

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Hospitality Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 North Monroe Drive Xenia, OH 45385	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42731 Based on record review and staff interview, the facility failed to ensure there was a Registered Nurse (RN) scheduled for at least eight consecutive hours daily. This had the potential to affect all 41 residents residing in the facility. Findings include: Review of the staffing schedules revealed there was no RN scheduled on the following dates: 07/07/24, 07/11/24, 07/15/24, 07/16/24, 07/20/24, 07/21/24, 07/25/24, 07/26/24, 07/29/24, 07/31/24, 08/03/24, and 08/04/24. Interview on 08/08/24 at 3:56 P.M., the Director of Nursing (DON) confirmed the facility did not have an RN working for eight consecutive hours on the following dates: 07/07/24, 07/11/24, 07/15/24, 07/16/24, 07/20/24, 07/21/24, 07/25/24, 07/26/24, 07/29/24, 07/31/24, 08/03/24, and 08/04/24.		

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.

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

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation, staff interview, and policy review, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect all 41 residents who resided in the facility. Findings include: 1) Observation on 08/08/24 at 10:48 A.M., revealed a fly swatter on a cart next to the oven. Interview at the same time, District Dietary Manager (DDM) #400 verified the fly swatter was on the cart next to the oven. Observation on 08/08/24 at 12:07 P.M. revealed three flies continuously flying above and around the steam table. Interview on 08/08/24 at 12:08 P.M., [NAME] #405 verified the flies were present and stated flies were always in kitchen. 2) Observation on 08/08/24 at 10:49 A.M., revealed a puddle of water, measuring approximately one foot by four feet below the three-compartment sink. Dietary Manager (DM) #410 took a mop and cleaned up the water from the floor. Interview on 08/08/24 at 10:51 A.M., [NAME] #405 verified the puddle below the three -compartment sink and stated every time he washed dishes, the sink leaked. [NAME] #405 stated he had reported the leak to management several times; however, nothing had been done to fix it. [NAME] #405 stated the sink had leaked since he started two years ago. 3) Observation on 08/08/24 at 10:50 A.M., revealed the floor between the cover to the grease trap and the wall was caked with a thick, dark brown substance. The area measured approximately one foot squared. Interview at the same time, DDM #400 verified the substance on the floor and stated it was probably grease. DDM #400 stated the grease trap had last been cleaned two or three months ago and stated that must not have gotten that cleaned up. Interview on 08/08/24 at 11:02 A.M., [NAME] #405 stated the grease trap had always been a problem. [NAME] #405 stated the grease trap overflows every time he empties the three-compartment sink. Observation on 08/08/24 at 12:22 P.M. revealed a puddle of water below the 3-compartment sink, measuring approximately one foot by four feet. 4) Observation on 08/08/24 at 10:54 A.M., revealed several dead bugs on the floor in the dish room near the door to the hallway of the A-unit. Interview on 08/08/24 at 10:56 A.M., DM #415 verified the bugs on the floor in the dish room. DM #410 stated one of the bugs appeared to be a beetle. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) Observation on 08/08/24 at 10:55 A.M., revealed an area on the wall and ceiling above the reach-in cooler, measuring approximately three feet by one foot of a grey fuzzy substance. Interview at the same time, DDM #400 verified the presence of a grey fuzzy substance and stated it was probably dust stuck to the area due to condensation released by the cooler. 6) Observation on 08/08/24 at 12:02 P.M., revealed Dietary Aids (DA) #415 and #420 were plating food for the lunch meal. Both DAs were observed wearing hair nets that covered their ponytails; however, did not cover the rest of their hair. Both DAs had approximately four to five inches of hair that was not covered by any hair restraint. Interview at the same time, DM #410 verified DA #415 and DA #420 were not wearing their hair nets appropriately. Review of the facility policy titled, Staff Attire, dated 10/2023, revealed all staff would have hair confined to a hair net or cap. 7) Observation on 08/08/24 at 12:04 P.M. revealed the vents to a window air conditioning unit was coated in a grey and fuzzy substance. The air conditioning unit was on and blowing into the food service area, directly towards the beverage station and the holding cart, which was being loaded with lunch trays. Further observation revealed a grey and fuzzy substance coating around the windows of the kitchen and all around the area for a large fan which was blowing toward outside of the building. Additionally, a string, measuring approximately six inches long, of a grey fuzzy substance was hanging from the top corner of the window, blowing in the breeze of the air flow into the kitchen. Interview at the same time, DDM #400 verified the grey and fuzzy substance was dust. 8) Observation on 08/08/24 at 12:11 P.M., revealed the window below the large fan which was blowing towards the outside of the kitchen had several streaks of a dried unidentified substance. The streaks of the unidentified substance contained numerous dead insects, which were stuck to the dried substance. Interview at the same time, DDM #400, verified the streaks of unidentified substance on the window and the dead bugs sticking to it. 9) Observation on 08/08/24 at 12:15 P.M., revealed a string, measuring approximately three inches of a grey and fuzzy substance dangling from a sprinkler head above the food preparation counter and blowing in the breeze of the kitchen. [NAME] #405 was actively preparing pizza for the lunch meal. Interview on 08/08/24 at 12:18 P.M., DM #410 verified the string of grey and fuzzy substance on the sprinkler head and stated she had submitted work orders for cleaning the sprinkler head. Review of facility work orders dated 05/01/24 through 08/08/24, revealed no work orders associated with the cleaning of the sprinkler heads in the kitchen. Review of the facility policy titled, Equipment, dated 09/2017, revealed all food service equipment would be in proper working order. Review of the facility policy titled, Environment, dated 09/2017, revealed all food preparation areas and food service areas would be maintained in a clean and sanitary manner, including floors, walls, ceiling, and ventilation. This deficiency represents non-compliance investigated under Complaint Numbers OH00156510 and OH00155553.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on review of facility's mold testing results, physician interview, review of Quality Assurance and Performance Improvement (QAPI) documentation, and staff interview, the facility failed to inform Medical Director (MD) #500 of high levels of mold discovered in the facility. This had the potential to affect all the residents of the facility. The census was 41. Findings include: Review of an Environmental and Residential Microbial Inspection Report dated 05/13/24, revealed the facility was inspected for mold on 05/08/24 by a mold testing speciality company. The areas tested for mold revealed the following areas: a) room [ROOM NUMBER] (unoccupied). b) 200 Hall shower room. c) 300 hallway. d) Therapy room. e) A common area. f) The main dining room. The mold readings in these areas were compared to readings from outside the facility. The results in the tested areas revealed higher levels of mold than outside of the facility and mold remediation was required to be completed. Review of QAPI meeting documents dated 05/21/24 revealed no documented evidence of MD #500 being informed of mold testing results dated 05/13/24. Phone interview with MD #500 on 08/14/24 at 9:40 A.M., revealed she was not made aware of the mold testing results dated 05/13/24. MD #500 stated she should have been informed of the results. Interview with the Administrator on 08/14/24 at 2:15 P.M. confirmed MD #500 was not informed of the mold testing results dated 05/13/24.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 42731 Based on observation, staff interview, review of facility audits, and review of operation manuals, the facility failed to ensure essential equipment was maintained in a safe and properly functioning manner. This had the potential to affect all residents in the facility. The facility census was 41. Findings include: 1) Observation on 08/08/24 at 10:36 A.M., revealed an ice machine at the entrance to the 200 hall, had a wet blanket laying under it with a puddle of water, which extended beyond the area of the blanket. Water was observed dripping onto the floor from the bottom of the machine. Interview at the same time, State tested Nursing Assistant (STNA) #308 verified the wet blanket over the puddle of water. STNA #308 picked up the wet blanket and walked away from the area. Observation on 08/08/24 at 12:33 P.M., revealed another puddle of water had formed below the ice machine. Interview at the same time with Licensed Practical Nurse (LPN) #317, verified the presence of the puddle of water below the ice machine. LPN #317 verified the ice machine was leaking from the bottom. 2) Observation on 08/08/24 at 10:45 A.M., revealed the stove in the kitchen was not in use. The stove had six burners and an oven below, which was also not in use. Interview at the same time, District Dietary Manager (DDM) #400 stated two of the six burners did not work and the oven also did not work. Interview on 08/08/24 at 10:46 A.M., [NAME] #405 stated the oven had not worked in a long time. [NAME] #405 stated a new oven was ordered awhile back but it did not fit, and they never got another one. Review of the Unit Inspection Food Report, dated 06/28/24, revealed DDM #400 completed an audit on the kitchen and indicated only one burner on the stove was functioning properly. 3) Observation on 08/08/24 at 10:49 A.M., revealed a puddle of water, measuring approximately one foot by four feet below the three-compartment sink. Dietary Manager (DM) #410 take a mop and clean up the water from the floor. Interview on 08/08/24 at 10:51 A.M., [NAME] #405, verified the puddle below the three-compartment sink. [NAME] #405 stated every time he washed dishes, the sink leaked. [NAME] #405 stated he had reported the sink leaking to management several times and nothing had been done to fix it. [NAME] #405 stated the sink had leaked since he started two years ago. Additionally, [NAME] #405 stated the grease trap overflows every time he empties the three-compartment sink. Observation on 08/08/24 at 12:22 P.M., revealed a puddle of water below the three-compartment sink, measuring approximately one foot by four feet. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) Interview on 08/08/24 at 11:05 A.M., [NAME] #405 stated the top oven of the double oven runs hot so he has to be careful not to overcook and/or burn the food cooked in it. [NAME] #405 stated he cooked the food by watching it closely; however, when asked about following the cooking time on a recipe, [NAME] #405 stated, Good luck, stating the food would not be cooked properly. Observations on 08/08/24 between 12:00 P.M. and 12:20 P.M., revealed [NAME] #405 was only using the lower oven of the double oven in the kitchen. Review of the facility policy titled, Equipment, dated 09/2017, revealed all food service equipment would be maintained in proper working order.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on observation, resident interview, mold testing company interview, staff interview, and review of the facility's mold testing results, the facility failed to abate and remediate the presence of mold in the facility and the facility failed to ensure residents were provided with a clean, safe, homelike environment. This had the potential to affect all 41 residents residing in the facility. Findings include: Review of an Environmental and Residential Microbial Inspection Report dated 05/13/24, revealed the facility was inspected for mold on 05/08/24 by a specialty mold testing company. The areas tested in the facility for mold were room [ROOM NUMBER], the shower room on the 200-hall, the 300-hallway, the therapy room, a common area, and the main dining room. The mold readings in these areas were compared to mold readings from outside the facility. The results in the tested areas revealed higher levels of mold than outside of the facility and mold remediation was required. The following remediation was recommended to properly abate the mold: a) Treat the heating, ventilation, and air condition (HVAC) units, all HVAC ductwork, all HVAC ventilation, and all HVAC air returns with an Environmental Protection Agency (EPA) registered antimicrobial chemical. b) Remove and replace all air filters with Minimum Efficiency Reporting Value (MERV) seven or higher. c) Sanitize any visibly water-damaged areas with a direct application of antimicrobial chemical. d) Sanitize the kitchen, including all wood surfaces, with antimicrobial chemicals and follow up with an air scrubber (a device that attaches directly to the ductwork of a HVAC system and removes air contaminants). e) Sanitize the bathrooms, including all wood surfaces, with antimicrobial and follow up with an air scrubber. f) Sanitize the interior of the structure, including all rooms, all closets, and all doors with antimicrobial chemicals and follow up with an air scrubber. Observation on 08/08/24 at 10:03 A.M., revealed a pad behind the fire door to the 600-hall. The pad appeared to have a sticky component and there were approximately 20 dead black insects of varying size stuck to it. Interview on 08/08/24 at 10:06 A.M. with Maintenance Assistant (MA) #333, verified the sticky pad with dead insects. MA #333 stated the pest control company may have set it up there. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/08/24 at 10:07 A.M., revealed an area approximately five feet by four feet with a pile of wet blankets on the floor in front of Resident #11's air conditioner (AC) unit. There was additional water observed, which spread beyond the coverage of the blankets. Interview with Resident #11 at the same time, stated the puddle of water had been present for approximately three days. Interview on 08/08/24 at 10:13 A.M. with State tested Nursing Assistant (STNA) #322, verified the water and blankets on the floor and stated the air conditioning unit appeared to be leaking. Observation at the entrance of the 200-hall on 08/08/24 at 10:38 A.M., revealed the wood flooring was peeled, cracked, jagged, and raised. Observation on 08/08/24 at 10:40 A.M. at the entrance of the 100-hall with STNA #323, revealed the wood floor was cracked, peeling, and broken with jagged edges. Interview at the same time with STNA #323, verified the condition of the floor. Interview on 08/08/24 at 3:20 P.M. with Maintenance Supervisor (MS) #332, verified the wood floor was cracked, peeling, and raised in the 200-hall. MS #332 stated he had worked at the facility since March 2024, and it had been that way since he had started working there. Interview with the Administrator on 08/13/24 at 7:50 A.M., revealed the facility's mold was not properly addressed according to the mold testing specialist company's recommendations. Observation on 08/13/24 at 8:35 A.M., revealed room [ROOM NUMBER] (unoccupied) had mold under the wallpaper. Interview with the Administrator and MS #332 at the same time, stated the wallpaper was removed and the walls were cleaned with three parts water and one part of household bleach. The walls were then painted over with Kilz (a primer that is mold and mildew-resistant paint). The Administrator was unsure what chemical was recommended by the mold testing company to get rid of the mold. Observation on 08/13/24 at 8:38 A.M., revealed room [ROOM NUMBER] (unoccupied) had mold around the AC wall unit. Interview at the same time with MS #332, stated the wallpaper was removed and the walls were cleaned with three parts water and one part of household bleach. Observation of a storage room located at the end of the 200-hall on 08/13/24 at 8:50 A.M. with MS #332, revealed a black substance to the right of the AC window unit. Resident supplies, paper hand towels, and linens were present in the room. MS #332 identified the black substance as mold. Observations on 08/13/24 at 9:18 A.M., revealed room [ROOM NUMBER] (unoccupied) had a black substance throughout the room with appearance consistent with mold. The right corner of the room appeared to have been repaired. Interview at the same time with MS #332, revealed the insulation and drywall was removed. MS #332 stated no water and bleach solution, or any other chemical was used to disinfect the walls. MS #332 stated the cause of the mold was from a water leak from an adjacent custodial room that also had walls repaired due to the mold. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of a beauty salon room on 08/13/24 at 9:22 A.M., revealed some drywall had been partially removed exposing the inside of the wall. Black and white substances were inside the wall cavity. MS #332 confirmed the substances were mold and the he was in the process of repairing the damage. MS #332 stated the adjacent Director of Nursing (DON's) office wall would have to be repaired too. Further observation revealed the room was not isolated or contained and there was not ventilation to the outside occurring. Interview with the Administrator on 08/13/24 at 10:48 A.M., confirmed mold remediation was not completed as recommended by the mold testing specialty company. The Administrator confirmed HVAC vents were not properly disinfected as recommended and air scrubbers were not used in the facility. Interview via telephone with Mold Testing Company Staff (MTCS) #550 on 08/14/24 at 9:23 A.M., revealed the facility's testing results dated 05/13/24 were positive for high levels of microtoxin producing molds that could have adverse health effects. MTCS #550 reported that household bleach and water would not be an adequate treatment for the molds and the levels of mold found in the facility required an EPA registered chemical to properly get rid of the mold. MTCS #550 stated during removal of mold and repair of the mold damage, the mold needed to be contained which included proper containment, a proper cleaning product, and signs posted about the mold clean-up would be required. Air scrubbers should be used in the facility to clean the air circulating. MTCS #550 confirmed that staff at his company would have not recommended household bleach as a mold treatment. This deficiency represents non-compliance investigated under Complaint Numbers OH00156510 and OH00155553.		