

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/19/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F0000	<p>This visit was for the Investigation of Complaints IN00118562, IN00120198, and IN00120778.</p> <p>Complaint IN00118562-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F167.</p> <p>Complaint IN00120198-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00120778-Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: December 16, 17, 18, &amp; 19, 2012</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 7</p>	F0000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Medicaid: 63 Other: 10 Total: 80</p> <p>Sample: 12</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/20/12 Cathy Emswiller RN</p>			

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure the action plan implemented for a grievance related to supervision of resident's in the dining room was maintained for 2 of 2 grievances reviewed related to supervision of residents during meals. (Resident #F).</p> <p>Findings include:</p> <p>Facility Grievance Forms were reviewed on 12/18/12 at 1:00 p.m.</p> <p>A Grievance form was completed on 10/21/12. The Grievance form indicated Resident #F's family member voiced a concern that the resident was left alone in the Main Dining Room. The Action Plan on the Grievance indicated a Nurse was to stay in the Dining Room until the resident's were taken out. The Grievance form indicated the resolution was for follow up by the weekend manager with the Nursing Staff.</p> <p>A second Grievance Form was completed on 12/15/12. The Grievance Form was</p>	F0166	<p><b>F166</b> <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u></p> <p>·Resident #F will not be left unattended in the dining room while dining. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</u></p> <p>·All residents who dine in the dining room have the potential to be affected by the alleged deficient practice. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</u></p> <p>·Residents will not be allowed to dine alone in the dining room. A designated staff member will be stationed in the dining room for the duration of the meal - breakfast, lunch, and dinner.</p> <p>·Nursing staff on all shifts will be in-serviced by the Director of Clinical Education or his designee on this requirement.</p> <p>·Additionally, new employees will be educated on this requirement during their orientation.</p>	01/14/2013			

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	<p>received from the Administrator after the 10/21/12 was reviewed. The Grievance Form indicated Resident #F's family member voiced a concern that the resident was left in the Dining Room with no Nurse staff. The Action Plan on the form was blank.</p> <p>When interviewed on 12/18/12 at 3:00 p.m., the Director of Nursing indicated the 10/21/12 Grievance form was completed by the previous Administrator and the Director of Nursing did not recall the Grievance being forwarded to her. The Director of Nursing indicated the facility practice was for a nursing staff member to be in the dining room while the residents were eating.</p> <p>When interviewed on 12/18/12 at 3:00 p.m., the facility Administrator indicated the previous Administrator completed the 10/21/12 Grievance Form. The Administrator indicated he was not aware of a facility policy related to staff required in the dining room. The Administrator indicated he was not informed of any other follow up to the previous grievance had occurred.</p> <p>This federal tag relates to Complaint IN00118562.</p> <p>3.1-7(a)</p>		<ul style="list-style-type: none"> <li>·The ED or his designee will audit one meal per day for x12 weeks and then three meals per week for x3 months.</li> <li><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</u></li> <li>·The results of these audits will be presented to the QA&amp;A committee x 6 months or longer until substantial compliance is obtained.</li> <li>·Trends or patterns identified will have action plans written and implemented.</li> <li>·The Executive Director will oversee this process.</li> <li><u>By what date the systemic changes will be completed.</u></li> <li>·January 14, 2013</li> </ul>				

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F0282 SS=D	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's toileting plan was followed for 1 of 3 resident's reviewed with toileting plans in the sample of 12. (Resident #F)</p> <p>The facility also failed to ensure the resident's AFO foot brace was applied correctly and the CNA applying the brace had received proper training in the application of the foot brace for 1 of 3 residents reviewed with brace devices in the sample of 12. (Resident #F)</p> <p>Findings include:</p> <p>During orientation tour on 12/16/12 at 5:10 p.m., Resident #F was observed sitting in recliner chair next to his bed. The resident had a metal brace on his right foot.</p> <p>On 12/16/12 at 6:55 p.m., the resident was observed sitting in a chair at table in the Main Dining Room feeding himself dinner. At 7:40 p.m., CNA #3 was observed assisting the resident out of the dining room chair. The CNA placed the</p>	F0282	<p><b><u>F282</u></b> <i>It is the practice of this facility that services be provided by qualified persons in accordance with the resident's written plan of care. <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u></i></p> <ul style="list-style-type: none"> <li>·Resident F Care Plan reviewed and Resident Information sheet updated to reflect current toileting plan.</li> <li>·CNA in-serviced regarding correct application of AFO boot</li> <li><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</u></li> <li>·100% audits of residents with toileting plans</li> <li>·Resident information sheets updated with resident current toileting plan</li> <li>·100% audit of residents with braces, splints for proper application and ensuring Resident care sheets are current.</li> <li>·Staff re-educated regarding correct application of current splints and braces.</li> <li><u>What measures will be put into place or what systemic changes will be made to ensure that the</u></li> </ul>	01/14/2013

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	<p>resident's walker in front of him and the resident began walking out of the dining room with the CNA next to him. The CNA walked the resident down the hall and into his room. When entering the resident's room, CNA #3 assisted the resident into the recliner chair next to his bed. The CNA did not attempt to take the resident to the bathroom at this time.</p> <p>On 12/18/12 at 8:22 a.m., CNA #1 was observed dressing the resident and applying a brace to his right foot. The foot brace had a metal sole. The CNA placed the foot brace on the resident's foot and then put the resident's shoe on. The CNA did not place the sole of the brace under the padding of the resident's shoe. There was a sign on the resident's closet door which indicated the brace was to be applied under the padding in the resident's shoe.</p> <p>On 12/18/12 at 1:30 p.m., the resident was observed ambulating down the hall from the dining room using his walker. CNA #1 was walking with the resident down the hall into his room. When entering his room the CNA assisted the resident into the recliner chair next to his bed. The CNA did not attempt to take the resident to the bathroom at this time. The CNA removed the resident's right shoe and then removed the brace on the</p>		<p><u>deficient practice does not recur:</u> -</p> <ul style="list-style-type: none"> <li>·Recommendations for toileting schedules will be reviewed during AM clinical start up and Resident care sheets updated daily with any changes to toileting schedules.</li> <li>·New orders for splints and braces will be reviewed during AM clinical start up with nursing and therapy to ensure information is updated daily on resident care sheets.</li> <li>·Staff will be educated on application of any new splints or changes to splints on an on-going basis.</li> </ul> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</u> - -</p> <ul style="list-style-type: none"> <li>·DNS or designee will audit all residents with splints/braces to ensure proper placement and staff knowledge daily x 4 weeks, and then weekly x 8 weeks and then monthly x 3 months observing residents on all three shifts.</li> <li>·DNS or designee will audit 10% of residents with toileting plans weekly x 12 weeks and then monthly x 3 months observing staff on all three shifts providing toileting to residents.</li> <li>·Information gathered from the audits will be forwarded to the QAPI Committee for review x 6 months or longer until substantial compliance is achieved.</li> </ul>				

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	<p>resident's right foot. The foot brace had a metal sole. The sole of the brace was on top of the padding in the resident's shoe.</p> <p>The record for Resident #F was reviewed on 12/17/12 at 9:45 a.m. The resident's diagnoses included, but were not limited to, pneumonia, anxiety state, anoxic brain injury, gout, and high blood pressure.</p> <p>When interviewed on 12/18/12 at 1:40 p.m., CNA #1 indicated she was not aware the brace was to be applied under the padding in the shoe. The CNA indicated she had not received any recent inservices or instructions on place the brace under the shoe padding.</p> <p>When interviewed on 12/18/12 at 3:00 p.m., the Director of Nursing indicated the residents' family had voiced a concern to her about the placement of the resident's brace. The Director of Nursing indicated there was a sign in the room instructing staff on placement of the leg brace. The Director of Nursing also indicated Therapy staff had inserviced some of the staff on the proper use of the brace. The Director of Nursing also indicated staff should have toileted the resident after meals as per his toileting plan.</p> <p>When interviewed on 12/19/12 at 8:45</p>		<p><i>·Trends or patterns noted will have action plans written and interventions implemented</i></p> <p><i>·The Executive Director and DNS will oversee this process</i></p> <p><u>By what date the systemic changes will be completed: -</u></p> <p><i>January 14, 2013</i></p>				

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	<p>a.m., the Director of Nursing indicated CNA had not been inserviced prior to 12/18/12.</p> <p>This federal tag relates to Complaint IN00118562.</p> <p>3.1-35(g)(2)</p>			

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F0323 SS=E	<p><b>483.25(h)</b> <b>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b> 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. Based on observation, record review, and interview the facility failed to ensure fall preventions devices were in place and prevention interventions were followed related to floor mats not in place and residents left unattended in rooms and bathrooms for 3 of 4 residents reviewed for falls in the sample of 12. (Residents #C, #F, and #J) The facility also failed to ensure fall investigations were complete related to lack of obtaining statements from staff members caring for the resident prior to the fall for 1 of 4 residents reviewed for falls in the sample of 12. (Resident #L)</p> <p>Findings include:</p> <p>1. On 12/17/12 at 9:15 a.m., Resident #F was observed sitting in a recliner in his room. The resident had a pressure alarm in place.</p> <p>On 12/18/12 at 8:22 a.m., CNA #1 entered the resident's room. The resident was in bed. The CNA assisted the resident</p>	F0323	<p><b>F323</b> <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice</u> ·Residents C, F and J had their care plans reviewed and updated resident care sheets. Resident L had investigation of fall reviewed by IDT and care plan and care sheet reviewed. Residents rooms were assessed for implementation of care plan interventions. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</u> ·All residents care plans will be reviewed along with the Resident care sheets to verify that interventions are identified on the Resident care sheets. Resident care sheets will be updated with any intervention that may not have been previously listed. ·All resident rooms will be assessed to ensure that interventions identified on their Resident care sheets are implemented in the rooms. ·Verification of Investigations will be reviewed for the past week to ensure completion of</p>	01/14/2013	

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	<p>to a seated position on the side of the bed. The CNA then placed the resident's walker in front of him and assisted him to a standing position. The CNA ambulated the resident into the bathroom in the room and the resident sat on the commode with his walker in front of him. The CNA then left the bathroom and walked to the sink on a counter in the resident's room to get a plastic trash bag from the trash can under the sink counter. The CNA then opened the room door and called out to someone in the hallway. CNA #1 then returned to the bathroom for a few minutes and then again left the bathroom and walked to the sink on the counter in the room and wet a washcloth at the sink and returned to the bathroom. A few minutes later the CNA left the bathroom again and walked to the recliner chair and picked up a piece of clothing for the resident and then walked to the closet in the room and removed a disposable brief from the closet and returned to the bathroom to dress the resident. CNA then again left the bathroom and walked back out to get the resident's sock. The resident remained in he bathroom during the above times and was not in the CNA's view when she was out of the bathroom.</p> <p>The record for Resident #F was reviewed on 12/17/12 at 9:45 a.m. The resident's diagnoses included, but were not limited</p>		<p>investigation including statements. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</u> ·Resident care sheets will be updated daily with any change in interventions. Nurses will be re-educated on updating resident care sheets with any change in interventions. ·CNA staff will be re-educated on use of Resident care sheets and following interventions for each resident as outlined on the resident care sheets. ·Nurses and Nurse management will be re-educated on completion of Verification of Investigation form. ·DNS or designee will review all Verification of Investigations for completion including staff interviews. <u>How the corrective action will be monitored to ensure the deficient practice will not recur i.e QA program</u> ·A member of nursing management will complete round audits on each shift ensuring interventions listed on Resident care sheets are implemented and followed. Audits will be completed 5 x week x 6 weeks, 3x week x 6 weeks and then monthly. Results of the audits will be reviewed by the DNS/ADNS and reported to QAPI meeting monthly for a minimum of 6 months.</p>				

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	<p>to, pneumonia, anxiety state, anoxic brain injury, gout, and high blood pressure.</p> <p>Review of the current Physician orders indicated there were Physician orders for the resident to have pressure alarm to the recliner and the dining room chair. There was also a Physician's order for the resident to have a bed sensor alarm in place.</p> <p>The 10/18/12 Minimum Data Set (MDS) quarterly assessment indicated the resident required assistance of staff for transfers and walking in the room. The assessment also indicated the resident's BIMS (Brief Interview for Mental Status) indicated the residents cognitive patterns were severely impaired.</p> <p>When interviewed on 12/18/12 at 2:40 p.m., the Director of Nursing indicated the residents had alarms in place for fall prevention and the CNA should not have left the resident unattended in the bathroom.</p> <p>2. On 12/16/12 at 7:20 p.m., 7:37 p.m., and 8:12 p.m., Resident #C was observed in bed. The floor mat on the resident's left side was folded up in half and not covering the length of the bed. There were no staff members or visitors</p>		<p>·ED/DNS will report each month to QAPI results of audits of Verification of Investigations and completion. <u>What date the systemic changes will be completed.</u> ·January 14, 2013</p>				

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	<p>in the resident's room.</p> <p>On 12/17/12 at 9:39 a.m., 11:30 a.m., and 12:25 p.m., the resident was observed in bed. There was no floor mat in place on the resident's left side. There were no staff members or visitors in the room.</p> <p>On 12/18/12 at 7:50 a.m. and 8:20 a.m., the resident was observed in bed. There were two floor mats stacked on top of each other on the resident's left side. There was no floor mat on the other side. There were no staff members or visitors in the room.</p> <p>The record for Resident #C was reviewed on 12/17/12 at 11:30 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, high blood pressure, senile dementia, congestive heart failure, and insomnia. The current Physician orders indicated there was a Physician order dated 11/20/12 for mats to be in place on the floor to each side of the bed.</p> <p>Review of the 9/25/12 quarterly Clinical Health Status form indicated the resident fall risk score was (15). Residents with a score of 10 or higher were identified as fall risks. The 9/25/12 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance</p>						

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	<p>of staff for transfers, bed mobility, and hygiene. The assessment also indicated the resident's balance for walking was unsteady and he was only able to stand with staff assistance.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 5/26/10 indicated the resident had a history of falls, needed extensive assistance with transfers, had a diagnosis of dementia with poor safety awareness, and severely impaired cognition. The care plan was last revised on 11/7/12. Care plan interventions included for the resident's bed to be in the low position with mat beside the bed.</p> <p>The 11/2012 Nursing Progress Notes were reviewed. An entry made on 11/12/12 at 15:44 (3:44 p.m.) indicated the resident was observed laying on the floor with his head facing the foot of the bed and a "small bump" was noted on the right side of the resident's head.</p> <p>When interviewed 12/18/12 at 3:00 p.m., the Director of Nursing indicated the floor mats should have been in place as ordered by the Physician.</p> <p>3. On 12/18/12 at 8:47 a.m., Resident #J was observed sitting a wheel chair in the</p>			

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	<p>Main Dining Room. The resident's forehead area was ecchymosis (bruised) and round knotted area was observed to the right forehead area. On 12/18/12 at 8:50 a.m., CNA #2 started wheeling the resident from the Main Dining Room down the hall towards her room. The CNA wheeled the resident into her room with the wheel chair facing the window. CNA #2 then left the room. There were no other staff members or visitors in the room.</p> <p>The record for Resident #J was reviewed on 12/17/12 at 10:08 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, chronic airway obstruction, depressive disorder, and osteoarthritis. Review of the current Physician orders indicated there were Physician orders for the resident to have sensor alarms to the wheelchair and the bed.</p> <p>The resident's current care plans were reviewed. There was a care plan which indicated the resident was at risk for falls related to a history of a falls, incontinence, and the need for assistance with transfers and toilet use. The care plan was initiated on 12/28/11 and was last revised on 11/8/12. A care plan intervention for the staff not to leave the resident in the wheel chair in her room or</p>			

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	<p>in the bathroom unattended. This intervention was initiated on 10/22/12.</p> <p>The 6/6/12 Clinical Health Status assessment indicated the resident's fall risk assessment score was (11). A score of 10 or above indicated the resident was at risk for falls. There were no further fall risk assessments completed after 6/6/12.</p> <p>The 12/12 Nursing Progress Notes were reviewed. An entry made on 12/14/12 at 00:26 (12:26 a.m.) indicated the resident was observed on the floor in her room. A Change in Condition Report-Post Fall/Trauma was completed on 12/14/12. The report indicated the resident was noted on the floor in her room and a tennis ball size mass was noted to her right forehead area above the eye, first aid was administered, and the resident was taken to the hospital.</p> <p>The 12/14/12 hospital records were reviewed. The results of a CT scan done indicated the resident had a right frontal scalp hematoma with no evidence of intracranial hemorrhage of skull fracture.</p> <p>When interviewed on 12/18/12 at 3:00 p.m., the Director of Nursing indicated the resident had a recent fall and should not have been left unattended as per her plan of care.</p>				

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	<p>4. On 12/17/12 at 3:45 p.m., Resident #L was observed sitting in a wheel chair in the Main Dining Room. There was an alarm box attached to the wheelchair.</p> <p>The record for Resident #L was reviewed on 12/18/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to, hip joint replacement, Alzheimer disease, muscle weakness, and stress fracture of the femoral neck. Review of the current Physician orders indicated there were orders for the resident to have a bed alarm and bilateral floor mats in place. The 10/26/12 Clinical Health Status note indicated the resident's fall risk assessment indicated the resident was at risk for falls.</p> <p>Review of a 12/13/12 Change In Condition Report-Post Fall/Trauma form indicated the resident had a fall from the wheel chair. The Verification of Investigation form for the above fall indicated resident stated "I was trying to go home." The top of the third page of the form indicated "Witnesses: Identify all that may have knowledge of event prior to, during, or alleged event." There was only one interview completed on this form. The interview was written by the RN who completed the form. There were no interviews from any other staff</p>			

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	<p>involved in the resident's care prior to the fall.</p> <p>The 12/16/12 Nursing Progress Notes indicated a Change of Condition note was entered on 12/16/12 at 14:26 (2:26 p.m.). This note indicated the resident was in the process of self transferring in another resident's room and the alarm sounded and staff responded.</p> <p>Review of a 12/16/12 Verification of Investigation form completed at 15:26 (3:26 p.m.) indicated the resident was lowered to the floor by staff while in another resident's room.</p> <p>The top of the third page of the form indicated "Witnesses: Identify all that may have knowledge of event prior to, during, or alleged event." There was one witness interview documented on this form. The statement of an LPN was written by an RN. The statement indicated staff heard the alarm sounding and responded as resident was in the process of self transferring herself, could not bear weight, and was lowered to the floor for safety. There were no interviews from any other staff involved in resident's care prior to the fall.</p> <p>The facility policy titled "Change in Condition-Post Fall Investigation Summary Guidelines for Completion"</p>			

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	<p>was received from the Director of Nursing on 12/19/12 at 9:40 a.m. The policy had a revised date of January 2011. The Director of Nursing indicated the policy was current. The policy indicated staff were to attempt to establish what the resident was doing or attempting to do prior to the fall.</p> <p>When interviewed on 12/19/12 at 8:45 a.m., the Director of Nursing indicated interviews should have been obtained from other staff members including staff such as the CNA's who were also caring for the resident prior to her being found in another resident's room.</p> <p>This federal tag relates to Complaint IN00120778.</p> <p>3.1-45(a)(2)</p>			