IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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February 22, 2019

David Aronin, Registered Agent
Chateau Nursing and Rehabiliation Center, L.L.C.
2201 Main Street
Evanston, Illinois 60202

RE: Complaint #: IL0108039
Survey Date: December 24, 2018
Docket #: 19-C0052
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 Chateau Nrsg & Rehab 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
Chateau Nrsg & Rehab Center/December 24, 2018//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. CHATEAU NURSING AND REHABILIATION CENTER, L.L.C., D/B/A, CHATEAU NRSG & REHAB CENTER, Respondent.	))))))))))	Docket No. NH19-C0052

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 IL0108039 Investigation conducted by the Department on December 24, 2018, at Chateau Nrsg & Rehab Center, 7050 Madison Street, Willowbrook, Illinois 60521. On February 21, 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), 300.1210b), 300.1210d)6), 300.1220b)3) and 300.3240a). 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), 300.1210d)6) and 300.3240a).

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 22nd day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. CHATEAU NURSING AND REHABILIATION CENTER, L.L.C., D/B/A, CHATEAU NRSG & REHAB CENTER, Respondent.	)	Docket No. NH 19-C0052

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:	David Aronin
Licensee Info:	Chateau Nursing and Rehabiliation Center, L.L.C.
Address:	2201 Main Street Evanston, Illinois 60202

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 22nd day of February, 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
	IL6010367	A. BUILDING: _____ B. WING _____	C 12/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU NRSG & REHAB CENTER	7050 MADISON STREET WILLOWBROOK, IL 60521

(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 1878110/IL108039	S 000		
S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 nursing, activities, dietary, and such other

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to supervise a resident who was at high risk for falls in the dining room. The facility also failed to identify and implement specific interventions to prevent further falls and injuries.

This resulted in R1 sustaining an right orbital floor fracture (traumatic injury to eye socket) and lacerations to the lip requiring suturing and R3 sustaining a head injury requiring 7 staples for closure.

This applies to 2 residents (R1 and R3) reviewed for falls.

The findings include:

1). R1's face sheet showed R1 was admitted on 2/25/18 with diagnoses that included history of falling, difficulty in walking and vascular dementia.

Upon admission, R1's Minimum Data Set (MDS)

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dated 3/5/18, showed R1 had a BIMS (Brief Interview for Mental Status) score of 3 which indicated R1's cognition was severely impaired. R1's BIMS score on 7/18/18 was a 7, which indicates R1's cognition continued to be assessed as being severely impaired. In addition, R1's 7/18/18 MDS showed R1 required oversight, encouragement or cueing during walking and locomotion. R1 received a BIMS score of 4 on 10/9/18 during a significant change assessment, which indicated R1's cognition continued to be severely impaired. During that assessment, R1 was determined to need extensive assistance with locomotion on the unit.

R1's Fall Events showed R1 sustained falls on 4/7/18, 9/25/18 and 10/10/18. The fall assessment on 9/25/18 showed R1 was "noted with fall in 1B dining room after dinner. R1 sustained injury/laceration ¾ inches to lower right lip, also 5 cm hematoma noted above the right eye, R1 was unresponsive X (times) [for] 1 minute, moderate bleeding from head and lip. 911 EMS (Emergency Medical System) was called, ice compresses applied ...R1 was transported ...to ER (Emergency Room) ..."

R1's 9/25/18, Emergency Room Record Final Report showed R1 sustained a 2.5 cm (centimeter) laceration on the upper lip crossing right side of vermillion border (a sharp line beteen the upper lip and normal skin) requiring 9 sutures to close; ecchymosis (bruise) to right upper and lower eyelid and a large hematoma on dorsum (back) of right hand. R1 sustained a fall, laceration, contusion, sprain, strain, head injury, dizziness, in addition to an orbital floor fracture . R1's Consultation Final Report completed on 9/27/18 showed steri strips were placed on R1's right brow line laceration and sutures placed to a

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laceration on the corner of R1's right lip and found to have a right maxillary sinus (nose) fracture. The Consultation Report continued to show during the examination, R1 was drowsy, had significant bruises on the right side of her face, arousable, but difficult to speak due to lip laceration.

On 12/20/18 at 11:10 AM, V4 (Nurse) denied being the dining room when R1 fell. V4 reported being at the nursing station while R1 was in the dining room. V4 stated he had direct eye sight to where R1 was seated. V4 stated he saw R1 rise, take a couple of steps and fall before he could reach her. V4 added there was an unnamed CNA (Certified Nursing Assistant) assigned to the dining room, who had left the dining room unattended.

On 12/20/18 at 11:23 AM, V2 (Director of Nursing, DON) stated when residents are fall risks, they should not be alone or unsupervised in the dining room. V2 stated V4 was actually in the dining room when R1 fell face forward, which was contradicted by V4.

On 12/20/18 at 1:15 PM, V6 (CNA) stated residents who are high fall risks should never be left alone in the dining room.

On 12/20/18 at 2:17 PM, V7 (CNA) stated residents who are high fall risks should never be left alone in the dining room.

On 12/20/18 at 2:08 PM, V8 (physician) for R1 stated R1 did not have the concept of danger for herself and V8 was not aware that there wasn't staff in the dining room when R1 fell. V8 added "they should have had someone with R1, staff knew R1 was a high fall risk."

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R1's Fall Risk Assessments completed on 2/25/18; 4/7/18 and 10/10/18 all showed scores that indicated R1 was determined to be at high risk.

R1's progress note after fall on 10/10/18 at 9:47 AM showed R1's "right knee is reddened ..."

R1's care plan on 2/26/18, showed Falls as a problem and noted R1 was at risk for falls. After R1's fall on 4/7/18, the new approach/intervention documented on 4/9/18 was "provide low stimulating environment at night to promote sleep. After R1's fall on 9/25/18, the new approach/intervention documented on 10/2/18 was "bilateral floor mats and bed bolsters to prevent injury." After R1's fall on 10/10/18, the new approach/intervention documented on 10/10/18 was "transfer to chair after dressing."

2). R3's face sheet showed R3 was admitted on 8/31/18 with diagnoses that included Huntington's disease, unspecified dementia, repeated falls, lack of coordination, weakness, abnormal posture and difficulty in walking.

Upon admission, R3's admission Minimum Data Set (MDS) dated 10/1/18, showed R3 as rarely or never understood and without a BIMS (Brief Interview for Mental Status) score in addition to R3 requiring extensive assistance with bed mobility and transfer with the 2 persons' physical assistance. R3 received a BIMS score of 10 on the quarterly assessment completed on 12/07/18 which indicates R3 cognition was moderately impaired in addition to R3 requiring extensive assistance with bed mobility and transfer with the 2 persons' physical assistance.

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Progress notes showed on 10/31/18 at 1:40 PM, R3 was found on the floor bleeding from the head. R3 was transported to the ER (Emergency Room). R3's POS dated 11/1/18 showed a physician's order - "Patient has 7 staples to back of head. Monitor ..."

On 12/18/18 at 10:20 AM, R3 was observed in bed at the end of the hallway requesting help and asking for water. Writer could not locate a call light and stepped into hallway to ask for staff assistance. V9 (CNA) and V10 CNA responded and stated R3 does not have a call light, but has a bell to ring instead. V9 and V10 located the bell underneath R3's bed after about 10 minutes. R3's remote control was located by V2 on the over bed table and not within the reach of R3. There was no basket at R3's bedside to place the remote control.

R3's Safety Events - Fall Events showed the following:

9/1/18 at 12:00 PM - Fall "observed sliding over the bed bolsters down the left side of the bed hitting the head first to the floor mat ...
9/8/18 at 4:00 AM - Fall - staff heard a noise ...resident observed on the floor ...R3 responded "I flipped and fell down on the floor" ...skin tear below left knee
9/27/18 at 7:45 AM - Observed sitting on floor mat. R3 with "very poor safety awareness and high fall risk ..." "Resident stated she slid off her bed, trying to get her diaper."
10/16/18 at 10:18 PM - Fall at bedside - "got out of bed trying to get to her wheelchair"
10/19/18 at 6:02 PM - Fall - "found scooting on floor"
10/19/18 at 6:15 PM - Fall in room - "sitting on floor mat"

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10/20/18 at 6:52 AM - Fall - "got out of bed, crawling on floor"
10/23/18 at 8:30 PM - Fall - " ...observed sitting on the floor next to her bed ...was trying to pick up pillow off the floor and fell. Noted a small skin tear 2 cm X 2 cm with a small amount of bleeding ...
10/24/18 at 9:24 PM - Fall - "resident was observed sitting on the floor in her room near the door ...said she was trying to get her TV (television) remote"
10/27/18 at 8:00 AM - patient observed on floor halfway into the hallway" ..."foley disconnected from bag but catheter still in patient ..."
10/31/18 at 1:40 PM - "Observed sitting at foot of bed" "Bleeding from back of head, noted laceration to left side of posterior scalp."
10/31/18 progress note at 1:41 PM showed ...resident on floor, serosanguineous blood noted on floor ...going out to hospital for evaluation and scalp bleeding ..."
11/1/18 at 5:50 AM - "Resident observed on the floor in the hallway"
11/4/18 at 7:15 AM - Fall - "Resident got out of her bed"
11/6/18 at 1:25 AM "On floor in hallway ...fell from bed, scooted into hallway."

After R3's fall on 11/6/18, the progress note showed R3's son stated "you know this happens like every day and I get a call like every day of my life, are there any precautions that you guys are taking to make sure she doesn't fall."

R3's care plan on 9/2/18, showed Falls as a problem and noted R3 was at risk for falls. The following new approach/intervention showed as follows:
9/1/18 event - approach/intervention dated 9/2/18 was "Medication to assist with involuntary

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movements; bilateral floor mats, bed will remain locked at all times, bed in lowest position and bed bolsters in place.
9/8/18 event - approach/intervention dated 9/10/18 was "Medication review for anxiety." This intervention did not occur.
9/27/18 event - approach/intervention dated 9/27/18 was "do not leave R1 unattended on the bedpan"
10/12/18 event - approach/intervention dated 10/12/18 was "Bell within reach". On 12/18/18 at 10:20 AM, R3's bell to call for help was not with the resident. V9 and V10 located the bell underneath R3's bed after about 10 minutes
10/16/18 event - approach/intervention dated 10/16/18 was "Provide adequate pillows for comfort"
10/19/18 at 6:02 PM event - no new approach/intervention
10/19/18 at 6:15 PM 2nd event - no new approach/intervention
10/20/18 event - approach/intervention dated 10/22/18 was "Toileting Program and Monitor Behaviors for Trends and Patterns"
10/23/18 event - approach/intervention dated 10/23/18 was "MD (medical doctor) to review for anti-anxiety meds" Same intervention as after 9/8/18 event. This intervention did not occur.
10/24/18 event - approach/intervention dated 10/24/18 was "R3 was trying to get R3's remote off the floor. We will attempt a basket on the side of the bed to place the remote" On 12/18/18 at 10:20 AM there was no basket on the side of the bed. The remote control for the TV was on the overbed table next to the wall. R3 was unable to reach it.
10/27/18 event - approach/intervention dated 10/28/18 was "R3 will have a room change to ...unit"
10/31/18 event - approach/intervention dated

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(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		

10/31/18 was "Offer helmet to protect head from injury"
11/1/18 event - approach/intervention dated 11/1/18 was "Reoriented to room and TV, TV on at all times"
11/4/18 event - approach/intervention dated 11/4/18 was "Staff to monitor pillows are in place, remote and bell are within reach" Same interventions as after 10/16/18 and 10/12/18 and 10/24/18 events. Additional approach/intervention included "Offer to toilet around 7:00 AM" Similar intervention after 10/20/18 event
11/6/18 event - approach/intervention dated 11/6/18 was "provide toileting assistance after meals" Similar intervention after 10/20/18 event.

R3's initial care plan dated 9/1/18 showed R3 was at risk for injury of which approach/interventions included to keep the call light in reach at all times and to keep personal items and frequently used items within reach.

On 12/18/18 at 2:11 PM, V2 (Director of Nursing) stated that the interventions documented on 9/2/18 on R3's care plan were already in place and initiated on 9/1/18 interim care plan.

On 12/19/18 at 12:09 PM, V5 (restorative nurse) was asked if V5 was aware that R3 had sustained 8 additional falls after implementing the toileting program and if V5 felt the toileting program was effective. V5 replied "not really, I think everyone was trying to adjust to her and find the best solution."

On 12/19/18 at 3:34 PM, V2 stated the care plan for R1 was not updated after R1's fall on 9/25/18.

On 12/20/18 at 10:05 AM, V3 (physician) of R3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010367	A. BUILDING: _____ B. WING _____	C 12/24/2018

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S9999	Continued From page 10	S9999		

stated, V3 was aware of multiple falls including requiring staples for a head wound. V3 stated V3 witnessed R3 wanting the bell which was not close or within reach of R3. V3 acknowledged due to R3's condition, R3 is unable to hold on to the bell and R3's involuntary movements may cause R3 to drop or throw the bell. V3 acknowledged that R3's room is near the end of the hall and should be closer to the nursing station. V3 added "I am always worried that I am going to get another call that she has busted her head." V3 shared the staff should have more interaction with R3 and provide activities that are engaging for R3, so R3 doesn't frustrated and try to do things on R3's own.

Facility provided a policy titled "Fall - Clinical Protocol" revised August 2008 showed "The staff will document risk factors for falling in the resident's record ...The staff will document falls that occur while the individual is in the facility ... staff will attempt to define possible causes within 24 hours of the fall ...the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling ...If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops ...The staff and physician will monitor and document the individual's response to intervention intended to reduce falling or the consequence of falling ...if the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 11 Facility provided policy titled "Care Plans (Comprehensive)" updated April 2015 showed the policy statement as "An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's ...needs is developed for each resident. Facility provided a policy titled "Quarterly Review of Care Plans" revised August 2006 showed 1. "The care planning/interdisciplinary team is responsible for maintaining care plans on a current status." 2. "The care planning/ interdisciplinary team is responsible for the periodic review and the updating of care plans: a) when there has been a significant change in the resident's condition b) when the desired outcome is not met ... (B)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: CHATEAU NRSG & REHAB CENTER COMPLAINT #: 0108039
LIC. ID #: 0046177
DATE COMPLAINT RECEIVED: 12/13/18 12:32:00

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.