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| F 000 | INITIAL COMMENTS<br><br>Complaint 1142935/IL54604 - F278, F279, F323<br><br>Complaint 1142939/IL54608 - F278, F279, F323 | F 000 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by: | F 278 | | 10/8/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 278 | Continued From page 1<br>Based on record review, observation, and interview, the facility failed to ensure Minimum Data Set assessments accurately reflect resident's status for 2 of 6 residents (R2 and R3) reviewed for current assessments, in the sample of 6.<br><br>Findings include:<br><br>1. The Facility information face sheet documents that R2 had diagnoses which include, aspiration Pneumonia, History of Multiple Cerebral vascular accidents, History of Respiratory Failure, Dysphagia, and Aphasia. The Physicians Order Sheet, dated 9/11 document that R2 is on a pureed diet with honeythick liquids.<br>On 9/30/11 at 12:10PM, R2 was eating in the dining room. R2 was observed throughout the lunch meal to eat very quickly, and cough or choke on every mouthful. R2 continued to take in more food and fluid while still coughing and choking on the previous mouthful of food.<br>On 10/4/11 at 2:55PM, E16 Registered Nurse (RN), and Minimum Data Set (MDS) Coordinator stated, " I do think (R2's) fast eating, coughing and choking, without swallowing, is a behavior. I don't know why it isn't on the last MDS dated 7/15/11. We are not tracking eating behaviors for (R2)." On 10/4/11 at 3:45PM E17 stated, "Every night I have to tell him to slow down. He constantly coughs and chokes because he eats too fast. Everyone tells me he has done that since he was admitted."<br>The MDS dated 7/15/11 documents no behavioral symptoms were noted, despite observations and interviews noting otherwise.<br><br>2. R3's Resident Incident Report, dated 9-26-11, | F 278 | | |

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| F 278 | Continued From page 2<br>documented " while in dining room, res (resident) (R3) noted to have difficulty swallowing et (and) turned blue. Staff initiated Heimlich maneuver without success. 911 called finger sweep done. Res. placed on floor. CPR (Cardiopulmonary Resuscitation) initiated. 911 arrived et took over CPR. Res taken to hosp (hospital) via stretcher."<br>The local hospital's Emergency Nursing Record, dated 9-23-11 at 1816, documented, "Pt (patient) eating sandwich at dinner table became unresponsive after choking. EMS (emergency medical staff) gave Epi x2 (times two), Atropine x2, PEA (?) on the monitor. ET (?) tube 7.5 Placed pt bagged per EMS. EMS suctioned removing sandwich." It was also noted R3's death was called at 1842 on 9-23-11.<br>In interviews with R4, on 10-4-11 at 11:20a.m.; E14, Certified Nursing Assistant (CNA), on 9-30-11 at 2:55p.m.; E12 (CNA) on 9-30-11 at 3:20p.m.; Z8, Outside Agency Care Provider, on 10-4-11 at 10:16a.m.; E19, Dietitian, on 10-4-1 at 1:00p.m; Z6, Speech Therapist, on 10-3-11 at 11:32a.m.; E5, Licensed Practical Nurse (LPN),on 9-30-11 at 11:20a.m.; E8 (CNA), on 9-30-11 at 11:20a.m.; E9 (CNA), on 9-30-11 at 11:25a.m.; and E13 (LPN), on 9-30-11 at 2:35p.m they all verified R3 had difficulty swallowing, had a history of eating too fast, swallowed food whole and needed to be monitored closely while eating.<br>R3's MDS, dated 8-26-11, did not document R3 had signs and symptoms of a swallowing disorder or that she had eating behaviors. It was also noted R3 was assessed as a supervision of set up help only with eating and fluids.<br>Interview of E16 (RN), on 10-3-11 at 11:45a.m., E16 stated R3's eating behaviors were not documented on R3's MDS. | F 278 | | |
| F 279 | 483.20(d), 483.20(k)(1) DEVELOP | F 279 | | 10/8/11 |

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| F 279 SS=D | Continued From page 3<br>COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interview, the facility failed to provide care planning for 2 of 2 residents (R2 and R3) reviewed for care plans, in the sample of 6.<br><br>Findings include:<br><br>1. The Facility medical record information face sheet documents that R2 has diagnoses which include Aspiration Pneumonia, Respiratory Failure, History of Multiple Cerebral Vascular Accidents, Dysphagia and Aphasia. | F 279 | | |

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| F 279 | Continued From page 4<br>On 9/30/11 at 12:00 noon, R2 was feeding himself the lunch meal. R2 had a bowl of food as well as a sippy cup of fluid. He coughed and choked with every mouthful of food. R2 would often put additional food into his mouth before swallowing the last mouthful.<br>On 10/4/11 at 3:00 PM E16, Registered Nurse/Care Plan Coordinator, (RN/CPC) reviewed R2's plan of care, last updated on 7/21/11. She stated that R2 does have a problem with eating very fast which causes him to cough, and that he requires frequent cueing to slow down to avoid aspiration. E16 confirmed that the behavior of very fast eating with coughing and choking is not being tracked by staff and is not addressed in the current plan of care. On 10/4/11 at 3:30 PM E17 Licensed Practical Nurse (LPN) stated, "Oh yes you have to tell him to slow down and swallow. He keeps pushing food into his mouth before he has swallowed the last mouthful. Everyone tells me he has done that since his admission."<br>R2's plan of care , last updated 7/21/11 notes that R2 has a problem with choking and past aspiration pneumonia. It does not address R2's behavior of very fast eating and coughing or interventions to be utilized to avoid possible aspiration or choking.<br><br>2. R3's Resident Incident Report, dated 9-26-11, documented " while in dining room, res (resident) (R3) noted to have difficulty swallowing et (and) turned blue. Staff initiated Heimlich maneuver without success. 911 called finger sweep done. Res. placed on floor. CPR (Cardiopulmonary Resuscitation) initiated. 911 arrived et took over CPR. Res taken to hosp (hospital) via stretcher."<br>The local hospital's Emergency Nursing | F 279 | | |

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| F 279 | Continued From page 5 | F 279 | | |

Record, dated 9-23-11 at 1816, documented, "Pt (patient) eating sandwich at dinner table became unresponsive after choking. EMS (emergency medical staff) gave Epi x2 (times two), Atropine x2, PEA (?) on the monitor. ET (?) tube 7.5 Placed pt bagged per EMS. EMS suctioned removing sandwich." It was also noted R3's death was called at 1842 on 9-23-11.

In an interview of E5, LPN, on 9-30-11 at 11:20a.m., E5 stated R3 need supervision and cueing to slow down. E8, CNA, stated on 9-30-11 at 11:20a.m., that R3 shoveled in her food and needed to be told to slow down all the time. On 9-30-11 at 11:30a.m., E10, CNA, stated R3 ate too fast and had to be slowed down all the time. On 9-30-11 at 11:25a.m., E9, CNA, stated "you had to sit by her and get her to slow down when eating...she ate so fast." On 9-30-11 at 2:35p.m., E13, LPN, stated R3 had a problem with pocketing food and eats too fast. On 9-30-11 at 11:24a.m., E6, LPN, stated R3 ate too fast and needed supervision and R3 would not swallow before putting more food in her mouth.

R3's Care Plan, goal date 9-6-11, documented R3 was on a mechanically altered diet related to chewing difficultly and history of swallowing difficultly. R3's Care Plan did not document R3's eating behaviors of, rapid eating, shoveling food, coughing, choking, aspiration potential nor her level of needed supervision.

On 10-3-11 at 11:45a.m., E16 stated R3's eating behaviors where not care planned

The facility's Care Plan Policy and Procedure, not dated, documented "All residents will have comprehensive assessments and an individualized plan of care-developed to assist them in achieving and maintaining their optimal status".

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| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to assess, monitor, implement interventions, develop a plan of care and provide supervision at meals for 1 of 2 residents (R3) reviewed for swallowing difficulties and eating behaviors, in the sample of 6. This failure resulted in R3 choking on a sandwich during unsupervised dining. R3 was transported to the hospital at 6:16 pm and was pronounced dead at 6:42pm on that same date.<br><br>Findings include:<br><br>R3's Resident Incident Report, dated 9-26-11, documented " while in dining room, res (resident) (R3) noted to have difficulty swallowing et (and) turned blue. Staff initiated Heimlich maneuver without success. 911 called finger sweep done. Res. placed on floor. CPR (Cardiopulmonary Resuscitation) initiated. 911 arrived et took over CPR. Res taken to hosp (hospital) via stretcher."<br>The hospital Emergency Nursing Record, dated 9-23-11 at 1816 (6:16PM), documented, "Pt (patient) eating sandwich at dinner table became unresponsive after choking. EMS | F 323 | | 10/8/11 |

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| F 323 | Continued From page 7 | F 323 | | |

(emergency medical staff) gave Epi x2 (times two), Atropine x2, PEA (?) on the monitor. ET (?) tube 7.5 Placed pt bagged per EMS. EMS suctioned removing sandwich." R3's death was called at 1842 (6:42PM) on 9-23-11.

On 10-4-11 at 11:20a.m., R4 stated "that night the girl put the sandwich in a bowl down in front of R3 then walked away to go get a spoon... by the time she came back R3 was unresponsive and blue."

On 9-30-11 at 2:55p.m., E14 Certified Nurse Aid (CNA), stated she had placed a bowl of ground meat and whole bread in front of R3 on 9-23-11, left R3 to get another meal tray and returned to R3's table to check on her. E14 stated R3 was confused at times, had a history of eating too fast, not chewing food, swallowing food whole, and needed to be monitored closely and cued.

On 9-30-11 at 3:20p.m., E12, CNA, stated she saw chunks of "white", bread, in R3's mouth. E12 also stated R3 was a choking precaution, at risk for choking, had a history of eating fast and needed verbal clueing to chew her food slow and swallow.

On 10-4-11 at 10:16a.m., Z8, Outside Agency Care Provider, stated the Sunday prior to R3's choking incident, of 9-23-11, she had informed staff about R3's coughing when eating a sandwich. Z8 also stated that staff could not put food in front of R3 and walk away because R3 would grab at food, cram food in her mouth, pouch food and shovel food without supervision. Z8 also stated R3 had a history of choking and swallowing difficulties.

A Physician's Order Sheet (POS), dated 8-1-11 to 8-31-11 documented, "Diets...Mechanical Soft...Nectar thick liquids...provide 1:1

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| F 323 | Continued From page 8 | F 323 | | |

supervision at meals". A line was drawn through the "provide 1:1 supervision at meals" without a documented date, time and/or initial (signature). On the same POS, a line was drawn through the diet order and "d/c (discontinue) 7-13-11" but, again, there were no initials or signature.

On 10-3-11 at 12:55a.m., Z3, R3's Physician, stated it would be out of character for him (Z3) to draw a line through an order and not initial a change of order.

R3's Initial Annual Significant Change Nutritional Assessment, dated 3-30-11, documented R3's inability to swallow regular food/fluids due to Dementia and a history of coughing/choking. It was also noted R3 required full supervision and cueing at meals and was at risk for aspiration. On 10-4-11 at 1:00p.m., E19, Dietitian, stated the 3-30-11 assessment was most current.

R3's Rehab Discharge Summary, Speech Therapy, dated 7-13-11, documented "Pt (patient) seen for about (?) treatments for dysaphia. Pt. remains on mechanical soft & (and) nectar thick fluids. Pt needs supervision for rates and bolus size to increase safety of swallow. Pt. required instruction including both verbal and tactile cues." On 10-3-11 at 11:32a.m., Z6 Speech Therapist confirmed R3's needed supervision for safety.

Physician order's, dated 7-13-11, documented "d/c skilled st (speech therapy) due to goal achieved at optimal level. Pt. still requires supervision in dr (dining room) to rate of intake & (and) bolus size."

On 10-3-11 at 2:50p.m., E18, Dietary Manage, stated R3 should be served one bowl at a time. R3's current diet card documented "mechanical soft, nectar thicken liquids food in bowls served one at a time."

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| F 323 | Continued From page 9 | F 323 | | |

On 9-30-11 at 11:20a.m., E5, LPN stated R3 needed supervision and cueing to slow down.

E8, CNA, stated on 9-30-11 at 11:20a.m., that R3 shoveled in her food and needed to be told to slow down all the time.

On 9-30-11 at 11:30a.m., E10, CNA, stated R3 ate too fast and had to be slowed down all the time.

On 9-30-11 at 11:25a.m., E9, CNA, stated "you had to sit by her and get her to slow down when eating...she ate so fast."

On 9-30-11 at 2:35p.m., E13, LPN, stated R3 had a problem with pocketing food and eats too fast.

On 9-30-11 at 11:24a.m., E6, LPN, stated R3 ate too fast and needed supervision and R3 would not swallow before putting more food in her mouth.

R3's MDS, dated 8-26-11, did not document R3 had signs and symptoms of a swallowing disorder or that she had eating behaviors. It was also noted R3 was assessed as a supervision of set up help only with eating and fluids.

Interview of E16 (RN), on 10-3-11 at 11:45a.m., E16 confirmed R3's eating behaviors were not documented on R3's MDS.

R3's Care Plan, goal date 9-6-11, documented R3 was on a mechanically altered diet related to chewing difficultly and history of swallowing difficultly. R3's Care Plan did not document R3's eating behaviors of, rapid eating, shoveling food, coughing, choking, aspiration potential nor her level of needed supervision. Interview of E16 (RN), on 10-3-11 at 11:45a.m., E16 confirmed R3's eating behaviors were not documented on R3's Care Plan.

R3's Choking Risk Assessments, dated 3-10-11, 6-3-11 and 8-6-11, did not document

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| F 323 | Continued From page 10<br>R3's eating behaviors, or difficulty with swallowing and /or gagging or choking episodes.<br>The facility's Choking Assessment Policy and Procedure, dated 10-9-09, documented a choking risk assessment was to be completed on all residents quarterly and as necessitated by resident need. | F 323 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.690c)<br>300.1210a)<br>300.1210b)<br>300.1220b)3)<br>300.1810d)<br>300.3240a)<br><br>Section 300.690 Incidents and Accidents<br><br>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that | F9999 | | |

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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 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

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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 300.1810 Resident Record Requirements

d) All physician's orders, plans of treatment, Medicare or Medicaid certification, recertification statements, and similar documents shall have the authentication of the physician. The use of a physician's rubber stamp signature, with or without initials, is not acceptable.

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)

This requirement is not met as evidenced by:

Based on record review and interview, the facility failed to assess, monitor, implement interventions, develop a plan of care and provide supervision at meals for 1 of 2 residents (R3) reviewed for swallowing difficulties and eating behaviors, in the sample of 6. This failure resulted in R3 choking on a sandwich during unsupervised dining. R3 was transported to the hospital at 6:16 pm and was pronounced dead at 6:42pm on that same date. In addition, the facility failed to timely and completely report this incident to the Department.

Findings include:

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1) R3's Resident Incident Report, dated 9-26-11, documented "while in dining room, res (resident) (R3) noted to have difficulty swallowing et (and) turned blue. Staff initiated Heimlich maneuver without success. 911 called finger sweep done. Res. placed on floor. CPR (Cardiopulmonary Resuscitation) initiated. 911 arrived et took over CPR. Res taken to hosp (hospital) via stretcher."

The hospital Emergency Nursing Record, dated 9-23-11 at 1816 (6:16PM), documented, "Pt (patient) eating sandwich at dinner table became unresponsive after choking. EMS (emergency medical staff) gave Epi x2 (times two), Atropine x2, PEA (?) on the monitor. ET (?) tube 7.5 Placed pt bagged per EMS. EMS suctioned removing sandwich." R3's death was called at 1842 (6:42PM) on 9-23-11.

On 10-4-11 at 11:20a.m., R4 stated "that night the girl put the sandwich in a bowl down in front of R3 then walked away to go get a spoon... by the time she came back R3 was unresponsive and blue."

On 9-30-11 at 2:55p.m., E14 Certified Nurse Aid (CNA) stated she had placed a bowl of ground meat and whole bread in front of R3 on 9-23-11, left R3 to get another meal tray and returned to R3's table to check on her. E14 stated R3 was confused at times, had a history of eating too fast, not chewing food, swallowing food whole, and needing to be monitored closely and cued.

On 9-30-11 at 3:20p.m., E12, CNA, stated she saw chunks of "white" bread in R3's mouth. E12 also stated R3 was a choking precaution, at risk for choking, had a history of eating fast and

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needed verbal clueing to chew her food slowly and swallow.

On 10-4-11 at 10:16a.m., Z8, Outside Agency Care Provider, stated the Sunday prior to R3's choking incident of 9-23-11, she had informed staff about R3's coughing when eating a sandwich. Z8 also stated that staff could not put food in front of R3 and walk away because R3 would grab at food, cram food in her mouth, pouch food and shovel food without supervision. Z8 also stated R3 had a history of choking and swallowing difficulties.

A Physician's Order Sheet (POS), dated 8-1-11 to 8-31-11 documented, "Diets...Mechanical Soft...Nectar thick liquids...provide 1:1 supervision at meals." A line was drawn through the "provide 1:1 supervision at meals" without a documented date, time and/or initial (signature). On the same POS, a line was drawn through the diet order and "d/c (discontinue) 7-13-11" but, again, there were no initials or signature.

On 10-3-11 at 12:55a.m., Z3, R3's Physician, stated it would be out of character for him (Z3) to draw a line through an order and not initial a change of order.

R3's Initial Annual Significant Change Nutritional Assessment, dated 3-30-11, documented R3's inability to swallow regular food/fluids due to Dementia and a history of coughing/choking. It was also noted R3 required full supervision and cueing at meals and was at risk for aspiration.
On 10-4-11 at 1:00p.m., E19, Dietitian, stated the 3-30-11 assessment was most current.

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R3's Rehab Discharge Summary, Speech Therapy, dated 7-13-11, documented "Pt (patient) seen for about (?) treatments for dysaphia. Pt. remains on mechanical soft & (and) nectar thick fluids. Pt needs supervision for rates and bolus size to increase safety of swallow. Pt. required instruction including both verbal and tactile cues." On 10-3-11 at 11:32a.m., Z6 Speech Therapist confirmed R3's needed supervision for safety.

Physician orders, dated 7-13-11, documented "d/c skilled st (speech therapy) due to goal achieved at optimal level. Pt. still requires supervision in dr (dining room) to rate of intake & (and) bolus size."

On 10-3-11 at 2:50p.m., E18, Dietary Manage, stated R3 should be served one bowl at a time. R3's current diet card documented "mechanical soft, nectar thicken liquids food in bowls served one at a time."

On 9-30-11 at 11:20a.m., E5, LPN stated R3 needed supervision and cueing to slow down.

E8, CNA, stated on 9-30-11 at 11:20a.m., that R3 shoveled in her food and needed to be told to slow down all the time.

On 9-30-11 at 11:30a.m., E10, CNA, stated R3 ate too fast and had to be slowed down all the time.

On 9-30-11 at 11:25a.m., E9, CNA, stated "you had to sit by her and get her to slow down when eating...she ate so fast."

On 9-30-11 at 2:35p.m., E13, LPN, stated R3

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had a problem with pocketing food and eats too fast.

On 9-30-11 at 11:24a.m., E6, LPN, stated R3 ate too fast and needed supervision and R3 would not swallow before putting more food in her mouth.

R3's MDS, dated 8-26-11, did not document R3 had signs and symptoms of a swallowing disorder or that she had eating behaviors. It was also noted R3 was assessed as a supervision of set up help only with eating and fluids.

Interview of E16 (RN), on 10-3-11 at 11:45a.m., E16 confirmed R3's eating behaviors were not documented on R3's MDS.

R3's Care Plan, goal date 9-6-11, documented R3 was on a mechanically altered diet related to chewing difficultly and history of swallowing difficultly. R3's Care Plan did not document R3's eating behaviors of rapid eating, shoveling food, coughing, choking, aspiration potential nor her level of needed supervision. Interview of E16 (RN), on 10-3-11 at 11:45a.m., E16 confirmed R3's eating behaviors were not documented on R3's Care Plan.

R3's Choking Risk Assessments, dated 3-10-11, 6-3-11 and 8-6-11, did not document R3's eating behaviors, or difficulty with swallowing and/or gagging or choking episodes.

The facility's Choking Assessment Policy and Procedure, dated 10-9-09, documented a choking risk assessment was to be completed on all residents quarterly and as necessitated by

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| F9999 | Continued From page 17<br>resident need.<br><br>2) The incident date and time for R3's choking incident was 9-23-11 at 5:30p.m. and the Department was notified on 9-26-11. The Incident Report did not indicate R3 was pronounced dead at the hospital, 30 minutes after he was transported.<br><br>Interview of E2, Director of Nursing (DON), on 10-3-11 at 3:05p.m., E2 confirmed that she did not timely notify the Department of R3's 9-23-11 incident.<br><br>The facility's Incident/Accident Report, policy and procedure, note dated, documented "b. Illinois Department of Public Health, by phone, within twenty-four (24) hours of the occurrence. During normal work hours, the Regional Office must be called. ON weekends and holidays, the Long Term Care Complaint Hotline hone number is to be used."<br><br>(B) | F9999 | | |