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	03/19/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, the facility failed to ensure residents were receiving the correct urinary catheter size in accordance with the resident's physician order and care plan. This affected one (#93) of three residents reviewed for urinary catheter placement. The facility census was 102. Findings include: Medical record review for Resident #93 revealed an admission on [DATE] with diagnoses including but not limited to quadriplegia and neuromuscular dysfunction of bladder. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #93 dated 01/07/26 revealed an intact cognition. Resident #93 required set up for eating and total staff dependance for bed mobility, transfers and toileting. Resident #93 was coded as having an indwelling urinary catheter. Review of the plan of care for Resident #93 revealed resident has an indwelling urinary catheter related to neurogenic bladder secondary to quadriplegia. Interventions include change Mitrofanoff catheter 12 French (F)/10 cubic centimeters (cc) balloon every 30 days, ensure indwelling urinary catheter is in privacy bag and catheter leg strap at all times and secure catheter tubing using an anchoring device. Review of the physicians' orders for Resident #93 revealed an order dated 12/30/25 to change Mitrofanoff catheter 12F/10 cc [NAME] every 30 days on the 28th of each month. Review of the medication administrator record for Resident #93 was silent for any urinary catheter changes in the month of March 2026 prior to the observation of the incorrect urinary catheter in place on 03/17/26. Review of the progress notes for Resident #93 dated 03/01/25 to 03/22/25 was silent for any additional urinary catheter changes. Observation on 03/17/26 at 4:50 P.M. of Resident #93's urinary catheter with Licensed Practical Nurse (LPN) #71 verified the catheter was not the correct size. LPN #71 stated the catheter should be a12 F/10 cc balloon but Resident #93 has a 14 F/10 cc balloon in at this time. LPN #71 did not know how long the current catheter was in place. This deficiency represents non-compliance investigated under Complaint Number 2806320.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and pharmacist interviews and policy review, the facility failed to ensure medications were administered as physician ordered. This affected one (#104) of three residents reviewed for medication administration. The facility censes was 102. Findings include: Medical record review for Resident #104 revealed an admission on [DATE] and a transfer to the hospital on [DATE]. Resident #104 returned to the facility on [DATE] and discharged on 12/28/25. Diagnoses included but not limited to end stage renal disease with hemodialysis, essential hypertension, and history of myocardial infarction. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #104 had an intact cognition. Resident #104 required set up assistance for eating, supervision for bed mobility and transfers. Resident #104 was independent for toileting. Review of the plan of care for Resident #104 dated 12/12/25 revealed resident has altered cardiovascular status related to hypertension, hyperlipidemia and myocardial infarction. Interventions include administering medications per physicians' orders, monitoring vital signs, observing for signs and symptoms of chest pain, heartburn, and shortness of breath and reporting abnormal findings to the physician. Review of the physicians' orders for Resident #104 revealed an order for Diltiazem extended-release beads oral capsule 120 milligrams give one capsule by mouth one time a day initiated on 12/27/25. Review of the medication administration record (MAR) for the month of December 2025 revealed the Diltiazem was not administered as ordered as marked unavailable by the licensed nurse. Review of the progress notes for Resident #104 dated 12/26/25 at 11:45 P.M. revealed the resident was readmitted to the facility post hospitalization for altered mental status and the physician was updated. Review of the electronic medication administration note for Resident #104 dated 12/27/25 at 11:36 A.M. revealed diltiazem extended release 24 hour 120 mg capsule was not administered due to medications not yet arrived from pharmacy. Review of the nurses progress note dated 12/27/25 at 4:24 P.M. revealed Resident #104 called the police and reported that he didn't receive his medications. Progress notes continues to state that the pharmacy had not yet made a delivery this morning and the nurse pulled medications from the emergency medication bank that were available. Medications were delivered shortly after and resident was reminded that he did receive his medications. Review of the nurses' progress note dated 12/28/25 at 2:45 A.M. for Resident #104 revealed Resident #104 called the 911 via his cell phone to be transferred to the hospital. Vital signs were obtained and documented as blood pressure 154/87, pulse 77 and respirations 18. Interview on 03/18/26 at 2:01 P.M. with Pharmacist #110 for facility provided medications stated the pharmacy did not receive the medication orders for Resident #104 until 12/27/25 at 4:21 A.M. Pharmacist #110 stated the medications were delivered to the facility including the diltiazem extended release on 12/27/25 at 3:30 P.M. and signed for by the facility staff. Interview on 03/18/26 at 2:45 P.M. with Director or Nursing (DON) verified the nurse did not notify the physician of the diltiazem not being administered as ordered. DON stated she was not aware that the medication had been delivered to the facility and not administered. Review of the facility policy titled Medication Administration undated revealed the policy was silent regarding the physicians orders that medication could be held until arrival from the pharmacy. This deficiency represents non-compliance investigated under Complaint Number 2714065.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations and staff interviews, the facility failed to ensure staff appropriately changed contaminated gloves during incontinent care. This affected one (#95) of three residents reviewed for incontinent care. The facility census was 102. Findings include: Medical record review for Resident #95 revealed an admission on [DATE] with diagnoses including but not limited to hemiplegia and hemiparesis following a stroke and urinary incontinence. Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #95 dated 12/16/25 revealed an intact cognition. Resident #95 required set up assistance for eating, moderate assistance for bed mobility and total dependance for toileting. Resident #95's toileting transfer was not attempted due to medical condition or safety concerns. Resident #95 was incontinent of bowel and bladder. Review of the plan of care dated 03/14/25 for Resident #95 revealed activities of daily living self-care performance focus. Intervention included toileting hygiene assistance of two helpers is required to complete the activity. Observation on 03/18/26 at 3:20 P.M. of incontinent care for Resident #95 completed by Certified Nursing Assistant (CNA) #21 revealed staff enter the room, provide privacy from roommate and gathered supplies. CNA #21 donned gloves and removed blankets, untaped the incontinent brief and tucked the ends between her upper thighs. CNA #21 pulled moistened wipes from the package and began washing the anterior perineal area using the same area of the wipe for multiple strokes of different areas of skin folds. After completing the anterior perineal hygiene, the resident was assisted to her left side, and the incontinent garment is pulled from under the resident and disposed of. CNA #21 proceeded to pull a wipe from the package and wipe residents' buttocks from the outer portion of the buttocks to the inner gluteal folds. CNA #21 used a disposable wipe starting at the top of the intergluteal cleft and wiping to and past the area of the rectum. CNA #21 using same wipe completed swipe from vaginal area to rectum. CNA #21 made several swipes using the same wipe and then disposes of the wipe. CNA #21 reaches for the clean incontinent brief and rolled the top section of the brief and tucks it under the left buttocks. CNA #21 asked Resident #95 to roll on her back and adjust the brief between her legs before securing the tabs in place to each side. CNA #21 then used gloved hand to squeeze barrier cream onto her gloved hand and applies the barrier cream to the top inner area of both thighs. CNA #21 removed gloves and placed gloves into trash receptible. CNA #21 assisted the resident with blanket placement. CNA #21 tied the trash bag up, pulled it from the trash receptible and leaves the room walking down the hall to the soiled linen closet. CNA #21 opened the soiled linen closet using the handle and places the trash bag into a barrel and exits the room. Interview on 03/18/26 at 3:47 P.M. with CNA #21 verified she did not change her gloves when she removed the soiled incontinent brief or complete hand hygiene before applying clean incontinent brief. CNA #21 verified she used one pair of gloves to complete the entire task of perineal care and when she removed the gloves did not complete hand hygiene before leaving the room. Interview on 03/18/26 at 4:20 P.M. with the Director of Nursing (DON) stated the staff member should have changed her gloves, washed her hands after removing soiled incontinent brief. DON stated the staff member should have applied new gloves before applying the clean brief. Additionally, the staff member should have washed her hands or used alcohol based hand sanitizer prior to leaving the room. This deficiency is based on incidental findings discovered during the course of this complaint investigation.