IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 22, 2019

Sara McMahan, Registered Agent
Eden Retirement Center, Inc.
400 South Station Road
Glen Carbon, Illinois 62034

RE:	Complaint #:	IL00108601, IL00108615
	Survey Date:	January 22, 2019
	Docket #:	19-C0082
	Violation Type:	Level B

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Eden Village Care Center.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Eden Village Care Center/January 22, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. EDEN RETIREMENT CENTER, INC., D/B/A, EDEN VILLAGE CARE CENTER, Respondent.	)))))))))	Docket No. NH19-C0082

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00108601 and IL00108615 Investigation conducted by the Department on January 22, 2019, at Eden Village Care Center, 400 South Station Road, Glen Carbon, Illinois 62034. On March 18, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.

3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$ 2,200.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a) and 300.1210b). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
525 West Jefferson, 5th Floor, QA
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 19th day of March, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. EDEN RETIREMENT CENTER, INC., D/B/A, EDEN VILLAGE CARE CENTER, Respondent.	)	Docket No. NH 19-C0082

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Sara McMahan
Licensee Info:	Eden Retirement Center, Inc.
Address:	400 South Station Road Glen Carbon, Illinois 62034

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 19th day of March, 2019.

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002679	A. BUILDING _____ B. WING _____	C 01/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VILLAGE CARE CENTER	400 SOUTH STATION ROAD GLEN CARBON, IL 62034

(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) COMPLETE DATE
S 000	Initial Comments Complaint # 1940227/IL108601- F684 Complaint # 1940246/IL108615- F684 Statement of licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following	S9999	**Attachment A** **Statement of Licensure Violations**	

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procedures:

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to timely identify and treat cellulitis for 2 of 2 residents (R2, R3) reviewed for quality of care for wounds in the sample of 6. This failure resulted in R2 and R3 being hospitalized for cellulitis and sepsis.

Findings include:

1.R2's Electronic Medical Record (EMR) documents in part, R2 was admitted to the facility on 11/30/18 with partial diagnoses including Biliary Acute Pancreatitis, History of Cerebral Vascular Accident, and Hypertension.

R2's Physician's Order, dated 11/20/18, documents "Skin Assessment, (High Risk) Special Instructions: Check Skin Daily and Document Weekly."

R2's Minimum Data Set (MDS) dated 12/27/18 documents R2 Brief Interview for Mental Status is 14 cognitively intact.

R2's Care Plan dated 12/18/18 documents a goal that R2's skin will remain intact during the next 90 days. The intervention for this goal documents "Conduct a systematic skin inspection daily."

R2's Shower Record/Skin Audits, dated 12/1, 12/6, 12/9, 12/12, 12/19 and 12/22/18 documented reddened areas to her buttocks region.

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On the back of R2's December 2018 Treatment Flow sheet, documentation dated 12/21/18 noted there were "0 (no) reddened or opened areas noted at this time."

R2's Shower Record/Skin Audit, dated 12/26/18 did not identify any issues with R2's skin condition.

R2's Progress Note, dated 12/26/18, documents, "Elder remains on Therapy as ordered. Elder up per w/c (wheelchair) to main DR (Dining Room) this AM, appetite good, elder fed self. No c/o pain or sob (shortness of breath) noted, resp. (respirations) even and unlab (unlabored). No cough or congestion noted. No c/o (complaints) noted per elder. Family, daughter reported noting rash like area to RLE (Right Lower Extremity), thigh, elder stated itches at times, and stated she thought it was just dry skin, on MD (medical doctor) list for doctor to see today."

R2's Progress Note, dated 12/26/18, at 5:17 PM, documented R2 was seen by V10, R2's Physician, with no new orders received.

V10's Progress Note, dated 12/26/18, did not document that he assessed R2's rash.

On the back of R2's December 2018 Treatment Flow sheet, documentation dated 12/28/18 documented "no redness or open areas noted."

R2's Shower Record/Skin Audit, dated 12/30/18 documented reddened areas rash and bruise noted to R2's right lower extremity. There was no documentation in R2's Progress Notes on 12/30/18 regarding reddened areas, rash and bruise found during R2's shower and if the facility

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assessed these areas.

There is no documentation in R2's Progress notes from 12/26 through 1/3/19 regarding a rash to R2's right lower extremity.

R2's Progress Note dated 1/4/19 at 2:30 PM documents, "CNA (Certified Nurse's Aide) called this nurse to elder's bathroom. Scattered macular rash on right thigh. C/O itching to area. Also noted reddened, slightly edematous area on inner and posterior right knee. Skin warm, dry, no open area noted at knee. No c/o pain to knee area. (V10) notified."

R2's Treatment Record dated 1/4/19 documents, "Red, macular rash on R (right) thigh. Red area on inner R (right) knee, sl (slight) slight edematous. C/O (Complains of) itching to rash site. Denied pain. No open areas, no drainage from rash or knee. "

On 1/4/19, there was no documentation in R2's Medical Record V10 provided a response to the facility regarding R2's rash.

On 1/17/19 at 9:30 AM, V12 Licensed Practical Nurse (LPN) stated, I saw the rash on (R2's) right thigh on 1/4/19 and called (V10's) office, and I never spoke to (V10) but I spoke with someone, told them about the rash and they told me to fax the information to the office and I did. I never received a call back with any new orders."

R2's Progress Notes dated 1/5/19 at 1:53 PM document, "At 12:00 PM, elder resting in recliner chair at BS (bedside), alert to self and pleasantly confused. Noted increased weakness and also noted change in mental status today. At Noon, Daughter, POA (Power of Attorney) here and

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concerned about elders change in condition. Elder assessed per Nurse and noted, BP (blood pressure) 122/62, T (Temperature) 99.1 AX (axillary), P (pulse) 64, R (respirations) 16, O2 sats (oxygen saturation) 96% on RM (room) air. Elder denied pain or sob (shortness of breath) to nurse at first but then voiced c/o complaints pain to RLE (right lower extremity), skin pink and w/d (warm and dry) to touch. Slight nonpitting edema noted to RLE/ankle area. No redness or tenderness noted to touch. POA/daughter here and requested elder be sent to ER (Emergency Room). Elder alert and verbally responsive with staff and family, but noted increased confusion. Called (V10's) exchange at 12:20 PM, and spoke with MD at 12:30 PM, and gave update. (Ambulance) here at 1:10 PM and transported elder per stretcher to (local hospital), called (nurse at ER) there, and gave report. ADON (Assistant Director of Nurses) called and updated."

R2's Emergency Room Visit Report dated 1/5/19, V3 Emergency Room Medical Doctor documents "General Context: Patient brought to the emergency room for low blood pressure and cellulitis right leg, fever. " The ER Visit Report documented "HPI (History of Present Illness): Patient presents to the ER with swelling to right leg with obvious cellulitis, fever, mild confusion." Emergency department (ED) Progress Note: 1/5/19 5:03 PM, Patient to be admitted to the medical floor, patient is a DO NOT RESUSCITATE, Diagnosis cellulitis right leg."

R2's Hospital Consultation from V4, Medical Doctor, dated 1/6/19 documents " REASON FOR CONSULTATION: Right lower extremity cellulitis. HISTORY OF PRESENT ILLNESS: This is a 98 year old female well known to me with previous

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history of polymicrobial bacteremia secondary to cholecystitis. Currently has been doing well. Patient was at the nursing home and subsequently had developed right lower extremity pain and redness. Patient is also running a low grade fever and has bed slightly lethargic on the day of admission. Patient was sent to the emergency room for further evaluation." The Consultation Report documented " EXTREMITIES: Right shin there are areas of erythema with fluid- filled small blisters that ruptured with serosanguineous bloody fluid draining from it. ASSESSMENT AND PLAN: 1. Sepsis with hypotension, change in mental status associated with right lower extremity cellulitis, currently on Unasyn and Vancomycin, which is adequate. I would continue current mode of therapy. Follow up on blood culture, repeat complete blood count (CBC) and basic metabolic panel (BMP) in am. Blood pressure is stable on bolus of intravenous fluid (IV) fluid. 2. Change in mental status, most likely secondary to cellulitis and sepsis."

R2's Hospitalist V11's History and Physical documented " 98 year old female with past medical history of Coronary Artery Disease, Hyperlipidemia, Hypertension, Cerebral Vascular Accident (CVA), history of Colon Cancer status post resection who had an admission in November of this year due to gram-negative septicemia was sent from skilled nursing facility for right lower extremity pain and redness. History was taken from the patient and her daughter at bedside. As per the daughter patient usually calls her once a day, however she did not receive a phone call from her mom today. When the daughter went to see her mom, she found that her mom has right lower extremity pain and swelling. She was also having low grade fevers

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for one day. At baseline, the patient is able to walk and is able to hold a conversation. She was at her baseline until up to 3 days back. Patient appeared sleepy. She was easily arousable and answered some of the questions. She stated that her major complaint is right lower extremity pain. "The report documented "The source of infection is most likely right lower extremity cellulitis, start IV vancomycin and Unasyn. repeat lactate."

On 1/14/19 at 10:42 AM, V16, R2's daughter, stated, "On 1/5/19, I tried calling my mom at the nursing home and she didn't answer her phone, so I came to the home to visit her, she was wrapped up in a blanket in her chair, I was repositioning her blanket and noticed her red swollen leg, I told the nurse she needed to go to the ER. The facility would have had to see her swollen leg. She has an infection in her leg, fungus in her groin. She still has the infection in her right leg that they (hospital) are treating with IV antibiotics. Her BP was very low in the ER, I think 75/40 due to the infection. Her leg was red, swollen and blistered. Also, on the bottom of the same leg she has a sore."

On 1/17/19 at 11:00 AM, V10 stated, "I remember on 1/4/19 someone notified me of the rash on (R2's) right thigh, I told someone if they were concerned they should send her to the ER. I don't remember who I talked too. Then they called me on the 5th and said they were sending her to the ER. When I saw (R2) on December 26th I did see the rash, kind of looked like it might have come from a bad scratch. I don't know why I did not put it in my notes when I saw her that day."

R2's January 2019 Physician Order Sheets and Progress Notes have no documentation noting

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that V10 had contacted the facility with his recommendations.

2. R3's Face Sheet, documented R3 was admitted to the facility on 11/5/18 with diagnosis including, Fractured Right Tibia, muscle weakness, UTI, Peripheral Neuropathy, Heart Failure, Hypertension, Hyperlipidemia, Hypothyroidism, Atrial Fibrillation, Pacemaker, Convulsions, Cardiomeagly, Chronic Pain, Metabolic Encephalopathy.

R3's Care Plan dated 11/16/18 documents "Open, weeping areas on lower left leg r/t (related to) cellulitis in left leg." The approach, dated 11/16/18 documented "Skin inspection and assessment every day." The approach, dated 11/20/18 documented "check condition of my skin on legs, underneath right leg splint, every shift. Monitor for redness, rubbing or potential pressure areas. Notify MD of problems."

R3's Shower Record/Skin Audit, dated 12/31/18, documented "leg brace on right." There were no other skin issues identified on this Audit.

R3's Progress Note dated, 1/3/19, at 4:33 PM document, "PT (patient) c/o left leg pain to daughter on the phone, Not writer on day shift at either med pass times. Noted red, warm, swollen region to lower posterior thigh, calf is very tender, ankle tender, pt yelled at palpation of posterior tibial (tib) pulse check, pedal pulse +1 . left toes cool, pt has impaired circulation, did have cap refill. Vital signs (VS) 99.3, 61, 18, 115/53. R3's doctor's office informed. Director of Nurses (DON) called to view left lower extremity (LLE) as well. Ambulance paged at 4:00 PM. Ambulance

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here and pt left at 4:30 PM. POA informed of transfer and status. ER called per staff nurse."

R3's ER History of Present Illness, dated 1/4/19 documents in part, Chief Complaint: Tonight is sent from the nursing home secondary to left leg redness and fever. History of Present Illness: This is an 86 year old demented Caucasian female with known past medical history of frequent falls, who has recently been admitted to our hospital in November of this last year secondary to right tibial fracture and who was sent from the nursing home yesterday secondary to left leg redness and fever. The patient had a temperature of 100.2 degrees in the ER yesterday and the patient was found to have a significantly elevated white cell count in the ER of 40.9 with 26 bands, as well as acute renal failure with a creatinine of 2. Peripheral vascular ultrasound did not demonstrate any acute deep vein thrombosis (DVT). The patient was admitted to the hospital for her left lower extremity cellulitis. Assessment and Plan: 1. Left lower extremity cellulitis. The patient has been admitted to med-surge. Continue antibiotic therapy. Blood cultures are pending. Monitor area of cellulitis. Monitor vital signs closely and urine output. Continue IV hydration overnight. 2. Sepsis, rule out severe sepsis with fever, significant leukocytosis, tachypnea, acute renal failure. The source of sepsis appears to be cellulitis. We will continue antibiotic therapy. 3. Leukocytosis, secondary to cellulitis. 13. DVT prophylaxis with renally closed Lovenox and full code status. I suspect the patient will likely need at least 2 nights of inpatient medical therapy for acute cellulitis, sepsis and comorbid conditions listed above.

R3's POS dated January 2019 documents in part," Daily Skin Assessment: High Risk for

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EDEN VILLAGE CARE CENTER	400 SOUTH STATION ROAD GLEN CARBON, IL 62034

(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) COMPLETE DATE
S9999	Continued From page 9	S9999		

Breakdown. Once a Day 7-3 shift."

R3's Treatment Flow Sheet, dated 1/1/19-1/31/19, documents "Daily Skin Assessment: High Risk for Breakdown. Once a Day." There was no skin assessment documented as being completed on 1/1/19, 1/2/19 or 1/3/19.

On 1/15/18 at 10:40 AM, V14 R3's daughter stated, I was talking to my mom on the phone on 1/3/19 and she told me her left leg hurt. I called the nurse and told him to go in and look at her left leg and found it was red, warm and swollen, that's when they sent her to the ER.

On 1/17/18 at 9:15 AM, when asked if the nurses should have seen the cellulitis on (R2) and (R3) during the daily skin assessments, instead of R2's and R3's daughters alerting the nurses to this, V5 Assistant Director of Nurses stated, They have all of their shift to do the skin assessment, regardless of who found the cellulitis the outcome would have been the same.

The facility's Policy and Procedure for Skin Assessments, revised 3/6/2018, documents " In order to document issues related to skin integrity or other injuries, it is the Policy of the (Facility) that a Shower Record/Skin Audit will be completed as outlined below." The Procedure documented " 1) The charge nurse will pass out Shower Record/Skin Audit forms to certified nursing personnel along with the daily assignment sheet. 3) After completion of the Resident shower, certified nursing personnel will complete the Shower Record/Skin Audit form to include but not be limited to the following information: a) Reddened areas b) Opened areas c) Skin tears d) Bruising e) rashes f) Podiatry consult needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002679	A. BUILDING: _____ B. WING _____	C 01/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VILLAGE CARE CENTER	400 SOUTH STATION ROAD GLEN CARBON, IL 62034

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S9999	Continued From page 10 g) Date shower or bath given h) Resident refusal for bathing if applicable i) other information as necessary. 4) After completion of the Shower Record/Skin Audit form certified nursing personnel will submit such to the charge nurse for review. 5) Nursing Personnel will document on the Shower Record/Skin Audit form any additional information that may be needed as well as any actions taken (treatment, incident report, etc.) 6)After review, nursing will submit the Shower Record/Skin Audit form to the Director of Nursing for additional review. 7) Shower Record/Skin Audit sheets will be maintained by the facility for one year to assure availability for additional review if necessary." (B)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: EDEN VILLAGE CARE CENTER COMPLAINT #: 0108615
LIC. ID #: 0023382
DATE COMPLAINT RECEIVED: 01/10/19 14:21:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

_X_ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: EDEN VILLAGE CARE CENTER COMPLAINT #: 0108601
LIC. ID #: 0023382
DATE COMPLAINT RECEIVED: 01/10/19 10:33:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.