STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145920	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Prophetstown	310 Mosher Drive Prophetstown, IL 61277

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview, and record review the facility failed to identify, assess, and implement treatment for a pressure ulcer before developing into a stage three pressure ulcer for 1 of 6 residents (R6) reviewed for pressure ulcers in the sample of 17. The findings include: On 8/5/24 at 10:25 AM, V12 (Wound Licensed Practical Nurse) performed a dressing change to R6's pressure wound to her left buttock. V12 removed the dressing and R6 had a pressure ulcer present measuring 2.6 centimeters (cm) x 1.8 cm x 0.1 cm. R6's Weekly Skin assessment dated [DATE] shows that she has discolored excoriation to her left buttock area. R6's Shower Assessment Sheet dated 7/17/24 shows a circle around her buttock area and it documents, ointment on. On 8/7/24 at 9:07 AM, V15 (Certified Nursing Assistant/CNA) said that she was the CNA that filled out the shower sheet on 7/17/24. V15 said that she circled the buttocks area because there was a dressing on her buttock and wrote ointment on because there was redness around the dressing that she put ointment on. R6's Wound Observation Tool dated 7/19/24 shows that a stage 3 pressure ulcer on her left buttock was identified that measured 1.5 cm x 2 cm x 0.2 cm. No other assessment of the pressure wound were provided prior to 7/19/24. On 8/7/24 at 9:05 AM, V12 said that she saw the open pressure ulcer when she toileted R6 on 7/19/24. V12 said that when she saw it, it was a stage three open pressure ulcer. V12 said that the staff should have told her about the open wound once it happened but no one notified her. V12 said that when the wound was found, she asked the staff why no one reported it to her and she said that every one said that they thought that she already knew about it. The facility's undated Pressure Injury Prevention and Management Policy shows, Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record .Nursing assistants will inspect skin during bath and will report any concern to the resident's nurse immediately after the task.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview, and record review the facility failed to ensure a resident's splints were applied to bilateral upper extremity contractures for 1 of 1 resident (R28) reviewed for splints in the sample of 17. The findings include: R28's Physician's Order Sheet printed on 8/6/24 shows an order dated 9/20/23 for: Resident to wear bilateral WHO's (Wrist Hand Orthotics) daily, on at AM and off at HS (bedtime). R28's Care Plan shows diagnoses of: spastic quadriplegic cerebral palsy, osteoarthritis and mild intellectual disability. R28's Minimum Data Set assessment dated [DATE] shows that she is dependent on staff for activities of daily living, has impairment to both sides of her upper and lower extremities and received no days of splint or brace assistance in the last 7 days. On 8/5/24 at 10:58 AM, R28 was sitting in the common area of the facility in a high back wheelchair. R28 had bilateral contractures to her hand, wrist and arm. At 11:05 AM, there was a blue hand splint laying on the floor near her garbage can in her room. At 1:16 PM, R28 did not have any splints on her upper extremities. On 8/6/24 at 9:20 AM and 1:26 PM, R28 was laying in bed. R28 did not have splints on her bilateral upper extremities. R28's blue splint was still laying on the floor next to her garbage can. On 8/6/24 at 1:26 PM, V17 (Restorative Certified Nursing Assistant) said that R28 does have bilateral hand splints that she uses. V17 said that she applies them daily if the resident wants them on but does not document their application, removal or refusal anywhere. R28's Care Plan does not address when splints should be applied. The facility's Prevention of Decline in Range of Motion Policy dated 7/1/23 shows, The facility will provide treatment and care in accordance with professional standards of practice. This includes .appropriate equipment (braces or splints) .Care Plan interventions will be developed and delivered through the facility's restorative program .Interventions will be documented on the resident's person centered care plan. Documentation should include, but not limited to: type of treatments, frequency and duration of treatments, measurable objectives, resident goals. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on observation, interview, and record review the facility failed to ensure water temperatures in resident bathrooms were maintained at a safe level and failed to ensure fall precautions were implemented for residents with a history of falling. These failures apply to 4 of 17 residents (R36, R31, R9, and R53) reviewed for safety and supervision in the sample of 17. The findings include: 1. On 8/5/24 at 10:57 AM, surveyor, using a calibrated thermometer, checked the water temperatures in R53's bathroom sink which was 123.8 degrees Fahrenheit (F). On 8/5/24 at 11:02 AM, R31's bathroom sink water temperature was 134.4 degrees F and on 8/5/24 at 2:05 PM, R9's bathroom water temperature was 125.1 degrees F. On 8/5/24 at 10:59 AM, V3 (Certified Nursing Assistant/CNA) said some resident bathroom water temperatures get so hot you can't even touch them. V3 said R31's bathroom was such a room. V3 said he has informed maintenance about the concern with no response. On 8/5/24 at 12:19 PM, V4 (Maintenance Director) said the water should be between 100 and 110 degrees F, no more and no less; anything greater than 110 degrees can be scalding. On 8/5/24 at 12:38 PM, V5 (Maintenance Assistant) was checking the water temperature in R31's room. As the water was running steam was visible. V5 said, I can see it's hot, I can't even hold my hand under it. V5 said the temperature is 136 (degrees F) and going up. The facility's Safe Water Temperatures Policy (undated) shows the following: It is the policy of this facility to maintain appropriate water temperatures in resident care areas. Water temperatures will be set to a temperature of no more than 100-110 degrees F. 2. On 8/5/24 at 10:37 AM, R53 propelled herself from the dining room to the bathroom in her room and transferred herself onto the commode. R53 had bare feet. On 8/5/24 at 10:43 AM, V11 (CNA) entered R53's bathroom, stood by R53 as R53 transferred back to her wheelchair. V11 did not use a gait belt to assist R53. R53's Admission Record dated 8/6/24 shows her diagnoses include, but are not limited to, lack of coordination, unsteadiness on feet, abnormalities of gait and mobility, need for assistance with personal care, and history of falling. R53's MDS (Minimum Data Set) dated 6/12/24 shows R53 has severe cognitive impairment and requires substantial/maximal assistance with sit to stand, chair/bed to chair transfer, and toilet transfer. R53's current care plan provided by the facility shows R53 has fallen six times in the last year. R53 needs staff assistance prior to transfers and staff are to ensure R53 wears non-skid footwear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/5/24 at 10:25 AM, R36 was in the dining room doing activities. R36 kept standing up on her own. V11 (CNA) walked with R36 out of the dining room. V11 did not use a gait belt when ambulating with R36. R36 had a shuffling, unsteady gait and her head was always looking down. At 10:29 AM, V11 walked back into the dining room with R36 and still no gait belt was being used. On 8/5/24 at 11:31 AM, R36 was walking around unassisted in the dining room. Activities staff, V12 (Wound Care Nurse), and V8 (Licensed Practical Nurse) all walked by R36 and no one intervened or assisted R36. R36's Admission Record dated 8/7/24 shows R36's diagnoses include, but are not limited to, dementia, unsteadiness on feet, lack of coordination, and weakness. R36's MDS dated [DATE] shows R36 requires partial/moderate assistance with sit to stand, chair/bed to chair transfer, walk 10 feet, walk 50 feet with two turns, and walk 150 feet. R36's current care plan provided by the facility shows R36 is a fall risk and has fallen nine times in the past year. On 8/7/24 at 10:07 AM, V3 (CNA) said R36 ambulates by herself and does not need a gait belt. V3 said they sometimes use a gait belt when R53 transfers from her chair to the commode so they can hold onto it while they clean/wipe her, but R53 is independent with transfers. The facility's Use of Gait Belt Policy (undated) shows the following: It is the policy of this facility to use gait belts wit residents that cannot independently ambulate or transfer for the purpose of safety.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview, and record review the facility failed to ensure a resident received ice cream as ordered for 1 of 3 residents (R6) reviewed nutrition in the sample of 17. The findings include: R6's Face Sheet shows that she admitted to the facility on [DATE]. R6's Physician's Order Sheet printed on 8/7/24 shows an order dated 7/31/24 for ice cream at lunch and dinner for additional nutrition. R6's Vitals Summary shows that on 7/9/24 she was 116.8 pounds and on 7/30/24 she was 109.8 pounds. R6's Nutrition Note dated 7/31/24 shows, staff report poor appetite .try ice cream with lunch and dinner On 8/5/24 at 11:35 AM, R6's noon meal was delivered to the table. R6 had pureed enchiladas, potatoes, pureed carrots and pureed strawberry dessert. R6 was not provided ice cream. R6 did not consume any of her meal. R6 left the dining room at 11:52 AM. On 8/6/24 at 11:46 AM, R6 was seen leaving the dining room. V7 (Cook) said that R6 barely ate any of her meal and was not served ice cream. On 8/6/24 at 11:50 AM, V6 (Dietary Manager) said that R6 should be served ice cream with lunch and dinner and it is on her meal ticket. V13 (Cook) said that she just missed it today. On 8/6/24 at 12:18 PM, V14 (Dietitian) said that she likes to order ice cream or pudding for residents who are eating 50% or less and not maintaining weight to help reduce weight loss. V14 said that if ice cream is ordered to help with nutrition, it should be give with the meal and should be given at the ordered meal. R6's Care Plan shows that she has a nutritional problem or potential nutritional problem r/t (related to) anorexia with interventions to: Provide and serve supplements as ordered .Ice cream lunch and dinner . The facility's undated Weight Monitoring Policy shows, Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview, and record review the facility failed to ensure the placement of a feeding tube was checked prior to administering medications and enteral feeding for 1 of 1 resident (R35) reviewed for tube feeding in the sample of 17. The findings include: R35's Hospital Notes dated 8/1/24 shows, [AGE] year old male with a history of dementia was recently hospitalized .had undergone G-tube placement on 7/26/24 .patient was seen in the emergency roiagnom on [DATE] after patient pulled out tube leading to the dislodged G-tube which was replaced in ED He was sent back to [emergency room] again last night after he pulled the G-tube leading to dislodgment where the balloon was outside the gastric lumen based on the CT imaging On 8/6/24 at 9:00 AM, V18 (Registered Nurse) prepared R35's morning medications to administer via his Percutaneous Endoscopic Gastrostomy (PEG) tube. V18 entered R35's room, opened the feeding tube port, attached a syringe without a plunger into the tube feeding port and administered water, medications, and 8 ounces of enteral feeding. V18 did not check placement of the feeding tube prior to administering. On 8/6/24 at 2:21 PM, V2 (Director of Nursing) said that placement of a PEG tube should always be checked before administering any tube feeding or medications to ensure that the tube is in the correct place. V2 said that placement should be check by aspirating gastric content using a syringe. The facility's Enteral Tube Feeding via Gravity Bag Policy revised on 11/23 shows, Verify placement of feeding tube. If anything suggests improper tube positioning, do not administer feeding or medication .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34490 Based on observation, interview, and record review the facility failed to ensure a resident's bilateral under arm pain was assessed, the physician notified, and treatment interventions implemented for 1 of 4 residents (R2) reviewed for pain in the sample of 17. The findings include: On 8/5/24 at 2:10 PM, R2 said that he has been having pain under both of his arms in his armpit area for about a week. At that time, V12 (Wound Licensed Practical Nurse) entered the room. R2 explained the pain to V12. V12 said that he probably had skin tags and she will have the nurse practitioner see him. On 8/6/24 at 1:49 PM, R2 said that he is still having the armpit pain and no one has done anything about it or even looked at them. R2's armpits were observed. There were no skin tags present or any redness observed. On 8/6/24 at 1:53 PM, V18 (Registered Nurse) was asked if she had heard anything about R2 having bilateral armpit pain. V18 said that R2 is always complaining about some type of pain but she had not heard that he was having armpit pain. R2's Progress Notes from 8/1/24-8/7/24 do not document any assessments of his bilateral armpit pain. R2's Medication Administration notes show that he received pain medication on 8/2/24 at 3:18 PM and 8/3/24 at 7:56 AM but did not document the location of the pain. On 8/6/24 at 2:21 PM, V2 (Director of Nursing) said that if a resident is complaining of pain, the nurse should go and assess the resident to identify where the pain is at, what makes it better, what makes it worse and do a visual assessment to see if there is any observable signs of an issues. V2 said that if it is a new pain for the resident, the physician should be notified and orders carried out if provided with new orders. V2 said that the nurse should document their assessment of the pain in the resident's medical record. The facility's undated Pain Management Policy shows, Based on professional standards of practice an assessment or evaluation of pain by the appropriate members of the interdisciplinary team may necessitate gathering the following information, as applicable to the resident: history of pain and its treatment .Identifying key characteristics of the pain: duration of pain, frequency, location, timing, pattern, radiation of pain . Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manager each individual resident's pain beginning at admission

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35174 Based on observation, interview, and record review the facility failed to ensure multidose medication vials were marked with expiration dates after opening which applies to 58 residents in the facility. The findings include: The CMS-671 form dated 8/5/24 showed the facility's census to be 58 residents. On 8/7/24 at 10:35 AM, V9 (Licensed Practical Nurse) opened the medication room and medication storage refrigerator. The 2 opened vials of Tuberculin testing solution were stored in the refrigerator. The first vial was almost empty, and the second vial was approximately half empty. Both vials had no written opened date or expiration date on them. On 8/7/24 at 10:40 AM, V9 stated when the vials are opened the nurse should write the date on them. The opened date will determine the expiration date. V9 stated Tuberculin is good for about a month after opened. On 8/7/24 at 12:00 PM, V2 (Director of Nursing) stated multidose vials need to have the date it was opened written on them. The facilities Medication Expired Dates and Storage Sheet (initialed 8/7/24) showed Aplisol/Tubersol-Tuberculin PPD/Mantoux Injection- Should be maintained according to manufacture recommendations in refrigerator. Expires 30 days after opening. Nurses write on the product the open and expire dates.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37232 Based on observation, interview, and record review the facility failed to follow the pureed menu for 6 of 6 residents (R4, R6, R11, R23, R43 and R51) reviewed for dietary services in the sample of 17. The findings include: A facility provided list indicated R4, R6, R11, R23, R43, and R51 were on a pureed diet on 8/5/24. The menu for 8/5/24 showed pureed enchiladas were to be served and a number 6 scoop providing a 5.33 ounce (oz.) serving size was to be used to plate the enchiladas. On 8/5/24 11:26 AM, V7 (Cook) said there were 6 residents on a pureed diet. V7 started plating the pureed food. V7 used a spoodle with a green handle to plate the pureed enchilada. Written on the handle of the spoodle was 4 oz. V7 placed one 4 oz. scoop of the pureed enchiladas on the plates (1.33 oz. less than what the menue called for). On 8/5/24 at 12:08 PM, V7 said she was done plating the pureed food and used the 4 oz. spoodle to plate the pureed enchiladas. On 8/5/24 at 12:08 PM, after serving the pureed meals, there was pureed enchiladas in the serving container covering the bottom of the container. On 8/5/24 at 12:12 PM, V6 (Dietary Manager) said a number 6 scoop would provid 5.33 oz. and the menus should be followed.