STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRINCETON PLACE	500 LOUISIANA BOULEVARD NE ALBUQUERQUE, NM 87108

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on record review and interview, the facility failed to report incidents that had occured within 24 hours and failed to provide follow up report within 5 working days from the date of the incidents to the State Survey Agency, for 3 (R #'s 1,2 and 3) of 3 (R #'s 1,2 and 3) residents reviewed for incidents. If the facility fails to report incidents to the State Agency, then the State Agency will be unable to assure residents a safe and hazard free environment. The findings are: A. Record review of Health Facility Incident Report Case #VS 9774 with a date completed of 07/27/20 revealed, Date of Incident: 07/21/2020- Time of Incident: 07:00 pm. During surveillance of the outside perimeter, the resident (Name of R #1) reached into his own pocket retrieved money and put it in (Name of R #3) sock. Then pulled out a bag of an unknown substance from (Name of R #3) T-shirt pocket and placed it in his (R #1) pocket. Then (Name of R #2) went towards (Name of R #3) right side of his wheel chair and pulled out a cloth from behind his (R #2) back and unrolled a piece of cloth which contained a loaded needle containing a black substance, which he (R #2) continued to inject into the backside of (Name of R #3) right arm. On Saturday 07/25/20, the receptionist retrieved a food delivery for (Name of R #2) from a friend and over the (sic) heard the friend tell (Name of R #2) in Spanish 'to make sure to check his burger', the receptionist searched the food bag and found a small black bag with unknown substance, the receptionist notified the security guard. B. On 07/30/20 at 3:11 pm during an interview with the Administrative Assistant (AA), she stated, I've been here for a year and this is the first time that I have reported something like that (Health Facility Incident Report Case #VS 9774). We follow the guidelines from the DOH (Department of Health) on reportable's and they (DON (Director of Nursing)and Administrator (ADM)) guide me on what to report. AA confirmed that the incident report for each incident had recently been submitted and she was currently working on the 5 day follow up report for each incident. C. On 07/30/20 at 3:28 pm during an interview with Security Services (SS) #1, he stated, (Name of R #3), about a week prior, was caught with a lady injecting him and he was caught with stuff in a burrito. I got called to the social services because they caught the lady red-handed (having been discovered in or just after the act of doing something wrong or illegal) and they showed me the other burrito. It (burritos) was dropped off by someone who identified (Name of R #1) as her uncle. The incident on the on the video (smoking incident) was on 07/21/20 and the burrito incident was prior. The burger incident was on Sunday the 26th (07/26/20). SS #1 confirmed that a woman, who stated R #1 was her uncle, brought burritos to the facility that contained drug like substances in them prior to the smoking incident on 07/21/20. D. On 07/30/20 at 4:00 pm during an interview with the Director of Nursing (DON), she stated, So, in regards to the burrito (incident), no one owned up to it being theirs. On 07/16/20 was the burrito incident, it possibly was for (Name of R #1 and Name of R #2), but once it was brought in, nobody claimed it. Security found it. I don't know what was in the hamburger, I think that was the one that looked like a crystal substance. The burger and the burrito, no one owned up to it being theirs, but (Names of R #1 and R #2) implied that it involved them. On the burrito incident, I don't think there was a specific name on the burritos. On the burger (incident) it said (Name of R #2), but he said he was framed and he knew nothing about it. The smoking incident was on 07/21/20 and it says it was reported on 07/28/20. DON confirmed the burrito incident was on 07/16/20, the smoking incident was on 07/21/20, the burger incident was on 07/25/20, and all three incidents were reported together on 07/27/20. DON also confirmed all three drug related incidents should have been reported separately and sooner than they were originally reported, along with a 5 day follow up report.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the following was discovered: Two residents (R#1 and R#3) were observed: 1. R#1 and R#3 were residing in an admission quarantine unit (AQU) (a separate unit in which residents are monitored for possible infectious disease) 2. R#1 and R#3 were observed leaving their AQU and entering into a facility hallway that was not quarantined. 3. R#1 and R#3 were observed passing a nurses station where other non quarantined residents and staff were present. 4. R#1 and R#3 then exited the building into an open patio area where other non-quarantined residents were smoking 5. R#1 and R#3 joined these residents in the open patio area where they continued to smoke and congregate within 3 feet of each other. This resulted in Immediate Jeopardy being called on 07/31/20 at 2:47 pm. The Assistant Director of Nursing notified in person at this time. A first plan of removal was received on 08/01/20 at 10:06 pm and accepted on 08/02/20 at 1:26 pm. The facility Administrator was notified. The scope and severity was reduced from Level 4, K to Level 2, E. The plan of removal included: R's #1 and 3 are not staying in designated smoking areas or their quarantine unit and they don't adhere to social distancing. These residents were offered alternatives to smoking and their care plans updated 58 other smoking residents were identified as smokers. All were offered alternatives to smoking. 18 accepted alternate options and 40 refused. Those that chose to continue smoking were informed they could not smoke until they were released from quarantine period has been lifted. Staff was in-serviced regarding the smoking policy changes. An alternate smoking area that will be separate from and not require quarantined residents to pass through the open resident unit will be completed on or before 08/02/20 and staff will be in-serviced as to this unit. Compliance will be monitored daily and results presented to the Quality Assurance Performance Improvement Committee (a committee that monitors facility issues and activities and implements plans to review and improve identified issues.) Based on observation, record review and interview, the facility failed to ensure that 3 (R #s1, 2 and 3) of 3 (R #s1, 2, and 3) residents reviewed for isolation and quarantine practices complied with quarantine requirements. This deficient practice is likely to result in the spread of potentially deadly infectious diseases to other residents and staff. The findings are: Findings for R#1 A. Record review of R#1 face sheet reveals that R #1 was readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall), [MEDICAL CONDITION] (a condition marked by a deficiency of red blood cells or hemoglobin in the blood), Major [MEDICAL CONDITION], Opoid dependence, Chronic pain, [MEDICAL CONDITION] (habitual sleeplessness), and Pressure ulcer of sacral region, stage 1 (Injury to skin and underlying tissues resulting from prolonged pressure on the skin). B. Record review of physician's orders [REDACTED].#1 an order for [REDACTED]. Record review of daily care notes reveals that R#1 left the facility for outside appointments on 07/17/20, 07/21/20, 07/23/20 and 07/24/20. D. On 7/30/20 at 2:53 pm R #1 was observed in the non-quarantine designated smoking area sitting within 3 feet of other unidentified residents as they all smoked Findings

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) for R #2 E. Record review of face sheet for R #2 revealed a re-admission date of [DATE] and an original admission date of [DATE] with the following Diagnoses: [REDACTED]. F. Record review of physician's orders [REDACTED].#2 revealed the following:Start date: 07/22/20. End date: 08/05/20. Special instructions: For COVID precautions. G. On 07/31/20 at 11:00 am during an interview with Hospitality Aide (HA), he stated that R #2 is housed on one of the isolation floors and that R #2 smokes in the common area with other residents who are not on isolation precautions. He verified that there is only one entrance and one exit for all residents who smoke to access both the area designated for those residents on isolation precautions as well as the area for those residents who are not on isolation precautions. H. On 08/03/20 at 1:22 pm during an interview with Certified Nursing Assistant (CNA) #2, she stated that R #2 does not follow the quarantine orders and does not listen when staff redirect him. Findings for R#3 I. Record review of R#3 face sheet reveals that he was readmitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. J. Record review of R#3 daily care notes reveals that R#3 left the faciity on [DATE], 07/21/20, 07/23/20 and 07/30/20. K. Record review of physician's orders [REDACTED].#3 is on isolation droplet precautions due to possible COVID-19 exposure due to appointments outside of the facility L. On 07/31/20 at 10:50 am R #3 was observed passing through an open area past a nurse's station, down a hallway, into the common smoking area. He sat within three feet of other unidentified residents as he smoked unsupervised by staff. M. On 07/31/20 at 11:05 am during an interview with Hospitality Aide (HA) he stated that he was responsible for monitoring and observing residents as they smoked. He stated that he usually stood at the doorway and handed cigarettes to residents as the left the building and entered the smoking courtyard. He stated he was unaware of R #3's isolation precautions. N. On 07/31/20 at 11:05 am during an interview with Certified Medication Aide (CMA) #1 she confirmed that R #3 is on isolation precautions and that residents on isolation precautions were to be smoking in a designated area away from the common smoking area. O. On 07/30/20 at 3:58 pm during interview with Director of Nursing (DON) she stated that R #1 and 3 are consistently noncompliant and are resistant to comply with quarantine orders. She stated that R#1 and #3 continue to exit their assigned quarantine areas and walk around the hallways and out to the smoking area.