STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714

(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 Complaint #13618, substantiated, all or in part, with a deficiency cited at F363.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714**

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F 225	Continued From page 1	F 225		

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, the facility failed to ensure a thorough investigation was conducted regarding an allegation of abuse for 1 of 1 case mix resident (Resident #2). who had an allegation of abuse. The facility failed to ensure staff immediately reported another staff for taking residents' food and local law enforcement was notified for 1 of 1 case mix resident (Resident #6) who had an allegation of misappropriation of property. These failed practices had the potential to affect 14 residents who were independent with transfers and 29 residents who needed assistance with feeding according to the Resident Census and Conditions of Residents form dated 6/18/08.. The findings are:

1. Resident #2 had diagnoses Bipolar Disorder, Depressive Disorder, Abnormality of Gait, Osteoporosis, and Spinal Stenosis. A Minimum Data Set (MDS) dated 3/17/08 documented the resident had modified independence in cognitive skills for daily decision making and was independent in transfer and ambulation.

a. An Office of Long Term Care Incident and Accident Report (I & A) submitted on 4/28/08 documented the resident reported that on the evening before (4/27/08) while transferring herself to bed she was unable to get her legs in the bed. She requested assistance from CNA (Certified Nursing Assistant) #1. She stated the CNA roughly placed her legs on the bed and stated Resident #2 "pees on herself because she is lazy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714**

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F 225	Continued From page 2 and doesn't want to try to get up to the bathroom." b. A Facility Investigation Report (DMS-762) dated 4/29/08 documented in section titled "Type of Incident" documented an allegation of Verbal and Physical Abuse. The form documented CNA #1 was interviewed as were 5 residents. There was no documentation that any staff members were interviewed. c. On 6/19/08 at 4:45 p.m., the Administrator was asked if any staff were interviewed. She stated, "They must have. They did not write it anywhere." 2. Resident #6 had a diagnosis of Senile Dementia. A Quarterly MDS dated 5/27/08 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance of 1 person for eating. a. An Office of Long Term Care Incident and Accident Report (I & A) with date of occurrence as 6/16/08 and discovered by facility administration on 6/17/08 at 9:00 a.m. documented a CNA witnessed CNA #2 "removed a chicken nugget off of a resident's tray and ate it. Resident stated 'that's mine' she [CNA] reportedly stated that 'you still have 3 on your tray'. She then removed another chicken nugget from another resident's tray and ate it. She later ate a bowl of soup after residents were done eating." b. The DMS-7734, under section titled "Steps taken to prevent continued abuse or neglect during the investigation:" documented, "CNA was called in to speak with DON (Director of Nursing) and Administrator. CNA (CNA #2) was terminated."	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ____ B. WING ____	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714**

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F 225	Continued From page 3 c. The CNA who witnessed the incident was not named on the DMS-7734. There was no documentation of any remedial actions taken regarding the CNA who witnessed the incident and did not report it until the following day. d. On 6/19/08 at 4:45 a.m., the Administrator was asked the name of the CNA who witnessed the incident. The CNA was identified as CNA #3. The Administrator was asked what remedial action was taken regarding CNA #3 who did not report the incident immediately. She stated the CNA was counseled. She was asked for documentation of actions taken. At 5:30 p.m. the DON provided a form titled "Personnel Consultation Form" dated 6/17/08 that documented the CNA did not immediately report the incident to supervisor and Corrective action would be "Next occurrence of this nature will be terminated." e. On 6/19/08 at 5:30 p.m., the DON was asked why the Personnel Consultation form was not signed or dated by the employee in the section titled "Employee's Signature and Date" she stated, "I just wrote this. This is a record of what we went over that morning verbally." f. The DMS-7734 received from the facility on 6/19/08 at 4:40 p.m. documented, "No" under the section titled "Notifications...Law Enforcement". On 6/19/08 at 4:45 p.m. the Administrator was asked if the incident was reported to local law enforcement she stated "No, I only report abuse."	F 225		
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ____ B. WING ____	C **06/20/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE** **BELLA VISTA, AR 72714**

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F 226	Continued From page 4	F 226		

and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, the facility failed to ensure their Abuse Policy and Procedure documented reporting of verbal abuse or misappropriation of resident property to the local police and failed to implement their Policy and Procedure regarding thorough investigation, reporting and protection for 2 of 2 case mix residents (Residents #2 and 6) who had an allegation of abuse and/or misappropriation of property. These failed practices had the potential to affect 14 residents who were independent with transfers and 29 residents who needed assistance with feeding according to the Resident Census and Conditions of Residents form dated 6/18/08. The findings are:

1. Resident #2 had diagnosis Bipolar Disorder, Depressive Disorder, Abnormality of Gait, Osteoporosis, and Spinal Stenosis. A Minimum Data Set (MDS) dated 3/17/08 documented the resident had modified independence in cognitive skills for daily decision making and was independent in transfer and ambulation.

a. An Office of Long Term Care Incident and Accident Report (I & A) submitted on 4/28/08 documented Resident #2 reported that on the evening before (4/27/08) while transferring herself to bed she was unable to get her legs in the bed. She requested assistance from CNA (Certified Nursing Assistant) #1. She stated the CNA roughly placed her legs on the bed and stated Resident #2 "pees on herself because she is lazy and doesn't want to try to get up to the bathroom."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ____ B. WING ____	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714**

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F 226	Continued From page 5	F 226		

b. A Facility Investigation Report (DMS-762) dated 4/29/08 documented in section titled "Type of Incident" documented an allegation of Verbal and Physical Abuse. The form documented CNA #1 was interviewed as were 5 residents. There was no documentation any staff members were interviewed.

c. On 6/19/08 at 4:45 p.m., the Administrator was asked of any staff was interviewed. She stated, "They must have. They did not write it anywhere."

d. The facility policy and procedure documented in the section titled "Investigation: Interview all staff on that unit, as well as other staff or other available witnesses. Witnesses are to document their knowledge of the incident in a written narrative, signed and dated, on the 'Employee/Witness Investigation Statement' form.

2. Resident #6 had a diagnosis of Senile Dementia. A Quarterly MDS dated 5/27/08 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance of 1 person for eating.

a. An Office of Long Term Care Incident and Accident Report (I & A) with date of occurrence as 6/16/08 and discovered by facility administration on 6/17/08 at 9:00 a.m. documented a CNA witnessed CNA #2 "removed a chicken nugget off of a resident's tray and ate it. Resident stated 'that's mine' she [CNA] reportedly stated that 'you still have 3 on your tray'. She then removed another chicken nugget from another resident's tray and ate it. She later ate a bowl of soup after residents were done eating."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714

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F 226	Continued From page 6 b. The DMS-7734, under section titled "Steps taken to prevent continued abuse or neglect during the investigation:" documented, "CNA was called in to speak with DON (Director of Nursing) and Administrator. CNA (CNA #2) was terminated." c. The CNA who witnessed the incident was not named on the DMS-7734. There was no documentation of any remedial actions taken regarding the CNA who witnessed the incident and did not report it until the following day. d. On 6/19/08 at 4:45 a.m., the Administrator was asked the name of the CNA who witnessed the incident. The CNA was identified as CNA #3. The Administrator was asked what remedial action was taken regarding CNA #3 who did not report the incident immediately. She stated the CNA was counseled. She was asked for documentation of actions taken. At 5:30 p.m. the DON provided a form titled "Personnel Consultation Form" dated 6/17/08 that documented the CNA did not immediately report the incident to supervisor and Corrective action would be "Next occurrence of this nature will be terminated." e. The section of the facility Policy and Procedure titled "Reporting/ Investigating/Response documented, "All employees are required to immediately notify the administrative or nursing supervisory staff that is on duty of any complaint of, allegation of, observation of, or suspicion of resident abuse, mistreatment or neglect, so that the resident's needs can be attended to immediately and investigation can be undertaken promptly.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714**

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F 226 Continued From page 7 F 226

f. On 6/19/08 at 5:30 p.m., the DON was asked why the Personnel Consultation form was not signed or dated by the employee in the section titled "Employee's Signature and Date" she stated, "I just wrote this. This is a record of what we went over that morning verbally."

g. The DMS-7734 received from the facility on 6/19/08 at 4:40 p.m. documented, "No" under the section titled "Notifications...Law Enforcement". On 6/19/08 at 4:45 p.m. the Administrator was asked if the incident was reported to local law enforcement she stated "No, I only report abuse."

h. The facility Policy and Procedure documented, "Administrator shall take the following actions to address issues of resident care raised by suspected abuse:... The Administrator or designee shall call local Police when assault, sexual abuse, homicide, forgery or wanton neglect is suspected/confirmed by investigation." The policy did not address reporting of verbal abuse or misappropriation of resident property.

F 282 SS=D 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, the facility failed to ensure a pureed diet was served for 1 of 1 (Resident #5) case mix resident who had a physician order for a pureed diet. This failed practice had the potential to effect 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714

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F 282	Continued From page 8 residents who had an order for a pureed diet as documented on a list provided by the Administrator on 6/20/08. The findings are: Resident #5 had diagnoses of Dementia and Esophageal Reflux. The Admission Minimum Data Set (MDS) dated 5/7/08 documented the resident was moderately impaired in cognitive skills for daily decision-making, was independent for eating with set-up help only, had a chewing problem and received a mechanically altered diet. a. A physician order dated 5/27/08 documented, "Diet: Pureed with Nectar Thick Liquids with Aspiration Precautions." b. On 6/18/08 at 5:30 p.m., the resident was served a mechanical soft diet that consisted of a cup of chicken noodle soup, cole slaw, baked beans, shredded pork, mashed potatoes and nectar-thick water. c. On 6/19/08 at 12:40 p.m., the resident was served a pureed diet except for the chicken noodle soup.	F 282		
F 363 SS=B	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Complaint #13618, substantiated (all or in part) in	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	7 PROFESSIONAL DRIVE BELLA VISTA, AR 72714

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F 363	Continued From page 9	F 363		

these findings.

Based on observation, record review and interview, the facility failed to ensure menus were followed for 1 of 1 (Resident #2) case mix residents and other residents with dislikes of spicy foods. This failed practice had the potential to affect 7 residents who disliked acidic foods as documented on a list provided by the Administrator on 6/20/08. The findings are:

1. Resident #2 had a diagnosis of Diabetes Type II.

a. A physician order dated 3/119/07 documented a regular no concentrated sweet diet.

a. On 6/18/08 at 12:30 p.m., the resident was in bed with a lunch tray on an overbed table. The tray contained a breaded meat patty with dark meat. The resident stated she could not tell if it was meat or fish. The lunch menu documented, "Breaded chicken patty".

b. On 6/19/08 at 12:15 p.m., the resident was served a breaded meat patty, fried zucchini, brown in color, garlic bread stick and mashed potatoes and gravy. The meat appeared to be ground and dark.

c. The lunch menu for 6/19/08 documented spaghetti with meat sauce, fried zucchini and garlic bread. The alternate menu for the lunch meal on 6/19/08 documented Lemon Chicken and baked sweet potato.

2. On 6/18/08 at 4:30 p.m., the menu for the week of 6/15/08 through 6/21/08 documented 4 of 7 lunch menus were changed and 5 of 7 supper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045143	A. BUILDING ______ B. WING ______	C 06/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA CARE CENTER	**7 PROFESSIONAL DRIVE** **BELLA VISTA, AR 72714**

(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 363	Continued From page 10 menus were changed. 3. On 6/19/08 at 12:15 p.m., several other residents in the dining room were served noodles with no sauce and a scoop of unidentifiable brown substance. 4. On 6/19/08 at 12:40 p.m., the Dietary Manager was asked if the meat patty was the same as the ones served for 12/18/08 lunch. She stated, "No, these are chicken." When told the meat looked dark she went to the steam table and picked up 2 meat patties which looked dark. The third one was of a lighter color. The Dietary Manager stated, "That is chicken." The Dietary Manager was asked what the brown ground substance was and what meat was substituted for the spaghetti meat sauce. She referred the question to the cook who showed surveyors ground meat patties and fried zucchini which both looked similar. There was no lemon chicken or baked sweet potatoes on the steam table. The cook was asked why the residents didn't get sauce on their noodles and the cook stated that those residents didn't like spicy foods.	F 363		