DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **325045**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/01/2014**

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 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to conduct a thorough investigation of two incidents for two Residents (R #1 and R #2) of two (R #1 and R #2); 1. a significant injury during a transfer causing a comminuted intertrochanteric fracture (a fracture in which the bone has broken into several pieces) for 1 (R #1) resident and 2. an injury of unknown origin for 1 (R #2) residents who sustained fractures to the second, third, and fourth metatarsals (the arch of the foot). If the facility does not conduct a thorough investigation as to what happened regarding injuries of unknown origin, then injuries to residents can go un-noticed. The findings are: Resident #1 A. Observations for Resident #1 revealed the following: 1. On 04/30/14 at 9:55 am, Resident #1 was observed to be seated in a wheelchair on the 700 unit. He was also observed to be hunched over, his head tilted to the side, and he was noted to have a contracture (a permanent shortening of a muscle or joint) to his left hand. When attempting to interview the resident, he was only able to communicate by raising his head up or down. 2. On 04/30/14 at 4:30 pm, the resident was seen sitting in his wheelchair on the 700 unit, leaning over to the left side with his head tilted to the side. 3. On 05/01/14 at 7:45 am, the resident was sitting in his wheelchair in the 700 day room unable to verbally communicate and leaning to the side. B. Review of the medical record for Resident #1 revealed the following: 1. [DIAGNOSES REDACTED]. 2. Nursing Progress Notes dated 04/03/14, indicated, At 1330 (1:30 pm) this writer (referring to Licensed Practical Nurse-LPN #1) returned from lunch and was told by Certified Nursing Assistant (CNA) #1 assigned to this patient that when putting (name of Resident #1) to bed, his leg gave out so I lowered him to the floor and the new CNA (referring to CNA # 2) helped me put him back to bed. 3. Nursing Progress Notes dated 04/03/14, indicated, At 1530 (3:30 pm) CNA (referring to CNA # 3 who was coming on evening shift) said patient was c/o (complaining of) pain to left leg.Left leg was externally rotated and swollen.Pt. (patient) c/o pain.Pt. medicated for pain. 4. Final X-ray Report dated 04/03/14, indicated, Views of the left hip show a comminuted intertrochanteric fracture. C. Hospital Record dated 04/03/14, indicated, The patient presents following fall.character of symptoms is pain and swelling.the degree at present is severe.The patient was being transferred by his caregivers when they accidentally dropped him onto his left side. The patient noticed immediate pain and swelling to his left hip.The patient has been in significant pain since the accident. D. Incident Report dated 04/04/14, for Resident #1 indicated the Type of Alleged Incident was Injury. The incident report further indicated that Resident was being transferred from w/c (wheelchair) to bed.Legs gave out-lowered to floor.c/o pain to L (left) hip. E. Incident Follow Up dated 04/08/14, for Resident #1 indicated that the facility did not conduct a thorough investigation as to what happened when Resident #1 sustained the comminuted intertrochanteric fracture which resulted in actual harm. F. On 04/30/14 at 11:45 am, during interview the Administrator stated, regarding the follow up investigation for (name of Resident #1), I didn't do the follow up. I was not here at the time and I asked (name of Registered Nurse (RN #3)) to help. This sheet (referring to the Incident Follow up) is all there is. I should have followed up with this investigation, but I did not. G. On 04/30/14 at 4:25 pm, during interview RN #3 stated, regarding the follow up investigation for (name of Resident #1), I did the follow up investigation. (Name of the Administrator) did the initial incident report dated 04/03/14 and I realize the follow up investigation should have been more thorough as to what happened to this resident and it wasn't. Resident #2 H. Observations for Resident #2 revealed the following: 1. On 04/30/14 at 9:30 am, and at 10:17 am, Resident #2 was observed to be laying in bed with two half side rails in the up position. 2. On 05/01/14 at 8:16 am, Resident #2 was observed sitting in her wheel chair by the front entrance of the facility. I. Review of the medical record for Resident #2 revealed the following: 1. [DIAGNOSES REDACTED]. 2. Nursing Progress Notes dated 01/02/14, revealed Resident laying on floor on her stomach with head on carpet in hallway and rest of body near bathroom. C/O left ankle pain. Painful to movement noted ankle swollen. 3. Nursing Progress Notes dated 01/11/14, indicated, Found laying on floor on left side next to roommates bed. C/O right foot pain. 4. Nursing Progress Notes dated 01/12/14, indicated, Unable to put wt (weight) on feet. 5. Nursing Progress Note dated 01/12/14, indicated Client with increased pain to right foot. J. Incident Report dated 01/15/14, indicated the Type of Alleged Incident is injury-fx (fracture). The incident report further indicated that Resident #2 had two falls recently on 01/02/14 and on 01/11/14.continued to have pain. X-ray of R (right) toes indicated fx of right three toes. K. Final X-ray Report dated 01/14/14, indicated a portable left foot x-ray was completed which identified Fractures of the bases of the second, third, and fourth metatarsals. L. Incident Report Follow up dated 01/22/14, for Resident #2 indicated that the facility did not conduct a thorough investigation regarding the injuries that Resident #2 sustained. In addition, the Incident Report follow up was very inconsistent with identifying whether Resident #2 sustained a fracture to the right or left foot. M. On 05/01/14 at 10:25 am, during interview the Administrator stated, I submitted the follow up investigation (regarding Resident #2), but what I submitted (referring to the Incident follow up document) to the Department of Health, did not portray that a thorough follow up investigation had been done.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure 1 (R #1) of 1 (R #1) residents received adequate supervision and assistance from staff to prevent an accident in which the resident was being transferred from the bed to a wheelchair. The facility also failed to ensure a nursing assessment was immediately conducted when the resident was on the floor and prior to being moved. The resident was then transferred from the floor back to the wheelchair without an assessment being completed. The resident complained to the staff about being in pain and no pain assessment was documented. No prescribed pain medication was administered when the initial fall occurred earlier in the day. The resident was sent to the hospital in extreme pain. This deficient practice likely caused the resident significant pain as well as a left comminuted intertrochanteric femur fracture (a fracture in which the bone has broken into several pieces) that required surgical intervention. The findings are: A. Observations for Resident #1 revealed the following: 1. On 04/30/14 at 9:55 am, Resident #1 was observed to be seated in a wheelchair on the 700 unit. He was also observed to be hunched over, his head tilted to the side, and he was noted to have a contracture (a permanent shortening of a muscle or joint) to his left hand. When attempting to interview the resident, he was only able to communicate by raising his head up or down. 2. On 04/30/14 at 4:30 pm, the resident was seen sitting in his wheelchair on the 700 unit, leaning over to the left side with

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **325045**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/01/2014**

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F 0323

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
his head tilted to the side. 3. On 05/01/14 at 7:45 am, the resident was sitting in his wheelchair in the 700 day room unable to verbally communicate and leaning to the side. B. Review of the medical record for Resident #1 revealed the following: 1. [DIAGNOSES REDACTED]. 2. Physicians Orders dated 11/21/12, indicated Acetaminophen 325 mg (milligrams) orally
one or two tablets q (every) 4-6 hours prn (as needed) for mild pain. 3. Care Plan initiated 02/26/13, indicated Resident is at risk for falls r/t (related to) impaired balance.and unsteady gait. 4. Physicians Orders dated 02/19/14, indicated Vicodin (a narcotic) 5-300 mg one tablet by mouth every six hours prn for.pain. 5. Quarterly Minimum Data Set ((MDS) dated [DATE], indicated Resident #1 has a short term and long term memory problem and his cognitive skills for daily decision making are moderately impaired. The MDS further indicated Resident #1 is 71 inches tall, weighs 190 pounds, and requires extensive assistance for Activities of Daily Living (ADLs) to include bed mobility, transferring, dressing, eating, toilet use and personal hygiene.and is not steady for balance. He is only able to stabilize with staff assistance for moving from a seated to standing position and for surface to surface transfers. It further indicated that the resident has a functional limitation in range of motion in both the upper and lower extremities. 6. Nursing Progress Notes dated 04/03/14, indicated At 1330 (1:30 pm) this writer (referring to Licensed Practical Nurse-LPN #1) returned from lunch and was told by Certified Nursing Assistant (CNA) #1 assigned to this patient when putting (name of Resident #1) to bed, his leg gave out so I lowered him to the floor and the new CNA (referring to CNA # 2) helped me put him back to bed. The nursing progress notes indicated no documentation that a nursing assessment was completed by LPN #1 when she was being made aware by CNA #1 that the resident was on the floor. 7. Nursing Progress Notes dated 04/03/14, indicated At 1530 (3:30 pm) CNA (referring to CNA # 3 who was coming on evening shift) said patient was c/o (complaining of) pain to left leg.Left leg was externally rotated and swollen.Pt. (patient) c/o pain.Pt. medicated for pain. 8. Nursing Progress Notes dated 04/03/14, indicated that Acetaminophen 2 tablets was given to the resident at 4:30 pm (this was three hours later from when CNA #1 indicated she told LPN #1 he was having pain). The Nursing Progress notes indicated that no pain medication including Vicodin or Tylenol (which was available for administration) was documented as ever being administered to the resident when LPN #1 was initially told by CNA #1 that the resident was complaining of pain at 11:00 am. 9. Final X-ray Report dated 04/03/14, indicated, Views of the left hip show a comminuted intertrochanteric fracture. 10. Intervention/Task Document dated 04/03/14, indicated that Resident #1 was transferred by one CNA (CNA #1) on the day shift. It further indicated that no pain assessment was documented by LPN #1 as being completed on 04/03/14 for the day or evening shift. 11. Q Shift CNA chart reporting document dated 03/04/14, indicated that during the day shift, Resident #1 was transferred with only One person physical assist. 12. Medication Administration Record (MAR) dated April 2014, indicated that Vicodin was not administered to the resident until 7:23 pm (almost eight and a half hours later). C. Hospital Record dated 04/03/14, indicated, The patient presents following fall.character of symptoms is pain and swelling.the degree at present is severe.The patient was being transferred by his caregivers when they accidentally dropped him onto his left side. The patient noticed immediate pain and swelling to his left hip.The patient has been in significant pain since the accident. D. Admitting Hospital Radiology Report dated 04/03/14, indicated Comminuted displaced left intertrochanteric fracture. E. On 04/30/14 at 10:45 am, during interview LPN #2 stated, For transfers, we use maximum two person assist and I don't think he (referring to Resident #1) can bear any weight. We always used two people with him because he is a heavy transfer (meaning he is a tall and heavy man). F. On 04/30/14 at 10:50 am, during interview, CNA #3 stated that she came on the evening shift at 3:00 pm on 04/03/14, and wasn't told anything in change of shift report from the off going CNA (referring to CNA #1). So, When I went to get him (referring to Resident #1) up before dinner, as I was putting his shoes on and I was raising his left leg, and he was screaming in pain. This was around 4:00 pm. Prior to this, I wasn't told anything. If you knew how to work with him and knew how to transfer him, usually I could get him up by myself. But, if you were someone who hardly worked on this unit or were new, it would be a lot harder. Now we have to transfer him in the Hoyer lift (A mechanical device used to transfer). G. On 04/30/14 at 1:35 pm, during interview CNA #1 stated that she has worked with Resident #1 before and, We have always used a two person transfer with him because he is heavy. The CNA then stated, At about 11:00 am, I started getting him up. The other CNA (referring to CNA #4) was busy getting people up and I couldn't find the orientee (referring to CNA #2) and I needed to get him (the resident) up. I went and looked down the hall and I couldn't find anybody else. So, I sat him (the resident) up at the edge of the bed and I got his weaker side which was his right leg. I grabbed his left side and I picked him up and tried to transfer him by myself and I guess his leg buckled and it gave out. He couldn't bear any weight. I sat him down on the floor on the right side. I walked out of the room and left him on the floor. I couldn't find anyone on the floor to help me. They were on break or attending other residents. I let the nurse (referring to LPN #1) know that his knee buckled and that I sat him on the floor. The nurse said 'ok thanks for telling me.' I had to go look for CNA #2 and CNA #4 to help me. So me, (name of CNA #2 and CNA #4) then got him up off of the floor. We used three people to get him up to his wheelchair. I never saw the nurse (referring to LPN #1) go in the room when he (Resident #1) was on the floor. I then took him to the dining room. At lunch, I went to start to feed him and he was saying 'owe, owe'. I asked him where at. He said 'my leg'. I told the nurse again (referring to LPN #1) that he (Resident #1) is now saying his leg hurts. She said she would give him some Tylenol. Then, I went and had CNA #2 help me lay the resident back down in bed. This was after lunch. This was about 1:45 pm. Both me and CNA #2 did a arm to arm transfer and I grabbed his legs and we laid him (Resident #1) on the bed and swinged (sic) him over and laid him down. He was saying his leg hurts. I then told him (Resident #1) that I was going to change him and I asked him if he could pick up his butt to help me. He was curled up more on his left side. At this time, he was saying 'Owe, it hurts' I asked him what hurts? He didn't say anything. So, I then log rolled him on the left side and he was saying 'Owe'. I then rolled him to the other side and pulled down his pants and he was saying 'Owe. This time, he wasn't able to help me lift his butt and usually he is. Then, I told the nurse that he is still saying his leg hurt and she said she would give him some more Tylenol. Again, I never saw the nurse (referring to LPN #1) go in his room. At about 2:30 pm, was when CNA #3 came in. I did not let her know that I had to sit the resident on the floor or him having pain (referring to Resident #1). When she was asked why? she stated, I was in a rush and we (both CNA #1 and #3) didn't click. I didn't let her know about him having pain at all. Then I left at 3:00 pm. H. On 04/30/14 at 2:25 pm, during interview RN #2 stated, With (name of Resident #1) regarding his pain, it looks like he was only given Vicodin one tablet at 7:23 pm and then was given Tylenol at 8:30 pm on 04/30/14. That was the only medications that were given to him before he went out to the hospital that evening. I'm not seeing anything documented on the MAR being given before then. If a resident falls, the nurse is then supposed to go into the room with the CNA to do an assessment and the CNA will do vital signs. The resident should not be moved until we, as the nurses, have the opportunity to assess the resident. The day nurse (referring to LPN #1) did not chart on the pain assessment anything about the residents pain. That would have been also on the progress notes or incident report and I'm not seeing that documented either. There was no pain assessment documented. That would be an expectation of the nurses to do so. I'm not seeing anything documented for his pain. I. On 04/30/14 at 3:20 pm, during interview LPN #1 stated, The CNA (referring to CNA #1) told me when I was coming back from lunch (don't remember the time) that she had to ease the resident (referring to Resident #1) down to the ground. He is a very tall man and sometimes the transfer is difficult. She had another CNA help her put him back to bed. I did my assessment later on. It was at the change of shift about 2-2:30 pm when I did my first assessment. The evening CNA (referring to CNA #3) went to get him up and he was saying he was having a lot of pain. I went in his room and he was having a lot of pain on his leg and it looked swollen. He couldn't say what happened. He shook his head when I asked him if he was in pain and I could tell he was hurting really bad. When the CNA (referring to CNA #1) told me his leg buckled earlier on in the day, I took it as that's when she was putting him back to bed. Prior to 2-2:30 pm, I didn't do an assessment on him because I thought he was ok and I saw he was eating in the dining room and I thought he was fine. All I know is, it was so busy that afternoon. Later on, is when I went to do my assessment. He is a difficult transfer. He used to be a one person but sometimes depending on the staff, they will have to get help because he is a tall and heavy man. When someone falls, a nurse is supposed to be there to assess the patient. The CNAs can't move the person until we do our assessment, then if they are ok, they can be put back to bed. J. On 04/30/14 at 3:45 pm, during interview CNA #2 stated, I recall (name of CNA #1) asked me for help to lift the resident off the floor and at that time all three of us (CNA #1, #2, and #4) helped pick him up off the floor. He was sitting on his butt. We did a three person transfer and transferred him to his wheelchair. Then we took him to lunch. After lunch, (name of CNA #1) and I laid him down and I left. K. On 04/30/14 at 3:50 pm, during interview RN #2 stated, On 04/03/14, (the date of the incident) there was no assessment done by the nurse for pain. The nurse did not chart any pain for 04/03/14. From looking at the nursing pain assessment, there was nothing documented during the day shift of 04/03/14 or on the evening shift of 04/03/14. L. On 05/01/14 at 8:15 am, during interview RN #2 stated, On the CNA transfer sheet, the CNA (referring to CNA #1) charted that she did a one person transfer

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	325045	A. BUILDING ______ B. WING _____	**05/01/2014**

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) on the morning of 04/03/14. It indicated that she transferred him with only one person even though the record indicated for him to be a two person transfer. M. On 05/01/14 at 9:00 am, during a second interview, LPN #1 stated that she did look at Resident #1 when she got back from lunch, but that he was already in the dining room. She indicated, I didn't think it was anything urgent until the oncoming CNA (referring to CNA #3) came on and said he was in pain. Earlier on in the day, I just assumed that someone else (referring to another nurse) was told that he was on the floor and that there was a problem. The first time I would have given him any Tylenol was about 4:30 pm. I do recall she (referring to CNA #1) told me he (Resident #1) was having pain at 2:30 pm, and the first time I gave him any pain medication was at 4:30 pm. It was at the change of shift and it was hectic. At 4:30 pm, he shook his head that he was in pain and had his head covered up. I just couldn't get down there to his room to give the medication to him any sooner. If I did go to lunch at 1:00 pm, that was the first thing I was told by (name of CNA #1) that she had lowered him to the ground and she couldn't transfer him. She did tell me that she had to get help to get him up. But when I saw him, he was already in the dining room. Prior to this, most of the CNAs that work the unit use a two person transfer to transfer him. On this day, (name of CNA #1) didn't work on that unit very much. N. On 05/01/14 at 9:12 am, during interview, the Physical Therapist stated, From what I was getting from the staff was that he (Resident #1) was pretty dependent on staff for transfers especially on the left side because he was contracted. Sometimes, I would hear from staff that he could stand on the right leg and then sometimes not. I don't think he could have put much weight on the left side though. O. On 05/01/14 at 10:04 am, during interview CNA #4 stated, Right before lunch on the day of the incident (referring to 04/03/14) (name of CNA #1) came and got me and (name of CNA #2) and asked if we could help her. When we walked in his (Resident #1's) room, he was already on the floor. He was not saying anything. At that point, she (CNA #1) and (name of CNA #2) transferred him from the floor to the wheelchair. I pushed the wheelchair underneath him to sit on. After that, I left the room. I did not see the nurse ever go in the room before we moved him. I never saw her come in the room at all. When the three of us moved him from the floor to the wheelchair, he was just quiet and didn't say anything. He was then taken to the dining room and I don't know if he was complaining of pain. I was with other residents. When the evening CNA (referring to CNA #3) came in, he was complaining of pain and yelling before dinner time. He wasn't able to say what or where. Our process is, that if someone is on the floor, we are supposed to call the nurse and they are supposed to examine the resident before getting the resident up. Then, if they are fine, we can transfer them back to bed and get a full set of vitals. Again that day, I did not see the nurse physically go in the room or asking for the three of us to wait before moving him off the floor. Usually when I worked with (name of Resident #1), I got two people to transfer him because he was heavy even for me to transfer him, and usually his legs buckled. I would always get another person to help me transfer him. P. Review of the Fall Prevention and Management Policy and Procedure dated 10/08/13 indicated: If a resident falls, the following steps shall be taken; assess the resident post fall including vitals signs, level of consciousness, presence of pain, presence of other injuries, obtain assistance to lift uninjured resident.