STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	05/05/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure resident dignity for one (#15) of eleven sample and three (#6, #4, #2) non-sample residents during dining. The facility census was 48. The findings were: On 5/3/05 from 7:14 AM to 7:58 AM observation revealed sample resident #15 was seated at an assisted dining table in the assisted dining room. At 7:14 AM the observation revealed the resident had a cup of coffee present, but did not have food even though the resident's tablemates had their meals and were being assisted with dining. At 7:48 AM (34 minutes later), the resident received food and independently began eating. A second observation on 5/4/05 at 7:04 AM revealed resident #15 received coffee while his/her tablemates were served food and assisted with eating. At 7:57 AM (53 minutes later), the resident received his/her meal and independently ate. Interview with certified nurse aide (CNA) #12 on 5/4/05 at 7:57 AM revealed the resident required assistance and cueing, for which staff were not available until they had finished assisting other residents. The interview revealed the CNA did not know why the resident was in the dining room when staff were not available to assist him/her. During an interview on 5/4/05 at 4:35 PM, the director of nursing (DON) stated staff had other options and that the resident did not have to be at	F 241		

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

Administrator 5/19/05

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.

Accepted w/ Changes: Reviewed w/ Brenda Dorn, DON on 6/3/05

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F 241	Continued From page 1 the table when staff were busy assisting other residents. Observation of the assisted dining area on 5/4/05 at 7:45 AM revealed resident #6 utilized a wheeled chair with an attached table, and required staff assistance to get to the dining room. The observation revealed staff placed the resident in the center of the room, and delivered the meal tray to the resident. Residents seated at all three tables had their backs to this resident. At 8:04 AM the resident received cueing and assistance with food. The resident remained in the center of the room, despite open space at a table. At 8:12 AM CNAs #7 and #11 were asked why the resident continued to eat in the middle of the room. Both stated there was not enough room at the tables for the resident. CNA #7 added that the resident used the attached wheelchair table as his/her table. Review of the resident's medical record revealed a quarterly Minimum Data Set (MDS) assessment dated 2/16/05. The facility assessed the resident as severely impaired for cognition. Review of the 4/6/05 significant change MDS assessment showed resident #4 had severe cognitive impairment. Observation in the secure care unit (SCU) on 5/3/05 at 8:25 AM showed the resident was seated at the dining room table. The resident was eating his/her breakfast. CNA #11 entered the unit to collect the tray cart to return soiled breakfast dishes to the kitchen. CNA #14 told CNA #11 that the resident was still eating. CNA #11 told CNA #14 to transfer the resident's beverages into Styrofoam cups, so she could put the regular glasses on the cart. CNA #14 then transferred the resident's beverages from two regular drinking glasses into two Styrofoam cups.	F 241	F241 The facility will promote care for Rsdts in a manner & envir. that maintains or enhances each rsdts dignity & respect in full recognition of his/her individuality: A) Rsdt #15 will be taken to the dining area only when staff is available to provide the proper assistance for dining. Rsdt #6 will be seated at a table with other tablemates. Rsdt #4 will use regular drinking glasses at all meals. Rsdt #2 will not be involved in ROM exercises while other residents are eating in the area. B) Rsdts will be taken to dining rm. when there is staff available to assist with dining. When necessary, a tray will be obtained from the buffet to ensure the food is hot. Rsdts will be seated at the dining tables for all meals to ensure pleasurable dining. Rsdts will use ~~reg.~~ drinking glasses ~~for all~~ at meals. Any remaining dirty dishes will be stored in a bin and sent to the kitchen at the end of the next meal. Activities and Restorative will schedule group exercises after all residents have finished eating. The nurses passing medications on day shift will randomly observe resident dignity issues in the dining rooms. Identified problems will be corrected immediately.	6/20/05

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F 241	Continued From page 2 During an interview on 5/4/05 at 4:35 PM, the DON stated the beverages did not need to be transferred to Styrofoam cups. The DON stated the drinking glasses could have been sent to the kitchen with the lunch cart. Observation of the assisted dining area on 5/4/05 at 8:15 AM revealed resident #2 received passive range of motion exercises while seated in a wheeled reclining chair in the assisted dining room. Three other residents present were eating. The observation revealed upper and lower extremity exercises were done and the exercise time did not involve other residents present. Interview with the restorative CNA at 8:22 AM on 5/4/05 revealed it was "routine" to do the exercises in the dining area. The CNA state that once the residents lie down, "...they don't want to get back up." During an interview on 5/4/05 at 4:35 PM, the DON stated exercises should be done after all other residents were finished eating. Review of the resident's medical record revealed an annual MDS dated 2/15/05 and assessed the resident as severely impaired for cognition.	F 241	C) The DON and DRC (Director of Resident Care) will in-service staff on the residents' right to dignified treatment with emphasis on the cited issues. A CNA will be assigned the task of arranging the assisted dining cart to ensure rsdts receive their meals hot & they have staff available for assistance. A CNA will be assigned to ensure all resident have seating at tables. D) A Performance improvement monitor will be started to evaluate rsdts dignity & respect. This report will be evaluated monthly by the PIS (Performance Improvement System) committee.	~~6-30-05~~
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced	F 309		

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F 309	Continued From page 3 by: Based on observation, staff interview, and medical record review, the facility failed to provide care to promote continence for one of five sample residents (#1) with bowel incontinence. The findings were: Review of the 8/2/04 significant change and 4/29/05 quarterly Minimum Data Set (MDS) assessments revealed resident #1 was frequently incontinent of bowel (two to three times per week). Review of the updated bowel and bladder assessment, dated 7/31/04, showed the resident was able to maintain some control of bowel when the toileting schedule was followed. Review of the care plan showed the toileting schedule was identified on the activities of daily living (ADL) flow sheets. Review of the April and May 2005 ADL flow sheets revealed the resident was to be toileted at 7 AM, 10 AM, 1 PM, 4 PM, and 7 PM. The resident was to be checked and changed at 10 PM, 12 AM, and 4 AM. Observation on 5/3/05 revealed the resident was not toileted or checked and changed from 7:15 AM until 12:09 PM (4 hours and 54 minutes). During that time, at 9:50 AM, certified nurse aide (CNA) #14 and registered nurse (RN) #7 transferred the resident to bed. The resident was not toileted. At 9:56 AM, the CNA told the RN that she realized the resident was supposed to be toileted at 10 AM, but they just laid the resident down. The CNA asked if she should take the resident to the toilet. The RN told her "no." At 10 AM, the CNA asked the RN if she should check and change the resident, and the RN said "no." At 12:09 PM, CNA #14 checked and changed the resident while the resident was in bed. The resident had been incontinent of bowel. During the observation, the CNA stated when she last took care of the resident (a month	F 309	F309 The facility will ensure rsdts receive the necessary care & services to attain or maintain the highest practicable physical, mental, & psychosocial well-being by: A) Rsdt #1 will be toileted according to her individual toileting ~~sch.~~ schedule as indicated in her care plan. B) All rsdts will be toileted according to their individual toileting ~~sch.~~ schedule as outlined in their flow sheet (care plan). The Nurse Team Leaders will randomly observe resident toileting times (including resident # 1) to ensure that their individual schedules are followed. Immediate in-servicing and corrective action will be taken if problems are identified. C) New CNAs will be oriented to the toileting flow sheets & rsdts individual schedules. DON and/or DRC will conduct a review of toileting ~~sch~~ schedules with CNAs and nurses. D) A Performance improvement monitor will be started to evaluate compliance with rsdts toileting schedules. This report will be evaluated monthly by the PIS committee. (Performance improvement System)	6-20-05

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F 309	Continued From page 4 beforehand), the resident was able to go to the bathroom when put on the toilet. An interview on 5/4/05 at 8 AM with CNA #10 revealed the resident "...does good with the toileting schedule." The CNA further stated the resident normally had a bowel movement between 9:30 AM and 10:00 AM. During an interview on 5/4/05 at 4 PM, RN #7 stated the toileting schedule in the ADL flow sheets was current.	F 309		
F 316 SS=D	483.25(d)(2) QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide services to promote continence for one of eight sample residents (#1) with urinary incontinence. The findings were: Review of the 8/2/04 significant change and 4/29/05 quarterly Minimum Data Set (MDS) assessments revealed resident #1 was frequently incontinent of bladder (incontinent daily, with some control present). Review of the updated bowel and bladder assessment, dated 7/31/04, documented the resident was able to maintain some control of bladder when the toileting schedule was followed. Review of the current care plan showed the toileting schedule was identified on the activities of daily living (ADL) flow sheets. Review of the April and May 2005 ADL flow sheets showed the resident was to be	F 316	F316 The facility will ensure that rsdts who are incontinent of bladder will receive appropriate treatment & services to prevent UTI & to restore as much normal bladder function as possible as evidence by: A) Rsdt #1 will be toileted according to her individual toileting schedule as indicated in her care plan. B) All rsdts will be toileted according to their individual toileting schedule as outlined in their flow sheet (care plan.) The Nurse Team Leaders will randomly observe resident toileting times (including resident #1) to ensure that their individual schedules are followed. Immediate in-servicing and corrective action will be taken if problems are identified.	6-20-05

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F 316	Continued From page 5 toileted at 7 AM, 10 AM, 1 PM, 4 PM, and 7 PM. The resident was to be checked and changed at 10 PM, 12 AM, and 4 AM. Observation on 5/3/05 showed the resident was not toileted or checked and changed from 7:15 AM until 12:09 PM (4 hours and 54 minutes). During that time, at 9:50 AM, certified nurse aide (CNA) #14 and registered nurse (RN) #7 transferred the resident to bed. The resident was not toileted. At 9:56 AM, the CNA told the RN that she realized the resident was supposed to be toileted at 10 AM, but they just laid the resident down. The CNA asked if she should take the resident to the toilet. The RN told her, "no." At 10 AM, the CNA asked the RN if she should check and change the resident, and the RN said, "no." At 12:09 PM, CNA #14 checked and changed the resident while the resident was in bed. Observation revealed the resident had been incontinent of bladder. During the observation, the CNA stated when she last took care of the resident (a month previously), the resident was able to go to the bathroom when put on the toilet. An interview on 5/4/05 at 8 AM with CNA #10 revealed the resident "...does good with the toileting schedule." During an interview on 5/4/05 at 4 PM, RN #7 stated the toileting schedule in the ADL flow sheets was current.	F 316	C) New CNAs will be oriented to the toileting flow sheets & rsdts individual schedule. DON and/or DRC will conduct a review of toileting sch. with CNAs and nurses. D) A Performance improvement monitor will be started to evaluate compliance with rsdts toileting sch this report will be evaluated monthly by the PIS committee. 6.20.05	
F 323 SS=D	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review	F 323		

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F 323	Continued From page 6 of facility policies, the facility failed to assure the environment was free of accident hazards in the secure care unit (SCU) and the beauty shop. The findings were: 1. The census of the SCU was six. Observations in the SCU revealed the following accident hazards: Observation on 5/2/05 at 4:55 PM revealed registered nurse (RN) #5 put liquid potassium chloride in the juice of resident #10. The RN stated she usually put the potassium chloride in the juice, and instructed the certified nurse aides (CNAs) to discard it if the resident did not drink it. The juice was then put in front of the resident at the dining room table. Four other residents were seated at the table. Resident #1, who was seated next to resident #10, had juice in a similar glass. The glasses were only about eight inches apart. The RN and CNA #33 were in and out of the dining room, and frequently had their backs to the dining room table. During an interview on 5/4/05 at 8 AM, CNA #10 stated the resident should be watched closely if the nurse put potassium chloride in the juice, because some residents should not have potassium. During an interview on 5/4/05 at 4:35 PM, the director of nursing (DON) stated the nurse should observe the resident take the potassium chloride. During the tour on 5/2/05 at 2:30 PM, RN #7 stated the door to exit the SCU required a code entered into a key pad next to the door. The following observations on 5/3/05 revealed concerns with the door to the SCU: a. At 8:25 AM, resident #20 (who was inside the SCU) pushed on the door, and the door opened. RN #4 was there, and was able to	F 323	F323 The facility will ensure the rsdts' environment remains free of accident hazards as evidenced by: A) Nurses will watch Rsdt #10 take her medicine. This will assure the rsdt takes her medicine without endangering other residents. Rsdts in the SCU will be kept safe in their area by assuring the door locks each time staff/visitors come & go. A sign will be put on the door alerting anyone who closes the door to make sure it locks behind them by testing the latch. In the event the door will not lock, the maintenance dept. will be contacted. Rsdt #4 & 16 will be removed to the activity rm when housekeeping is mopping the floors. Wet floor sign will be put up & only ½ the area will be mopped at a time to assure safety. When the beauty shop is unattended, hot curling irons will be stored out of sight. B) Nurses are to watch all rsdts take their medications to assure other rsdt are not in danger of getting the wrong drug. Pharmacy assistant will randomly observe med passes, including med passes to resident #10; if there are any problems with med pass, an immediate in-servicing and corrective action will be taken. The lock on the SCU will be replaced with a new locknetic system. Maintenance & a local electrician Will complete this project.	4-20-05

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F 323	Continued From page 7 re-direct the resident back into the unit. No alarms or other sounds were audible when the door opened. b. At 10:25 AM, resident #4 was seated in the dining room area. The RN (#7) and CNA (#14) were in resident rooms. The door to the SCU was not fully latched; the surveyor exited the door without putting the code into the keypad. c. At 10:50 AM, the CNA (#14) was assisting a resident in the bathroom. Residents #4 and #16 were in the dining room area. The surveyor exited the door without putting the code into the key pad. During an interview on 5/3/05 at 11:04 AM, CNA #14 stated the door did not always lock. An interview on 5/3/05 at 12:20 PM with RN #7 verified that the door did not always lock. She stated the magnetic strip got dust build-up, and it sometimes helped if the strip were wiped. She stated she had wiped the magnetic strip the day before. An interview on 5/4/05 at 8 AM with CNA #10 revealed the door did not always lock. When asked if residents had ever gotten out of the SCU, the CNA replied "...not that we didn't catch." During an interview on 5/4/05 at 9:40 AM, the maintenance director stated they have had problems with the door "since day one." He stated his expectation is that staff let him know when the door is not working properly so he can adjust it. He further stated staff did not tell him the door was not locking the day before (5/3/05). An interview on 5/4/05 at 4:35 PM with the DON revealed the expectation is that a code is required to exit the SCU. Observation on 5/3/05 at 10:51 AM revealed housekeeper #1 mopped the hallway from wall to wall. No "wet floor" signs were displayed to show the floor was wet. In addition, the housekeeper mopped the entire surface of the dining room	F 323	All residents in the SCU will go to the activity rm, or bedroom if safe and appropriate, when the floors are being mopped . The house-keeper will use a wet floor sign & mop only ½ of the floor surface at a time. Housekeeping manager will randomly observe that floors are being mopped appropriately; immediate in-servicing and corrective action will be taken if problems are identified. The beautician will unplug the curling irons when not in use and place them in a metal container in a drawer in beauty shop. C) DON and/or DRC and Housekeeping manager will in-service staff to inform them of the environmental hazard precautions: the SCU door, Beauty Shop (beautician will also be inserviced), wet floors and nurses to watch residents take their medicine. All staff need to be always diligent in detecting environmental hazards and finding solutions to provide a safe home for the rsdts. D) A Performance improvement monitor will be started to evaluate compliance with hazardous situations in the Care center. This report will be evaluated monthly by the PIS committee.	6-30-05

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F 323	Continued From page 8 area from wall to wall. No "wet floor" signs were displayed. Resident #4 was seated at the dining room table, and resident #16 was walking on the wet floor. During an interview on 5/5/05 at 8:45 AM, the housekeeping supervisor stated staff should mop half the hallway at a time in order to leave a dry area to walk on. In addition, she stated wet floor signs should be displayed. Furthermore, she stated housekeeping staff should ask the aides to put the residents in the TV room while they mop the dining room. Review of the facility's policy "Procedure for cleaning lobby and corridor cleaning" (#3240-37, reviewed 2004) revealed wet floor signs were to be used. 2. Observation on 5/4/05 at 8:25 AM revealed a beauty shop was located across from the nursing station. Two doors were opened to access the beauty shop, but no staff were in the room. One door was visible from the nursing station, but the other door was not. Inside the room was a rack containing two curling irons. Upon touching the curling irons, one of the curling irons was hot.	F 323		
F 325 SS=D	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and medical record review, the facility failed to ensure one (#41) of	F 325		

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F 325	Continued From page 9 five sample residents with weight loss received all assessed, preventative interventions for weight loss. The findings were: Observation of resident #41 on 5/4/05 at 7:40 AM revealed the resident ate 100% of the pureed foods on his/her plate. Interview with certified nurse aide (CNA) #11 on 5/4/05 at 7:40 AM revealed the resident had a previous history of consuming all of his/her pureed meals. Medical record review revealed a vital sign data sheet which listed the resident's weight history. According to the data sheet, the resident's admission weight during January 2005 was 140 lbs. The March 2005 weight listed was 142 lbs. The resident's most recent weight documented on 4/29/05 as a re-weight was 134 lbs., a loss of 8 lbs. (5.6%) in one month. The admission Resident Assessment Instrument dated 2/10/05 documented the resident's height as 66 inches tall, and assessed the resident as triggering for nutrition. According to the admission dietary assessment dated 2/8/05, the resident was assessed for nutritional status and required additional protein and calories. A documented intervention was planned to provide the resident with fortified foods. Observation of the pureed food preparation and interview with cook #1 on 12:29 PM on 5/3/05 revealed all pureed diets were given "half" portions which was a "blue" 2 oz. scoop. The cook stated that some of the pureed diets required fortification. Interview with the dietary manager on 5/4/05 at 2:44 PM revealed pureed diets should get the same portion size as other residents unless the dietary card specifies a small portion. The dietary manager stated that most residents on pureed diets received the small portion except for resident #41, who should	F 325	Resident #41's diet card has been up-dated to reflect fortified foods, and follow-up weekly weights will be recorded for Res #41. F 325 A. The facility will ensure that All residents will receive all assessed nutritional interventions. B. The Dietary Manager (DM) and Registered Dietitian (RD) will in-service the staff on the importance of fortification and ~~the~~ following ~~of~~ the diet cards. C. The Dietary Manager will conduct a weekly QI monitoring the accuracy of the tray line concerning the pureed and other diets. D. The DM will record all fortified and other therapeutic nutritional interventions onto the tray cards. This will be monitored by the RD on a bi-weekly basis in the form of a QI.	6-20-05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	05/05/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 325	Continued From page 10 receive a regular fortified portion. The manager stated fortified foods were recently added to the resident's diet. Review of the dietary card with the dietary manager on 5/4/05 at 2:44 PM revealed the resident should receive regular portions, but the card failed to indicate whether the resident required fortified foods. The dietary manager retrieved a steam table listing of residents who required fortified foods which did include resident #41. Observation of the tray line on 5/3/05 at 4:41 PM revealed the resident received a 2 ounce (half portion) serving of non-fortified meat and vegetables.	F 325		
F 363 SS=D	483.35(c)(1)-(3) DIETARY SERVICES 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: Based on observation, staff interview, dietary card review, and menu review, the facility failed to ensure residents (#4, #2, #27, #12, #7, #28 and #41) who required pureed diets received comparable menu items for one meal. In addition, one (#41) resident did not receive the portion size in accordance with the menu. The findings were: The posted menu for the evening meal on 5/3/05 revealed the main entree was "Hamburger/Cheese Pizza" Observation of the pureed meal preparation on 5/3/05 at 12:29 PM revealed residents on pureed diets would receive	F 363	F 363 A. The facility will ensure that Req. (4, 2, 27, 12, 7, 28, & 41) and all residents will receive the Planned ~~appropriate~~ menu items correlating to the ordered diet, including the correct portion size. B. The Dietary Manager (DM) and Registered Dietitian (RD) will in-service the staff on the importance and procedures of the pureed diet and of appropriate serving sizes. C. Items will be weighed prior to being pureed and the scoop size will be established based on the final pureed weight for service. D. This will be monitored by the DM during the tray accuracy QI.	6-20-05

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F 363	Continued From page 11 pureed ground beef with gravy and mashed potatoes as a substitute for the listed pizza item. Interview with cook #1 at 12:29 PM on 5/3/05 revealed the pizza item did not puree well; the crust caused a 'gummy' or sticky consistency. Further interview revealed the cheese and tomato sauce from the pizza were not added elsewhere in the planned pureed diet. The interview revealed seven residents required pureed diets and all seven received small portions using a #16 (2 oz.) blue serving scoop. Review of diet cards on 5/3/05 at 4:18 PM revealed six residents (#4, #2, #27, #12, #7, #28) with pureed diets who required "small" servings. One resident, resident #41, was to receive a regular serving size. Observation of the tray line for pureed diets on 5/3/05 at 4:41 PM revealed all persons served pureed diets received a 2 ounce serving of meat and vegetables, including resident #41. The observation revealed the residents received the pureed ground beef and gravy and not a pizza-like mixture as listed on the menu plan. Interview at 2:44 PM on 5/4/05 with the dietary manager revealed residents who receive pureed diets should get a regular portion size unless a 'small' portion is labeled on the dietary card. The manager stated residents on pureed diets should receive the posted menu item.	F 363		