

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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	F 000			
F 159 SS=C	<p>Annual Licensure and Certification Survey</p> <p>Validation Survey - SubPart U: Alzheimer's Unit</p> <p>No extended survey was conducted.</p> <p>483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>	F 159		4/29/07	

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 159	<p>Continued From page 1</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that resident funds for 58 of 58 residents were not commingled with facility (County) funds, failed to provide an ongoing balance record for each resident statement, and failed to reconcile the resident trust fund account monthly.</p> <p>The findings are:</p> <p>1. During review of the resident trust funds with E4, the Accountant, on 3-14-07 at 3:15 P.M., it was determined that resident funds are commingled with the facility (County) general operating funds. E4 stated that the residents' monthly Social Security checks are received at the facility and the checks are transferred to the County Treasurer. According to E4, the County Treasurer deposits the checks into the County's general operating account and later in the month,</p>	F 159			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 159	Continued From page 2 the County Treasurer issues a check for the residents' portion. The check from the County Treasurer for the residents' portion from the Social Security checks is deposited into the residents' trust fund interest bearing checking account. According to E4, the following are the dates checks were received. Date received at facility: Date received from Treasurer: 12-1-06 12-27-06 1-3-07 01-27-07 2-2-07 02-28-07 2. A resident trust fund statement was reviewed. The statement did not have an ongoing balance to reflect the balance following each transaction. E4 acknowledged that statements do not provide an ongoing balance. 3. E4 was asked for the last complete monthly reconciliation of the resident trust fund account. E4 provided a copy of the November 2006 reconciliation report. E4 acknowledged that the November reconciliation was the most recent reconciliation.	F 159			
F 323 SS=E	483.25(h)(1) ACCIDENTS 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 and interview, the facility failed to ensure that chemicals in 5 of 5 unlocked soiled utility rooms were not accessible to residents.	F 323		4/29/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 323	Continued From page 3 The finding is: During the General Observation tour on 3-12-07 and 3-13-07 accompanied by E5, the Maintenance Supervisor, the 5 soiled utility rooms were observed. Each of the 5 units have a soiled utility room. The rooms were not locked and the cabinets in the room were not locked. Each of the soiled utility rooms are equipped with a chemical dispensing station on the wall behind the 3 compartment sink. In the cabinet under the sink is a gallon container of the concentrate for "Mikro-quat" disinfectant and for "Neutral Disinfectant Oasis 531". Precautionary labels were on the containers. The dispensing stations have push buttons that dispense the chemicals for use. The resident would have access to the end of the dispensing chemical tube and the concentrate. Ambulatory, cognitively impaired residents were observed in the areas of the soiled utility rooms. Interview with E5, Maintenance Supervisor, showed that the dispensing stations were installed with the new construction.	F 323			
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that insulin was given as ordered for two residents in the sample of 29, on 2/28/07 (R17 and R27). The Findings include:	F 333		4/29/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 333	<p>Continued From page 4</p> <p>1. Review of the current Physician's Order Sheet (POS) for R17 shows that this resident has diagnoses which include Insulin Dependent Diabetes Mellitus (IDDM). Review of the Medication Administration Record for the month beginning February 15th through March 15th showed that R17 did not receive the regularly scheduled insulin of Novolin N 100 Units/Milliliter (MI) 10 Units at 5:00 p.m. on 2/28/07. It also showed that R17 did not have a blood glucose test taken at 4:00 p.m. on 2/28/07 as ordered to determine if this resident required Sliding Scale Insulin as ordered for 4:00 p.m. Review of the medical record including physician's orders did not show that R17's physician was notified that these insulin medications were held.</p> <p>2. Review of the current Physician's Order Sheet dated March 2007 for R27 shows diagnoses that includes Diabetes Mellitus with orders for Humalog 100 units/ML before breakfast, lunch and before supper; Lantus 100 units/ML 8 units at bedtime. Review of the Medication Administration Record (MAR) for 2-16-07 thru 3-15-07 showed that R27 did not receive the regularly scheduled insulin of Humalog 6 units before supper on 2-28-07. In interview with R27 on 3-14-07 at 10 A.M. R27 states she had two reactions of feeling weak and shaky from not getting food timely after taking insulin last week. R27 states she has problems with her blood sugars fluctuating. R27 states she does not remember how her blood sugars were on the day she moved to the new facility.</p> <p>During interview with E2, the Director of Nursing, on 3/14/07 at 12:00 p.m., E2 presented a Physician's Order from the Medical Director which stated "May have drug holiday on all</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 333	Continued From page 5 residents for 12 noon and 4 p.m. medications due to the move to new building." E2 stated that Sliding Scale insulins had been brought over to the new building so that residents could receive them as ordered. When questioned, E2 stated that regularly scheduled insulins were not given on 2/28/07 for the noon and 4 p.m. doses. During interview, E2 did confirm that R27 did not receive insulin as ordered after looking at R27's MAR for February 28, 2007. During a subsequent interview with E2 at 3:00 p.m. on 3/14/06, she stated that that attending physicians were not notified of the medication hold orders.	F 333			
F 363 SS=E	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: Based on observation, record review, and interview, the facility failed to follow planned menus and recipes for 19 of 19 residents on puree diets and for 36 of 36 residents on No Concentrated Sweet diets. The findings are: 1. During observation of the preparation of the puree pork on 2-13-07 at 10:00 A.M., E8, Cook, was preparing the puree pork. E8 put pieces of pork into a food processor and added beef broth and pureed it. E8 was asked to see the recipe	F 363		4/29/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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	<p>Continued From page 6</p> <p>she used to puree the meat. E8 did not weigh the meat and measure the liquid broth. E8 did not have a recipe to follow. Following the observation, E9, the cook supervisor showed a card file that where the recipes were, however, this was not the pureed menu according to the spreadsheet. E6, the Dietary Supervisor was asked to see the recipe that goes with the pork chop and gravy menu item for the 2-13-07 noon meal. E8 produced the recipe book. The puree recipe called for 15 ounces of meat, 2 1/2 slices of bread, and a cup of gravy for 5 servings. E9 was asked on 2-14-07 at approximately 10:00 A.M. if she used the recipes. E8 said "not always." Because the recipe was not followed, the 19 residents on a pureed diet did not receive the proper amount of protein in accordance with the menu and diet.</p> <p>2. During observation of the 3-14-07 at the noon meal service in 200/400 wing dining room, the No Concentrated Sweet (NCS) diets were not followed for the residents. The NCS diets were observed to be served the regular dessert. The menu listed Angel food cake to be served to NCS diets. The observed NCS diets were served a whole piece of Jam Cake with Creamy Frosting. The serving line in the dining room did not have the angel food cake. E6 said the NCS diets were to be served diet fruit instead.</p> <p>3. According to the current Physician's Order Sheet for 2/16/07 - 3/15/07, R30 has multiple diagnoses including Diabetes Mellitus, and receives hemodialysis three times a week. R30's diet order is for No Concentrated Sweets/ No Added Salt. R30 has his blood glucose checked four times daily and receives Novolog insulin per sliding scale.</p>	F 363			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 7	F 363			
F 364 SS=B	<p>On 3/14/07 approximately 12:40pm, R30 asked to have some sugar. No tray card was on the table for R30. E10 (dietary aide) was passing by and was asked if R30 could have sugar. E10 said "Yes, he can have sugar, he's on a regular diet." E10 was asked if R30 was on a No Concentrated Sweets (NCS) diet. E10 replied that if R30 was on a NCS diet that he could have the "blue sugar" (artificial sweetener). E10 then got the artificial sweetener from the holder and gave it to R30.</p> <p>483.35(d)(1)-(2) FOOD</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to serve food for 10 of 10 residents at palatable and at proper temperatures.</p> <p>During observation the noon meal service on 3-13-07 in the unit 5 (Garden Court) the Alzheimer unit, the food was not stored or held at 140 degrees Fahrenheit (F). The hot foods for the unit were transported from the dietary department in a closed heated high boy cart. The cart was plugged in at 11:25 A.M. The modified buffet service began at 12:05 P.M. The outside of the steamtable pans were warm to the touch. Temperatures were taken and the pork chops were 110 degrees F., the ground pork was 110 degrees F., the ground turkey was 108</p>	F 364		4/29/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2007
NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802		
(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 364	Continued From page 8 degrees F. and the sliced turkey was 110 degrees F. The meal was going to be served by E7, Certified Nurse Assistant (CNA). E7 stated that she would have served the food at the above temperatures. E7 said that she did not have a thermometer or a method to take food temperatures. After being prompted by the surveyor, E7 called the dietary department and E6, the Dietary Manager brought hot food to the replace the food. It was determined that the hot cart was not turned on.	F 364			
F 371 SS=C	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that chemicals were stored to prevent potential contamination of food and failed to thaw food properly. and failed to hold and serve food for 10 of 10 residents at 140 degrees or higher. The findings are: 1. During initial dietary department tour on 3-12-07 at 9:30 A.M., it was observed that a gallon container of bleach was stored on a shelf above the cook's food preparation sink. 2. In cook's food preparation sink were packages of frozen sliced turkey breast thawing in standing water. The water was not running.	F 371		4/29/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHAMPAIGN COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL DRIVE URBANA, IL 61802
--	--

(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