STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. BUILDING _____ B. WING _____	C 06/19/2008

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MCALLISTER NURSING & REHAB	**18300 S. LAVERGNE AVE POB 367 TINLEY PARK, IL 60477**

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F 323	Continued From page 21 5. On-going education will be provided to nursing staff until all employees have received training. 6. All new employees will be educated on the fall program. 7. The DON and or designee will complete random audits to monitor that fall prevention interventions are implemented timely and are in place as ordered, fall assessments are completed on admission, re-admission, and quarterly as due that supervision is being provided in the dining room. 8. The DON will bring identified trends to the Quality Assurance Committee. The interdisciplinary team will formulate a plan of action as needed until resolution. Completion date: 6-18-08	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)5) Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour,	F9999		

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F9999	Continued From page 22 seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. This REGULATION is not met as evidenced by: Based on observations, record reviews, and interviews the facility: 1. Failed to provide treatment as ordered for pressure sores for R8, R7, and R6. 2. Failed to provide preventative measures to prevent further pressure sores for R6, R7, R8, R13, R14, and R15. 3. Failed to assess residents at risk and update assessments at least quarterly for R7, R14, R15, and R13. 4. Failed to monitor residents with a known history of pressure sores: R6, R7, R8, R13, R14, and R15. Findings include the following: 1 .R6's diagnosis includes Dementia Neurogenic Bladder and Bilateral Contractures of Joints. R6's Minimum Data Set reveals R6 is chair-fast and totally dependent on staff for all aspects of care. R6 is incontinent of bladder and bowel. Review of facility's weekly decubitus report for week of 6/9/08-6/13/08 indicates R6 has a	F9999		

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chronic wound to the coccyx area since 12/05 and was found to have developed a Stage II to the right ischial area on 6/5/08. The ischial wound measured 1.2 cm in length x .6 cm in width x .1 cm in depth. The wound appearance was open and pink.

On 6/5/08 R6's coccyx wound was re-measured at 4 cm in length x 4 cm in width x .4 cm in depth dipped in 80% skin crater covered in crater with 20% open pink in upper portion of wound. The coccyx wound was stage at Stage II. Wound recommendations included to continue with Hydrogel and pack with gauze loosely to the coccyx area and to cleanse and apply Hydrocolloid every 3 days and as necessary and check placement daily for the right ischial wound. Further recommendations included re-position every 2 hours, Zinc Sulfate 220 mg daily for 6 weeks, multivitamins daily, pillow under calves to off load pressure from heels.

On 6/16/08, at 1:50 PM, surveyor requested to observe R6's wounds with E6 (LPN). There was no dressing in place to R6's coccyx. The wound to the coccyx was observed to be an open crater type wound. There was no drainage to the coccyx wound. A DuoDerm dated 6/15/08 was in place to right ischium. Surveyor asked E6 if she was aware R6 had no dressing in place to the coccyx area. E6 stated she had not started treatments that day.

Review of R6's Treatment Administration Record lacked documentation R6 had received the ordered treatments to the coccyx area on 6/13/08 and 6/15/08. The TAR lacked the ordered treatment of hydrocolloid every days for the right ischial wound. A treatment to apply aloe vesta

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F9999	Continued From page 24 prot ointment daily and prn. was on the TAR and was signed off as given. Review of R6's Medication Administration Record lacked documentation the recommendation from the wound care nurse for Zinc Sulfate 220 mg and Multivitamins were carried over to the MAR or that the physician was notified. R6's last Braden Assessment was done in January 2008 and was assessed as high risk. R6's care plan dated 4/6/08 had goals which included R6 remaining free of pressure ulcers. The care plan was not updated to address the new pressure ulcer to the right ischium. On 6/16/08 surveyor requested E4 (ADON) to have R6's coccyx wound re-measured. Review of R6's wound sheet assessment revealed R6's wound had increased in size from the previous measurement of 6/5/08 to 4.5 cm in length x 3.5 in width with no depth measurement done. On 6/17/08 an order of treatment for the coccyx wound was changed to cleanse with normal saline, gently pack with alginate, and cover with dry dressing daily and as necessary (prn). An order for the recommended Zinc Oxide 220 mg daily and Vitamin C 500mg daily was finally obtained on 6/17/08. 2. R8 was admitted to the facility on 6/10/08 with diagnosis that includes Ischemic Cardiomyopathy and Diabetes Mellitus. Review of R8's initial nurses note dated 6/10/08 documents R8 was found to have a decubitus ulcer on the coccyx area. There was no initial measurement or staging of R8's wound upon admission. An order to cleanse wound with wound cleaner and apply	F9999		

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accuzymen ointment, cover with gentle heal dressing was noted on the initial nurses note and Physicians Order Sheet. The order on the POS was dated 6/10/08 but was not noted or signed off until 6/12/08. Review of R8's Braden Assessment done by the facility on 6/10/08 assessed R8 as high risk for pressure ulcers.

Review of R8's Treatment record lacks documentation R8 received the ordered treatment on 6/11/08, 6/12/08, and 6/15/08. On 6/16/08, surveyor observed R8 sitting in a wheel chair in her room. There was no pressure relieving pad on R8's wheel chair. R8 did not have a pressure relieving mattress in place.

Documentation on nurses notes dated 6/13/08 includes an assessment of R8's coccyx wound. R8's wound was assessed as unstageable measuring 2.5 cm x1.5 cm unable to determine depth.

On 6/17/08 at 9:50 AM, R8 was observed again sitting in her wheel chair waiting to go therapy. Surveyor requested to observe R8's coccyx wound. R8 was placed back to bed by staff and E6 (LPN) removed R8's diaper. There was no dressing in place to R8's coccyx. E6 stated the treatment had been done on R8 on 6/16/08, but treatments for 6/17/08 had not completed. E9 (CNA) stated R8 had a dressing on earlier in the morning but was removed due to incontinence care. E6 stated she was not informed by E8 of the dressing removal.

Review of initial dietary assessment done on 6/14/08, under skin condition, noted R8 had no skin breakdown. On 6/17/08, E11 made an addendum to the dietary assessment noting R8

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F9999	Continued From page 26 did have a Stage 3 coccyx wound. E11 stated in interview on 6/18/08 at 3:45 PM, on the initial dietary assessment she did not know R8 had a pressure ulcer until 6/16/08. A recommendation was then made by E11 to change diet order to no concentrated sweets, physician to consider Arginaid 1 packet twice a day, and multivitamins with minerals. 3. R15 diagnosis includes Chronic Ischemic Heart disease and Diabetes Mellitus. Review of facility weekly decubitus sheet documented R15 was found to have acquired in house stage I ulcer to the coccyx area measuring 4cm x 8 cm x <0.1 cm. The wound was described as superficial and pink The wound care nurse recommendation was to observe wound daily, turn schedule, cushions, and off-loading. On 6/13/08, R15's wound measured the same but was identified as blanchable and closed. Review of R15's June 2008 Physician Order Sheet (POS) revealed an order to apply aloe vista barrier cream daily and as necessary (prn). R15's Treatment Record lacks documentation the aloe vesto barrier was applied from 6/6/08 through 6/17/08. On 6/17/08, surveyor requested to do a wound check on R15 with E4 (ADON) and E7 (LPN) assisting. R15's left buttock was very reddened and excoriated and there was a small open area to R15's right buttock. E7 was asked by surveyor if he was aware that a daily skin check was to be done on R15. E7 stated he was not informed of the daily skin check. Review of R15 record lacked documentation the wound care recommendation was carried over to the POS or Treatment Record.	F9999		

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F9999	Continued From page 27 R15 was re-assessed by facility on 6/17/08 and was found to have a Stage II ulcer to the right buttock measuring 0.5 cm length x 0.2 cm width and < 0.cm in depth. A recommendation for Bactroban ointment after normal saline cleanse, apply dry dressing, and to apply aloe vesta barrier cream to Stage I surrounding area. R15's Braden Scale dated 6/17/08 assessed R15 as a low risk for pressure ulcer. Review of facility current skin care prevention protocol states "the risk level will then be determined using combination of the Braden Scale and the Wound and Skin Report. For example, if the resident scores low risk on the The Braden Scale but has multiple risk factors on the Wound and Skin Report, the resident will be a moderate risk." 4. R7 has been treated in the facility for a Stage III pressure ulcer on the Right Gluteal Fold. Surveyor observed R7 on 6/16/08 at 12:00pm. R7 was noted to be in bed and in a gown. The resident had not been provided personal care and was indicating that she wanted to get up and out of bed. Surveyor had noted that the treatment for R7's wound had not been signed out for the previous two days (6/14 and 6/15). Surveyor returned to the room with E6 (Nurse) to observe the wound. E6 quickly removed the dressing that was in place and disposed of the dressing before it could be examined by the surveyor. A strong odor was noted coming from R7, and the dressing appeared to be crumpled and wrinkled. A daily skin check or log was not present in the	F9999		

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F9999	Continued From page 28 treatment book, MAR (Medication Administration Record) or in any other log. E2 (Director of Nursing) and E6 were asked numerous times for this information, and none was provided to the survey team. On 6/17/08, at 10:30am, surveyor observed that R7 was dressed and staff was attempting to transfer R7 to the wheel chair. R7 indicated that she did not want to get up and that it hurt to sit in the wheel chair. R7 stated that the chair hurt her sore. Staff continued to attempt to transfer R7 until E6 stated to leave her in bed. R7 stated that sometimes the staff keep her up too long and that hurts. A review of R7's medical record indicates that the last care plan for skin was dated 1/28/08, and does not include the pressure ulcer. In addition the care plan for skin does state, "assess skin condition daily and note any changes." "Air mattress on bed." R7's MDS(Minimum Data Set) with a reference date of 4/4/08, had not been coded correctly with the Stage III pressure ulcer. Since it was not sealed, this MDS was corrected. The MDS also codes R7 as needing total assistance with all activities of daily living and that R7 receives numerous pressure sore preventative measures. The last risk scale for pain and risk for pressure sores was dated January 2008. The facility failed to provide treatment to R7, failed to provide preventative measures such as a pressure relieving bed and frequent position changes, failed to conduct ongoing assessments of R7, failed to accurately score the MDS for pressure ulcers and update the plan of care to	F9999		

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F9999	Continued From page 29 reflect the Stage III pressure ulcer, and failed to provide pain relief from the pressure sore. 5. R13 was observed on 6/17/08, with E7 (Nurse) at 10:50am in R13's room. R13 was noted with a red (Stage I) area to the buttocks and peri area. The resident was noted to be in bed with no heel protectors in place and no padding between the two knees. E7 stated that he had checked R13 the previous day, and his skin was not open but reddened. E7 confirmed the lack of heel protectors and padding between the knees and stated that R13 needs to be assisted and re-positioned by staff. A review of R13's medical record indicates that R13's last pressure sore risk scale had been completed in January and had not been updated quarterly as required. In addition, staff was unable to locate a daily skin check for R13, and no record of this could be found on the TAR (Treatment Administration Record) and/or the MAR. The treatment order also calls for R13 to get a barrier ointment to the buttocks and peri area every shift, yet this treatment is only signed out for one time a day. 6. R14 was identified by the facility as having an acquired Stage I pressure ulcer on the coccyx. R14 was observed on 6/17/08, with E7. R14 was noted to have a continuation of the Stage I pressure ulcer. In addition, R14 was noted to be resting in bed with no heel protectors in place. E7 was unable to supply the survey team with a daily skin care check for R14. A review of the physician's orders indicate the following orders for R14, "apply bilateral heel protectors while in bed, Skin assessment daily."	F9999		

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F9999	Continued From page 30 The last pressure sore risk assessment had been completed in February 2008. At that time R14 did not have a pressure ulcer. The facility's policy states, "Skin Risk Assessment is to identify residents with potential risk of skin integrity and ensure that the proper measures are instituted based on the resident condition." "A care plan is then developed based on the resident's identified risk factors." The policy also states under assessment and documentation, "Wound assessment is a continuous process that serves to provide information about the wound status, staging, its etiology, and the efficacy of the interventions." The policy also states, "The staff nurse identifying the wound shall make initial assessment and initiate treatments per the physician's order. Record and date all information and document on Treatment Record as well as the Wound and Skin Report/Wound and Skin Notes." (A) ========== 300.1210a) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	F9999		

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F9999	Continued From page 31 each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These REGULATIONS are not met as evidenced by: Based on observation and interviews, the facility: 1. Failed to monitor and supervise residents that have been identified as at risk for falling. 2. Failed to implement and update resident care plans for residents with fall histories. 3. Failed to re-evaluate residents after a fall. This failure resulted in R1 falling and sustaining a fracture that resulted in hospitalization, and R2 falling and also requiring hospitalization and treatment. In addition, the facility failed to update fall assessments and failed to implement fall prevention techniques for R9. The facility also failed to assess and update R3's plan of care to prevent falls.	F9999		

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F9999	Continued From page 32 Findings include: 1. R1's diagnosis includes Diabetes Mellitus, Dementia, muscle weakness, and history of falls. R1 was admitted to the facility on 2/8/08. Review of R1's initial fall assessment dated 2/8/08 assessed R1 as high risk for falls. On 2/8/08 an assessment for the use of a soft cushion restraint was done on R1. Documentation indicates R1 needed the soft cushion restraint for upper body support and to enable better sitting balance. Documentation of restraint reduction was noted but did not detail the previous type of restraint use. Review of R1's POS denotes an order for use of soft cushion restraint was obtained on 2/17/08. R1's MDS dated 2/22/08 assessed R1 as moderately cognitively impaired, non-ambulatory, wheel chair mode of transportation, and requires extensive assistance from staff. Facility 24 hour sheet for 6/16/08 documented R1 was sent to hospital for evaluation of possible right hip fracture. Review of R1's nurses notes dated 6/15/08-9:00 AM denotes R1 was found on floor in dining room post breakfast. Upon assessment by staff, R1 complained of pain to right leg with limited range of motion. R1's physician was notified and sent to hospital for evaluation. R1 was admitted to hospital for right hip fracture. On 6/18/08, surveyor reviewed R1's record at the hospital which revealed R1 had an Open Reduction Internal Fixation of right hip on 6/16/08.	F9999		

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F9999	Continued From page 33 On 6/17/08, surveyor reviewed nurses notes written by E7 (LPN). E7 stated he had found R1 lying in the floor in the dining room on 6/15/08. E7 stated R1 was alone in the dining room at the time she was found and probably took off her soft cushion restraint while alone and attempted to get up. E7 stated the skilled unit was short of staff on 6/15/08 due to staff call-in. R1's incident report of 6/15/08 documented the incident with a preventive measures taken listed as the use of a lap top cushion, attempt to keep in line of sight. Review of June 2008 incident reports reveal R1 had a fall on 6/5/08 while sitting across from nurses station. R1 removed the lap top cushion restraint and got up and fell sustaining no injuries. Under additional comments to prevent recurrence it states R1 totally confused and hostile - an alternative restraint will have to be considered. Recommendations on incident/accident follow sheet denoted R1 to be re-evaluated for further methods to keep from hurting self. There was no further investigation or addressing of the fall. On 6/9/08, R1 again removed lap top cushion from wheel chair and attempted to pick up sticks off the floor and fell on her left side with no injury. Under additional comments to prevent recurrence for alternative restraint or solution. Review of incident/accident follow-up sheet dated 6/9/08 E4 (ADON) wrote physical therapy to be engaged for alternate restraint. Lap top cushion is not working. There is no follow-up investigation regarding this fall.	F9999		

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F9999	Continued From page 34 2. R2 is a 55 year old male admitted to the facility on 4/25/08, from another nursing facility. R2 was admitted with the following diagnosis: Diabetes, Dysphagia, Post Motor Vehicle Accident with Subdural Hematoma, and Nondisplaced Fracture of Lumbar 2, 3, and 4. The initial nursing assessment indicates that R2 required a 1 person transfer, needing assistance with all activities of daily living, and as alert and oriented. In addition, R2 was described as having an unsteady gait. Nursing notes from 4/26/08, state, "Side Rails up times two, fall precautions." Later that morning at 11:15am, notes state: "resident up in wheel chair in hallway, attempting to stand and ambulate several times." Later that same day the afternoon shift charted the following: "Resident is alert times one..resident requires extensive assistance." "Resident has a very unsteady gait and continues to attempt to ambulate." On 5/21/08, at 4:00pm, R2 was noted to get up from the wheel chair and fall backwards onto his buttocks. Nursing notes state the following: "resident alert and confused as usual attempted to get up from the wheel chair and walk and resident fell backward onto buttocks." On 5/26/08, the following was charted at 8:00am, "resident alert with confusion, continue to get up from the wheel chair unassisted, difficult to re-direct. Chair alarm intact, observations continue." At 10:00am, 12:00pm and 1:00pm, the resident remained in the same condition with agitation and attempts to stand up and walk without assistance. The nurse then contacted the physician and obtained an order for Ativan 1mg to be given intramuscularly.	F9999		

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F9999	Continued From page 35 On 5/27/08, the resident was again noted with the same behavior. Nursing notes state, "Constant cueing and re-direction to not stand without assistance." On 5/28/08, at 7:00am, R2 was observed on the floor of the dining room. According to the incident report no injuries were noted. According to the incident report, a lap restraint was added to prevent R2 from getting up out of his wheel chair. R2 was noted at 8:00pm to be confused and needing redirection. The physician was notified and once again R2 was given Ativan 1mg for restlessness. At 10:15pm, R2 was observed on the floor in his room on his back. The resident was assessed to have no injuries at that time. No further documentation regarding these two incidents was noted in the medical record. On 5/30/08, the night shift wrote, "resident up all night, when assisted to bed resident repeatedly getting up...endorsed for continuos monitoring." On 6/2/08 the resident was noted to be up at the start of the shift and monitored by staff, and then on 6/4/08, at 10:00am, the therapy department noted the resident to be more confused and unable to respond to therapy. The nurse notified the physician and R2 was transferred to the hospital and admitted to the Intensive Care Unit for Change in Mental Status. A review of the hospital record indicates that R2 was admitted to the hospital for "Acute/Chronic Subdural Hematoma, Possible Epidural Component." R2 was treated for an evacuation of the hematoma on 6/5/08, with a burr hole. The resident required hospitalization for 14 days.	F9999		

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F9999	Continued From page 36 Interview with E7 (Nurse) on 6/18/08, indicated that R2 was very confused, always trying to get up without assistance, and would not respond to re-direction. E7 stated that R2 was very difficult to handle. The resident was noted to demonstrate an increase in confusion and orientation from 5/21/08, until his discharge to the hospital. On 5/23/08 and 5/26/08, the resident was noted to be more anxious and confused. Yet staff failed to respond to these changes. A review of the care plan for R2 indicates that the plan of care was not updated or adjusted for his behavior and falls. The falls risk assessment was not updated after falls. The staff did not monitor the resident after each incident to ensure R2 did not suffer injury from the falls. The facility did not attempt alternative interventions when R2 became agitated and confused. This failure resulted in R2 falling 3 times in a 7 day period and being given an anti-anxiety medication twice. 3. R9 was admitted to the facility on 5/6/08, on Hospice. R9 was found on the floor on 6/9/08, at 12:00pm. During the survey of June 17 and June 18, R9 was observed in bed with both side rails in the upright position. R9 was observed to be confused and at times attempting to get out of bed. R9's fall assessment was not updated after the fall nor was the care plan. According to E7, resident was getting a low bed. On 618/08, the resident was supplied with a low bed. 4. R3 has a long history of falls with numerous incidents. A review of R3's falls assessment indicates that the assessment and plan of care	F9999		

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F9999	Continued From page 37 had not been updated since January of 2008. R3 was observed several times during the survey to attempt to leave her wheel chair without assistance. The facility's policy states the following: "Upon admission, every resident will be assessed to determine existence of fall risk factors, which will include evaluation of fall history, symptoms, physical and cognitive status." "The Fall Risk Screening will be completed upon admission, quarterly, with a significant change in condition and whenever a fall occurs." "Residents assessed at risk for falls will be placed on the Falls Management Program, and an identifying marker/sticker will be used for quick and easy identification." "A care plan will be implemented that identifies the risk and provides staff with interventions to prevent falls, and or reduce risks". The facility failed to follow their own policy for prevent accidents related to falls. (A) ========== 300.2090 a) Section 300.2090 Food Preparation and Service a) Foods shall be prepared by appropriate	F9999		

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F9999	Continued From page 38 methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use. This REGULATION is not met as evidenced by: Based on direct observations and recipe review, the facility failed to follow its own standardized recipe for the puree diets. Findings include: Tour of Kitchen on 6-17-08 at 9:30 a.m: The puree diets were being prepared by the Cook. E5 (Food Service Supervisor) instructed the Cook to follow the standardized recipe for the puree diets which reflected roast beef. The recipe called for roast beef and broth. The Cook used roast beef and water. According to the Cook, she prepares for 11 puree portions. Observation was made where the Cook placed an unknown amount of beef into blender and poured an unknown amount of water into blender from a gallon pitcher. Then the Cook blended the mixture and then used a measuring cup of 1/4 cup of water and placed it into the blender 2 times. The recipe for 10 servings called for 1.87 lbs. of beef and 2 cups of broth. According to the Cook she used 11 pieces of beef. There was no scale present to weigh the portions of meat. (B) ==========	F9999		

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F9999	Continued From page 39 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). This REGULATION is not met as evidenced by: Based on direct observation and interviews, the facility failed to served food under sanitary conditions. Findings include: Tour of Kitchen on 6-17-08 at 9:10 a.m. with E5 (Food Service Supervisor): The following was observed: 1. Inside the the ice machine, the frame was observed with rust. Rust was also observed inside the ceiling. 2. The large mixture bowl was observed covered. Once uncovered, there were dried food splatters on the outside of bowl and the holder. 3. There were 2 utility carts: One located in the dry storage area, and one by the stove in the kitchen. Both were observed to have dried food spills and particles on them. 4. The stand-up electrical box by the heated pellets was observed to have large amounts of dried food particles on its top and plate. 5. The 2 suction cups being used for the heated	F9999		

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F9999	Continued From page 40 pellets were observed to be greasy with dried food particles on its handles. 6. Freezer: a) 1 large pan of uncooked ribs with foil not sealed, ripped edges, exposing ribs. b) 1 bag of jumbo manicotti not sealed. c) 1 package of pollack fillet not sealed. 7. Walk-In-Cooler: a) Bucket on the floor under condenser which was leaking. Bucket was half way filled with liquid. b) There was a container of turkey not sealed. c) There was an out-dated open container of cheese sauce dated 6-11-08. d) 1 container of applesauce, no label or date, lid was cracked. e) There were 3 cases of eggs on top on a milk crate. Milk crate being used as shelving. 8) At 9:30 a.m. Surveyor observed a container resting on the top shelf above the burners of the stove. Surveyor asked what it was. According to Cook, it was hard boiled eggs. Cook stated that they were resting there since 9:00 a.m. and were going to be used for egg salad. E5 took temperature of the hard boiled eggs with the facility calibrated thermometer. Temperature was at 76 degrees. E5 discarded the eggs. 9) On 6-16-08 at the noon meal at the Intermediate Care Section, observation from window to the outside: Both garbage bin lids were open. (B)	F9999		

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F9999	Continued From page 41 ========== 300.2090 b) Section 300.2090 Food Preparation and Service b) Foods shall be attractively served at the proper temperatures and in a form to meet individual needs. This REGULATION is not met as evidenced by: Based on direct observations, menu review, and interviews, the facility failed to served food items attractively. Findings include: The posted menu for the luncheon meal on 6-16-08 reflects: Philly Steak on Bun, Asparagus, Steamed Onions and Peppers, Potato Chips, and Fruit Cup. Direct observations in the Dining Room in the Intermediate Care Section: The General diets received the following: Pulled beef, melted cheese with sour creme, served on a hot dog bun.. According to E5 (Food Service Supervisor), the pulled roast beef was cooked with the chopped peppers and onions . The recipe calls for the pulled beef to be placed in a bun with green peppers and onions According to E5, he does not serve rolls to resident because they are too hard to chew, and that is why the hot dog buns were given. The asparagus was overcooked and falling apart.	F9999		

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F9999	Continued From page 42 The potato chips were served directly on the plate. This plate was on a heated pellet. Fruit cup was to be served. Instead pineapple was served. On 6-17-08, Group Meeting at 11:15 a.m., residents all agreed that the luncheon meal served on 6-16-08 was not served attractively, and this was the first time they had seen this meal. According to to the Group Interview, residents do not have input into the menu. Residents requested to have a Food Committee and not just have their likes and dislikes stated at the Resident Council Minutes. Residents complained that the menus have changed without warning. They use to have a nice Breakfast such as 2 eggs, 2 toast, and 2 bacon or sausage. Now they receive 1 egg, 1 toast and 1 bacon or 1 sausage. (AWL)	F9999		