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	06/16/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to timely assess a resident's wounds. This affected one (#95) of three residents reviewed for wounds. The census was 98.684Findings include: Review of Resident #95's medical record revealed an admission date of 04/26/23. Diagnoses listed included hypertension, chronic obstructive pulmonary disease, osteomyelitis, end stage renal disease, dependence on renal dialysis, morbid obesity, and diabetic neuropathy. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #95 had moderately impaired cognition and had no venous or arterial ulcers. Review of the physician orders for Resident #95 revealed an order dated 04/27/26 for calcium alginate (absorbent wound dressing) and duoderm (bordered foam dressing) to the bottom of right foot. Review of treatment administration records (TAR) revealed the calcium alginate, and duoderm treatment was completed 04/27/256 through 05/07/26. Review of a weekly skin checks date 04/28/26 and 05/05/26 revealed Resident #95 was documented as having no new skin areas. Review of wound nurse practitioner (WNP) notes dated 04/30/26 revealed no documentation of a right foot wound being assessed. Review of WNP notes dated 05/07/26 revealed Resident #95 had an arterial ulcer to the right fifth toe and plantar foot measuring 11.9 centimeters (cm) in width by 8 cm in length by 0.4 cm depth. The arterial ulcer was documented as new on 05/07/26. Further review of Resident #95's medical record revealed he was sent to the hospital on [DATE] for further evaluation of the right foot arterial ulcer. Interview with the Director of Nursing (DON) on 06/15/26 at 10:25 A.M. confirmed Resident #95's right foot wound was discovered on 04/27/26 when a treatment was ordered. The DON confirmed the WNP had not assessed Resident #95's right foot ulcer during a visit to the facility on [DATE]. Resident #95's right foot ulcer was not assessed until 05/07/26. Review of the facility's undated policy titled Skin Care and Wound Management Overview revealed each resident is evaluated upon admission and weekly thereafter for changes in skin condition. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident skin condition is also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital. A Skin Impairment Documentation form will be completed for all skin impairment issues that require measurement to indicate if healing is occurring. This deficiency represents non-compliance investigated under Complaint Number 3039303.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility to ensure resident medications were not left at bedside during administration. This affected one (#88) of three reviewed for medications. The census was 98.Review of Resident #88's medical record revealed an admission date of 01/28/19. Diagnoses listed included obstructive sleep apnea, osteoarthritis, arthritis, and obesity. Review of a quarterly Minimum Data Set (MDS) revealed Resident #88 had moderately impaired cognition. Observation during an interview with Resident #88 on 06/15/26 at 10:58 A.M. revealed a medication cup containing various pills and tablets on the bedside table. Resident #88 stated his nurse had left them there for him to take. Interview and observation with the Director of Nursing (DON) on 06/15/26 at 11:01 A.M. confirmed medications were left at Resident #88's bedside. The DON confirmed nurses should watch residents take their medications. Interview with Licensed Practical Nurse (LPN) #216 on 06/15/26 at 11:08 A.M. confirmed he left medications at Resident #88's bedside. LPN #216 stated that Resident #88 was talking on the telephone when he went to administer his medications. Review of physician orders and facility provided documentation revealed the medications left at Resident #88's beside were amlodipine besylate (blood pressure) 10 milligrams (mg), aspirin 81 mg, divalproex (anticonvulsant/mood disorders) delayed released (DR) 500 mg, docusate sodium (stool softener) 100 mg, apixaban (anticoagulant) 5 mg, hydralazine hydrochloride (blood pressure) (HCL) 25 mg, labetalol (high blood pressure) 300 mg, lacosamide (anticonvulsant) 200 mg, levetiracetam (anticonvulsant) 750 mg, lisinopril (blood pressure) 10 mg, multivitamin with minerals, and senna (laxative/stool softener) plus 8.6-50 mg. Review of the facility's policy titled Storage of Medications dated effective September 2025 revealed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. This deficiency represents non-compliance investigated under Complaint Number 3041875.