

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 02/04/2025
NAME OF PROVIDER OR SUPPLIER Allen View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>34291</p> <p>Based on observation, and resident and staff interviews, the facility failed to accommodate resident preferences to create a home-like environment when the common dining room was closed without resident notice. This affected 10 (#6, #25, #32, #36, #38, #41, #71, #79, #92, and #110) of 114 residents who frequently dine in the common dining room. The facility identified two (#33 and #53) residents who receive no food by mouth. The census was 116.</p> <p>Finding included:</p> <p>Observation on the dining room door leading into the dining room for residents on 02/04/25 at 7:22 A.M. revealed there was a sign on the door indicating the dining room was closed.</p> <p>Interview with Dietary Aide (DA) #305 on 02/03/25 at 7:25 A.M. revealed the sign on the door referred to 02/02/25 because a nurse aide from the facility told them they did not have enough staff and the residents would not be coming to the dining room for meals for that day.</p> <p>Interview with DA #159 on 02/03/25 at 7:27 A.M. revealed there were only four nurse aides on the hall and there was not enough nurse aides to provide service in the dining room on 02/02/25 for all three meals. DA #159 stated that type of situation happened periodically, maybe once a month and usually on the weekends.</p> <p>Interview with Resident #91 on 02/03/25 at 3:55 P.M. revealed there was a sign on the door to the dining room on 02/02/25 the entire day that noted the dining room was closed and the resident did not know why.</p> <p>Interview with Licensed Practical Nurse (LPN) #306 on 02/03/25 at 8:22 A.M. revealed the dining room had been closed recently due to staffing issue but did not know if it was related to low kitchen or nursing staffing levels.</p> <p>Interview with Dietary Manager (DM) #282 on 02/04/25 at 7:21 A.M. revealed she did not work on 02/02/25, but to her understanding a nurse aide came to the kitchen and said the facility did not have enough staff to provide assistance, so they closed the dining room on 02/02/25.</p> <p>Interview with Resident #50 on 02/04/25 at 7:32 A.M. revealed the dining room was closed on 02/02/25 because they did not have enough nurse aides to come to the dining room to help with service of the meals that day.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Certified Nurse Aide (CNA) #234 on 02/04/25 at 7:39 A.M. revealed if there was low staffing the facility would close the dining room.</p> <p>Interview with the Administrator and the Director of Nursing (DON) on 02/04/25 at 9:25 A.M. revealed the nursing staff were supposed to get permission if the dining room was closed. The Administrator and the DON stated the only reason they could think of when the dining room was closed was when the heating was being fixed in the dining room.</p> <p>Interview with Resident #92 and Resident #38 on 02/04/25 at 10:28 A.M. revealed both residents ate in the dining almost everyday and verified the dining room was closed on 02/02/25.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162006.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>34291</p> <p>Based on observation, resident and staff interviews, and policy review, the facility failed to ensure there was sufficient staffing levels to accommodate for the common dining room to remain open for resident use. This affected 10 (#6, #25, #32, #36, #38, #41, #71, #79, #92, and #110) of 114 residents who frequently dine in the common dining room. The facility identified two (#33 and #53) residents who receive no food by mouth. The census was 116.</p> <p>Finding included:</p> <p>Observation on the dining room door leading into the dining room for residents on 02/04/25 at 7:22 A.M. revealed there was a sign on the door indicating the dining room was closed.</p> <p>Interview with Dietary Aide (DA) #305 on 02/03/25 at 7:25 A.M. revealed the sign on the door referred to 02/02/25 because a nurse aide from the facility told them they did not have enough staff and the residents would not be coming to the dining room for meals for that day.</p> <p>Interview with DA #159 on 02/03/25 at 7:27 A.M. revealed there were only four nurse aides on the hall and there was not enough nurse aides to provide service in the dining room on 02/02/25 for all three meals. DA #159 stated that type of situation happened periodically, maybe once a month and usually on the weekends.</p> <p>Interview with Resident #91 on 02/03/25 at 3:55 P.M. revealed there was a sign on the door to the dining room on 02/02/25 the entire day that noted the dining room was closed and the resident did not know why.</p> <p>Interview with Licensed Practical Nurse (LPN) #306 on 02/03/25 at 8:22 A.M. revealed the dining room had been closed recently due to staffing issue but did not know if it was related to low kitchen or nursing staffing levels.</p> <p>Interview with Dietary Manager (DM) #282 on 02/04/25 at 7:21 A.M. revealed she did not work on 02/02/25, but to her understanding a nurse aide came to the kitchen and said the facility did not have enough staff to provide assistance, so they closed the dining room on 02/02/25.</p> <p>Interview with Resident #50 on 02/04/25 at 7:32 A.M. revealed the dining room was closed on 02/02/25 because they did not have enough nurse aides to come to the dining room to help with service of the meals that day.</p> <p>Interview with Certified Nurse Aide (CNA) #234 on 02/04/25 at 7:39 A.M. revealed if there was low staffing the facility would close the dining room.</p> <p>Interview with the Administrator and the Director of Nursing (DON) on 02/04/25 at 9:25 A.M. revealed the nursing staff were supposed to get permission if the dining room was closed. The Administrator and the DON stated the only reason they could think of when the dining room was closed was when the heating was being fixed in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident #92 and Resident #38 on 02/04/25 at 10:28 A.M. revealed both residents ate in the dining almost everyday and verified the dining room was closed on 02/02/25.</p> <p>Review of the undated policy titled, Nurse Staffing Information, revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The facility will provide the sufficient number of staff to care for the resident population.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162006 and represents continued non-compliance from the survey dated 12/30/24.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>34291</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure nurse staffing information was updated and posted daily as required. This affected all 116 residents who resided in the facility. The census was 116.</p> <p>Findings included:</p> <p>Observation on 02/03/25 at 6:55 A.M., 11:27 A.M., and 3:25 P.M., and on 02/04/25 at 7:00 A.M. and 8:30 A.M. revealed the posted daily nurse staffing information was dated 12/24/24. Observation on 02/04/25 at 9:20 A.M. revealed the daily nurse staffing information was changed to 02/04/25.</p> <p>The interview with the Administrator on 02/04/25 at 9:30 A.M. revealed she did not know why the daily posting of nursing staff was dated 12/24/24 but confirmed it should be changed daily, and admitted she changed the posted nurse staffing information that morning to reflect the correct day of the staffing in the facility.</p> <p>Review of the undated policy titled, Nurse Staffing Information, revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The facility will provide the sufficient number of staff to care for the resident population. Daily nurse staffing requirements will vary based upon resident census, acuity, and safety needs. The facility will post the daily nurse staffing information for public viewing and maintain the data for a minimum of 18 months or as required by State law, whichever is greater.</p> <p>This deficiency represents an incidental finding discovered during the complaint investigation.</p>		