IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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January 25, 2021

Business Filing Incorporated, Registered Agent
Herrin Rehabilitation and Nursing Center, LLC
600 S 2nd Street, Ste 104
Springfield, Illinois 62704

RE:	Complaint #:	IL128205
	Survey Date:	11/13/20
	Docket #	20-C0384
	Violation Type:	A Violation

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 Integrity HC of Herrin.

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,

Alfonso Cano III
Bureau Chief, Long-Term Care
Office of Health Care Regulation
Illinois Department of Public Health

Enclosure
cc: Administrator
File
Integrity HC of Herrin/11/13/20//RegAgent/S. Hobson

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. HERRIN REHABILITATION AND NURSING CENTER, LLC, D/B/A, INTEGRITY HC OF HERRIN, Respondent.	))))))))))	Docket No. NH 20-C0384

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; 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 "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

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 Investigation conducted by the Department on 11/13/20, at Integrity HC of Herrin, 1900 North Park Avenue, Herrin, Illinois 62948. On January 20, 2021, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care 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 Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" 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 CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Integrity HC of Herrin, 1900 North Park Avenue, Herrin, Illinois 62948 on 11/24/20. The Facility's current license number is 0051045. The term of the conditional license shall be from 02/20/21 through 08/19/21. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON 02/20/21.

The Conditional License will be withdrawn, and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.1210b)4), 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).

Fine = $25,000.00

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
Attn: Scott Hobson
525 West Jefferson, 5th Floor – Quality Assurance
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 Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; 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.

Plans of Correction, Hearing and Waiver Requests 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: Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Alfonso Cano III
Bureau Chief, Long-Term Care
Office of Health Care Regulation
Illinois Department of Public Health

Dated this 25 day of January, 2021.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. HERRIN REHABILITATION AND NURSING CENTER, LLC, D/B/A, INTEGRITY HC OF HERRIN, Respondent.	)))))))))))	Docket No. NH 20-C0384

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; 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:	Business Filing Incorporated
Licensee Info:	Herrin Rehabilitation and Nursing Center, LLC
Address:	600 S 2nd Street, Ste 104 Springfield, Illinois 62704

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 25 day of January, 2021.

Scott Hobson
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
	IL6003362	A. BUILDING: _____ B. WING _____	C 11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF HERRIN	1900 NORTH PARK AVENUE HERRIN, IL 62948

(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	Final Observations Statement of Licensure Findings: 1 of 1 finding Complaint 2058579/IL128205 300.1210b)4) 300.1210d)6) 300.1220b)3) 300.3240a) 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 procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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 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.	S9999		

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S9999	Continued From page 2 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observations, interview, and record review, the facility failed to implement safety measures for 3 of 3 (R1, R2, and R11) residents reviewed for accidents in the sample 11. This failure resulted in R2 ingesting a whole napkin, being transferred to the local hospital for symptoms of aspiration, a full paper towel being removed from his airway, and intubation being required. Findings Include: 1. R2's facility admission record dated 11/06/2020 documents R2 was admitted to the facility on 5/9/17 with diagnoses that include: chronic obstructive pulmonary edema, hypertension, schizoaffective disorder, dysphagia, and unspecified dementia. R2's MDS (Minimum Data Set) dated 10/08/2020 documents R2 has a BIMS (Brief Interview for Mental Status) score of 01, which indicates R2	S9999		

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S9999	Continued From page 3 has a severe cognitive deficit. R2's current care plan (not dated) documents an undated focus area of "self-care deficit in feeding r/t (related to) impaired sight and impaired cognition" with interventions that include; provide verbal cues and use hand over hand if needed. R2's nurses notes dated 10/23/2020 at 6:45 PM document "res (resident-R2) was sitting upright in w/c (wheelchair) at table in dining room feeding self r/t (related to) evening meal. This nurse observed large amt (amount) of thick yellow sputum noted in mouth. Res alert resp (respirations) uneven et (and) labored .... O2 sat 81%...unable to cough or clear airway ...O2 applied at 15 L (liters) ...transferred res from w/c to bed ... (name of local ambulance service) notified for transfer to ER ...." The local ambulance service patient care report dated 10/23/2020 documents "Primary survey showed pt (patient) had no life-threatening injuries or symptoms ....Staff advised "he may have aspirated on his dinner tonight and he's a little combative, and we heard stridor with his breathing so we put him on 15 LPM (liters per minute) ...Pt was transported to (name of local hospital), where care was transferred without incident ..." R2's local hospital record dated 10/23/2020 documents under ED (Emergency Department) provider notes, "The patient is a 70-year old nursing home patient who is at baseline nonverbal and requires help for all activities of daily living who presents to the emergency department with increased work of breathing according to the nursing home. He was apparently being fed when he started to have	S9999		

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difficulty breathing. Nursing home noted stridor. He was given supplemental oxygen but did not improve with saturation in the high 80's. Additionally, the (sic) stated to EMS (Emergency Service Personnel) that they suspected aspiration although no obvious vomiting. Upon arrival the patient was noted to be hypoxic a 70 (oxygen saturation) on non-rebreather the and (sic) and was in respiratory distress ...Upon arrival the patient is in acute respiratory failure with hypoxia and at risk of respiratory arrest. Pneumothorax was ruled out with a chest x-ray ...Decision to intubate patient. ...Testing in (sic) sedated with retrieval of a full-size paper towel within the airway going down into the chords." Under history and physical R2's active hospital problems and plan includes "acute respiratory failure secondary to aspiration of foreign body."

On 11/04/2020 at 5:04 PM, V3 (Registered Nurse) stated she was at the facility on 10/23/2020 when R2 was transferred to the local emergency room for possible aspiration. V3 stated she was in the dining room and observed R2 having trouble breathing and not communicating normally. V3 confirmed the progress note she wrote documented R2 was eating independently at the time of the occurrence. Reviewed the care plan that documents verbal cues with hand over hand assistance during meals and V3 stated she had not observed R2 to require hand over hand assist during meals.

On 11/10/2020 at 10:32 AM, V19 (Dietary Manager) stated she had worked at the facility for approximately 18 years. V19 stated R2 was not eating in his room so he was to have his meals served in the dining room. When asked what supervision R2 should have received during

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meals, V19 stated, "They should have been watching him eat." V19 stated the new employees didn't know R2 wasn't supposed to receive a napkin with his meal and she has a note up on the wall now for that reason. When asked how long R2 had not been receiving napkins with his meals, V19 stated she thought it was care planned. When asked if R2 had attempted to ingest napkins before, V19 stated "Once in a while. He can't see what he is eating." V19 stated this is maybe the third time R2 has attempted to eat a napkin. On 11/10/2020 at 2:28 PM, V19 stated there was probably no documentation related to previous incidents of R2 attempting to ingest a napkin because staff always intervened in time to stop him. V19 stated staff would take the paper napkin off R2's tray when they delivered it and R2 would use a cloth (bib like) napkin. When asked if that was a decision V19 made independently stated, "No, it was a team decision but not the team I have now. It was before them."

On 11/10/2020 at 2:44 PM, V16 (Activities Director) stated she did not remember R2 attempting to ingest napkins prior to the incident on 10/23/2020, but she remembered R2 attempting to ingest a magazine during an activity. V16 stated she took the magazine away and began to monitor R2 closely during activities. V16 stated it occurred a while back and she can't remember if she told anyone else about it. V16 states she thinks she remembers hearing R2 was not to have napkins.

On 11/11/2020 at 10:45 PM, V18 (Certified Nursing Assistant) stated she had never witnessed R2 attempt to ingest napkins (non-food items) but stated she remembers someone (unknown) saying R2 had a history of ingesting

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S9999	Continued From page 6 napkins. On 11/05/2020 at 8:37 PM, V9 (Certified Nursing Assistant) stated she had never witnessed R2 attempting to ingest non-food items, but she thinks R2 may have in the past. On 11/10/2020 at 12:32 PM, V20 (Family Member) stated she had been notified by the local hospital that R2 was admitted to the hospital and had ingested a whole napkin. V20 stated she had not been told R2 had a history of attempting to ingest napkins. V20 stated she had been to visit R2 prior to Covid and did not remember him receiving a napkin with his meal but did remember him having a "bib." On 11/10/2020 at 1:28 PM, V2 (Director of Nurses) stated she was not aware R2 had attempted to ingest napkins in the past. V2 stated she believed R2 had finished his evening meal and was drinking coffee at the time of the incident. V2 stated R2 would eat independently and usually consumed 100% of his meals and then liked to drink a couple of cups of coffee. V2 stated the dining room was being monitored by staff and she believes the registered nurse (V3) was monitoring the dining room at the time of the incident. On 11/12/2020 at 2:10 PM, V23 (Physician) stated he is not aware of R2 attempting to ingest non-food items in the past, but R2 is confused and very sick. V23 stated R2 ingesting a full size paper towel should not have happened while someone was supervising him and R2 was intubated because of the acute aspiration of the paper towel which resulted in hypoxia. 2. R11's admission record documents R11 was	S9999		

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admitted to the facility on 11/16/18 with diagnoses that include chronic obstructive pulmonary disease, heart failure, cognitive communication deficit, and unspecified dementia.

R11's MDS (Minimum Data Set) dated 10/01/2020 has a BIMS (Brief Interview for Mental Status) score of 00, which indicates he has a severe cognitive deficit.

On 11/05/2020 at 12:01 PM, R11 was observed in the dining room. R11 was served his plate by staff. R11 had a surgical mask on his face covering his nose and mouth. R11 took a bite of food and attempted to put it in his mouth through the mask. R11 then took a second bite of his food and attempted again to put it in his mouth through the mask. R11 began attempting to chew the food and the mask appeared to be partially in R11's mouth as he chewed. Staff continued to serve trays to residents and did not observe R11 attempting to eat through his mask. This surveyor told V24 (Regional Clinical Director) who immediately removed R11's face mask.

On 11/10/2020 at 10:32 AM, V19 (Dietary Manager) stated R11 was served his meals in the dining room because he wasn't eating well in his room. V19 stated he just needs prompting to eat.

On 11/10/2020 at 1:28 PM, V2 (Director of Nurses) stated R11 feeds himself and wasn't eating well in his room so he was moved to the dining room. V2 stated R11 requires cueing to eat. V2 stated she wasn't aware of R11 attempting to eat his meal through his mask on 11/05/2020 and would implement interventions.

3. R1's admission record dated 11/06/2020 documents R1 was admitted to the facility on

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7/9/18 with diagnoses that include dementia, chronic kidney disease, muscle weakness, schizoaffective disorder, disorientation, and difficulty in walking.

R1's MDS (Minimum Data Set) dated 10/01/2020 documents R1 has a severe cognitive impairment. Under section G R1's MDS documents, R1 requires two person physical assist to toilet.

R1's fall risk assessment dated 10/20/2020 documents a score of 12, which indicates R1 is at high risk for falls.

R1's current care plan (not dated) documents a focus area of ADL (Activities of Daily Living) self-care deficit related to dementia and impaired balance. The interventions listed include; R1 requires total staff participation to use toilet and transfer and to encourage R1 to use the bell to call for assistance.

On 11/04/2020 at 9:01 AM, R1 was observed sitting in a wheelchair in her room with her head laying flat down on a pillow on her bedside table. V4 (Certified Nursing Assistant/CNA) stated R1 was ok and he was getting ready to take her to the bathroom. At 9:31 AM, R1 was in the bathroom with V4 when V6 (Licensed Practical Nurse) asked V4 to assist her. V4 left the bathroom and left R1 unattended on the commode. Continuous observation was done and V4 returned to the bathroom at 9:57 AM (26 minutes) to assist R1 off the commode. No other staff were observed entering or exiting the bathroom. There was no call bell or light observed in the bathroom.

On 11/05/2020 at 11:55 AM, V4 (CNA) confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003362	A. BUILDING: _____ B. WING _____	C 11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF HERRIN	1900 NORTH PARK AVENUE HERRIN, IL 62948

(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 there were no call lights/bells in any of the bathrooms and that he left R1 on the commode. V4 stated, "She wouldn't use the call light anyway." On 11/10/2020 at 1:28 PM, V2 (Director of Nurses) confirmed there were no working call lights/bells in the bathrooms on 11/04/2020. V2 stated it was not typical for staff to leave R1 on the commode unattended. When asked what she would expect staff to do V2 stated, "I would expect the staff member to stay with the resident or stand right outside the door. I was there that day. They could have come and gotten me." (A)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: INTEGRITY HC OF HERRIN COMPLAINT #: 0128205
LIC. ID #: 0051045
DATE COMPLAINT RECEIVED: 10/28/20 03:36:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
131	RESIDENT INJURY	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.