		X1) PROVIDER/SUPPLIER/CLIA	ì	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					LETED (2004
		155228	B. WING 01/18				/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
WILLOW	S OF RICHMOND			2070 CHESTER BLVD RICHMOND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	IN00424062. Complaint IN00424 related to the allega	ne Investigation of Complaint 4062- Federal deficiencies ations are cited at F-584, F-812,	F 00	000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the face	ie	
	F-814 & F-925 Survey date: Januar	ry 18, 2024			alleged or conclusions set for the statement of deficiencies. Plan of Correction is prepared and/or executed solely becau	The d	
	Facility number: 00	00133			is required by the provisions of		
	Provider number: 1	55228			Federal and State Law. Pleas	e	
	AIM number: 1002	66080			accept this Plan of Correction	as	
	C DIT				Credible Allegations of		
	Census Bed Type: SNF/NF: 51				Compliance. The facility respectfully requests paper		
	Total: 51				compliance for this citation.		
	Census Payor Type Medicare: 5 Medicaid: 42 Other: 4 Total: 51	:					
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review com	npleted on January 24, 2024					
F 0584 SS=D Bldg. 00	comfortable and h including but not l						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Merry Goodwin Health Facility Admistrator 02/02/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED	
155228			B. W	ING		01/18/	2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2070 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		TE	COMPLETION
TAG				TAG	DEFICIENCY		DATE
	The facility must p §483.10(i)(1) A sa homelike environment to use his or her pextent possible. (i) This includes encan receive care at the physical layour resident independing safety risk. (ii) The facility sharms for the protection of from loss or theft. §483.10(i)(2) Hours services necessar orderly, and comform services necessar orderly, and comform services necessar orderly, and comform services in good condition (iv); §483.10(i)(4) Privates dental from loss or the services necessar orderly, and comform services necessar orderly.	provide- ofe, clean, comfortable, and ment, allowing the resident personal belongings to the Insuring that the resident and services safely and that and services safely and that and services not pose a all exercise reasonable care of the resident's property sekeeping and maintenance by to maintain a sanitary, ortable interior; an bed and bath linens that and comfortable and safe and comfortable and safe					
	Based on observation	on and interview the facility ne dining room in a clean and	F 0:	584	It has and will continue to the policy of this facility for the residents to have housekeepir and maintenance services necessary to maintain a sanita	ng	01/29/2024

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Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
155228		B. WING 01/18/2024					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2070 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	During an observati there were 2 dining underneath them an around close to the residents in the dini During an observati Assistant Director C at 11:25 a.m., the tw underneath them an observed. The ADC snack time at 10:00 under the tables had indicated the activit to housekeeping of have been cleaned u	on on 1/18/24 at 11:20 a.m., room tables with food d two cockroaches walking food debris. There were 6 ng room attending an activity. on and interview with Of Nursing (ADON) on 1/18/24 wo dining room tables with food d the 2 cockroaches were on indicated the facility had a.m., and that is where the food d come from. The ADON y staff should have reported the food debris so it could			orderly, and comfortable intering Although 6 residents countable been affected by this prathere were none that were directed. All staff reeducated on properly cleaning up food debimmediately when they are set (Attachment 1). Housekeeping Supervisor Designee will audit dining roor times a week for 4 weeks, 3 times a week for 4 weeks, 3 times a week for 4 weeks and randorongoing thereafter to ensure the dining area is free of any food debris (Attachment 2). Any findings will be immediately corrected, and Housekeeping Supervisor or designee will report all audit findings during QAPI meetings and all recommendations will addressed.	Id actice ectly ris en r or m 5 mes mly hat	
F 0812 SS=F Bldg. 00	§483.60(i) Food so The facility must - §483.60(i)(1) - Pro approved or consi federal, state or lo (i) This may include directly from local applicable State a regulations. (ii) This provision of	le food items obtained producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility					

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE Co		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155228	B. WING		01/18/2024
	PROVIDER OR SUPPLIER	2	2070 C	ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD IOND, IN 47374	
(V4) ID	CHMMADY	STATEMENT OF DEFICIENCIE	ID	T	(V5)
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAU			IAU		DATE
	practices. (iii) This provision	owing and food-handling does not preclude residents oods not procured by the			
	serve food in according standards for food Based on observation review the facility for a sanitary manner with baseboards and wall around on the floor disrepair this had the residents who ate the Finding include: During an observation Dietary Manager or were several cockretic kitchen with cockretic cockroaches walking	on, interview and record railed to maintain the kitchen in with food debris between the ls, cockroaches walking and baseboards loose and in the potential to affect 50 of 50 their meals from the kitchen. Sion and interview with the in 1/18/24 at 11:10 a.m., there each traps through out the baches in them, there were three tog around the kitchen floor.	F 0812	It has and will conting to be the policy of this facility to procure food from sources approved or considered satisfactory by federal, state of local authorities. 50 of the residents residing at the facility could have been affected due to receiving meals from the kitchen. All dietary staff reeducated on cleaning scheen to ensure that food service are are clean and sanitary (Attachment 3). A deep clean	or ave g their dules eas
		er killed the three cockroaches cility had a problem with veral months.		the kitchen was immediately done. Steam table replaced a all areas that has cove based inspected and replaced if need	and
	_	with the Dietary Manager on m., indicated the kitchen had 25 the floor.		(Attachment 4). When Sysco (facility food vendor) delivers, boxes will immediately be inspected, put away and will be	all
	control company or indicated the pest or glue trappers to iden	with the Owner of the pest in 1/18/24 at 12:35 p.m., control company had put down intify what kind of bug the cility had German cockroaches		disposed of properly (Attachm 5). The owner of the pest concompany we use will continue treat 2 X a month himself, monand give recommendations as	ntrol to nitor
		very fast. The Owner of the		needed. Dietician will comple	
	pest control compar	ny indicated in order for the		food safety and sanitation	

facility to have "this big of problem" someone

checklist monthly (Attachment 6).

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155228	B. WING 01/18/2024			/2024	
		<u> </u>	<u> </u>	CTDEET /	ADDRESS CITY STATE 7IB COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	S OE DICHMOND				HESTER BLVD		
VVILLOVV	S OF RICHMOND			KICHIVI	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	was bringing them	in and he thought maybe it was			Maintenance Directo	or	
	the facility food ver	ndor and had reported this to			or designee will audit the cond	dition	
	-	vner of the pest control			of the cove base in dietary 5 X	(a	
	company also indic	ated the baseboards in the			week for 2 weeks, 2 times a w	eek	
	kitchen were loose	and had food in between them			for 1 month and then 1 time		
		eaned. The Owner had			weekly thereafter (Attachment	7).	
	-	ty to get this cleaned and fixed.			Dietary Director or designee \		
		ed the baseboards were hard to			audit the condition of the kitch		
	-	here they were located but it			to ensure cleanliness daily X 2	2	
		Owner had sent pictures to			months, 4 times a week X 1		
	•	aseboards with food in them			month, and 2 times a week		
	and they still had no	ot cleaned them up.			thereafter (Attachment 8).		
					Any findings will be		
		ion and interview with the			immediately corrected.		
		n 1/18/24 at 12:00 p.m., the			Maintenance Director, Dietary		
		eath the dish sink was loose			Director or designee will repor		
	•	wall with food in between the			audits during QAPI meetings,	and	
		pard. The baseboards			all recommendations will be		
		l steam table was also loose			addressed.		
		om the wall. The Dietary					
	-	it was the dietary staff's					
	_	the baseboards, but they had					
		The Maintenance department					
	-	repair the baseboards. The					
		dicated the baseboards had					
	been loose for a lon	ig unic.					
	During an interview	w with the Administrator on	1				
	-	., indicated 50 of 51 residents					
	_	ity received their meals from					
	the kitchen.	ity received their means from					
	the Kitchell.						
	The sanitation incom	ection policy provided by the					
	•	/18/24 at 1:30 p.m., indicated					
		onduct inspections to ensure					
		were clean and sanitary. All					
		shall be kept clean, sanitary,					
		bish and protected from					
	roaches.	oisii ana protectea from					
	13denes.						

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155228	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/18/2024	
		100220	_	T ADDRESS, CITY, STATE, ZIP COD	01/10/2024	
	PROVIDER OR SUPPLIER		STREE 2070 RICH			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0814 SS=D Bldg. 00	3.1-21(i)(3) 483.60(i)(4) Dispose Garbage §483.60(i)(4)- Disproperly.	ates to Complaint IN00424062. and Refuse Properly pose of garbage and refuse				
	Based on observation review the facility flids closed and failed 4 dumpster free from observations. Finding include: During an observation of 4 dumpster's behopen with bags of the food and trash around large black birds insoluted the dumpster outside the dumpster outside the dumpster food/trash was not at the disposal of gard provided by the Adripm., indicated facility seconstructed to have covers. Dumpster's not being loaded. So clean so that accum	on, interview and record ailed to keep 4 of 4 dumpster of to keep the area around the m food and trash for 1 of 1 on on 1/18/24 at 11:00 a.m., 4 and the facility had their lids rash visible and there was and the dumpster's. There were side the dumpster's and r's. with the Administrator on an indicated it was the staff who took out trash to relids were closed and around the dumpster's. Dage and refuse policy ministrator on 1/18/24 at 1:30 aity would properly dispose of a refuse. Dumpster's kept shall be designed and tightly fitting lids, doors or shall be kept covered when arrounding area shall be kept ulation of debris and ions were minimized.	F 0814	It has and will contir to be the practice of this facili ensure the facility properly disposes of garbage and refu properly. All residents could have beel affected since they live at this facility. Staff immediately cle area and dumpster lids were closed. All staff were re educated on to be kept cleaned by dumpste and properly closing dumpste when not in use (Attachment Garbage disposal company contacted, and they have rep lids on two receptacles (Attachment 10). Housekeeping Supervisor or designee will complete the Dumpster lid closure and dumpster area audit (Attachm 11) 5 times a week for 4 week times a week for 4 weeks and then randomly ongoing therea Any findings will be immediately corrected, and housekeeping supervisor or designee will report all audits during QAPI meetings, and a recommendations will be	ty to se n saned area ters er lids 9). laced nent ks, 3	

PRINTED: 02/12/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155228 B. WING 01/18/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2070 CHESTER BLVD WILLOWS OF RICHMOND RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE addressed. This Federal tag relates to Complaint IN00424062. 3.1-21(i)(5) F 0925 483.90(i)(4) SS=F Maintains Effective Pest Control Program Bldg. 00 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and record F 0925 It has and will continue 02/01/2024 review the facility failed to maintain an effective to be the policy of this facility to pest control program to prevent the facility from maintain an effective pest control being free of cockroaches this had the potential to program so the facility is free of affect 51 of 51 residents residing at the facility. pests and rodents. All residents could Finding include: have been affected since they reside at this facility. Staff During an observation on 1/18/24 at 11:00 a.m., 4 immediately cleaned area and of 4 dumpster's behind the facility had their lids dumpster lids were closed. All open with bags of trash visible and there was staff re educated on area to be food and trash around the dumpster's. There were kept cleaned by dumpsters and large black birds inside the dumpster's and properly closing dumpster lids outside the dumpster's. when not in use (Attachment 12). Garbage disposal company During an observation and interview with the contacted, and they have replaced Dietary Manager on 1/18/24 at 11:10 a.m., there lids on two receptacles were several cockroach traps through out the (Attachment 13). kitchen with cockroaches in them, there were three All dietary staff cockroaches walking around the kitchen floor. reeducated on cleaning schedules The Dietary Manager killed the three cockroaches to ensure that food service areas and indicated the facility had a problem with are clean and sanitary cockroaches for several months. (Attachment 14). A deep clean of the kitchen was immediately During an observation on 1/18/24 at 11:20 a.m., done. Steam table replaced and there were 2 dining room tables with food all areas that has cove based underneath them and two cockroaches walking inspected and replaced if needed

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around close to the food debris. There were 6

residents in the dining room attending an activity.

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(Attachment15). When Sysco

(facility food vendor) delivers, all boxes will immediately be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155228		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/18/2024		
	OF PROVIDER OR SUPPLIED	₹	STREET ADDRESS, CITY, STATE, ZIP COD 2070 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	During an interview control company or indicated the pest of glue trappers to ide facility had. The fa and they reproduce pest control compan facility to have "this was bringing them the facility food we the facility. The Owner and needed to be company also indick itchen were loose and needed to be company also indick itchen were loose and needed to be company also indick itchen were loose and needed to be company also indick itchen were loose and needed to be company also indick itchen were loose and needed to be company also indicated the facility of the beand to be done. The the facility of the beand they still had not be done. The the facility of the beand they still had not be done and they still had not be done and away from the wall and the basebounderneath the food and pulled away from Manager indicated responsible to clear been short staffed. Was responsible to Dietary Manager in been loose for a lor During a Confident p.m., indicated on the staffing the period of the p.m., indicated on the staffing the period of	with the Owner of the pest in 1/18/24 at 12:35 p.m., control company had put down intify what kind of bug the cility had German cockroaches very fast. The Owner of the my indicated in order for the sign of problem" someone in and he thought maybe it was indor and had reported this to where of the pest control sated the baseboards in the and had food in between them eaned. The Owner had try to get this cleaned and fixed, and the baseboards were hard to here they were located but it to owner had sent pictures to aseboards with food in them of cleaned them up. It ion and interview with the in 1/18/24 at 12:00 p.m., the eath the dish sink was loose wall with food in between the ord. The baseboards disteam table was also loose om the wall. The Dietary it was the dietary staff's in the baseboards, but they had The Maintenance department repair the baseboards. The indicated the baseboards had not time.			inspected, put away and will be disposed of properly (Attachm 16). The owner of the pest co company we use will continue treat 2 X a month himself, mor and give recommendations as needed. Dietician will complet food safety and sanitation checklist monthly (Attachment). All staff reeducated on mak Maintenance Director or Administrator aware of pests. Pest reporting log placed at nurses stations and in dietary record and monitor any issue: The findings will be provided to pest control company during scheduled visits (Attachment All staff reeducated properly cleaning up food debi immediately (Attachment 19). Maintenance Director or designee will audit the concording of the cove base in dietary 5 X week for 2 weeks, 2 times a week for 1 month and then 1 time weekly thereafter (Attachment 20). Dietary Director or design will audit the condition of the kitchen to ensure cleanliness of X 2 months, 4 times a week X month, and 2 times a week X month, and 2 times a week thereafter (Attachment 21). Any findings will be immediately corrected. Maintenance Director, Dietary Director or designee will report audits during QAPI meetings, all recommendations will be addressed.	ent introl to initor te 17 ing to s. to the 18). or lition ca eek hee daily 1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			l í	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155228	B. W.	ING		01/18	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2070 CHESTER BLVD				
WILLOW	'S OF RICHMOND			RICHIVI	OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	with CNA 1 on 1/18/24 at 1:36 she had seen cockroaches in					
	During an interview with CNA 2 on 1/18/24 at 1:42 p.m., indicated yes she had seen cockroaches in the facility.						
	During an interview with CNA 3 on 1/18/24 at 1:47 p.m., indicated yes she had seen cockroaches in the facility.						
	During an interview with CNA 4 on 1/18/24 at 1:52 p.m., indicated yes she had seen cockroaches in the facility.						
	indicated the facility	gs provided by the visor on 1/18/24 at 12:06 p.m., y had cockroaches on 10/24/23, 12/12/23, 1/9/24 and 1/17/24.					
	The facility census provided by the Administrator on 1/18/24 at 11:15 a.m., indicated the facility had 51 residents residing in the facility.						
	Administrator on 1/ the facility would n control program tha	licy provided by the //18/24 at 1:30 p.m., indicated naintain an effective pest at eradicates and contains pest and rodents such as					
	This Federal tag rel	ates to Complaint IN00424062.					
	3.1-19(f)(4)						

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