STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365514	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allen View Healthcare Center	2615 Derr 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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on resident interviews, family interviews, staff interviews, record review, review of the State agency online reporting portal, and review of facility policy, the facility failed to ensure allegations of abuse were reported to the State agency within the required timeframes. This affected one (Resident #100) of five residents reviewed for abuse. Findings include Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included heart failure, headache, chronic obstructive pulmonary disease, peripheral vascular disease, muscle weakness, and bacterial infection. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and was dependent on staff for showering/bathing and lower body dressing. Resident #100 also required supervision/touching assistance for bed mobility and moderate assistance for transfers and mobility. Interview on 12/24/24 at 1:10 P.M. with Resident #100, Resident #100's family, and Resident #99 revealed a staff made Resident #100 feel uncomfortable. She revealed she had a few instances of staff being rude and one main instance when staff were providing incontinence care and when she was turned away from the door, naked from the waist down, and she heard several staff in her room laughing. When she was turned back around toward the door, her legs were spread and she was still naked and she noticed the curtain was open, the door was open, and she was exposed to the hallway. Resident #100 revealed staff were laughing at her, she felt humiliated, and she felt the incident was emotionally abusive. Interview on 12/24/24 at 2:00 P.M. with the Administrator and Director of Nursing (DON), revealed the surveyor reported that an allegation of abuse was made by Resident #100 and her family. Surveyor informed and stated specifically the concern was an allegation of abuse based on staff behaviors during incontinence care. The Administrator and DON revealed they would talk with Resident #100 and investigate further. Review of the State agency online reporting portal revealed on 12/26/24 at 11:30 A.M. the allegation of abuse that was reported to the Administrator and DON on 12/24/24, was not reported to the State agency as required. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365514	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2024
NAME OF PROVIDER OR SUPPLIER: Allen View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2615 Derr Road Springfield, OH 45503	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 12/26/24 at 4:00 P.M. with Administrator, DON and Regional Clinical Operations (RCO) #450 confirmed the allegation was not reported to the State agency within the required 24 hours. The Administrator and DON revealed the facility felt it was not abuse and more of a customer service issue and was not planning on filing the abuse allegation. Review of facility policy titled, Abuse, Neglect and Misappropriation, undated, revealed the abuse definition included willful infliction of pain and mental anguish. It stated the facility shall timely identify any event which would place residents at risk. Required notification of agencies would be completed and the Executive Director would direct the investigation. The policy revealed all alleged violations of abuse and neglect shall be reported within 24 hours to the State survey agencies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, staff interview, review of hospital records, and review of facility policy, the facility failed to ensure Resident #115 was able to return to the facility following a hospital stay. This affected one (Resident #115) out of three residents reviewed for discharges. Findings include: Review of the medical record for Resident #115 revealed an admitted [DATE] and a discharge date of [DATE], with diagnoses of paraplegia, non-pressure chronic ulcer of buttock with unspecified severity, and unspecified injury at T7 to T10 level of the thoracic spinal cord. The resident was his own responsible party. Review of Resident #115's care plan dated 10/14/24 revealed resident was totally dependent on staff assistance for toileting hygiene and dressing and he required substantial/maximal assistance for bathing. Further review of the care plan revealed on 12/03/24 a care plan was initiated for behavioral health consults as needed. Review of the Discharge Return Not Anticipated Minimum Data Set (MDS) dated [DATE] revealed Resident #115 was cognitively intact. The resident was independent with eating and wheelchair mobility, required set-up assistance with oral hygiene and personal hygiene, required supervision for bed mobility, required partial assistance with transfers, required substantial assistance with toileting hygiene, and bathing, and was dependent on staff assistance with dressing. Review of the progress note dated 12/01/24 at 11:00 A.M. revealed Resident #115 grabbed his crushed pain medication off the [medication] cart and rolled away. Licensed Practical Nurse (LPN) #402 stepped in front of the resident, blocking his path. Resident #115 then punched LPN #402 with a closed fist, striking both of her hands. The note stated the incident was witnessed by many other staff members. Witness statements were taken, the police called, and the Director of Nursing (DON) and Administrator were contacted. Review of the progress note dated 12/02/24 at 2:50 P.M. revealed Resident #115 requested to discharge to a homeless shelter on this date. The resident stated no additional services were needed. Review of the Discharge Summary completed on 12/02/24 revealed a discharge date of [DATE] with a discharge location of St. [NAME] De [NAME] Men's Shelter Homeless Shelter. Review of the progress note dated 12/02/24 at 8:05 P.M. revealed Resident #115 was issued an emergency discharge letter. Resident #115 argued with staff that he would not be going anywhere and refused to get on the bus to leave. The residents belongings were packed for discharge. Resident #115 proceeded to call 911 and told them he could not breathe. The resident was transferred to the emergency room . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Emergency Discharge Notice dated 12/03/24 (the day after his discharge to the emergency room) revealed effective 12/03/24, Resident #115 was to be discharged to a motel. The reason for discharge was noted to be that the discharge was necessary for the residents welfare and the residents needs could not be met, the discharge was appropriate because the residents health had improved sufficiently so the resident no longer needed the services provided by the facility, the safety of the individuals in the center were endangered due to the clinical or behavioral status of the resident, and the health of individuals in the center would otherwise be endangered. Interview on 12/26/24 at 9:55 A.M. with Social Services Designee #403 revealed she would not have sent Resident #115 to a homeless shelter because he was a paraplegic and needed assistance with care. Interview on 12/26/24 at 10:46 A.M. with Social Services Director #400, revealed she referred Resident #115 to two different psychiatric (psych) hospitals that would not take him due to his payor type, the emergency room failed to treat his psych issues, and the facility didn't have the staff for one on one, so the homeless shelter was the next best option. Interview on 12/26/24 at 12:45 P.M. with the Administrator, the Director of Nursing (DON), and Regional Director of Clinical Services Nurse revealed the facility did not refuse to readmit Resident #115 from the hospital, but that the resident refused to return to the facility on [DATE]. Facility staff were unable to provide documentation that the resident was approved to return to the facility. Interview on 12/30/24 at 9:21 A.M. with Hospital Behavioral Health Social Worker #405 confirmed she spoke with the Director of Nursing (DON) at the facility on 12/02/24 and the facility refused to allow Resident #115 to readmit to the facility, and that the facility wanted the hospital to hold the patient until placement could be found. Hospital Behavioral Health Social Worker #405 confirmed the facility agreed to pick the resident up and drop him off at the homeless shelter. Hospital Behavioral Health Social Worker #405 confirmed she reported to the DON that the resident was not a proper candidate for a homeless shelter due to the need for assistance and the emergency room Physician had confirmed Resident #115 was not appropriate for homeless shelter placement. Review of the hospital paperwork revealed the resident was admitted to the hospital from the long term care facility and the facility would not accept the patient back. The notes indicated that on 12/10/24, Resident #115 was transferred from the hospital to a different hospital via Convenient Transportation (a transportation company). Review of the Transfer and Discharge Policy, undated, revealed the resident could be readmitted to the next available and appropriate bed. The resident may not readmit from an acute transfer if the resident met the criteria at 483.15(c)(i). This deficiency represents non-compliance investigated under Complaint Number OH00160628 and OH00160462.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, resident interview, staff interview, and facility policy and procedure, the facility failed to ensure Resident #100 received the home health company of choice upon discharge. This affected one (Resident #100) out of three residents reviewed for discharges. Findings include: Review of the medical record revealed Resident #100 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses of acute on chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and extended spectrum beta lactamase (ESBL) resistance. Review of the Discharge Return Not Anticipated Minimum Data Set (MDS) dated [DATE] revealed Resident #100 was cognitively intact and required supervision with toileting hygiene, bathing, dressing, bed mobility, transfers, and ambulation. Review of the Discharge Summary assessment dated [DATE] revealed Interim Healthcare Home Health Services were contacted by Social Services Designee #403 to provide home health services for Resident #100 upon discharge. Interview on 12/24/24 at 12:40 P.M. with Resident #100 and her family present, confirmed the resident was discharged home on 11/14/24 with Interim Healthcare Home Health Services. Resident #100 reported she did not receive the home health agency of her choice, even though Social Services Designee #403 had come to her room on three different occasions to ask what home health agency she wanted to use. Interview on 12/26/24 at 9:55 A.M. with Social Services Designee #403 confirmed she did not give Resident #100 a choice with home health services because the one she wanted did not return her calls. Social Services Designee #403 confirmed she did not follow up with Resident #100 for an alternative home health agency choice and she stated she chose the home health service company herself. Review of the Transfer and Discharge Policy, undated, revealed the facility would involve the resident and or resident representative in the development of the discharge plan and inform the resident and or resident representative of the final plan. This deficiency represents non-compliance investigated under Complaint Number OH00160628 and OH00160462.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, residents and staff interviews, record reviews, and review of facility policy and procedure, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL). This affected one (Resident #104) of three residents reviewed for activities of daily living. Findings include Review of the medical record for Resident #104 revealed an admitted [DATE]. Diagnoses included fracture of unspecified part of the neck of femur, chronic obstructive pulmonary disease, dementia with anxiety, hearing loss, heart disease, muscle weakness, and a ruptured abdominal aortic aneurysm. Review of the plan of care dated 12/07/24 revealed Resident #104 required assistance from staff for activities of daily living. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #104 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and required substantial maximum assistance for showering and bathing and was dependent with upper and lower body dressing. Review of the tasks revealed Resident #104 received a shower on 12/18/24 at 3:45 A.M., 12/19/24 at 4:30 A. M., and 12/24/24 at 4:00 A.M. all completed by Certified Nursing Aide (CNA) #470. Interview on 12/24/24 at 1:01 P.M. with Resident #104 and the resident's family revealed the facility did not have enough staff to provide for all care needs. The resident reported she was in a hospital gown and had not been changed since she admitted two weeks ago even though her family brought in a few outfits. Interview and observation on 12/26/24 at 8:40 A.M. with Resident #104 revealed she had been at facility for about two weeks and had not received showering/bathing services. Resident #104 revealed facility staff were also not assisting her with nail care and getting dressed as requested. Observation at this time revealed the resident's hair appeared to be disheveled and was sticking out in all directions. The resident was wearing a gown and the gown had dried food on the neckline of the gown, and breakfast for 12/26/24 had not yet been served to resident. Resident #104 was seen to have several broken and jagged nails and a few long nails that had not yet broken and were about 1/2 inch past the nail bed. Interview and observation on 12/26/24 at 8:45 A.M. revealed CNA #444 was bringing in the breakfast tray for Resident #104. CNA #444 confirmed the residents long and broken nails, she also confirmed the resident was wearing a gown and the gown had dried food on it, and that the resident had clothes on her chair and in her wardrobe. Resident #104 informed CNA #444 that she had been asking for a shower and to get dressed for days with no staff assistance. The resident stated she was to have therapy soon and would like to get cleaned up after her therapy session. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/26/24 at 9:00 A.M. with CNA #470 revealed she had provided only one shower for Resident #104 during her admission. CNA #470 revealed she had not provided any care and was not assigned to Resident #104 during the last week or current week (12/16/24 to 12/26/24). The CNA revealed the facility had low staffing levels and many times showers could not get completed or only bed baths were offered to save time. Interview on 12/24/24 at 9:07 A.M. with CNA #450 revealed she didn't feel there was enough staff to meet the residents needs, sometimes they would work with one CNA on the 500 hall, which was not enough. She stated sometimes residents had to wait to get care, and sometimes they did not get showers if they didn't have time. Interview on 12/24/24 at 9:22 A.M. with CNA #455 revealed she did not feel there was enough staff to meet the residents needs, she stated there were things that did not get done on a daily basis. Showers were always the last task to complete, if they were to get completed at all. Interview on 12/24/24 at 9:38 A.M. with CNA #460 revealed she did not feel there was enough staff to meet the residents needs. She stated they were constantly short staffed and she felt bad for the residents because that was why they were in the facility. Interview on 12/24/24 at 1:10 P.M. with Resident #100 revealed the facility had low staffing and care needs were not met, including showers. She revealed staffing was very low the last several weeks and they were not getting the care they need. Review of facility policy titled, Routine Resident Care, undated, revealed the facility shall promote resident centered care by attending to medical, nursing, physical, and emotional needs while in the care of the facility. Unlicensed staff were responsible for providing routine daily care under the direction of licensed nurse including bathing, dressing, and toileting. This deficiency represents non-compliance investigated under Complaint Number OH00161029.

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	365514	A. Building B. Wing	12/30/2024

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Allen View Healthcare Center	2615 Derr Road Springfield, OH 45503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident interview, family interview, staff interview, record review, review of the staffing tool, review of staff schedules, and review of facility policy, the facility failed to ensure the facility had adequate staffing to meet the resident's needs. This affected one (Resident #104) of three residents reviewed for staffing and had potential to affect all facility residents. The facility census was 113. Findings include Review of the medical record for Resident #104 revealed an admitted [DATE]. Diagnoses included fracture of unspecified part of the neck of femur, chronic obstructive pulmonary disease, dementia with anxiety, hearing loss, heart disease, muscle weakness, and a ruptured abdominal aortic aneurysm. Review of the plan of care dated 12/07/24 revealed Resident #104 required assistance from staff for activities of daily living (ADL). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #104 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and required substantial maximum assistance for showering and bathing, and was dependent on staff for upper and lower body dressing. Review of the tasks revealed Resident #104 received a shower on 12/18/24 at 3:45 A.M., 12/19/24 at 4:30 A. M., and 12/24/24 at 4:00 A.M. all completed by Certified Nursing Aide (CNA) #470. Interview on 12/24/24 at 1:01 P.M. with Resident #104 and the resident's family revealed the facility did not have enough staff to provide for all care needs. The resident reported she was in a hospital gown and had not been changed since she admitted two weeks ago even though her family brought in a few outfits. Interview and observation on 12/26/24 at 8:40 A.M. with Resident #104 revealed she had been at facility for about two weeks and had not received showering/bathing services. Resident #104 revealed facility staff were also not assisting her with nail care and getting dressed as requested. Observation at this time revealed the resident's hair appeared to be disheveled and was sticking out in all directions. The resident was wearing a gown and the gown had dried food on the neckline of the gown, and breakfast for 12/26/24 had not yet been served to the resident. Resident #104 was seen to have several broken and jagged nails and a few long nails that had not yet broken and were about 1/2 inch past the nail bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 12/26/24 at 8:45 A.M. revealed Certified Nurse Assistant (CNA) #444 was bringing in the breakfast tray for Resident #104. CNA #444 confirmed the residents long and broken nails, she also confirmed the resident was wearing a gown and the gown had dried food on it, and that the resident had clothes on her chair and in her wardrobe. Resident #104 informed CNA #444 that she had been asking for a shower and to get dressed for days with no staff assistance. The resident stated she was to have therapy soon and would like to get cleaned up after her therapy session. The CNA asked how many staff the facility was supposed to have as they seemed to be consistently short staffed. Interview on 12/26/24 at 9:00 A.M. with CNA #470 revealed she had provided only one shower for Resident #104 during her admission. CNA #470 revealed she had not provided any care and was not assigned to Resident #104 during the last week or current week (12/16/24 to 12/26/24). The CNA revealed the facility had low staffing levels and many times showers could not get completed or only bed baths were offered to save time. Interview on 12/24/24 at 9:07 A.M. with CNA #450 revealed she didn't feel there was enough staff to meet the residents needs, sometimes they would work with one CNA on the 500 hall, which was not enough. She stated sometimes residents had to wait to get care, and sometimes they did not get showers if they didn't have time. Interview on 12/24/24 at 9:22 A.M. with CNA #455 revealed she did not feel there was enough staff to meet the residents needs, she stated there were things that did not get done on a daily basis. Showers were always the last task to complete, if they were to get completed at all. Interview on 12/24/24 at 9:38 A.M. with CNA #460 revealed she did not feel there was enough staff to meet the residents needs. She stated they were constantly short staffed and she felt bad for the residents because that was why they were in the facility. Interview on 12/24/24 at 11:43 A.M. with Licensed Practical Nurse (LPN) #401 revealed she did not feel there was enough staff to meet the residents needs. She stated when there was a call off, the staff were not replaced. They would pull CNAs from different areas so sometimes, they had one CNA for 400 and 500 hall, which was not enough, they needed two just for 500 hall. Interview on 12/24/24 at 1:10 P.M. with Resident #100 revealed the facility had low staffing and care needs did not get met, including showers. She revealed staffing was very low the last several weeks and they were not getting the care they needed. Interview on 12/26/24 at 2:00 P.M. with LPN #480 revealed facility staffing was poor and they would run short staffed consistently. LPN #480 revealed showers would get missed and there were delays in call light response times frequently due to staffing shortages. At times the facility would have sister facility staff come to help and revealed it was typically one to two staff filling in. LPN #480 revealed if the facility had call offs, they would send a message to try to get someone to pick up, but if no one responded they just worked short staffed. Review of the staffing tool dated 12/11/24 to 12/17/24 found 12/14/24 to have staffing at 2.57 hours of care per resident per day and on 12/15/24 to have staffing at 2.55 hours of care per resident per day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of staffing schedules revealed nursing staff were scheduled typically with five nurses during the day and four nurses at night. The aides ranged from six to 10 CNA's during the day and four to eight at night. Further review of the staffing revealed occasions where the facility had four to five aides for a 12 hour shift including 12/20/24 when they had 4.25 aides for night shift to care for 113 residents. Review of the undated facility policy titled, Nurse Staffing Information, revealed the facility shall provide resident centered care to meet the needs for the residents. The facility shall provide sufficient staff to care for the resident population. Daily staffing requirements would vary based upon the resident census acuity and safety needs and staffing should be posted in a written and clear format. This deficiency represents non-compliance investigated under Complaint Number OH00160628 and OH00161029.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, staff interview, and review of facility policy, the facility failed to ensure appropriate nursing services to assure residents could attain and/or maintain the highest practicable physical, mental, and psychosocial well-being while ensuring Resident #115's mobility was not restricted. This affected one (Resident #115) out of three residents reviewed for discharges. Findings include: Review of the medical record for Resident #115 revealed an admitted [DATE] and a discharge date of [DATE], with diagnoses of paraplegia, non-pressure chronic ulcer of buttock with unspecified severity, and unspecified injury at T7-T10 level of thoracic spinal cord. Review of Resident #115's care plan dated 10/08/24 revealed the resident was at risk for impaired psychosocial well being related to a history of trauma and/or trauma related symptoms with interventions to approach the provision of care and services for those residents with a history of trauma with dignity and respect and provide consistent, open, respectful, and compassionate communication. Review of the care plan dated 10/14/24 revealed the resident was totally dependent on staff assistance for toileting hygiene and dressing and he required substantial/maximal assistance for bathing. Review of the Discharge Return Not Anticipated Minimum Data Set (MDS) dated [DATE] revealed Resident #115 was cognitively intact. The resident was independent with eating and wheelchair mobility, required set-up assistance with oral hygiene and personal hygiene, required supervision for bed mobility, required partial assistance with transfers, required substantial assistance with toileting hygiene, and bathing, and was dependent on staff assistance with dressing. Review of the progress note dated 12/01/24 at 11:00 A.M. revealed Resident #115 grabbed his crushed pain medication off the [medication] cart and rolled away. Licensed Practical Nurse (LPN) #402 stepped in front of the resident, blocking his path. Resident #115 then punched LPN #402 with a closed fist, striking both of her hands. The note stated the incident was witnessed by many other staff members. Witness statements were taken, the police were called, and the Director of Nursing (DON) and Administrator were contacted. Interview on 12/26/24 at 11:15 A.M. with LPN #402 confirmed on 12/01/24 at 11:00 A.M. while preparing Resident #115's medication, the resident grabbed his crushed medications off the cart and began to wheel away. LPN #402 confirmed she stepped in front of the resident, stuck her foot in the wheel of his wheelchair to keep him from going anywhere with his medications and blocked his path. LPN #402 confirmed she restrained him because his physician orders were for him to take his medications in front of the nurse. LPN #402 also confirmed Resident #115 did punch her in the hands. Review of the undated Resident Rights policy revealed the residents had a right to be free from restraints.

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NAME OF PROVIDER OR SUPPLIER Allen View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2615 Derr Road Springfield, OH 45503	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44070 Based on observations, staff interview, and review of facility policy, the facility failed to ensure resident meals were prepared, distributed, and served in a clean and sanitary manner to prevent contamination. This had the potential to affect all facility residents, except two (#74 and #87) that were identified with orders for no oral intake (NPO). The census was 113. Findings include: Observations on 12/24/24 from 11:45 A.M. to 12:20 P.M. revealed the trays were soaked and puddles of dish water were noted. Plates were placed on the trays and then held over the food warming table. While the trays with plates were hovering over the food warming table, (dish) water from the trays dripped into the food on the service line from the bottom of the tray. The divided plates were then brought from the dish area for the meal service. [NAME] #410 held a divided plate over the food while scooping food onto the plate and during that time, dishwater dripped from the divided plates into the food on the service line. [NAME] #410 wore gloves during tray line service and touched the handle for the cheesy potatoes. The handle then fell into the tray of cheesy potatoes, getting food product on it. [NAME] #410 then grabbed the soiled handle, pulled it out of the cheesy potatoes, and continued to serve food, getting cheesy potato material on other service scoop handles, plates and trays. The pork chop utensil handle also fell into the pan and became soiled with pork chop sauce/juices. [NAME] #410 then picked it up and continued to touch other handles and plates. Food fell into other containers on the service line and the cook used her gloved hand and reached in and pulled the food item out and threw it into the trash. The above observations were made while [NAME] #410 wore the same single pair of gloves without changing the gloves and without hand hygiene. Interview on 12/24/24 at 12:21 P.M. with Kitchen Manager #425 confirmed the facility had adequate gloves for staff to use and confirmed the above observations with [NAME] #410. Kitchen Manager #425 revealed at times the facility would need to run dishes through the dishwasher twice to get them clean and sanitized. She further confirmed the trays and plates had a significant amount of water on them during tray line and that she provided a rag to the staff on the line to start wiping them off. Kitchen Manager #425 confirmed the food particles dropped into other food serving areas and also confirmed [NAME] #410 had soiled gloves while touching food directly, as well as numerous plates and serving handles. Review of facility policy titled, Food: Preparation, dated February 2023, revealed facility staff shall practice proper handwashing techniques and glove use. All utensils and food contact equipment shall be cleaned and sanitized after every use. Staff shall use serving utensils appropriately to prevent cross contamination. This deficiency represents non-compliance investigated under Complaint Number OH00160628.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48570 Based on observation, staff interview, and policy review, the facility failed to ensure medications were administered in a clean and sanitary manner. This affected three residents (#97, #100, and #104) out of five residents reviewed for medication administration. Findings include: 1. Observation on 12/24/25 at 8:54 A.M. with Licensed Practical Nurse (LPN) #401 revealed medication administration of a Norvasc 10 milligram (mg) tablet. LPN #401 dropped the medication onto the top of the medication cart and picked it up with her bare hands and administered it to Resident #97. 2. Observation on 12/24/24 at 9:13 A.M. with LPN #401 revealed medication administration of a Vitamin D 25 microgram (mcg) tablet. LPN #401 dropped the medication onto the top of the medication cart and picked it up with her bare hands and administered it to Resident #100. 3. Observation on 12/24/24 at 9:31 A.M. with LPN #401 revealed medication administration of two Oyster Calcium 500 mg tablets. LPN #401 dropped the medication onto the top of the medication cart and picked it up with her bare hands and administered it to Resident #104. Interview on 12/24/24 at 9:43 A.M. with LPN #401 confirmed she did administer the Norvasc 10 mg to Resident #97; Vitamin D 25 mcg to Resident #100; and two Oyster Calcium 500 mg tablets to Resident #104, after dropping the medications onto the medication cart then picking the medications up with her bare hands prior to administration. Interview with LPN #401 confirmed she should not have picked up the medications and administered them after dropping and touching them with her bare hands, but she felt she dropped the medications because of having a band aide on her thumb. Review of the Medication Administration Policy, undated, revealed medications were not to be touched when opened from the dose package and dropped medications were to be discarded.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44070 Based on observations, resident and staff interviews, record review, and facility policy, the facility failed to ensure equipment was maintained and in working order. This affected two residents (#99 and #100) of three reviewed for environment. Findings include: 1. Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included heart failure, headache, chronic obstructive pulmonary disease, peripheral vascular disease, muscle weakness, and bacterial infection. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and was dependent on staff for showering, bathing, and lower body dressing. The resident also required supervision/touching assistance for bed mobility and moderate assistance for transfers and mobility. Interview on 12/24/24 at 11:05 A.M. with Maintenance Director #555 revealed he started a few days ago and that the facility had no outstanding list of maintenance requests. He revealed he was not aware of any items that had not been repaired including issues with beds, lights, call lights, or issues with plumbing. Interview on 12/24/24 at 11:15 A.M. with Licensed Practical Nurse (LPN) #407 revealed Resident #100 had an issue with her call light. LPN #407 confirmed staff were aware of the environmental issues and that the facility had no Maintenance Director and no one was covering on their behalf. LPN #407 revealed Resident #100 and their family were upset by the call light not being fixed timely. Interview on 12/24/24 at 1:10 P.M. with Resident #100 and Resident #100's family revealed her call light had not been working properly since she was admitted . The resident stated when she pushed the call light button, it would not activate to the hallway and staff were not alerted to the resident's need for assistance. Resident #100 also reported her previous roommate was helping her by activating her own working call light to try and get Resident #100 assistance. Resident #100 confirmed she had spoken with numerous staff related to the call light not working properly and she also reported that the facility provided no alternative method to alert staff to the resident's needs until the call light could be repaired/replaced. Observation on 12/24/24 at 1:12 P.M. with Resident #100 confirmed the residents call light was not in proper working order. The call light did not alert to the hallway after the resident pushed the button. The observation revealed if the button was consistently held down it was activated to the hallway, but if the button was not actively held down the light in the hallway would not activate. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/24/24 at 4:00 P.M. with Administrator and Regional Clinical Operations (RCO) #450 confirmed the facility's previous Maintenance Director ceased employment on 11/21/24 and the new Maintenance Director began employment on 12/17/24. The Administrator and RCO confirmed the facility had no maintenance staff during that time, but stated they had an on-call plan in place. They confirmed they were unaware of the broken call light and acknowledged the facility did not keep a log of items requested for repair. 2. Review of the medical record for Resident #99 revealed an admitted [DATE]. Diagnoses included cellulitis, of left and right lower limbs, obesity, diabetes, muscle weakness, edema, tachycardia and urinary tract infection. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #99 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and required substantial maximal assistance for showering, bathing, and lower body dressing. The resident also required supervision/touching assistance for bed mobility and transfers. Interview on 12/24/24 at 11:15 A.M. with Licensed Practical Nurse (LPN) #407 revealed Resident #99 had an issue with his light. LPN #407 confirmed staff were aware of the environmental issues and that the facility had no Maintenance Director and no one was covering on their behalf. LPN #407 revealed Resident #99 was upset by the light not being fixed timely. Interview on 12/24/24 at 1:15 P.M. with Resident #99 revealed his over the bed light had not been working properly for three weeks. Resident #99 confirmed he had spoken with numerous staff related to the light not working properly. Observation and interview on 12/24/24 at 1:18 P.M. with Resident #99 confirmed the residents light was not in proper working order. A bottom light activated, but the top light bulb was out and not actively working. Certified Nursing Assistant (CNA) #408 was at the bedside during this observation and confirmed the light was not working properly. Interview on 12/24/24 at 4:00 P.M. with Administrator and Regional Clinical Operations (RCO) #450 confirmed the facility's previous Maintenance Director ceased employment on 11/21/24 and the new Maintenance Director began employment on 12/17/24. The Administrator and RCO confirmed the facility had no maintenance staff during that time, but stated they had an on-call plan in place. They confirmed they were unaware of the broken light and acknowledged the facility did not keep a log of items requested for repair, and stated if there was a broken light bulb it should have been replaced. Review of facility undated policy titled, Maintenance Work Request System, revealed the facility shall establish effective means of requesting, coordinating and completing maintenance of a corrective nature. Corrective maintenance could be defined as actions to restore equipment and buildings to normal condition and operation. Maintenance requests should be divided up into three categories (urgent, routine, and deferred). The policy stated the department director would assign requests to personnel and review completed work orders daily for completeness and correctness of repairs and/or the need to purchase outside assistance. This deficiency represents non-compliance investigated under Complaint Number OH00160628 and OH00161029.