IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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March 15, 2019

Daniel Garden, Registered Agent
Clark Skilled Nursing Facility, LLC
3450 Oakton Street
Skokie, Illinois 60076

RE: Complaint #: IL00106197
Survey Date: January 17, 2019
Docket #: 19-C0092
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 Clark Manor Cnv 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
Clark Manor Cnv Center/January 17, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. CLARK SKILLED NURSING FACILITY, LLC, D/B/A, CLARK MANOR CNV CENTER, Respondent.	)))))))))	Docket No. NH19-C0092

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 IL00106197 Investigation conducted by the Department on January 17, 2019, at Clark Manor Cnv Center, 7433 North Clark Street, Chicago, Illinois 60626. On March 13, 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), 300.1210a), 300.1210b), and 300.1220b)3). 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 15th day of March, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. CLARK SKILLED NURSING FACILITY, LLC, D/B/A, CLARK MANOR CNV CENTER, Respondent.	)	Docket No. NH 19-C0092

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:	Daniel Garden
Licensee Info:	Clark Skilled Nursing Facility, LLC
Address:	3450 Oakton Street Skokie, Illinois 60076

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 15th 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
	IL6001796	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MANOR CNV CENTER	7433 NORTH CLARK STREET CHICAGO, IL 60626

(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 Investigation 1886425 / IL#106197	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a)b) 300.1220b)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	**Attachment A** **Statement of Licensure Violations**	

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as

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nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These Regulations were not met as evidenced by:

Based on interviews and record reviews, the facility failed to develop an individualized care plan, re-evaluate and revised/update care plan interventions in preventing accidents for one (R1) of five residents reviewed for accidents and supervision. This deficiency resulted in R1 sustaining a laceration on left eyebrow and acute nasal bone fractures.

Findings include:

R1 is a 72 year old, male admitted into the facility on 06/06/2018 with diagnoses of Bipolar disorder, Current Episode Depressed, Severe with Psychotic Features and Other Schizophrenia. R1 has moderately impaired cognition in making decisions regarding tasks of daily life, according to MDS (Minimum Data Set) dated 06/13/2018 under Section C. Per MDS also, the following were documented under Section E:
E0200 - Other behavioral symptoms not directed toward others: R1's behavior of this type occurred 1 to 3 days
E0500 - R1 is at significant risk for physical illness or injury; significantly interfere with care

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and significantly interfere with participation in activities and social interactions.
E0800 - Reject evaluation or care that is necessary to achieve the resident's goals for health and well-being: R1's behavior of this type occurred 1 to 3 days.

R1's POS (Physician's Order Sheets) documented:
08/20/18: May wear head helmet daily as tolerated for safety. Skin check daily, remove helmet for shower, care and any activities.
08/05/18: Behaviors: Monitor for the following: (Violent Behavior). Click Y if behavior was observed and N if No behavior and choose chart code "No behavior" intervention codes: (1) orient to reality (2) redirect/reorient (3) provision of therapeutic milieu (4) set limits (5) counseling (6) therapy behavior reinforcement +/- (7) referral to activities (8) therapeutic communication (9) refer to social services for evaluation (10) refer to Psychiatrist/pertinent medical practitioner (11) encouragement/reinforcement (12) non-stimulating environment (13) pharmacological intervention every shift. Additional behaviors to be monitored: spitting, throwing objects.

Care plan dated 06/18/18 indicated that R1 has a behavior of hitting head on the wall/floor/bed/wall rails, attempts to hit staff, threw computer on the ground, knocked off maintenance cart, places himself on the floor and rolling off, physically aggressive/agitated, crawls on the floor, refuses to go back to bed, threw urine at staff, threw a chair/milk/linens/water/tables/objects/wet diapers/utensils at staff.
Interventions: analyze key times, places, circumstances, triggers, and what de-escalates behavior and document; complete a cognitive

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assessment; evaluate for side effects of medications.

Care plan dated 06/19/18 documented that R1 is at risk for ineffective coping behaviors specifically a mood problem, related to diagnosis of Bipolar Disorder.
Interventions: Active-listen and identify perceptions of what is happening; administer medications as ordered. Monitor/document for side effects and effectiveness; Monitor/record mood to determine if problems seem to be related to external causes, that is, medications, treatments, concern over diagnosis.

Care plan dated 06/19/18 documented that R1 has impaired cognitive function/dementia or impaired thought processes which is related to or as evidenced by diagnosis Bipolar Disorder.
Interventions: Administer medication as ordered; Ask yes/no questions in order to determine needs; break tasks into one step at a time.

Post incident investigation report date completed 07/26/18 documented that on 07/20/18, R1 threw himself on the floor after incontinence care, sustained a small laceration to left side of forehead with minimal bleeding. R1 was transferred to a local hospital for further evaluation and treatment. R1 came back into the facility on 07/21/18.

Post incident investigation report dated 08/19 18 documented that R1 was observed with discoloration on right lower eyelid. Per report also, R1 has a behavior of intentionally putting self on the floor and banging head on the headboard. R1 is exhibiting maladaptive behavior.

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S9999	Continued From page 5 Facility's Incident Report dated 08/27/18, documented that R1 was observed sitting on the floor, noted blood on the face and there were traced amount of blood on the wall at 4:50 AM. According to the report also, R1 was interviewed stating that he hit his head intentionally on the wall because he wanted to die. R1 sustained a 1-inch laceration on left eyebrow and noted some bleeding and later was stopped. R1's roommates were sleeping when incident happened according to the report. R1 was transferred to the hospital as ordered. Hospital's Record dated 08/27/18 at 6:59 AM, documented that R1 presented to the emergency room with complaint of laceration on the left eyebrow. Triage notes indicated that R1 was cooperative, appeared disoriented and confused. Per hospital's report also, under Clinician History of Present Illness, R1 is a poor historian due to dementia, however, according to EMS (emergency medical services) crew that R1 was witnessed to be hitting his head intentionally against the wall that morning of 08/27/18 and found R1 to have a laceration on the left side of his head prompting to be transferred to the hospital emergency room as ordered. Hospital Records dated 08/27/18 revealed the following: Physical Examination: General - Elderly adult male, non-toxic appearing, no acute distress, alert, oriented x 1 and cooperative. (R1) looks demented, no acute distress. HEENT (Head, Eyes, Ears, Nose, Throat) - Big laceration over the left eyebrow, about 4cm (centimeters), hematoma, left eyelid. ENT - Left supraorbital laceration 4 x 1 cm. in length. Mild ecchymosis to left medial border of	S9999		

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eye. No battle sign. No raccoon eyes. Progress notes: CT scans are positive only for nasal bone fracture.

Hospital's Patient Discharge Transition Record dated 08/27/18 indicated that R1's facial laceration on the left eyebrow was repaired with five sutures.

Hospital's Discharge Instructions under addendum notes indicated that R1 was having nose bleeding; R1 was assessed and treated with drug swabbing and nasal packing. Per addendum notes also, R1's bleeding was controlled. R1 was later transferred to another acute hospital.

Under Emergency Department (ED) documentation dated 08/27/18 at 4:12 PM, R1 was transferred to ED as trauma transfer as nose bleed started after R1 was banging his head and was agitated. Physical examination indicated that R1 had a packing in right nares. R1's CT scan of head or brain without contrast dated 08/27/18 time stamped 4:41 PM documented: Impression: Acute nasal bone fractures, with hemorrhagic fluid within the nasopharynx.

On 01/16/19 at 1:52 PM, V6 (Registered Nurse) was interviewed regarding R1's incident on 08/27/18. V6 stated, "It was reported to me by V23 (CNA) that he (R1) was on the floor. It was between 4 to 5 in the morning. I went to his (R1) room and found him (R10) sitting on the floor close to the bathroom door and had an inch laceration on the left eyebrow. There was blood on the wall outside the bathroom. He (R1) stated he (R1) hit his head on the wall because he (R1) wanted to die. He was not wearing any helmet at the time. I did head to toe assessment and asked V23 monitored him (R1) and do one on one. He

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(R1) was later transferred out to the hospital as ordered. Prior to this, every 30 minutes I go to his (R1) room to check him (R1). When I did my rounds on him before the incident, he (R1) was lying on bed, awake and calmed. His (R1) room mates were all asleep at that time. The interventions that I do in order to prevent any accidents on him (R1) are close monitoring by me and the assigned CNA every 30 minutes to one hour; make sure floor mats are placed on the floor on each sides of the bed; his head helmet should be on at all times."

There were no documentation on progress notes dated 08/27/18 that R1 was exhibiting behavior issues and unable to tolerate the use of helmet. There was also no progress notes dated 08/26/18 documented in R1's medical record regarding behavior issue and use of helmet.

On 01/15/18 at 1:23 PM, V25 (LPN) was asked regarding R1. V25 stated, "He (R1) has behavior issues like paces the unit, pushing staff, yelling, banging on the table, refused medications sometimes and resistive to care. He (R1) is alert and oriented x 1 to 2, depends on his mood - sometimes, he would be angry and cursed at staff, spit at staff, throw something at staff, put himself on the floor and laid on the floor. He doesn't usually bang his head on the floor but on the wall when he is sitting on his wheelchair. He needs to wear a helmet which he takes off but staff monitors and put it back on his head. He has the helmet on during the day, his bed is always on the lowest position at night and had floor mats on both sides. For him, I usually redirect him and if he has PRN (when necessary) medication for his behavior, I give it but that would be the last thing I would do."

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V4 (Assistant Director of Nursing) was also asked regarding R1. On 01/15/19 at 2:46 PM, V4 stated, "He (R1) is basically behavioral the first day he was admitted into the facility. Not even 24 hours yet, he (R1) was sitting in the wheelchair, he (R1) pushed the wheelchair and put himself onto the floor. He (R1) will spit on us and very agitated. He was placed on monitoring every 15 minutes. Close monitoring when he is up on the chair and he was placed by the nurses' station. The incident on 8/27/18, it was a behavior issue that he (R1) woke up at 4:50 AM and stated he wants to die. V6 reported to me that resident was sleeping throughout the night, then at 4:50 AM, he got up, went to the bathroom and found him outside bathroom door sitting, bleeding, walls noted to have blood while roommates were sleeping."

On 01/15/19 at 3:30 PM, V28 (RN) was interviewed regarding R1. V28 stated, "He (R1) has a couple of behavior (spitting/hitting/putting himself on the floor) One time, he banged himself on the floor, we just put pillows. At times, we give medications, it helps. We do close monitoring. He is not wearing a helmet. I don't remember him wearing one. But we place landing mats on the floor. If he takes his helmet off, he has the landing mats on the floor in the room by the bed."

V2 (Social Services Director) was asked regarding R1 on 01/16/19 at 11:24 AM, stating, "He had some behavioral issues like screaming, yelling and had to be removed from the dining room, very difficult to redirect. I work with V5 (Psychiatrist) about behavior. I know he would not benefit from group or 1:1 because of confusion and cognitive impairment."

On 01/16/19 at at 2:30 PM, V35 (Care Plan/MDS Coordinator) was asked regarding care plan

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revisions and updates. V35 stated, "Care plans are being done upon admission, quarterly, significant change and annually. I don't do behavior care plans but when residents are on psychotropic medications, I do the care plan. My responsibility is to remind each department: Social Services for behavior; Restorative for ADLs (activities for daily living) and Nursing for medical: that care plans need to be initiated, revised and updated. We revised and update care plans when residents readmitted back into the facility and when additional diagnoses where added. During care plan meeting of each resident, nurses and CNAs (Certified Nurse Aides) report about residents improvement or progress. Any planned interventions from the previous care plan that were not effective will be discussed in the meeting and care plan will be revised or updated if there is a need and will be coordinated to the staff per departments for implementation."

On 01/17/19 at 2:15 PM, V26 (Restorative Nurse Assistant) was asked regarding interventions in preventing accidents on R1. V26 stated, "He (R1) has a behavior that can't be redirected, so he needs to use a helmet. But he cannot tolerate helmet that should be on at all times even while sleeping. When I'm there, if he wants to remove it the helmet, I take it off, sits with him for 20-30 minutes and then put it back and he is okay with that. He has no assistive devices and makes no sense if he use it. He needs close monitoring because when he stands up and walk, staff needs to bring him back to bed or wheelchair."

On 01/17/19 at 4:30 PM, V5 was interviewed regarding behavior management and care plan interventions. V5 stated, " With regards to behavior issues, behavior interventions like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001796	A. BUILDING: _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MANOR CNV CENTER	7433 NORTH CLARK STREET CHICAGO, IL 60626

(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 10	S9999		

counseling; communicate each other and talk about issues could be used. It is how you approach the residents. Another is de-escalation: If there is conflict, separate the residents and find out what is happening. Isolation of residents and engaging them in activities could also help in managing behavior issues. Understand the situation, like there is a reason why resident is exhibiting the behavior could be applied, if their needs are met met at the time; is there something else going on here why behaving that way. Medically speaking, I order laboratory examinations to find out underlying conditions that can contribute to behavior. In the Psychiatry world, behavior is managed by medications; care plan development and implementation- the social worker discussed the care plans with me. Care plans should be revised and updated if interventions are not effective. It should be done when needed. And care plan should be individualized to be effective."

Facility's policy titled, "Care Plan" revised date November 28, 2017, stated in part: "Policy Statement: It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations. Procedures: 5. These will be periodically reviewed and revised by a team of qualified person after each assessment."

(B)

LTC07202 COMPLAINT DETERMINATICN FORM

FAC. NAME: CLARK MANOR CNV CENTER COMPLAINT #: 0106197
LIC. ID #: 0054403
DATE COMPLAINT RECEIVED: 09/28/18 13:45:00

IDPH Code	Allegation Summary	Determination
101	PHYSICAL ABUSE	2
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.