STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145989	A. BUILDING _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER NURSING & REHAB CENTER	**516 WEST FRECH STREET STREATOR, IL 61364**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Compalint 1424394/IL 72323	F 000		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations and record review the facility failed to follow diet orders for two of three residents reviewed (R2, R3) for special diets in a sample of three. Findings include: 1. The Physician's Order Sheet (POS) dated 10/2014 for R2 documents the following orders under the section titled "diets": dysphagia diet, no added salt, no concentrated sweets, mechanical soft consistency, thin liquids, thick handle utensils at meals, assist with self feed, slow rate, one sip at a time, cut small bites, chin tuck, 90 degrees with meals, 1:1 assist PRN (as needed), slow pace, sippy cup with thick handle utensils to assist with self feeding and patient to utilize curved spoon at all meals to increase self feeding. On 10/3/14 at 12:27 PM, two peanut butter and jelly sandwiches were placed in front of R1. The peanut butter sandwiches were whole. R1 completed the first sandwich in seven bites with no sips in between bites. R1 ate the second sandwich in nine bites with no sips in between bites. R1 did not tuck her chin during this meal	F 367		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145989	A. BUILDING _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 1 and no staff intervened or monitored R1 during this meal. 2. The POS for dated 10/2014 for R3 documents the following orders under the section titled "diets"-no added salt, no concentrated sweets, mechanical soft consistency, thin liquids, 90 degree angle at all times, one bite/one sip at a time, small bites/sips, slow pace and supervision as needed. On 10/3/14 at 12:05 PM, R3 was served beef and noodles. During the entire lunch service R3 did not adhere to the one bite/one sip order. No staff intervened or monitored R3 during this meal.	F 367		