

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

PRINTED: 12/15/2009
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 12/10/2009
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 Annual Licensure and Certification Survey Complaint 0965180/IL44904 - No deficiency VALIDATION SURVEY FOR SUBPART U: ALZHEIMER UNIT The facility is in substantial compliance with Subpart U, 77 Illinois Administrative Code, Section 300.7000	F 000			
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	F 164			

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.

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F 164	<p>Continued From page 1 healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide visual privacy for two of twenty four sampled residents receiving personal care during bathing (R26), and gastrostomy care (R10).</p> <p>The findings include:</p> <p>1. On 12/08/09 at 2:10 pm Certified Nurse Aide (CNA)E11 came out of the 100 unit Bathing Room. While the door to the bathing room was open the bare upper body of a male resident who was receiving a whirlpool bath was clearly visible. There was also a CNA in the bathing room with the resident. There was no privacy curtain visible. E11 confirmed on 12/08/09 at 2:12 pm that R26 was receiving a whirlpool bath.</p> <p>On 12/08/09 at 2:20 pm CNA E16 came out of the whirlpool room opening the door wide as she left. R26 who was still in the whirlpool tub and was clearly visible from the nurses desk, shouted "Close the door!"</p> <p>On 12/08/09 at 3:00 pm the 100 Unit Bathing Room was inspected. There were ceiling tracks and privacy curtains available for the whirlpool tub that could have been used to provide visual privacy and prevent R26 from being exposed to the hallway. There was a short straight track that could be pulled to partially screen the entry door. The encircling curtain to enclose the tub was pushed all the way against the back wall behind</p>	F 164			

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F 164	Continued From page 2 the tub. R26 stated on 12/09/09 at 1:45 pm that he was getting a whirlpool bath (on 12/08/09) and CNA E15 did not know how to run the whirlpool so she had to get help from E11. R26 stated that there was no privacy curtain in the bathing room and he thinks that there should be. R26 stated that the staff would open the door wide open when they would come in and out and he told them not to open the door so wide. R26 stated he knows he was only exposed from the waist up but he still didn't like it. E26 stated he has had a whirlpool bath before and they did the same thing.	F 164			
F 248 SS=D	2. R10's Tube Feeding was observed on 12-8-09 at 10:05am with E17, Registered Nurse (RN) and E18, Licensed Practical Nurse (LPN), present in R10's room. R10's roommate was also in the room. After E17 gathered all the supplies to complete the task for changing the tube feeding bottle, spike the set, and giving the ordered flush, the privacy curtain was pulled between R10 and the door to the hallway. However the roommate was still in the room and was in full view of R10 during the entire procedure. Neither E17 nor E18 pulled the curtain around the foot of the bed to offer full visual privacy from the roommate. 483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 248			

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F 248	<p>Continued From page 3</p> <p>by: Based on interview, record review and observation the facility failed to ensure that 1 of 5 sampled residents (R5) got assistance with activities during 1 of 3 activity observations during the survey.</p> <p>Findings include:</p> <p>On 12-8-09 at 10:05am E13, Activity Assistant and E14, Certified Nursing Aide were conducting an activity on Unit 4 to make Christmas Cards for a group of residents in the activity area. R5 was sitting in her wheel chair moving herself in the immediate area around the table near the other residents making the Christmas Cards. At 10:55am R5 was trying to get up to the table in the activity area. R5 was bumping her wheel chair into the back of E13's chair. E13 got up from the table, briefly spoke to R5 but did not move R5 up to the table or involve her in the activity. After E13 spent a few minutes with a couple of residents seated behind R5, R5 laid her head down on the back of the chair in front of her. E13 moved a resident over to make room at the table so R5 could move up to the table at 11:00am.</p> <p>After R5 was up to the table, E13 did not give R5 anything to do. E13 turned away and went to help other residents. R5 picked up a marker from a package of markers sitting close by, but did not have anything to write on. E14 was sitting across the table helping other residents with their cards at this time. After 2 minutes R5 left the table without having made a Christmas Card or getting any encouragement from the staff to stay to make a card.</p>	F 248			

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F 248	Continued From page 4 According to R5's December 2009 Physician's Order Sheet (POS) the Diagnosis includes Senile Dementia, Anxiety, and Depressive Disorder. According to R5's Care Plan dated 11-9-09 it states "Allow inclusion in activities of interest. . . . resident lacks sense of initiative/ involvement . . . participate in facility events . . . assist to and from activities " E14 stated at 1:45pm on 12-8-09 that R5 did not make a Christmas card during the morning activity. E14 asked R5 if she wanted to make a card at this time and R5 said No. On 12-10-09 at 9:20am E7 Activity Director, stated they missed the opportunity to involve R5 by not giving her the supplies when she was put up to the table.	F 248			
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide emotional support to 1 of 1 sampled resident whose husband had just died(R20). Findings include: The Physician Order Sheet dated 11/16-December 15, 2009 states R20 has a diagnosis of Alzheimer's. The Minimum Data Set	F 250			

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F 250	<p>Continued From page 5</p> <p>states R20 has cognitive problems and requires assist with transfers, dressing and eating.</p> <p>E23, Licensed Practical Nurse stated on 12/8/09 at 11:50am that R20's husband died on Friday(12/4/09). E23 stated his death was pretty sudden, he went to the hospital on Thursday and died on Friday. E23 stated R20 told her that they had been married 69 years, she was still in love with him and then would cry.</p> <p>R20 stated on 12/10/09 at 9:50am that she and her husband had been married 69 years and "I loved him and really miss him". R20 became tearful when talking about her husband.</p> <p>The Interdisciplinary Progress Notes for November and December do not document the death of R20's husband, how R20 is dealing with his death or any emotional support given to R20.</p> <p>E24, Social Service, stated on 12/9/09 at 9:15am that she is the social worker for R20 but was off on the weekend and Monday. E24 stated when she returned to work on Tuesday (12/8) she was told that R20's husband had died Friday(12/4). E24 stated she greeted R20's family, but did not interact with R20 because R20 was busy with her family and the memorial service for her husband which was held in the chapel on Tuesday. When asked if there was any social worker available on the weekend, E24 stated that E25 worked the weekend.</p> <p>E25, Social Service stated on 12/9/09 at 9:20am that he worked the weekend and was aware that R20's husband had died on Friday(12/4). When asked if he provided any emotional support to R20 following the death of her husband, E25</p>	F 250			

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F 250 F 309 SS=D	Continued From page 6 stated he did not offer R20 any support. 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide necessary services for 1 of 2 residents in the facility receiving hemodialysis, by failing to accurately address access monitoring, failing to ensure accurate fluid restriction, and failed to provide inservice education regarding dialysis (R27). Findings include: During the initial tour on 12/7/09 at 10:00am, E4 (Assistant Careplan Coordinator) stated that R27 is on hemodialysis three times weekly, and has a fistula in the forearm as an access. Review of the diet list provided by the facility showed that R27 receives a regular diet with no fluid restriction. According to the current Physician's Order Sheet (POS) for 12/09, R27 was admitted to the facility in 6/09 with multiple diagnoses including Chronic Renal Failure, Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease and Senile Dementia. The diagnosis list includes Renal Dialysis status, but does not	F 250 F 309			

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F 309	<p>Continued From page 7</p> <p>identify the type of dialysis access. The Minimum Data Set (MDS) of 9/21/09 assesses R27 with no memory problems and no cognitive impairment.</p> <p>The careplan dated 9/3/09 states that R27 is on a regular diet 1200cc (cubic centimeters) fluid restriction. The careplan entry for dialysis has as a goal "Resident will not exhibit signs of fluid volume excess." The only approaches for this problem entry are "dialysis as ordered" and "monitor bruit and thrill in shunt every shift." No entries in the Treatment record and no nurses notes addressed monitoring thrill and bruit, or addressed access observations of any kind. Door Sign/Care Plan on the back of the room doors that staff use for reference does not address a fluid restriction or anything regarding access.</p> <p>The current POS does not list an order for a fluid restriction. The order on the initial POS dated 6/20/09 ordered regular diet with 1200cc fluid restriction. A hospital Patient Transfer Form dated 9/28/09 orders a 1200cc fluid restriction. Intake and Output sheets from 9/12/09 to 11/30/09 had very few entries and never all three shifts. The Nursing Monthly Summary dated 11/15/09 states that R27 is on the 1200cc fluid restriction. Dietary notes by the Registered Dietitian (RD) noted the 1200cc fluid restriction on 9/1/09 and 9/30/09. On 11/11/09 the RD did not address the fluid restriction, but no order to discontinue was found.</p> <p>On 12/9/09 at 12:00pm a full water pitcher was noted on R27's overbed table. E6 (nurse) stated on 12/9/09 at 1:00pm that R27 is on a 1500cc fluid restriction, and that R27 "doesn't usually" have a water pitcher in her room. E6 was asked</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>if there was any plan for how much fluids are provided by dietary and how much nursing is allowed to provide. E6 stated that R27 "doesn't leave her room" except for dialysis, and that E6 "watches it pretty carefully" as far fluids. E6 was also asked regarding type of dialysis access R27 had, and E6 pointed to upper chest, confirming it as a subclavian when prompted.</p> <p>On 12/10/09 at 8:30am, R27 was observed in her room, with 2 cups of juice, glass of water and carton of supplement on her breakfast tray. R27 showed her right subclavian dialysis catheter, and her left forearm fistula. R27 stated that when the fistula was put in she did not realize that meant that she would be stuck with needles, so she did not let them (dialysis) use the fistula, and she continues to use the subclavian. R27 stated that the fistula no longer works. R27 states she cannot take showers because she cannot get the subclavian dressing wet, she can only take baths or bed baths. (The careplan does not address these issues.) When asked if she was on any kind of restriction, R27 stated, "I don't know, sometimes they do, sometimes they don't. Then they tell me at dialysis I'm carrying too much fluid. Then I try to cut back. But they bring me all these good things." R27 also stated that she is frequently sick to her stomach.</p> <p>On 12/10/09 at 10:00am, the above information was discussed with E2 (Director of Nursing). E2 acknowledged that the access needs to be addressed. E2 provided a list of inservices for the last year that did not include anything related to dialysis. E4 later provided information that R27 was no longer on a fluid restriction, and that an inservice was being set up.</p>	F 309			
F 329	483.25(l) UNNECESSARY DRUGS	F 329			

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F 329 SS=D	<p>Continued From page 9</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide Physician rationale to justify the use of Antipsychotic medications for 2 of 5 sampled residents on Antipsychotic medications(R30,R29) and failed to provide documentation of Physician rationale to justify the dosage of an Antipsychotic medication above the recommended dosage for the elderly(R30). The facility failed to attempt a Gradual Dose Reduction(GDR) for 1 of 9</p>	F 329			

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F 329	<p>Continued From page 10</p> <p>sampled residents on Psychoactive medications (R29).</p> <p>The finding is:</p> <p>1. According to R30's Physician Order Sheet (POS) for the period of 11-16-09 to 12-15-09, R30 was admitted to the facility on 6-29-09 with diagnoses that includes Alzheimer Disease, Depression, Hyperlipidemia, Osteoporosis, Psychosis, Chronic Pain, and Renal Insufficiency. The Physician Order dated 9/17/09 states Geodon 20 mg(milligrams) is to be given twice daily for Psychosis. The Physician's Order dated 9/5/09 states Zyprexa 10 mg is to be given daily for Psychosis. The Physician's Order dated 9/5/09 states Geodon 10 mg IM(intramuscularly) is to be given twice daily as needed for Agitation / Psychosis.</p> <p>The regulation guidelines refers that Ziprasidone (Geodon) "Not customarily used for the treatment of behavioral symptoms." According to Lexi-Comp's Drug Reference Handbooks "Drug Information Handbook for Nursing"2007 page 1304, Ziprasidone (Geodon) is used for the "Treatment of Schizophrenia, treatment of acute manic or mixed episodes associated with bipolar disorder". The only label use is Tourette's syndrome. The regulation guidelines states that Olanzapine (Zyprexa) daily dose thresholds is 7.5 mg.</p> <p>R30's Medication Administration Record (MAR) and behavior tracking record for the period of 11-16-09 to 12-15-09 were reviewed. The behavior tracking listed the following tracking behavior: Restless, Physically Abusive, Verbally Abusive and Resisting Care. The only reported</p>	F 329			

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F 329	<p>Continued From page 11</p> <p>behaviors were on the evening shift on 12-1-09, 12-2-09, and 12-4-09. The oral Geodon 20 mg and the oral Zyprexa 10 mg were being given as ordered. The injectable intramuscular Geodon 10 mg. was given on 11-16-09 and 11-24-09. The Interdisciplinary Progress Notes listed no behaviors during 11-16-09 and 12-15-09.</p> <p>The Physician Progress note dated 10-21-09 states to "Decrease Geodon to 10 mg q. a.m. (every morning) and continue 20 mg q.p.m. (every afternoon/evening)" On 10-30-09 the Consultant Pharmacist reported that Geodon 10 mg was not available and recommended that Geodon 20 mg be given once a day. Z1, Nurse Practitioner, disagreed with the Consultant Pharmacist dose reduction, but did not provide rationale to justify not attempting a dose reduction.</p> <p>On 12-09-09 at 12:00 P.M. R30 was observed in the activity area sitting sound asleep with residents and staff around talking. At 12:45 P.M. staff were trying to feed R30. R30 was half asleep and staff had to awake R30 to fed him. R30 ate less than 50% of his food. R30 remained in the activity area on the wing until 1:45 P.M. asleep in the chair. R30 was taken to his room and he was observed sleeping in his bed from 2:00 P.M. to 4:00 P.M. On 12-10-09 at 8:40 P.M., R30 was asleep in the chair in the activity area.</p> <p>The Care Plan Coordinator, E4 was interviewed on 12-10-09 at 8:40 A.M.. E4 stated she(E4) spoke with Z1 at length regarding R30's Geodon and Zyprexa medication. Z1 stated she did not know R30 well enough to provide further justification for the use of the medications.</p>	F 329			

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F 329	<p>Continued From page 12</p> <p>2. The POS dated 11/16-12/15/09 states that R29 has diagnoses of Alzheimer's and Psychotic Mood Disorder. The Physician Progress Note dated 3/19/09 under the section titled "Attending Note" states, "Dementia with psychosis continueSeroquel, Ativan and Geodon".....</p> <p>The facility Behavior Tracking Log documents the following behaviors for R29:</p> <p>September 2009- 1 day documented with the behavior of insomnia.</p> <p>October 2009-6 days with behaviors of verbally abusive(2 times), physically abusive(2 times), insomnia(2 times), repetitive verbalization(1 time), repetitive questions(1 time), unrealistic fears(1 time) and repetitive anxious complaints(1 time).</p> <p>November 2009-8 days with behaviors of anger(6 times); verbally abusive(6 times), physically abusive(2 times), socially inappropriate(1 time), resisting care(5 times),repetitive verbalizations(1 time), insomnia(2 times), crying(1time) and thinks something terrible is going to happen(1time).</p> <p>December 2009-3 days with behaviors of insomnia(2 times), anger(1time), verbally/physically abusive(1 time) and resists care(1time).</p> <p>The Physician's Order dated 10/23/08 states R29 is to be given Seroquel 25mg twice a day. There is an order dated 12/31/08 to increase R29's Seroquel to 75mg three times a day. The POS's from January 2009 to December 2009</p>	F 329			

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F 329	<p>Continued From page 13</p> <p>state Seroquel 75mg three times a day continues to be given to R29. There is no evidence of any GDR being recommended by the pharmacy or being attempted by the facility.</p> <p>The Physician's Order dated 11/10/08 states Geodon 10mg IM to be given PRN(as needed) to R29. On 6/23/09 there is a Physician's Order to increase the Geodon to 20mg IM twice a day PRN.</p> <p>The Physician's Order dated 3/4/09 states Geodon 20mg po(by mouth) twice a day and Ativan 1mg po twice a day are to be given to R29. The POS's from March through December 2009 state Geodon 20mg and Ativan 1mg continue to be given to R29 twice day. There is no evidence of any GDR being recommended by the pharmacy or being attempted by the facility.</p> <p>The Initial Psychotropic Medication Assessment dated 10/23/08 states the diagnosis related to psychotropic drug use is "Dementia with associated psychotic mood disorder, Depression, and Anxiety". The behaviors identified are "verbal/physical aggression". The Quarterly Reassessments dated 1/7/09, 4/9/09 and 7/8/09 document "no change in behavior, medications continue". The Reassessment dated 3/4/09 states, "Evaluated by Psychiatrist(Z2). Meds[medications] changed due to no improvement in behavior". None of the assessments document any delusions or hallucinations for R29.</p> <p>The Psychiatrist Progress Note dated 3/11/09 written by Z2, Psychiatrist, states, "This is the second time [R29] has been sent to see me and no information about his[R29] status has been</p>	F 329			

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F 329	Continued From page 14 sent to me. The next time he comes for a visit someone who knows him must come with him so I can get a workable history. For now I will continue the same medications." The Interdisciplinary Progress Note dated 3/11/09 at 1:45pm states, "Received call from [Z2,Psychiatrist]. [Z2] states he needs more information to treat [R29].....[Z2] states on next visit someone...who knows [R29] must be present or [Z2] will refuse to treat [R29] further."	F 329			
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, staff failed to administer medications as ordered. There were 41 opportunities and three errors with a medication error rate of 7.31% (R32, R34). Findings include:	F 332			

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F 332	Continued From page 15 1. On 12/7/09 at 3:55 p.m. E18, Licensed Practical Nurse (LPN), administered Effexor 50 milligrams (mg) and Crestor 10mg to R32. The medications were given with water and no food was provided. On 12/7/09 at 4:45 p.m. R32 had not yet received her evening meal, and E20, Certified Nurse Assistant, stated the meal trays normally do not arrive on the unit until 5:00 p.m. R32's December 2009 Physician's Order Sheet (POS) lists an order with origination dates of 3/5/09 for the Effexor and Crestor to be given with the meal.	F 332			
F 368 SS=B	2. On 12/8/09 at 11:30 a.m. E21, LPN, administered Iron 325mg to R34. The medication was given with water and no food was provided. R34 had not received her meal. On 12/8/09 at 2:10 p.m. E21 stated the noon meal is served between 11:30 a.m. - 1:00 p.m. R34's December 2009 POS lists an order with an origin date of 6/16/09 for the Iron to be given after lunch. 483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368			

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F 368	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to offer a daily bedtime snack to 2 of 24 sampled residents(R12, R26). The findings include: 1. Six of six resident in the group meeting complained that they were not receiving nightly bed time snacks on 12/08/09 at 1:00 pm. Two of the residents stated that they were diabetic and did not receive a snack. All residents agreed that they would like a bed time snack. 2. R12 stated on 12/08/09 at 4:30 pm that no one offers her a bedtime snack. R12 stated that she tries to save part of her dessert from the supper meal so she can have a snack before bed. R12 stated that she gets hungry and would like to have a cookie or snack before bed. R12's most recent Minimum Data Set (MDS) dated 10/06/09 identifies R12 as having no cognitive impairment. R12's weight at the time of the assessment as 97 pounds and R12 is 58" tall. R12's care plan dated 9/14/09 states R12 experiences insomnia. One of the approaches included was "Offer snack before bedtime or when resident awakens during the night." R12's care plan dated 9/14/09 documents "Resident leaves 25% or more of food uneaten at most meals. Current body weight 97 (pounds), acceptable weight 93 +/- (plus or minus) 10 %. The care plan identified that R12 likes any kind of	F 368			

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F 368	<p>Continued From page 17 vegetables, coleslaw and cookies.</p> <p>The facility Administrator E1 was informed of resident complaints of no bedtime snacks on 12/09/09 at the daily status meeting at 4:30 pm.</p> <p>On 12/10/09 at 9:00 am R12 stated that no one offered her a bedtime snack again last night (12/09/09). R12 stated "A dark room and a cookie in the middle of the night is good for sleeping."</p> <p>On 12/09/09 at 12:15 pm residents R26 and R12 were in the dining room waiting to be served. R26 and R12 said no one comes around with a bedtime snack. R26 stated he received bedtime snacks when he lived in the old building, but he hasn't received one since residing in the new building.</p>	F 368			