STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325048	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO ON ACADEMY (THE)	10500 ACADEMY ROAD NE ALBUQUERQUE, NM 87111

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.** Based on record review and interview, the facility failed to ensure that incidents of falls with injury resulted in an incident report being filed, a follow-up investigation conducted, and a report to the state licensing agency being submitted for 1 (R #5) of 9 (R #s 1, 2, 3, 4, 5, 6, 7, 8 and) residents reviewed for incidents. This deficient practice has the potential to prevent staff from determining the cause of the incident, identifying the need for staff training and implementing needed changes. The findings are: A. Record review of the May 2016 Incident Log revealed that R #5 had a fall and sustained a clavicle fracture. B. Record review revealed that no Incident Report had been filed, no follow-up investigation conducted and no report was made to the state licensing authority. C. Record review of facility Incident Reporting Policy dated 11/14/15 indicated the following: Reportable incidents: any fall resulting in a significant injury (i.e. sutures/staples, fracture, dislocation) .The facility Administrator is responsible for notifying the following individuals/agencies of all reportable incidents/accidents: appropriate agencies as required by state-specific regulations. D. On 08/12/16 at 8:10 am, during interview with the Administrator, she stated that she was unable to find an incident report or evidence that the report was submitted to the state agency. She stated that at the time of the incident, the facility did not have a Director of Nursing and that this would have been the person to ensure that an incident report was conducted and report to the state filed and that this had not been done for the incident involving R #5
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** Based on record review and interview, the facility failed to implement their policy and procedure regarding incident reporting for a fall with injury by not completing a follow-up investigation and not reporting the incident to the state licensing agency for 1 (R #5) of 9 (R #s 1, 2, 3, 4, 5, 6, 7, 8 and 9) residents reviewed for incidents. This deficient practice has the potential to prevent staff from determining the cause of the incident, identifying the need for staff training and implementing needed changes. The findings are: A. Record review of the May 2016 Incident Log revealed that R #5 had a fall and sustained a clavicle fracture. B. Record review revealed that no Incident Report had been filed, no follow-up investigation conducted and no report was made to the state licensing authority. C. Record review of facility Incident Reporting Policy dated 11/14/15 indicated the following: Reportable incidents: any fall resulting in a significant injury (i.e. sutures/staples, fracture, dislocation) .The facility Administrator is responsible for notifying the following individuals/agencies of all reportable incidents/accidents: appropriate agencies as required by state-specific regulations. D. On 08/12/16 at 8:10 am, during interview with the Administrator, she stated that she was unable to find an incident report or evidence that the report was submitted to the state agency. She stated that at the time of the incident, the facility did not have a Director of Nursing and that this would have been the person to ensure that an incident report was conducted and report to the state filed and that this had not been done for the incident involving R #5
F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents received care and services to achieve their highest physical well-being, for 1 (R #1) of 10 (R #s ,[DATE]) residents sampled during a complaint investigation. A resident with documented dysphagia (difficulty in swallowing) was not provided with a modified-consistency diet and was not closely monitored or instructed by trained family or staff during mealtime. This deficient practice likely resulted in the resident choking on food, resulting in respiratory arrest (failure to breathe), [MEDICAL CONDITION] (cessation of heartbeats), and her subsequent death. The findings are: A. Record review of R #1's SBAR (Situation, Background, Assessment, Request) Communication Form dated [DATE] and completed by RN #1, found a Nursing Note section stating Resident was being fed by her (family member, FM #1). I was passing out trays. (CNA #2) came to my side of dining room and said we need your help. I came to that side and found resident choking and (CNA #2) doing abdominal thrust. I then said let me try. Resident had a glass of milk in hand and was attempting to take a drink. She became limp and glass was dropped. I instructed CNAs to call 911 and get other nurses. I then attempted abdominal thrusts to no effect. (LPN #2) arrived and attempted thrust as well as (RN #2). When we were unsuccessful, we laid her down on the floor. (RN #2) did a finger sweep and removed some food. A rescue breath was attempted to no effect. Another finger sweep was attempted with more food removed. Chest thrust were then initiated by (RN #2) until he was tired then relieved by (CNA #3) and then relieved by (RN #1). Chest compressions were continued until EMT (paramedics) arrived. EMT were eventually able to get heart started and a BP (blood pressure). At this time they transported her to (name of hospital.) B. Record review of R #1's hospital Critical Care Consultation/Admission form, dated [DATE], found statements indicating: 1. History of Present Illness: (name of R #1) is an 82 y.o. (year old) female admitted on [DATE] after respiratory arrest associated with choking episode. Per EMS (paramedics) patient currently resides at (facility), earlier this evening while eating dinner staff states that she choked. They administered CPR (cardio-pulmonary resuscitation) and called 911, when EMS arrived they were able to clear the obstruction but immediately after, she was in [MEDICAL CONDITION]. She was intubated (breathing tube inserted) . The patient was transported to the ER (emergency room) . 2. Assessment/Plan: Acute (sudden) [MEDICAL CONDITION] s/p (following) respiratory arrest following choking episode. Vent (ventilator, a breathing machine) support . Shock post (following) [MEDICAL CONDITION]. 3. Addendum: Pt's (Patient's) husband brought to the hospital by family. We discussed her poor prognosis in light of underlying disease, potentially prolonged [MEDICAL CONDITION] (time without oxygen), and current condition (shock, [MEDICAL

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 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) CONDITION]). They felt that she would not want continued life support given this situation and asked that she be extubated (breathing tube removed) and made comfortable. C. Record review of R #1's physician's telephone orders found: 1. An order dated [DATE] stating: ST (speech therapy) order to eval (evaluate) and tx (treat) as indicated (name of speech therapist). 2. An order dated [DATE] stating: ST clarification order: Pt to receive skilled ST services 5x/wk (5 times weekly) QD x (daily for) 30 days for cognitive-linguistic (communication) skills tx (name of speech therapist). 3. An order dated [DATE] stating: ST addendum to clarification order dated [DATE]: Pt to also receive skilled dysphagia tx 5x/wk QD x 30 days (name of speech therapist). 4. An order dated [DATE] stating: ST clarification order, correction for orders dated [DATE]: Pt to receive skilled ST services 5x/wk QD x 60 days (starting on [DATE]) for dysphagia tx, cognitive-linguistic skills tx (name of speech therapist). 5. An order dated [DATE] stating: ST dysphagia tx order: NO straws due to aspiration risk and pt's decreased attention span (name of speech therapist). D. Record review of R #1's care plan, dated [DATE], found that the Eating/Nutrition section found no references to the resident's dysphagia. The focus section listed only DMII (Diabetes mellitus, type 2) as a concern. The only goal listed was I will be given foods that I enjoy and am familiar with daily. Interventions included Therapy provided as ordered, but no specific interventions to address the resident's dysphagia or choking potential. E. Record review of R #1's Dysphagia Medical Workup form, dated [DATE] and signed by the Nurse Practitioner found checkmarks indicating that the resident was at risk for various types of aspiration, nasal regurgitation (vomiting), choking, frequent coughing up food during swallow, delayed or slow swallow reflex, and wet or gurly (sic) voice quality after swallowing of liquids. Suspected Pharyngeal (throat) Phase Deficits section had checkmarks for choking/coughing and delayed/impaired swallow reflex. F. Record review of R #1's four Dietary Communication forms found that none instructed the dietary department to alter the consistency of her diet. Communications were: 1. A form dated [DATE] (the resident's date of admission) stating that her diet was to be CCHO (Consistent Carbohydrate diet; a diabetic diet) with regular consistency. 2. A form dated [DATE] stating Dysphagia treatment order with the notation No straws due to aspiration risk (risk of food or fluids entering the lungs) and pt's decreased attention span. 3. A form dated [DATE] stating Select menu please, per family request (no desserts, please.) 4. A form dated [DATE] stating Please include diet cola with cup of ice and lid for lunch and dinner meals per patient request. No straws. G. Record review of Speech Therapist daily treatment notes indicated: 1. A note dated [DATE] stating Pt tolerated 75% of her lunch meal of regular diet texture with thin liquids with no overt clinical s/s (signs and symptoms) of penetration/aspiration, however after her meal she began coughing and choking profusely on thin liquids. Will train pt and staff to perform safe swallow strategies. 2. A note dated [DATE] stating Bedside dysphagia evaluation completed with pt exhibiting decreased oropharyngeal (mouth and throat) motor (muscle) control and decreased oral motor strength and ROM (range of motion) for musculature (muscles) for swallow. Plan of care developed and skilled treatment recommended for decreasing dysphagia, increasing safe swallow function, training pt and caregivers to perform safe swallow strategies. 3. A note dated [DATE] stating (in part) Pt made (moderate) attempts to clear her throat when she produced a wet voice quality and stated 'This is a problem for me sometimes,' pointing at and then touching her throat, saying, 'Sometimes I feel like something's caught.' 4. A note dated [DATE] stating Good response to therapy. Pt demonstrated tolerance for 50% of her dinner meal of meatloaf with gravy, sauteed vegetables and mashed potatoes, with no overt clinical s/s of penetration/aspiration. Pt did exhibit wet voice quality post-swallow, therefore provided education and training on use of effortful swallow to clear pharyngeal (throat) secretions. Pt was able to follow these directions with (moderate) level w/ (with) verbal and visual cues, and achieved a clear voice quality after ,[DATE] (5 of 5) trials. H. Record review of Speech Therapy Plan of Care dated [DATE] found the statements: 1. Therapy necessary to decrease dysphagia, increase safe swallow function, train patient and caregivers with safe swallow strategies, increase cognitive-linguistic skills . 2. Performed bedside swallow evaluation with patient exhibiting no deficit in timing/coordination of swallow with palpation of dry swallow, however she did exhibit oral motor musculature weakness and mild delay of initiation of swallow. 3. Swallowing, Lingual (tongue) Function: Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent supervision for carryover). 4. Swallowing, Mandibular (jaw) Function: Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent supervision for carryover). 5. Swallowing, Soft Palate Function: Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent supervision for carryover). 6. Swallowing, Sensation of Lips/Oral Cavity: Minimal impairment (,[DATE]% impairment; risk of trace aspiration, diet may need modified due to medical/dental status.) 7. Swallowing, Sensation of Oral Pharynx (throat): Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent supervision for carryover). 8. Swallowing, Respiratory Coordination: Mildly impaired. 9. Swallowing, Formation of Bolus (wad of food for swallowing): Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need m (statement not completed). 10. Swallowing, Choking: Reported by caregivers. 11. The patient performs pharyngeal strength and ROM (Range of Motion) exercises given 50% assistance with visual and verbal instruction/cues and repetition to initiate a full and complete pharyngeal swallow with mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped; cueing and intermittent supervision for carry-over) with SLP (speech-language pathologist) in a functional structured therapy session. 12. Long Term Goals: The patient will follow safety strategies for safe swallow function with 100% accuracy with verbal instruction/cues with assistance from caregiver and VMAs (written instructions) for all intakes. 13. SLP (Speech Language Pathology) has provided training for patient and for (FM #1) to encourage patient to perform effortful swallow to clear pharyngeal residue post-swallow, however pt continues to require 50% assistance with visual and verbal cues, repetition to perform this maneuver. SLP wrote an order for [REDACTED]. I. On [DATE] at 9:18 am, during interview with the Speech Therapist, she stated that she had done an evaluation of R #1 on admission, and had found her to have a marked cognitive (thinking) impairment. She stated that R #1 was able to feed herself, but that she had changed her diet to a chopped consistency. She stated that she had found that R #1 had decreased mouth and throat muscle strength. She also noticed a decreased attention span, and that while eating, R #1 would forget what she was doing and would need a lot of cueing as a result. She stated that she had written an order for [REDACTED].#1 to teach techniques that would encourage R #1 to swallow safely. J. On [DATE] at 9:30 am, during interview with the Speech Therapist, she stated that she had been unable to find a telephone order or Dietary Communication form for R #1 to indicate a change to a chopped diet, but that she was sure that she had spoken to the Dietary Manager about it. She stated that she and the Dietary Manager had had frequent discussions about R #1's needs. Further review of R #1's medical record by the Speech Therapist revealed that she had eaten a roast beef sandwich for one meal, which, the Speech Therapist concluded, meant that the diet order hadn't been changed. The Speech Therapist then stated that she hadn't changed the diet because the family didn't want her on a chopped diet. She further stated that trials of a chopped diet were being conducted, intermittently, with R #1. She indicated I don't want to speculate on what happened when she choked. I'm not a doctor. K. On [DATE] at 10:29 am, during interview with the Dietary Manager, he stated that he did not recall ever having spoken with the Speech Therapist about modifying R #1's diet consistency. He stated that diet changes are always relayed to him on a Dietary Communication form. He stated that trials of a different consistency are only attempted when a staff person was

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) working directly with the resident, in order to assess the effectiveness of the change. L. On [DATE] at 11:25 am, during interview with the Speech Therapist, she stated I'm not going to comment on my statement that the family requested that she not have a chopped diet, because I don't have any documentation of it. I'm sorry I opened my mouth. She stated that she had completed the Dysphagia Medical Workup form and given it to the Nurse Practitioner to sign, but had not had a discussion with the Nurse Practitioner about any diet changes. M. On [DATE] at 11:48 am, during interview with the Nurse Practitioner, she reviewed R #1's Dysphagia Medical Workup form, and confirmed that it had been completed by the Speech Therapist, and given to her (the Nurse Practitioner) to sign on [DATE]. She stated that, given the choking risk indicated on the form, she would have expected that the resident would already have been placed on a pureed or chopped diet. She stated that she leaves the specific consistency decision to the Speech Therapist, because it is her area of expertise. N. On [DATE] at 2:21 pm, during interview with R #1's husband, he denied that the facility had ever spoken with him about modifications to her diet. O. On [DATE] at 3:35 pm, during interview with FM #1, who is a nurse, she confirmed that she had been visiting with R #1 at the time of the choking incident. She stated that R #1 had been on a regular diet, not mechanical soft or anything, and at the time of choking had been eating a chicken thigh. She said that R #1 would usually choose softer items to eat when she was alone, because cutting and swallowing food was difficult for her, and that, due to embarrassment, she was resistant to having someone cut up her food for her at the table in the dining room. She stated that she believed that R #1 would have benefited from a chopped or pureed diet, but that the facility had never spoken with her about it. FM #1 denied that she had ever received any training or direction from the Speech Therapist on assisting R #1 to eat.
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 record review and interview, the facility failed to ensure that residents received care and services to achieve their highest physical well-being, for 1 (R #1) of 10 (R #s ,[DATE]) residents sampled during a complaint investigation. A resident with documented dysphagia (difficulty in swallowing) was not provided with a modified-consistency diet and was not closely monitored or instructed by trained family or staff during mealtime. This deficient practice likely resulted in the resident choking on food, resulting in respiratory arrest (failure to breathe), cardiac arrest (cessation of heartbeats), and her subsequent death. The findings are: A. Record review of R #1's SBAR (Situation, Background, Assessment, Request) Communication Form dated [DATE] and completed by RN #1, found a Nursing Note section stating Resident was being fed by her (family member, FM #1). I was passing out trays. (CNA #2) came to my side of dining room and said we need your help. I came to that side and found resident choking and (CNA #2) doing abdominal thrust. I then said let me try. Resident had a glass of milk in hand and was attempting to take a drink. She became limp and glass was dropped. I instructed CNAs to call 911 and get other nurses. I then attempted abdominal thrusts to no effect. (LPN #2) arrived and attempted thrust as well as (RN #2). When we were unsuccessful, we laid her down on the floor. (RN #2) did a finger sweep and removed some food. A rescue breath was attempted to no effect. Another finger sweep was attempted with more food removed. Chest thrust were then initiated by (RN #2) until he was tired then relieved by (CNA #3) and then relieved by (RN #1). Chest compressions were continued until EMT (paramedics) arrived. EMT were eventually able to get heart started and a BP (blood pressure). At this time they transported her to (name of hospital.) B. Record review of R #1's hospital Critical Care Consultation/Admission form, dated [DATE], found statements indicating: 1. History of Present Illness: (name of R #1) is an 82 y.o. (year old) female admitted on [DATE] after respiratory arrest associated with choking episode. Per EMS (paramedics) patient currently resides at (facility), earlier this evening while eating dinner staff states that she choked. They administered CPR (cardio-pulmonary resuscitation) and called 911, when EMS arrived they were able to clear the obstruction but immediately after, she was in cardiac arrest. She was intubated (breathing tube inserted) . The patient was transported to the ER (emergency room) . 2. Assessment/Plan: Acute (sudden) respiratory failure s/p (following) respiratory arrest following choking episode. Vent (ventilator, a breathing machine) support . Shock post (following) cardiac arrest. 3. Addendum: Pt's (Patient's) husband brought to the hospital by family. We discussed her poor prognosis in light of underlying disease, potentially prolonged hypoxia (time without oxygen), and current condition (shock, respiratory failure). They felt that she would not want continued life support given this situation and asked that she be extubated (breathing tube removed) and made comfortable. C. Record review of R #1's physician's telephone orders found: 1. An order dated [DATE] stating: ST (speech therapy) order to eval (evaluate) and tx (treat) as indicated (name of speech therapist). 2. An order dated [DATE] stating: ST clarification order: Pt to receive skilled ST services 5x/wk (5 times weekly) QD x (daily for) 30 days for cognitive-linguistic (communication) skills tx (name of speech therapist). 3. An order dated [DATE] stating: ST addendum to clarification order dated [DATE]: Pt to also receive skilled dysphagia tx 5x/wk QD x 30 days (name of speech therapist). 4. An order dated [DATE] stating: ST clarification order, correction for orders dated [DATE]: Pt to receive skilled ST services 5x/wk QD x 60 days (starting on [DATE]) for dysphagia tx, cognitive-linguistic skills tx (name of speech therapist). 5. An order dated [DATE] stating: ST dysphagia tx order: NO straws due to aspiration risk and pt's decreased attention span (name of speech therapist). D. Record review of R #1's care plan, dated [DATE], found that the Eating/Nutrition section found no references to the resident's dysphagia. The focus section listed only DMII (Diabetes mellitus, type 2) as a concern. The only goal listed was I will be given foods that I enjoy and am familiar with daily. Interventions included Therapy provided as ordered, but no specific interventions to address the resident's dysphagia or choking potential. E. Record review of R #1's Dysphagia Medical Workup form, dated [DATE] and signed by the Nurse Practitioner found checkmarks indicating that the resident was at risk for various types of aspiration, nasal regurgitation (vomiting), choking, frequent coughing up food during swallow, delayed or slow swallow reflex, and wet or gurly (sic) voice quality after swallowing of liquids. Suspected Pharyngeal (throat) Phase Deficits section had checkmarks for choking/coughing and delayed/impaired swallow reflex. F. Record review of R #1's four Dietary Communication forms found that none instructed the dietary department to alter the consistency of her diet. Communications were: 1. A form dated [DATE] (the resident's date of admission) stating that her diet was to be CCHO (Consistent Carbohydrate diet; a diabetic diet) with regular consistency. 2. A form dated [DATE] stating Dysphagia treatment order with the notation No straws due to aspiration risk (risk of food or fluids entering the lungs) and pt's decreased attention span. 3. A form dated [DATE] stating Select menu please, per family request (no desserts, please.) 4. A form dated [DATE] stating Please include diet cola with cup of ice and lid for lunch and dinner meals per patient request. No straws. G. Record review of Speech Therapist daily treatment notes indicated: 1. A note dated [DATE] stating Pt tolerated 75% of her lunch meal of regular diet texture with thin liquids with no overt clinical s/s (signs and symptoms) of penetration/aspiration, however after her meal she began coughing and choking profusely on thin liquids. Will train pt and staff to perform safe swallow strategies. 2. A note dated [DATE] stating Bedside dysphagia evaluation completed with pt exhibiting decreased oropharyngeal (mouth and throat) motor (muscle) control and decreased oral motor strength and ROM (range of motion) for musculature (muscles) for swallow. Plan of care developed and skilled treatment recommended for decreasing dysphagia, increasing safe swallow function, training pt and caregivers to perform safe swallow strategies. 3. A note dated [DATE] stating (in part) Pt made (moderate) attempts to clear her throat when she produced a wet voice

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Therapy necessary to decrease dysphagia, increase safe swallow function, train patient and caregivers with safe swallow strategies, increase cognitive-linguistic skills . 2. Performed bedside swallow evaluation with patient exhibiting no deficit in timing/coordination of swallow with palpation of dry swallow, however she did exhibit oral motor musculature weakness and mild delay of initiation of swallow. 3. Swallowing, Lingual (tongue) Function: Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent supervision for carryover). 4. Swallowing, Mandibular (jaw) Function: Mild impairment (,[DATE]% impairment; risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent supervision for carryover). 5. 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SLP wrote an order for [REDACTED]. I. On [DATE] at 9:18 am, during interview with the Speech Therapist, she stated that she had done an evaluation of R #1 on admission, and had found her to have a marked cognitive (thinking) impairment. She stated that R #1 was able to feed herself, but that she had changed her diet to a chopped consistency. She stated that she had found that R #1 had decreased mouth and throat muscle strength. She also noticed a decreased attention span, and that while eating, R #1 would forget what she was doing and would need a lot of cueing as a result. She stated that she had written an order for [REDACTED]. The Speech Therapist stated that she had worked with FM #1 to teach techniques that would encourage R #1 to swallow safely. J. On [DATE] at 9:30 am, during interview with the Speech Therapist, she stated that she had been unable to find a telephone order or Dietary Communication form for R #1 to indicate a change to a chopped diet, but that she was sure that she had spoken to the Dietary Manager about it. She stated that she and the Dietary Manager had had frequent discussions about R #1's needs. Further review of R #1's medical record by the Speech Therapist revealed that she had eaten a roast beef sandwich for one meal, which, the Speech Therapist concluded, meant that the diet order hadn't been changed. The Speech Therapist then stated that she hadn't changed the diet because the family didn't want her on a chopped diet. She further stated that trials of a chopped diet were being conducted, intermittently, with R #1. She indicated I don't want to speculate on what happened when she choked. I'm not a doctor. K. On [DATE] at 10:29 am, during interview with the Dietary Manager, he stated that he did not recall ever having spoken with the Speech Therapist about modifying R #1's diet consistency. He stated that diet changes are always relayed to him on a Dietary Communication form. He stated that trials of a different consistency are only attempted when a staff person was working directly with the resident, in order to assess the effectiveness of the change. L. On [DATE] at 11:25 am, during interview with the Speech Therapist, she stated I'm not going to comment on my statement that the family requested that she not have a chopped diet, because I don't have any documentation of it. I'm sorry I opened my mouth. She stated that she had completed the Dysphagia Medical Workup form and given it to the Nurse Practitioner to sign, but had not had a discussion with the Nurse Practitioner about any diet changes. M. On [DATE] at 11:48 am, during interview with the Nurse Practitioner, she reviewed R #1's Dysphagia Medical Workup form, and confirmed that it had been completed by the Speech Therapist, and given to her (the Nurse Practitioner) to sign on [DATE]. She stated that, given the choking risk indicated on the form, she would have expected that the resident would already have been placed on a pureed or chopped diet. She stated that she leaves the specific consistency decision to the Speech Therapist, because it is her area of expertise. N. On [DATE] at 2:21 pm, during interview with R #1's husband, he denied that the facility had ever spoken with him about modifications to her diet. O. On [DATE] at 3:35 pm, during interview with FM #1, who is a nurse, she confirmed that she had been visiting with R #1 at the time of the choking incident. She stated that R #1 had been on a regular diet, not mechanical soft or anything, and at the time of choking had been eating a chicken thigh. She said that R #1 would usually choose softer items to eat when she was alone, because cutting and swallowing food was difficult for her, and that, due to embarrassment, she was resistant to having someone cut up her food for her at the table in the dining room. She stated that she believed that R #1 would have benefited from a chopped or pureed diet, but that the facility had never spoken with her about it. FM #1 denied that she had ever received any training or direction from the Speech Therapist on assisting R #1 to eat.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Store, cook, and serve food in a safe and clean way** Based on observation, record review and interview, the facility failed to ensure that food was served under sanitary conditions by: 1. Failing to check food temperatures prior to serving and; 2. Failing to check water temperatures on the high temperature dishwasher. This deficient practice has the potential to lead to the spread of food borne illness that could affect the 44 residents who consume food prepared in the kitchen as identified on the Alphabetical Census provided by the Administrator on 08/11/16. The findings are: A. On 08/11/16 at 1:15 pm, during observation of the Food Temperature Log, it was revealed that the section for lunch temperatures for the day were blank. Lunch service had started at approximately 1:15 pm with 30 residents having been served. B. On 08/11/16 at 1:20 pm, during interview with the Dietary Manager (DM), he stated that he had not checked the food temperatures prior to serving the meal because staff were running behind. He was not able to answer how he ensured that residents received food that was maintained at a safe temperature range and said that approximately 35 to 40 residents had already been served their meal. C. On 08/11/16 at 1:38 pm, the DM checked the food temperatures and it was noted that the deli tray (consisting of rolled up deli meats) meats were 49 degrees F. The DM stated that cold foods should be held below 41 degrees and that he had no way of ensuring that the residents who had already been served received food that was maintained at a safe temperature. D. Record review of the Dishwasher Temperature Log for August 2016 revealed that no temperatures were documented for 08/05 and 08/11/16. On 08/03, 08/08 and 08/09/16, the water temperature was documented at 148 degrees for the wash cycle. The bottom of the Temperature Log contained the following statement, Minimum wash temperature is 150 degrees-Minimum rinse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325048	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO ON ACADEMY (THE)	10500 ACADEMY ROAD NE ALBUQUERQUE, NM 87111

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 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) temperature is 180 degrees. E. Record review of the Safe Food Temperatures Policy and Procedure dated 08/06/12 indicated that Cold foods will be held at 41 degrees F (Fahrenheit) or lower during meal service. F. On 08/11/16 at 1:40 pm, during interview with Dishwasher #1 (DW #1), when asked about the high temperature dish washing machine, he stated that he forgot to check the water temperatures after the breakfast meal that morning. He was unable to answer how he ensured that water had been at a temperature that would effectively sanitize dishware. DW #1 stated that he usually checks the water temperatures when he comes in in the morning at about 7:30 am. When asked how he ensures that temperatures are appropriate during the wash, he then stated that he also checks water temperature while the machine is running and that the wash temperature should be at least 150 degrees and the rinse temperature should be at least 180 degrees.
F 0463 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's room or bathroom and bathing area.** Based on interviews the facility failed to have a functioning call light system for 1 (R #2) of 10 (R #s 1-10) residents sampled during a complaint investigation. This deficient practice has the potential to result in accidents and cause stress and humiliation for residents who need assistance from staff for their ADL's (Activities of Daily Living), due to waiting for prolonged periods of time, up to an hour to get assistance from staff. The findings are: A. On 08/11/16 at 12:40 pm, during an interview with R #2's daughter, she stated that sometimes it might take a while for her mother to get assistance. She stated that her brother (R #2's son) timed how long it took for R #2's call light to be answered and it took one hour for her to get assistance. She stated that today it took at least 30 minutes to get her (R #2) to the bathroom. R #2's daughter also stated that her mother wears briefs and that she is not comfortable having a bowel movement in them so she will call when she needs to go to the bathroom. She stated that her mother has had to wait so long before that she had no choice but to go in her brief. Then she said that her mother has to wait for someone to come and change her. B. On 08/11/16 at 4:00 pm, during an interview with the ADON (Assistant Director of Nursing), she stated that the call light system works off of pagers that the staff carry. They have a running marquee (a sign that indicates the room number) in the hall that lists residents who have their call light on and it will also notify up at the nurses station. She stated that it is a relay system so every five minutes it notifies the next person in the chain of command as well as the CNAs (Certified Nursing Assistant) again. The ADON also stated that she is aware that it has taken up to one hour for a call light to be answered. She stated that it has happened after dinner when residents all want to go to bed. C. On 08/12/16 at 8:15 am, during interview with the ADON, she stated that when she started to look into the delayed call light answer times, she discovered a couple of different contributing factors. 1. Staff calling in on the 2 pm to 10 pm shift may have caused slower response times. 2. They discovered that there were not enough pagers for all staff. 3. There was an issue with a hospice resident having a companion. She stated, that staff was not responding to the call light because they felt the companion should have been taking care of that resident's needs. The ADON also stated that after business hours it is only the CNA and nurse that have the pagers and the only way management would know if there was a problem is if a family member were to complain. D. On 08/12/16 at 9:10 am, during interview with CNA (Certified Nursing Assistant) # 2, she stated that she really likes the old system better because you could see the light when it was going off. E. On 08/12/16 at 9:00 am, during interview with LPN #1 (Licensed Practical Nurse), she stated that yea the system is ok. She stated that as long as people wear the pagers, the system works pretty well. She said that people aren't really trained on them and not everyone understands how to clear them. So there may be a call going off that is an hour old. She thinks more training on how to use them would be good.