

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Northwood Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Villa Road Springfield, OH 45503	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on medical record review, observation, staff interviews, review of a facility investigation, and review of facility policy, the facility failed to ensure staff provided adequate supervision and intervention to prevent Resident #01, who had impaired cognition, was at risk for elopement, was housed on a secured memory care unit and who had a history of eloping from his bedroom window, from leaving the facility unsupervised. This resulted in Immediate Jeopardy when one resident (#01) was placed at potential risk for serious life-threatening harm and/or injury when the resident was displaying a change of condition and was observed pacing near the nurse's station and the resident was noted to be observing Licensed Practical Nurse (LPN) #110 closely. Resident #01 eloped from his bedroom window without staff knowledge and was found 2.3 miles from the facility, leaving a Dollar General store in a very busy area of town. This affected one (#01) of six residents reviewed for risk for elopement. The facility census was 71.</p> <p>On 06/12/24 at 3:03 P.M., the Administrator, Director of Nursing (DON), Regional Quality Assurance Nurse (RQAN) #403, Director of Clinical Services #401, Regional Director of Operations (RDO) #402 and Assistant Director of Nursing (ADON) #405 were notified that Immediate Jeopardy began on 06/09/24 at an unknown time, when Resident #01 exited the facility without staff knowledge. Resident #01 was seen pacing near the nurse's station on 06/09/24 at approximately 4:00 A.M. when LPN #110 provided the resident with water in the common area of the memory care unit. LPN #110 reported Resident #01 was observing her closely. State tested Nursing Assistant (STNA) #76 reports seeing Resident #01 on 06/09/24 at 5:00 A.M. when he asks her for a cup of ice water. On 06/09/24 at 5:50 A.M., LPN #110 went to Resident #01's room to administer his morning medication, when she noticed the resident was not in his room and noticed the bedroom window was partially raised with the screen removed and it was lying on the ground outside. The staff immediately conducted a head count which revealed Resident #01 was missing. The staff initiated their elopement plan and all staff started searching for Resident #01. The Police Department was contacted on 06/09/24 at 6:13 A.M. to help with the search. On 06/09/24 at 11:47 A.M., Director of Rehabilitation (DOR) #85 located Resident #01 leaving the Dollar General store approximately 2.3 miles from the facility and in a very busy area. Resident #01 continued to walk down the street and cross the middle of the street until he reached the Sunoco Gas Station which was 2.4 miles from the facility. On 06/09/24 at 12:03 P.M., nine-one-one (911) was called to assess Resident #01 and the resident refused care. On 06/09/24 at 12:20 P.M., Resident #01 was returned to the facility by emergency medical services (EMS). A head-to-toe assessment was completed and found Resident #01 to be free of any pain or distress. Resident #01 did have abrasions on both knees. Resident #01 had a previous elopement in May 2023 from the same room where he eloped from his bedroom window.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Immediate Jeopardy was removed on 06/09/24 when the facility implemented the following corrective actions:</p> <p>On 06/09/24 at approximately 5:45 A.M., LPN #110 identified Resident #01 was not in his room and the facility began searching for the resident.</p> <p>On 06/09/24 at 11:41 A.M., DOR #85 located Resident #01 at a Dollar General Store and the facility was notified.</p> <p>On 06/09/24 at 12:20 P.M., Resident #01 was returned to the facility by [NAME] EMS, accompanied by the [NAME] Police Department. ADON #405 initiated one to one safety supervision for Resident #01. At 12:30 P.M., Registered Nurse (RN) #109 completed a head-to-toe assessment on Resident #01 and the resident was free from any pain or psychosocial distress related to the incident. Resident #01 did have an abrasion noted to his bilateral knees.</p> <p>On 06/09/24, RQAN #403 reviewed progress notes for the last 30 days for all current facility residents for any like behaviors and no other concerns were identified.</p> <p>On 06/09/24, the Administrator installed metal L Brackets and additional upgraded hardware to prevent Resident #01's window from opening more than six inches or wide enough to prevent the resident from exiting the window.</p> <p>On 06/09/24, the Administrator audited all resident accessible windows and upgraded securement hardware throughout the facility. All windows were noted to be secured without any identified concerns.</p> <p>On 06/09/24, Unit Manager (UM) #134 completed elopement risk assessments for all current facility residents. There were no identified concerns from prior elopement assessments.</p> <p>On 06/09/24, Clinical Operations Specialist (COS) #121 completed wander risk assessments for all current facility residents. There were no identified concerns noted from the prior assessments.</p> <p>On 06/09/24, the Administrator audited all egress doors, alarm panels and the facility wander guard system to ensure proper alarm and functioning. There were no identified concerns noted.</p> <p>On 06/09/24, COS #121 audited all current facility residents with physician orders for wander guards. All wander guards were placed properly, functioning and within required expiration. No identified concerns were noted.</p> <p>On 06/09/24, UM #134 audited all current facility residents at risk of elopement, to ensure all those at risk have a care plan with appropriate interventions in place. There were no identified concerns in the audit.</p> <p>On 06/09/24, COS #121 audited to ensure all current facility residents with a wander guard were appropriately assessed for placement as ordered, had a physicians order and had a care plan in place. There were no identified concerns noted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 06/09/24, UM #122, Dietary Manager #400, DOR #85, Environmental Services Director #450 and Nursing Administrative Assistant #79 began educating all current facility staff in person, on the missing resident procedure and the facility Abuse/Neglect policy and all remaining staff via phone. The education was completed on 06/09/24.</p> <p>On 06/09/24, the Administrator held an elopement drill in person with staff on dayshift and night shift. Staff response was immediate and appropriate. There were no identified concerns noted.</p> <p>On 06/09/24, the facility held a Quality Assessment and Performance Improvement (QAPI) meeting with the Administrator, RQAN #403, ADON #405, UM #134, UM #122, COS #121, RDO #402 and Medical Director #501. Resident #01's elopement and the facilities corrective action plan was discussed. The facilities corrective action plan was approved by the QAPI committee.</p> <p>Maintenance Director #130 or designee will conduct elopement drills on each shift, twice weekly for a period of four weeks to ensure staff respond accordingly with the first elopement drill being conducted on 06/09/24. All variances will be corrected upon discovery and additional education/follow-up will be provided as deemed necessary. All findings will be reported to the facility's QAPI committee.</p> <p>Maintenance Director #130 or designee will conduct checks of exit doors/wander guard system once weekly, for a period of four weeks to ensure proper functioning with the first one being conducted on 06/09/24. All variances will be corrected upon discovery and education/follow-up will be provided as deemed necessary. Ongoing compliance will be further maintained through audits as dictated by the facility's QAPI committee.</p> <p>The DON or designee will complete elopement risk and wandering risk assessments on current residents weekly for a period of four weeks, to ensure no changes in behavior patterns are present, placing residents at risk for elopement and ensuring that appropriate and effective interventions are in place with the first one being conducted on 06/09/24. All variances will be corrected upon discovery and additional education/follow-up will be provided as deemed necessary.</p> <p>The DON or designee will review current resident progress notes in the clinical operations meeting five times weekly for a period of four weeks to monitor acute changes in behavior patterns that require further intervention with the first one being conducted on 06/09/24. All variances will be corrected upon discovery and additional education and follow-up will be provided as deemed necessary.</p> <p>The DON or designee will audit all current facility residents with physician's order for wander guard five times a week, for a period of four weeks to ensure proper functioning, placement and devices within stated expiration with the first one being conducted on 06/09/24. All variances will be corrected upon discovery and additional education/follow-up will be provided as deemed necessary. All findings will be reported to the facility's QAPI committee.</p> <p>The Administrator or designee will conduct checks of window securement hardware, three times a week for a period of four weeks to ensure windows are secure and safety latches remain intact with the first one being conducted on 06/09/24. All variances will be corrected upon discovery and education/follow-up will be provided as deemed necessary. Further continued ongoing compliance will be further maintained through audits as dictated by the facility quality assurance committee.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>RDO #402 will review all audits weekly for a period of four weeks to ensure completion and compliance. All variances will be corrected immediately upon discovery and additional follow-up and education will be provided as deemed necessary.</p> <p>The DON or designee will educate new hires and/or agency staff working in the facility prior to working their shift on the Wandering elopement procedure and Abuse/Neglect policy for four weeks. All variances will be corrected upon discovery and additional education and follow-up will be provided as deemed necessary.</p> <p>Although the Immediate Jeopardy was removed on 06/09/24, the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of Resident #01's medical record revealed he was admitted to the facility on [DATE]. Diagnoses include hyperlipidemia, tinnitus, major depressive disorder, essential primary hypertension, vascular dementia, and encephalopathy.</p> <p>Review of Resident #01's care plan dated 03/31/23, revealed the resident was at risk of elopement related to cognitive dysfunction, lack of capacity, poor judgment and decision making. Further review of the care plan revealed Resident #01 was at a moderate risk for wandering. Review of Resident #01's care plan revealed there was no specific care planned interventions addressing the resident's previous elopement from his window on 05/21/23.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/28/24, revealed Resident #01 had a brief interview for mental status (BIMS) score of 10 out of 15 indicating the resident had moderate cognitive impairment. Resident #01 was dependent on staff for medication administration and set up assistance with eating, dressing, oral hygiene, and putting on or taking off shoes. Resident #01 required supervision from staff with toileting, showering, and personal hygiene.</p> <p>Review of Resident #01's nursing progress notes revealed on 05/22/23 (late entry for 05/21/23) the resident's window was observed to be broken and the screen out in the courtyard. Resident #01 exited the facility through his window. Resident #01 was documented to be returned to the facility by the staff.</p> <p>Review of Resident #01's assessment titled, Wandering Assessment, dated 05/24/24, revealed the resident was determined to be a moderate risk for elopement.</p> <p>Review of Resident #01's assessment titled, Elopement Risk, dated 05/24/24, revealed the resident was capable of leaving the facility and had a history of elopement. Resident #01 resides on a locked unit with alarms.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #01's progress notes revealed a late entry note, dated 06/09/24 at 12:20 P.M., which documented the resident exited the facility from his room after breaking and opening the window. Resident #01 returned to the facility accompanied by EMS and facility staff. The progress note documented Resident #01 was free of pain and distress and placed on a one-on-one supervision. On 06/10/24 at 2:50 P.M., the progress notes identified Resident #01 had abrasions on both knees.</p> <p>Interview on 06/12/24 at 8:12 A.M. with STNA #76 revealed she was pulled from the memory care unit on 06/08/24 at approximately 11:00 P.M. and worked on another unit. STNA #76 stated this left one nurse (LPN #110) and one STNA (#78) to work the floor with a total of twenty-three memory care residents. STNA #76 confirmed one other STNA (#129) was assigned to work on the memory care unit on a one-on-one with Resident #20. STNA #76 confirmed the memory care unit is hard to work when it is only one nurse and one aide assigned to the unit. STNA #76 stated there are times that several residents are exit seeking and pushing on the doors.</p> <p>During an interview on 06/12/24 at 8:23 A.M. with LPN #110, who was the nurse for Resident #01 on the day of the elopement from the facility on 06/09/24, she stated she started her shift at 7:00 P.M. on 06/08/24 on another hallway. LPN #110 stated after competing her assignment, she took over the assignment on the memory care unit. LPN #110 stated she began her shift with two STNA's assigned to the memory care unit to work with her (STNA #76 and STNA #78). LPN #110 explained another STNA #129 was assigned to the memory care unit; however, she was assigned to provide one-on-one care for Resident #20 because this resident had eloped from the facility on 06/08/24. LPN #110 stated STNA #76 was pulled from the memory care unit to work on another hallway for the rest of the shift. LPN #110 confirmed this left one STNA (#78) providing care along with herself (LPN #110) for a total of twenty-three memory care residents. LPN #110 stated on 06/09/24 at 4:00 A.M. Resident #01 asked her for a drink of water. LPN #110 stated it was not unusual for Resident #01 to be up at 4:00 A.M. LPN #110 further stated looking back on the incident, Resident #01 was observed to be pacing back and forth by the nurse's station and he was keeping a close eye on her. LPN #110 stated she began her medication pass on 06/09/24 at 5:00 A.M. and arrived at Resident #01's room on 06/09/24 at approximately 5:50 A.M. when she identified Resident #01 was not in his room and the window was open wide. LPN #110 stated she did not notice it at first but later identified a piece of wood on the floor along with a metal screw which were a part of the window. LPN #110 stated she immediately began a headcount and Resident #01 was the only resident not accounted for. LPN #110 stated she contacted the management team on 06/09/24 at 5:55 P.M. LPN #110 confirmed STNA #129 remained on her one-on-one assignment for Resident #20, and STNA #78 was providing care to another resident down the hallway.</p> <p>Interview on 06/12/24 at 11:51 A.M. with DOR #85 stated he was assisting with searching for Resident #01 after his elopement on 06/09/24. DOR #85 stated he was driving down the streets and searching for Resident #01 and thought he may have passed Resident #01, but he was not sure. DOR #85 stated he observed Resident #01 enter a nearby store and DOR #85 parked his car and walked into the store. DOR #85 confirmed he saw who he thought was Resident #01 and asked what his name was. DOR #85 asks the cashier to contact the police as DOR #85 followed Resident #01 out the door of the store. DOR #85 confirmed he was unable to redirect Resident #01, so he followed him. DOR #85 confirmed Resident #01 crossed a busy road and did not use the crosswalk and walked into a gas station. DOR #85 stated the police arrived with other staff members and later the squad arrived and took Resident #01 back to the facility. DOR #85 could not say for sure but thought this was around noon on 06/09/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 06/12/24 at 12:23 P.M. with the Administrator revealed he stated he was not aware of Resident #01's previous elopement in May 2023 and could not provide any information related to that elopement.</p> <p>Interview on 06/12/24 at 2:32 P.M. with STNA #78 revealed two aides were assigned to work on the memory care unit on 06/08/24 until they pulled STNA #76 to work on another unit. STNA #78 stated it was not unusual for a STNA to be pulled from the memory care unit. STNA #78 confirmed it was herself and LPN #110 to provide care for twenty-three memory care residents. STNA #78 confirmed STNA #129 was assigned to provide one-on-one care supervision to Resident #20 because the resident eloped from the facility on 06/08/24. STNA #78 stated management was at the facility late on 06/08/24 and completed an elopement drill and education because Resident #20 had exited one of the memory care doors. STNA #78 confirmed she saw Resident #01 on 06/09/24 at 5:00 A.M. when he asked her for a cup of ice water. STNA #78 thought she must have woken Resident #01 when she turned on the light to provide care to his roommate. STNA #78 stated on 06/09/24 at around 5:30 A.M. LPN #110 told her that she could not find Resident #01. STNA #78 told LPN #110 she would help search for Resident #01 after she completed personal care on another resident. STNA #78 stated LPN #110 noticed the window in Resident #01's room was open wide, and Resident #01 was missing.</p> <p>A subsequent interview and observation on 06/13/24 at 12:30 P.M. with the Administrator confirmed the type of stop previously located in Resident #01's room was similar to the one in the conference room. The Administrator pointed at a small block of wood about two inches long with a metal screw on the face inside of the conference room window frame. The Administrator stated he replaced the pieces of wood and screws on Resident #01's window with metal L shaped brackets.</p> <p>Review of the facility policy titled, Wandering and Elopements, dated March 2019, revealed the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining a least restrictive life. Further review of the policy revealed the facility will provide strategies and interventions to maintain resident's safety.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154691.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on observations, staff interview, and facility policy review, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all 71 residents who reside at the facility. The facility census was 71.</p> <p>Findings include:</p> <p>An interview and observation during the initial tour of the kitchen on 06/11/24 at 10:26 A.M. with the Kitchen Supervisor (KS) #300 revealed the three compartment sink did not contain sanitizing solution to sanitize the dishes. KS #300 confirmed the facility has been out of sanitizer for the three compartment sink for several days. KS #300 confirmed the dirt, food debris, and black substance under [NAME] the three compartment sink and all along the walls throughout the kitchen and behind the equipment. KS #300 confirmed the cove base covering was tore off the wall under [NAME] the three compartment sink as well as a missing tile. KS #300 confirmed the trash cans in the kitchen have food debris and splattered substance running down the trash cans. KS #300 confirmed the unknown splatter and debris running down the front of the dishwasher and food debris along the top of the dishwasher. KS #300 confirmed the water dripping from the dishwasher into a large bucket underneath the dishwasher. The facility confirmed all 71 residents residing in the facility receive their meals/food from the kitchen.</p> <p>Interview with Regional Dietary Director (RDD) #400 on 06/11/24 at 11:47 A.M. revealed he had a work order request for the leaking dishwasher machine. RDD #400 confirmed the three compartment sink was out of sanitizing solution.</p> <p>Interview on 06/11/24 at 2:11 P.M. with the Customer Service Representative (CSR) #600 who completes the dishwasher maintenance and supplies the facility with sanitization confirmed the facility did not have sanitizer in their three compartment sink. CSR #600 confirmed the dishwasher does not have the correct seal and is allowing water to leak into a bucket placed underneath the leaking areas.</p> <p>Review of the facility policy titled, Sanitization, dated October 2008, confirmed the facility shall be maintained in a clean and sanitary manner. All equipment shall be washed to remove or completely loosen soils with hot water and sanitizing solutions. Kitchen waste shall be kept in clean leakproof tightly closed containers. If a sink is used for washing utensils, cooking equipment or dishes, it will be cleaned between uses with an approved sanitizing agent.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153481.</p>		