FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT #10-030-9022
Alden Lakeland Rehabilitation and Health Care Center

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Alden Lakeland Rehabilitation and Health Care Center (Alden Lakeland). It was alleged that the facility did not follow Nursing Home Care Act requirements when it repeatedly denied a resident the right to go on unescorted passes within the community. If substantiated, this would violate the Nursing Home Care Act (210 ILCS 45 et seq.), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300), the Centers for Medicare and Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities (42 C.F.R. 483) and the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Alden Lakeland is a 300-bed long-term acute care hospital in Chicago which houses a 30-bed Behavioral Health Unit.

To review this complaint, the HRA conducted a site visit and interviewed the Administrator, Assistant Administrator, Behavioral Health Counselor, and Social Service Director. The HRA obtained the recipient's record with written consent. The recipient is an adult who maintains his legal rights.

COMPLAINT SUMMARY

The complaint alleges that the recipient, who is a competent adult, requested and was refused an unsupervised pass to leave the facility and take a bus to downtown Chicago. Also, the complaint alleges that the recipient was repeatedly refused passes for no adequate reason although he had the approval from his physician. The recipient does not have a legal guardian or healthcare power of attorney and he makes his own decisions regarding medical treatment, including psychotropic medications, finances, and admission and discharge. Thus, the complaint alleges that the recipient has the legal authority to make his own decisions regarding his therapeutic day passes, however he has been denied this right for no adequate reason for five years.

FINDINGS

The record shows that the recipient was admitted to Alden Lakeland in May, 2006. During this time he was a resident of the Behavioral Health Unit. The HRA reviewed the recipient's clinical record for the period of one year: May, 2009 through June, 2010.

The recipient's clinical record contains a Pass Level Request completed 6/11/10 by the recipient with the help of his attorney, for a 5 hour unsupervised day pass. The pass request asks the recipient if he had been compliant with medication, if he had attended groups on a regular basis, and if there had been any incidents involving aggression, violence, or self-harm since he had been at Lakeland. It then asks the recipient to explain how that situation has changed, and what the recipient has done to gain control over these emotions and behaviors. His response states that he is careful in the community and knows the bus routes very well. It states that his last day pass went well and he returned on time. It acknowledges that he "bangs his head" at times in the facility, because the nursing home "upsets him", but he states that he doesn't bang his head when out in the community (and had not banged his head for one month).

Physician's Order Sheets indicate that for each month of the year the physician ordered "Therapeutic Pass w/meds and instructions w/accompaniment as needed." Specialists who worked with the recipient on specific issues (such as his foot, 11/24/09) placed restrictions on passes for very limited periods of time. The recipient's diagnoses are listed as Schizophrenia and Paranoia along with hypertension.

The recipient's clinical record contains nursing notes which describe the recipient's medical and behavioral issues that impacted the decisions to allow independent passes:

- 5/26/09 Laceration noted on the recipient's nose and he was taken to emergency room for evaluation. No medical problem reported.
- 6/27/09 Recipient spent the weekend with his family. No problems noted.
- 7/14/09 Recipient "preoccupied with wanting to go outside."
- 7/14/09 Laceration was noted on the resident's chin due to a fall and recipient was transported to emergency room for evaluation.
- 8/05/09 "Resident up ambulating with steady gait, pacing and following staff asking same questions repeatedly re: leaving facility. Increased anxiety/agitation, unable to follow instructions and/or perform task such as ADL's [activities of daily living]/shower, must be reminded to take meds, shower, change clothes. Resident is constantly hitting self in forehead with clenched fist. Continues to pace hallway, follow staff and hit self in forehead with clenched fist. Medicated with Ativan 2 mg tab for anxiety/agitation, unable to redirect." Later, recipient was transported to hospital for psychiatric evaluation. Pt fell on the floor in the hall. Later, recipient again fell in the dining room and was sent to emergency room for evaluation.
- 10/07/09 Resident visited group home for possible placement.
- 10/17/09 "Resident alert verbally responsive. Due meds was given on time. Noted with good appetite. Patient was persistent going out. Explain to resident that due to his medical condition he is still not fit to go out. Resident understands and went to his room.

- 10/21/09 "Resident came towards nurse noted an unsteady gait. Asking to go downtown."
- 10/25/09 Recipient fell while getting out of bed and was noted with a laceration above his left eye. He was sent to the emergency room for evaluation.
- 10/27/09 "….[illegible] Ate well am continues to request to go out to down town and presently not able to go…because of falls patient had suffered in recent times…"
- 11/2/09 "Resident was stabbed by another resident in the dining room after dinner. The stab was in his leg. There is no tear or puncture at the site of impact."
- 11/03/09 Recipient left for an appointment.
- 11/24/09 Resident underwent surgery on his foot and was given order of no weight on the right leg for 24 hours.
- 11/25/09 The recipient's foot was bleeding and he was transported to the hospital for evaluation. 12/07/09 Recipient lost consciousness at the nurses' station. He was transported to the emergency room for evaluation.
- 12/14/09 The recipient had his cast removed. Was then readmitted for an infection in his foot.
- 12/29/09 The recipient slipped and fell in his room. No visible injury.
- 12/31/09 The recipient continues to ambulate independently but sometimes he shows an unsteady gait.
- 1/05/10 "Resident ate and able to make his needs known. Persistent about leaving the facility but made aware that efforts to relocate and find a suitable place for him is ongoing."
- 1/19/10 "….Resident…persistently asking for discharge to group home."
- 2/06/10 "Resident continues to show persistent efforts at hurting himself, banging his forehead and frequent falls while asking to be transferred to the hospital."
- 2/07/10 "…Complains about his restrictions but continues to ask for when he'll be out of here."
- 2/07/10 Bruises noted on the residents eye and nose.
- 2/09/10 Recipient is evaluated for eye surgery but the physician states that it is impossible for the time being due to the recipient's head pounding and falling.
- 2/12/10 Recipient noted hitting his head and trying to induce vomiting. "From my understanding this seems like a pent-up anger been vented through agitation and self harm as patient consistently verbalized resolve to either be allowed out or be taken to the hospital. Face flush from been tucked in pillow. Patient was approached and advised that if he could stop hurting himself, staff will take him on a walk for couple of minutes. Patient continued to show agitation but with less intensity. Call later came from the Behavioral Clinical Director asking staff to desist from taking resident out. Concerns made known but she claimed this might be an attempt to reward bad behavior. She went further to state that efforts were been made to address resident's concern. I made my fear known that if care is not taken, resident might suffer irreparable injury as a result of self harm. Subjecting the resident to chemical restraint don't seem to be the best solution as persistent agitation almost every day has shown. This view was made known to the DON and my concern above re resident safety expressed."

- 2/12/10 "Resident was in the dining room waiting to be served dinner. Eyes popping, face red from persistent hitting on his face. Trying to induce vomiting, taken out of the dining room when other residents were becoming agitated…."
- 2/27/10 "….Still asking for when he will finally have the chance to go out."
- 2/28/10 "Resident starting to show agitation and to try to hurt himself again. Refused when efforts by staff to calm him down failed. Pt. shouting, 'I'm going to die here, I'm in hell, let me go.'" Later, "….Pt. had been persistent about leaving or be sent out to the hospital."
- 3/14/10 "….Earlier the resident was very agitated, jumping up and down screaming he should be sent to the hospital. He kept hitting his front head with his fist and put his fingers in his mouth in order to induce vomit. During the process he refused to stay still and leave his room…."
- 4/10/10 Recipient went on pass with family. No problem noted.
- 4/12/10 Recipient underwent eye surgery and had three subsequent follow-up appointments with his physician.
- 4/23/10 Recipient placed on fluid restriction due to drinking too many fluids.

The clinical record contains the social service progress notes for the period of time in question;

- 1/2/09 "Res reported that he had a great time being out of the facility with his family. Res reported that he would like to be discharged. Writer assured res that staff will cont to work on discharge…."
- 1/04/09 "Writer observed resident being physically aggressive to self as he continues to hit his head despite staff counsel and redirection. Resident received a day pass suspension so he can have enough time to process current stressors and anxieties with his counselor/staff…."
- 1/06/09 Recipient was restricted from community pass for the day for being too agitated.
- 6/08/09 "Writer met with res for 1:1 meeting. Res presents with stabled presentation. [Staff] picked up res to see possible placement for him in …. Res reported that he likes the place and is waiting to find out if he can move in."
- 7/05/09 "resident was observed with increased agitation. Resident was not allowed to go out due to unsteady gait and anxious presentation."
- 8/2/09 "….Resident was removed from special observation."
- 8/3/09 "Writer met with res for 1:1 meeting. Res presents with anxious presentation. Res asks daily about being discharged despite staff's counseling. Res is not receptive to staff. Res asks repetitive questions about his community pass and getting discharged."
- 8/13/09 "Writer met with res for 1:1 meeting. Res reported that he will be going to visit another home with [staff] in a week. Res presents with stabled presentation at this time and reported that he would like to go out into community…."
- 10/09/09 "Resident was returned to the facility after writer spotted him walking outside with unsteady gait. Resident was reminded that his medical condition is the reason that he cannot leave the facility without an escort."
- 10/09/09 Recipient visited a group home. No problems noted.
- 10/17/09 "Resident presents to be anxious and making repetitive complaints about obtaining a community pass."

- 10/29/09 "….Res presents with stabled presentation and has been cooperating with staff regarding his pass privileges. DON asked writer to purchase shoes for res to help him walk better…."
- 11/20/09 "….Res reported hating nursing homes repeatedly and would like to be discharged to either a group home or his own place."
- 2/19/10 Writer observed resident yelling and screaming by the nurses' station 'I want to leave, give me back my passes.' Resident disruptive continues to be repetitive concerning his pass status…. [Recipient] threw himself on the floor repeatedly, screaming, yelling non-stop, and inducing vomit by putting fist in his mouth…. [Recipient] was hospitalized after over three hours of non-stop behavior."
- 2/28/10 "Writer observed [Recipient] engaged in self-destructive behavior attempting to choke self, threw himself to the floor, hitting his head, banging his body towards the elevator, and difficult to redirect. 'Why he is gonna kill me because I blew off' repetitiously mentioned by [Recipient]."
- 4/29/10 "[Recipient] and writer discussed safe community navigation in 1:1 session today. The importance of watching surrounding traffic (regardless of traffic signals-potential for cars breaking road rules) was discussed. Additionally, the importance of walking at an appropriate speed across the street. Verbalizes understanding. Staff to observe and monitor road safety…."
- 4/14/10 Recipient and staff went to currency exchange and to file taxes. Staff notes that recipient was slow to cross the intersection and had an unsteady gait.
- 4/15/10 "Resident requests his community pass back. Resident remains inappropriate for independent community pass…not safe to cross the street independently…."
- 5/5/10 through 5/12/10 Recipient visited group home where he transferred in June, 2010.

A Psychosocial Assessment was completed for the recipient on 2/22/10. It states, "Pt. has been living at Alden Lakeland since May 2006. Prior to that he was living in his own condominium. Pt. said he hates it at the nursing home and wants to move out on his own. This has been an ongoing issue." The recipient had a Quarterly Assessment completed on 3/05/10. In addition to many complex diagnostic impressions the assessment states that "[Recipient] has shown increases in socially inappropriate behavior this quarter. [Recipient] will have episodes of yelling, screaming, cursing, throwing himself on the floor, pounding his head, holding his breath, and inducing vomit. [Recipient] denies SI or intent to do harm to his body. [Recipient] reports that this behavior occurs when he is 'too hot, stressed out, or upset.' Upon instances of acting-out behaviors, [Resident] is encouraged to utilize identified coping mechanisms (listening to music, going on a walk)….. [Resident] is easily distracted by his surroundings. Coping skills are poor. No active hallucinations noted or observed. Poor emotional control and inappropriate interpersonal skills…. Poor reasoning and minimal response to encouragement. Poor judgement and low enjoyment in daily activities. [Resident's] thought content has observed preoccupation with pass level and independent living…." The recipient's Comprehensive Psychosocial Assessment (6/6/110) offers the resident's attitude toward being discharged: "Resident is looking forward to being discharged to a group home for the developmentally disabled where he would be more happy and a better fit." His treatment recommendation is referral to a group home.

The recipient's Care Plan for the three months before his pass request indicates a behavior problem of self-injuriousness including head banging and throwing himself on the floor. The

approach for this behavior is that staff would provide the recipient with fifteen minutes of outdoor time for each day that self-injurious behavior is not displayed. Upon instances of these behaviors staff were to encourage the recipient to use his identified coping mechanisms: listening to music, going on a walk, sitting with staff, laying in bed or having a snack. The Plan also states that staff will educate the recipient on safe community navigation skills, and the recipient will visit group homes in the community. The Care Plans are not signed by the recipient or by staff, and there is no notation when or if the identified tasks (approaches) were completed.

The recipient's medication at the time of his pass request were: Risperdal, 2 mg orally at bedtime, Seroquel 300 mg orally at bedtime, Acetaminophen 650 mg orally every four hours as needed, Mylanta as needed, Milk of magnesia as needed, Seroquel 50 mg orally three times daily as needed, and Lorazepam 2 mg orally every four hours as needed (if not given by injection).

The record does not contain a physician's statement of decisional capacity for the recipient. His AXIS I diagnosis is Organic Brain Dysexecutive Syndrome, Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, and Generalized Anxiety Disorder with an AXIS II diagnosis of Mild Cognitive Delay. The record shows that the recipient had signed all admission documents, House Rules, and pass requests, however there is no informed consent for medication document in the record provided. The recipient does not have a legal guardian or power of attorney for healthcare. The recipient's Legal Advocacy attorney's record shows that the facility had been approached regarding the resident's passes as far back as 2007.

Facility staff who worked directly with the recipient were interviewed regarding the complaint. They stated that the recipient never reached the level of independent passes because he was unable to stop his self-destructive behaviors and also because he had eye surgery and could not be in the community for medical reasons at this time. They noted that the recipient was severely self-injurious and despite plans to address this, he was not able to reach the point where staff could trust that he could be in the community independently. Staff present at the site visit had taken the recipient on trips into the community such as the currency exchange or a coffee shop, however they did not feel that he could have managed these trips on his own. They stated that they work very closely with the psychiatrist who visits the recipient every two weeks and if the order indicates that the recipient cannot have independent passes they must follow this directive.

Staff were questioned about the recipient's Care Plan and if it could have been altered to address his self-destructive behaviors or perhaps he could have been transferred to another facility. The staff present had not worked with the recipient for longer than a year and they stated that they were working with an agency to place the recipient in a group home, however there were limited options. They were asked how the recipient responded to passes with families on the weekends and they stated that these visits were not problematic. Staff were asked about the recipient's repeated desire to be transferred out of the facility and if staff discussed the possibility (as noted in the nurse's notes) that perhaps the stress of being in the facility was causing the self-destructive behaviors, however they did not know about this discussion.

STATUTORY BASIS

The Nursing Home Care Act states, "No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States soley on account of his status as resident of a facility." (210 ILCS 45/2-101) Also, the Nursing Home Care Act mandates that every resident be permitted to participate in the planning of his care and medical treatment (210 ILCS 45/2-104).

The Nursing Home Care Act states that "Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation (210 ILCS 45/2-108). It also allows that this right may be restricted by a physician only in order to protect the resident or others from harm, harassment, or intimidation, provided that the reason for the restriction is placed in the clinical record by the physician.

The Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.4010) states that facilities must establish an Interdisciplinary Team for each resident with serious mental illness residing in a long term care facility. This team must identify the resident's individual needs by performing a comprehensive assessment to evaluate the resident's strengths and an assessment of their level of functioning in self-maintenance, social skills, community living skills, occupational skills, and symptom management skills. Based on these assessments the IDT develops the overall rehabilitation focus for the resident to achieve a level of skill development. Every three months the resident's progress toward goals is again evaluated for changes in the resident's condition (300.4020), "assuring the continued accuracy of the assessment."

The Centers for Medicare and Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities (42 C.F.R. 483.15) states that a facility "must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life." Section 483.10 Additionally, in Section (d) it states, "A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility." Also, in section 483.25 (2) it states, "A resident is given the appropriate treatment and services to maintain or improve his or her abilities…" Additionally, interventions to manage inappropriate behavior "must never be used for disciplinary purposes."

The Mental Health and Developmental Disabilities Code defines "Adequate and humane" care as "services reasonably calculated to prevent further decline in the condition of a recipient of services so that he or she does not present an imminent danger to self or others." (405 ILCS 5/1-101.2). It states that services must be provided in the least restrictive environment pursuant to an individual services plan and that in determining "least restrictive" the facility must consider the views of the recipient (5/2-102 a). Additionally, the Code states in section 5/2-101 that no recipient shall be presumed legally disabled nor held legally disabled except as determined by a court. Recipients are also permitted "unimpeded, private, and uncensored communication with persons of their choice by mail, telephone, and visitation (5/2-103)."

HOSPITAL POLICY

The Pass Policy of Alden Lakeland states, "The goal of Alden is for residents to be as independent as possible, as well as to function at the highest possible level for each individual. Level of independence is different for each resident based on their history of behaviors, ability to remain safe in the community, current moods and behaviors and compliance with treatment. Goal-directed, it is important for residents to learn the community reintegration skills needed to function independently, as well as to enjoy time out of in the community while out on pass. However, this is a behavioral health treatment program, and Alden has the responsibility to ensure that each resident is actively engaged and compliant in treatment and that each resident remains safe. The pass system is in place to help achieve all of these goals."

The Alden Lakeland pass procedures are developed on a level system. This system begins with a psychiatric evaluation completed within the 14 days after Admission. This results in a psychiatrist's order for pass level which is then effective 14 days after Admission. For new residents or those returning from a hospital stay, there is a three day observation period during which time the resident cannot leave the building, to ensure that the resident remains at baseline level of functioning. After three days the resident may leave the unit but not the building, and then a new psychiatrist's evaluation and order will determine the appropriate pass level. 14 days after Admission, after all comprehensive assessments are completed, the resident may move to a Level 1 Pass status, which allows the resident to go out on pass with supervision only. Supervised visits can be with family or relatives and individuals who are approved by the facility.

All new residents are placed on a 30-day observation period, starting after the 14 day assessment period. Residents are not allowed overnight passes on this level. In order to request a dependent pass on this level residents must complete a Behavioral Health Pass request form. The time frame for the pass is determined by staff. After 30 days on Level 1 residents may request increased levels of pass and after 5 dependent passes have been successfully utilized. Level 2 Pass status allows residents to leave the facility unsupervised for a maximum of one hour daily. Residents must remain on this level for 30 days and have 5 successful passes before requesting to move up to the next level. Level 3 Pass status allows residents to leave the facility unsupervised for a maximum of 5 hours daily. Residents must remain on this level for at least 30 days and have 5 successful passes before requesting to move up to the next level. Level 4 Pass status allows the resident to leave the facility for a maximum of 12 hours daily. Residents must remain on this pass level for at least 30 days and have 5 successful passes before requesting to move up to the next level.

Residents on a Level 5 pass status are allowed to leave the facility unsupervised, and can leave for the entire day, and for overnight passes.

In determining pass level increases, which is determined by the behavioral treatment team and doctor's order, the following criteria is taken into consideration:

- Compliance with prescribed medication for at least 30 days
- Compliance with 50% of programming
- Compliance with assessment process at admission, quarterly and annually
- Improvement in short-term goals noted in documentation
- Control over behaviors; no incidents of harm to self/others for at least 30 days

- No use of alohol/drugs at the facility and/or while out on pass for at least 30 days
- No safety concerns
- Appropriate pass level has been assessed and documented
- The most recent Mini-Mental status Exam has a cutoff score greater than 20
- The Behavioral Health Pass Level Increase Assessment form completed by treatment team and signed by psychiatrist
- Permission from legal guardian is provided in writing

The pass criteria to be out in the community for any reason states that the resident must be clean, wearing clean clothes, must be wearing shoes, must have taken his/her medications that day and the resident's behavior must have been appropriate that day. If these elements are not in place, the resident will not be able to go out on pass, no matter what the pass level.

Alden Lakeland pass policy states that staff may suspend/restrict a pass or decrease a resident's pass level for the following reasons:

- Drug/alcohol use,
- Bringing drugs/alcohol into the facility,
- Displaying aggressive behaviors,
- Displaying or reporting suicidal, self-harm, or homicidal ideation, intent, or plan.
- Other mood/behavioral instability noted.
- Deterioration/decompensation noted; resident not alert, oriented, displays poor decision-making abilities/ judgment.
- Refusal to complete ADL's
- Other concerns for resident's safety (or others') (e.g. inclement weather).
- Inability of resident to comply with time limits of pass level or follow-through with responsibilities of current pass level.
- Medication refusal, as well as refusal to participate in other recommended treatment services.
- Inability for resident to keep self safe or remain safe while either outside on pass or within the facility.

CONCLUSION

The record in this case shows a recipient who relentlessly requested independent passes into the community. The record also presents compelling evidence that the recipient was often not appropriate for these passes, generally due to self-injurious behaviors. It is worth noting though, that his monthly physician order sheets state "Therapeutic Pass w/meds and instructions w/accompaniment as needed." This order allows for passes and suggests that the recipient's situation would be reevaluated periodically to determine his need for accompaniment, however the record does not demonstrate continued reevaluation for this goal. Also noted, the recipient was given "coping mechanisms" for those times when he self-injured, and one of these was going on a walk. Additionally, the record is not clear about whether or not the recipient received the fifteen minutes of outdoor time each day that he did not exhibit self-injurious behaviors, as outlined in his Care Plan. On 2/12/10 the progress notes state, "Patient was approached and

advised that if he could stop hurting himself, staff will take him on a walk for couple of minutes. Patient continued to show agitation but with less intensity. Call later came from the Behavioral Clinical Director asking staff to desist from taking resident out. Concerns made known but she claimed this might be an attempt to reward bad behavior." Finally, it is not clear whether the recipient took part in his Care Plan formulation, as these documents were not signed by the recipient and he had no appointed representative. The general inconsistencies between the recipient's Care Plan and the facility's response to the recipient's needs suggest that the recipient would probably never have achieved his goal of independent passes, and in this case a revised plan or a referral to another placement would have been more humane than five years of refusing his independent pass requests.

The HRA substantiates the complaint that the facility did not follow Nursing Home Care Act requirements when it repeatedly denied a resident the right to go on unescorted passes within the community.

RECOMMENDATIONS

1. The Nursing Home Care Act (210 ILCS 45/2-104) guarantees recipients the right to visitation in the community and this right can only be restricted by a physician to protect the recipient or others from harm and the reason for the restriction is placed in the clinical record. Review with staff the process for achieving independent passes into the community so that recipients can either achieve their goal to leave the facility, or receive a Care Plan which offers achievable tasks which once accomplished, allows for passes (Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities 77 Ill. Admin. Code 300.4010 and 300.4020 and the Centers for Medicare and Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities 42 C.F.R. 483). If the recipient cannot reach the goal of achieving passes, indicate this by the physician's order and develop a revised Care Plan which incorporates this into its development. Include the recipient in the development and review of his Care Plan (Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 a).

2. Follow care plans as written or revise plans when goals are not or cannot be met. When a care plan calls for outside activity, provide such, with staff supervision if needed.

3. The Pass Policy requires that a resident take daily medication in order to exercise the pass privilege. The Nursing Home Care Act (20 ILCS 45/2-104(c)) includes the right to refuse treatment. Revise the policy to ensure protection of this right. Residents should not be denied the pass privilege solely for exercising the right to refuse treatment.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Alden Management Services, Inc.

August 2, 2011

Jill Quinto, HRA Chairperson
Illinois Guardianship and Advocacy Commission
1200 S. 1st Ave. Box 7009
Hines, IL 60141

Re: Alden Lakeland Rehabilitation and Health Care Center, Inc. ("Alden Lakeland")
HRA Case No. 10-030-9022

Dear Ms. Quinto,

Per the HRA's request and in further response to the HRA's Report of Findings and recommendations received in the above-referenced case, Alden Lakeland will review its policy regarding right to refuse treatment.

Please be advised that Alden Lakeland is not admitting that any violation existed by submitting this response. Furthermore, this response is not intended to be, nor does it constitute, an admission of liability or agreement of any kind by Alden Lakeland of the truth of the allegations or findings in this matter. Alden Lakeland does not waive and hereby preserves any and all substantive and procedural defenses that may exist to the HRA's determination.

If you require any further information, please feel free to contact me.

Sincerely,

Barbara N. Flores
Attorney for Alden Lakeland

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