone located at the front of the knee joint), 2. Muscle Wasting and Atrophy (decrease in muscle mass and strength), 3. Lack of Coordination, 4. Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 5. Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, not a specific disease), 6. Psychosis (a mental health condition characterized by a loss of contact with reality, often involving hallucinations, delusions, and disordered thinking), 7. Alzheimer's Disease (a progressive brain disorder that gradually destroys memory and thinking skills, eventually impacting the ability to carry out even simple tasks). C. Record review of R #101's current physician orders revealed an order dated 02/12/24 for R #101 to utilize half side bed rail for bed mobility. D. Record review of R #101's care plan dated 02/20/24 revealed the care plan did not contain any interventions for the use of bed rail. E. On 07/24/25 at 10:44 am during an interview with R #101, she could not identify what the bed rails were used for. F. On 07/24/25 at 10:58 AM, during an interview with the 2nd floor unit manager (UM2), confirmed R #101's care plan does not include goals or intervention for use of bed rails and should have. R #123 (continued on next page)

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	07/25/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 07/22/25 at 8:29 am during an observation of R #123's room revealed a quarter size rails (rails that take up a quarter part of the bed size) on each upper side of R #123's bed. H. Record review of R #123's admission Record revealed he was originally admitted to the facility on [DATE] with the following diagnoses: 1. Fracture of Neck of Left Femur (a break in the bone of the upper thigh, specifically within the region just below the hip joint ball), 2. Repeated Falls 2. Muscle Wasting and Atrophy (decrease in muscle mass and strength), 3. Lack of Coordination, 4. Dementia (a general term for a decline in mental ability severe enough to interfere with daily life, not a specific disease), 5. Schizophrenia (a chronic and severe mental health disorder that affects how a person thinks, feels, and behaves), 6. Disorder of bone density and structure (conditions where bones become weaker, more fragile, and susceptible to fractures due to changes in bone mass and/or structural integrity I. Record review of R #123's current physician orders revealed there was not an order for the use of bed rails. J. Record review of R #123's care plan dated 04/21/25 revealed the care plan did not contain any goals or interventions for R #123's use of bed rails. K. On 07/22/25 at 8:30 am during an interview with R #123, he stated he uses the bed rails for bed mobility and repositioning. R #123 could not remember how long he has the bed rails but did not recall having them upon admission. L. On 07/24/25 at 10:58 AM, during an interview with the 2nd floor unit manager (UM2), she stated she did not know if R #123 had bed rails upon admission as he was on a previous floor before arriving to her unit. She confirmed R #123 did not have orders for use of bed rails and R #123's care plan does not include goals or intervention for use of bed rails and should have. R #200 M. Record review of R #200's face sheet revealed an admission date of 03/18/24 with the following diagnoses: 1. Dementia in other areas classified elsewhere, unspecified severity, with agitation (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), 2. Post-traumatic stress disorder (PTSD-a mental health condition triggered by a terrifying event, (continued on next page)

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	07/25/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	causing flashbacks, nightmares, and severe anxiety), 3. Idiopathic epilepsy (a seizure disorder). N. Record review of R #200's electronic health record (EHR) revealed a physician order for morphine sulfate (pain medication) dated 07/03/25 to be administered every four (4) hours scheduled and then (PRN-pro re nata) as needed, every two (2) hours for breakthrough pain. O. Record review of R #200's Medication Administration Record (MAR) for the month of July 2025, revealed the following: 1. Morphine sulfate was administered every 4 hours as scheduled. 2. Morphine sulfate PRN was administered only 3 times in the month of July on 07/12/25 at 2:28 am, 07/03/25 at 6:07 pm, and on 07/17/25 at 2:32 am. P. Record review of R #200's comprehensive care plan revised on 04/01/25 revealed the following: 1. Goals or interventions for the use of pain medication related to her wound on her right heel were not located. 2. No monitoring for pain or effectiveness of pain medication. 3. The use of dementia-related pain monitoring (including the use of specialized tools like the PAINAID scale and the [NAME] Pain Scale due to cognitive impairments). Q. On 07/23/25 at 9:55 am, during an interview with UM #2, she confirmed R #200 had an active order for morphine sulfate, for scheduled pain medication and for breakthrough pain medication. UM #2 confirmed the revision of the comprehensive care plan for R #200 was last revised on 04/01/25 and does not include pain medication management for wounds and dementia-related pain monitoring.

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	07/25/2025

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 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. Based on observations, record review, and interviews, the facility failed to follow Physician Orders for 1 (R #10) of 1 (R #10) residents reviewed for comprehensive care plans (plan with measurable goals and timeframes to meet a resident's medical, nursing, mental health and psychosocial needs). This deficient practice could likely lead to harm of the resident. The findings are:A. Record review of R #10's Face Sheet revealed an admission date of 04/19/24.B. On 07/21/25 at 12:52 PM, during an observation of R #10's room revealed one bed rail attached to the resident's bed. C. Record review of R #10's Physician Orders, dated 02/27/25, revealed an order for bilateral side rails to assist with bed mobility.D. Record review of R #10's most recent Bed Rail Assessment, dated 02/27/25, revealed the following: -Resident does not have difficulty with balance or poor trunk control.-Recommendations for bilateral side rails.E. Record review of R #10's care plan, dated 03/03/25, revealed the resident requires bilateral siderails when in bed to enhance mobility and positioning. F. On 07/25/25 at 2:10 PM, during an interview with the Certified Nursing Assistant (CNA #1), she stated the bed rails were installed after R #10 had knee surgery, to assist in bed mobility. CNA #1 stated the resident was set up with bilateral bed rails and was unsure why the second rail was removed. She stated R #10 can safely use bilateral bed rails for repositioning and bed mobility. G. On 7/25/25 at 2:10 PM, during an interview with the UM #1, she stated R #10 uses bilateral bed rails for bed mobility. She stated she was unaware the resident had one bed rail in place and confirmed both the physician's order and the resident's care plan specified bilateral bed rails. UM #1 stated it was her expectation for staff to follow physician orders as written and not remove assistive devices.UM #1 stated physician orders, care plans and assessments must be completed and updated before any removal of assisted devices and failure to follow physician orders can result in injury to the resident.

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	07/25/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to utilize infection control practices for handling respiratory equipment for 1 (R #10) of 1(R #10) residents reviewed for respiratory services. This deficient practice is likely to place the resident at risk with cross contamination and the development of respiratory infections. The findings are: A. On 07/21/25 at 12:56 PM, during an observation of R #10's room, the resident's nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs) connected to an oxygen concentrator (device that concentrates the oxygen from a gas supply) sat directly on R #10's fabric covered bedding. B. On 07/24/2025 at 12:56 PM, during an observation of R #10's room revealed the resident's nasal cannula, connected to a running concentrator lay directly on resident's fabric bedding and draped over bed rail. C. On 07/25/25 at 2:04 PM, during an observation of R #10's room revealed resident's nasal cannula connected to concentrator, lay directly on the resident's bed with the nasal prongs touching the floor of the resident's room. D. Record review of R #10's Physician Orders, dated 02/06/24, revealed order for oxygen therapy. E. Record review of R #10's Care Plan dated 02/14/24, revealed the following: -Chronic obstructive pulmonary disease (progressive lung disease hindering airflow).-Resident to use call light during episodes of respiratory distress. -Oxygen via nasal cannula, 1-5 LPM (liters per minute). F. Record review of the Respiratory Therapy Prevention of Infection policy dated November 2024, revealed the following: -The policy is to guide the prevention of infection associated with respiratory therapy tasks and equipment. -Keep Oxygen cannula and tubing used in a plastic bag when not in use. -Change tubing every 7 days or as needed. G. During an interview, CNA #1 stated she changes the residents' nasal cannulas every other day. CNA #1 stated she wraps up the cannulas when not in use and places it on the resident's' concentrator. CNA #1 stated if a nasal cannula touches the floor, it should immediately be replaced with a new nasal cannula. She also stated improper storage of the nasal cannula could expose the residents to an illness. H. On 06/13/25 at 9:42 AM, during an interview, the Unit Manger (UM) stated staff must replace any nasal cannula touching the floor or any other surfaces to prevent respiratory illness. She stated when nasal cannulas are not in use, staff should wrap them up and secure the cannula and tubing to the concentrator. The UM stated the facility no longer uses bags to hold nasal cannulas and tubing. She stated it is her expectation for staff to replace the nasal cannula with a new one if it has touched the floor or any other surface, causing cross contamination.

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	07/25/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to a resident received appropriate treatment and services for dementia for 1 (R #44) of 1 (R #44) resident reviewed. This deficient practice could likely lead to residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. The findings are: A. Record review of R #44's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Epilepsy (a seizure disorder), 3. Heart Failure (a condition where the heart cannot pump enough blood to meet the body's needs), 4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), with agitation, 5. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety). B. Record review of R #44's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 05/01/25, revealed the following: 1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 13, cognitively intact. 2. R #44's short-term memory was ok so the prompts under this section were skipped (not answered). 3. R #44's long-term memory was ok so the prompts under this section were skipped. 4. All prompts under the Memory/Recall Ability section were skipped. 5. All prompts under Cognitive Skills for Daily Decision Making section were skipped. 6. Facility staff indicated that there is evidence of an acute change in mental status from the resident's baseline, but prompts are answered as the behavior was not present. C. Record review of R #44's current physician orders revealed an order dated 06/25/25 for Memantine HCl oral tablets to be given for R #44's diagnosis of dementia. D. Record review of R #44's care plan dated 04/18/25 revealed R #44 uses an antidepressant medication due to depression and dementia. No further goals or interventions for dementia were included in the care plan. E. Record review of R #44's care plan conference progress note dated 07/17/25 revealed R #44's plans for discharge are to remain in a long-term care setting. F. Record review of R #44's progress note dated 07/18/25 revealed R #44 was upset and spoke social services because he thought he was at the facility for rehab, not long term. G. On 07/21/25 at 10:30 am during an interview with R #44, he stated the facility does not help him with his dementia. R #44 said that he gets frustrated often because he forgets things and gets confused, but the facility staff just get mad at him. R #44 stated that he feels like the facility could help him with his memory problems instead of getting mad at him.

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	07/25/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on record review, observation and interview, the facility failed to ensure trash receptacles were covered to minimize odors and prevent pest or mice. If staff fail to keep trash cans closed both inside and outside the facility, then the environment may become unsanitary and increase the risk of pest infestation and disease transmission to residents.Finding are: A. Record review of the facility's Sanitation Policy, dated October 2024, revealed kitchen waste shall be kept in clean, leakproof, nonabsorbent, tightly closed containers.B. On 07/25/25 at 2:18 PM, observation revealed a dumpster located outside was uncovered. Further observation revealed the trash can lid in the kitchen was up, and trash was in the trash can and dumpster.C. On 07/25/25 at 2:18 PM, during an interview, the Kitchen Manager stated the outside trash cans must always remain closed to prevent flies and pests. The Kitchen Manager stated the kitchen trash can lid should be down. She stated it was her expectation for kitchen staff to follow the facility's Sanitation Policy.