STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325034	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Albuquerque	5900 Forest Hills Drive NE Albuquerque, NM 87109

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on record review and interview, the facility failed to follow a physician's order and professional standards of practice for 1 (R #1) of 1 (R #1) residents reviewed for medication administration. This deficient practice could likely cause staff to incorrectly administer a medication, which could cause the gastronomy tube (g-tube; a tube inserted through the belly that brings nutrition directly to the stomach) to clog and or incompatible medications to be administered together. The findings are: A. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 02/19/24, revealed the following: - The resident was admitted to the facility on [DATE]; - The resident was diagnosed with traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head), cerebrovascular accident (CVA; stroke), and transient ischemic attack (TIA; when blood flow to part of the brain stops for a brief period of time). B. Record review of R #1's careplan, dated 01/01/2024, revealed the resident had an enteral (food or drug administration via the human gastrointestinal tract) g-tube to meet nutritional needs. C. Record review of R #1's medical record revealed the following physician orders: - An order, dated 12/28/23, to flush the g-tube with 30 milliliters (mL) of water before and after each medication pass and 15 mL of water in between each medication administered via the g-tube. - An order, dated 12/29/23, dantrolene (treats muscle spasms) 25 milligrams (mg), three times daily. Administer crushed with water via g-tube. Donepezil (cognition-enhancing medication) 5 mg, at bedtime. Administered crushed with water via g-tube. Tylenol (pain relief) 650 mg, four times daily. Administered crushed with water via g-tube. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Record review of a video supplied by R #1's Power of Attorney (POA; appointed person that can make legal/medical decisions for another person), which recorded all care for R #1 and was installed by R #1's POA, showed on 4/24/24 at 9:16 pm, RN #1 entered R #1's room and administered three medications at the same time via a 50 mL syringe into the resident's g-tube. Review also showed RN #1 did not flush the g-tube prior to or after administering the three medications, and RN #1 gave all three medications at the same time from the same syringe. E. Record review of the Medication Administration Record (MAR) for R #1 revealed the following: - On 04/24/24, Registered Nurse (RN) #1 administered dantrolene, 25 mg, at 9:17 pm. - On 04/24/24, RN #1 administered donepezil, 5 mg, at 9:17 pm. - On 04/24/24, RN #1 administered Tylenol, 650 mg, at 9:17 pm. F. Record review of a peer reviewed article titled, Preventing Errors When Drugs Are Given Via Enteral Feeding Tubes, dated October 2013, by the National Institute of Health, stated each medication should be prepared individually so it could be administered separately. The article also stated after the drug is delivered, the tube should be flushed with at least 15 mL of purified water before and after each medication is given. G. On 05/15/24 at 12:00 pm, during an interview with the Director of Nursing (DON), he stated all employees are required to follow physician orders and medication administration professional standards of practice regarding medication administration via g-tube. The DON stated this included flushing the g-tube before medication administration, administering one medication at a time, flushing the g-tube with 15 mL of water in-between each medication administration, and flushing the g-tube when finished. The DON stated RN #1 gave R #1 more than one medication at a time and did not flush the g-tube as ordered.