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	04/21/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, review of facility policy, and staff interviews, the facility failed to ensure the resident's advance directives were clearly maintained and documented in the resident's medical record. This affected two (Residents #11 and #47) of two residents reviewed for advanced directives. The facility census was 110. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included diabetes, dementia, schizoaffective disorder, muscle weakness major depressive disorder, repeated falls, and cognitive communication deficit. Review of the signed physician attestation form for advance directives in the resident's paper chart dated 04/30/24 revealed Resident #11 was a Do Not Resuscitate Comfort Care-Arrest (DNRCC-A). Review of undated paperwork in Resident #11's paper chart in front of the signed physician attestation form revealed a stop sign on a paper with large letters DNRCC [Do Not Resuscitate Comfort Care]. Interview on 04/15/25 at 5:00 P.M. with Divisional Director of Clinical Operations #131 confirmed the code status in Resident #11's paper charts had documents stating both DNRCC-A with a stop sign and DNRCC signed by the physician. 2. Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, Alzheimer's disease, and respiratory failure with hypoxia. Review of the signed physician attestation form for advance directives in the resident's paper chart dated 04/30/24 revealed Resident #47 was a Do Not Resuscitate Comfort Care-Arrest (DNRCC-A). Review of undated paperwork in Resident #47's paper chart in front of the signed physician attestation form revealed a stop sign on a paper with large letters DNRCC [Do Not Resuscitate Comfort Care]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/15/25 at 5:00 P.M. with Divisional Director of Clinical Operations #131 confirmed code status in Resident #47's paper charts had documents stating both DNRCC with a stop sign and DNRCC-A signed by the physician. Review of facility policy titled Advanced Directives dated 02/02/23 revealed copies for the advanced directives shall be made and placed on the hard chart medical record. Review of facility policy titled OHIO DNR Comfort Care and DNRCC Arrest dated 06/2015 revealed DNRCC or do not resuscitate included residents who received care that eased pain and suffering but no resuscitative measures would be used to save or sustain life. The DNRCC-A (comfort care arrest) included residents who received standard medical care until the time of cardiac or respiratory arrest. Standard medical care may include cardiac monitoring or intubation prior to the occurrence of arrest.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, review of facility's self-reported incident (SRI) and investigation, resident and staff interview, review of police report, personnel file, and e-mails, and policy review, the facility failed to ensure a resident was free from verbal abuse by an employee and staff witnessing the abuse did not intervene. This affected one (Resident #90) of three residents reviewed for abuse. The facility census was 110. Findings include: Review of Resident #90's medical record revealed Resident #90 was admitted to the facility on [DATE]. Diagnoses included focal traumatic brain injury with loss of consciousness of thirty minutes functional quadriplegia, bipolar disorder, major depressive disorder and mood disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 was cognitively intact and was independent with toileting, transferring, personal hygiene, and walking ten feet. Review of Resident #90's progress notes from 08/21/25 to 04/16/25 revealed no information related to verbal abuse. Review of the facility's SRI dated 02/12/25 revealed Resident #90 alleged he was verbally abused by Former Administrator (FA) #132. FA #132 went in to speak with Resident #90 about discharge planning. Resident #90 had already talked with Licensed Social Worker (LSW) #41 about how he was not going to leave the facility and wanted to get FA #132 terminated. Through the investigation, staff noted that they heard FA #132 talking to Resident #90 in a very factual manner about his discharge. The conclusion of the facilities investigation stated Due to the complexity and history of attempting to discharge the resident safely, FA #132 used a more direct tone to ensure the plan was not misunderstood. There was no willful intent from FA #132 to make Resident #90 interpret the interaction in any other way than a discharge conversation which he did not want to have. Resident #90 was followed by LSW #41 and there were no negative effects noted, and Resident #90 did not express any concerns. The staff were educated on the facility's abuse policy and procedure. Other residents were interviewed with no findings. The SRI was unsubstantiated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Director of Nursing (DON)'s undated witness statement revealed FA #132 told the DON she was going to Resident #90's room on 02/11/25 at approximately 4:00 P.M. The DON was coming from another hallway and FA #132 asked the DON to witness the conversation. The DON put her things down at the nurse's station and followed FA #132 into the room. FA #132 began the conversation, and she was more than an arm's length away with a bedside table between her and Resident #90. Resident #90 was seated with his feet up in the recliner. The conversation escalated to a tone that was elevated and could be heard outside of the room at the nurse's station and down the hallway. FA #132 told Resident #90 that he didn't deserve to be there, and he was a despicable human. After the argument, FA #132 stated she was upset because Resident #90 stated he wasn't leaving until she was fired. In which, FA #132 responded I will never get fired buddy. FA #132 left the facility after the argument as it was the end of the day for her. FA #132 reported the incident to Regional Director of Clinical Operations (RDCO) #130 the following morning. Review of Licensed Practical Nurse (LPN) #23's witness statement dated 02/11/25 revealed LPN #23 was walking up the 400 hall and heard a distinctive raised voice around 5:10 P.M. LPN #23 continued up the hall and reached Resident #90's room and heard FA #132 screaming at Resident #90. LPN #23 heard FA #132 stated there is something wrong with you. You don't belong here. LPN #23 also heard FA #132 state You need mental help. Resident #90 was unable to defend himself because FA #132 stated I don't care about your side of the story. There's something wrong with you. I've had it up to here with you. After FA #132 left the resident's room, Resident #90 came up to LPN #23 in tears at the 400 and 500 hall nurse's station. Resident #90 was upset and stated he felt abused and discriminated against. Review of an email from Resident #90 to the DON dated 02/12/25 revealed Resident #90 let out some frustrations to LSW #41 on 02/11/25 about how he did not believe FA #132 was competent at her job and how she probably shouldn't have that job. FA #132 was making medical decisions and mental health decisions with no training in mental health and calling Resident #90 crazy. LSW #41 told Resident #90 that life at the facility was not going to get any better and in fact it was going to get worse. Resident #90 replied to her that he did not care, and he could take it and was not going to back down. LSW #41 went and told FA #132 about what he said about not leaving and about putting up with everything until she no longer had a job. FA #132 went to Resident #90's room and completely blew up on me. The email stated She didn't let me say anything. She refused to listen to me. I was trying to explain to her what this girl said was false and I could prove it. FA #132 told me she doesn't care what my side of the story is. Her mind was already made up. She screamed at me so loud and so much that they heard this on the other side of the building literally. The email also stated This woman sat there and told me that there was something wrong with me. That I have a mental disorder. It doesn't matter if doctors can't find it because she knows I have it. She knowns I have it. She says I don't belong in a nursing home, especially this one even though I can't walk properly. I thought I heard her say that I belong in a mental hospital. She treated me like a child. I have never in my life had someone speak to me the way that woman spoke to me today. Review of Registered Nurse Unit Manager (RN UM) #29's witness statement dated 02/12/25 revealed RN UM #29 was with FA #132 and the DON in Resident #90's room on 02/11/25 around 5:00 P.M. FA #132 was having a conversation with Resident #90. RN UM #29 had entered the room and was in the doorway when RN UM #29 got called to address another resident's issue. RN UM #29 returned to Resident #90's room at the end of the conversation between FA #132 and Resident #90. FA #132 was noted to be stern during the conversation and the heard the conversation could be heard in the hall as the door to the room was not closed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Certified Nursing Assistant (CNA) #115's witness statement dated 02/12/25 revealed CNA #115 was in a resident's room on 02/11/25 when the other resident and CNA #115 heard yelling. CNA #115 stood at the resident's door and heard I don't care I've had it up to here with you. You need mental health, and we can't offer that you are sick. Review of LPN #500's witness statement dated 02/12/25 revealed LPN #500 was coming out of a resident's room and saw FA #132, the DON and RN UM #29 coming out of Resident #90's room. Shortly after, LPN #500 was told by a coworker that they overheard and saw FA #132 yelling at Resident #90 in his room. Resident #90 later told LPN #500 that FA #132 went to his room and yelled at him. FA #132 did not want to hear anything he had to say, and she was just sick of his bull. Review of CNA #88's witness statement dated 02/12/25 revealed CNA #88 was called to Resident #90's room on 02/11/25 at approximately 6:00 P.M. Resident #90 stated he was verbally abused by FA #132. Resident #90 stated she came to his room and was yelling and cursing towards him and said she was tired of his expletive crap. Resident #90 stated she accused him of being a Junkie drug dealing troublemaker and he was mental and belonged in an asylum. Staff could hear FA #132 and were concerned for him. Resident #90 stated his wife will call the state (State Survey Agency) and report it as well as a lawyer for discrimination. Review of LSW #41's witness statement dated 02/13/25 revealed LSW #41 met with Resident #90 on 02/11/25. LSW #41 and Resident #90 were discussing discharge plans and current care concerns. Resident #90 reported he had attempted to see FA #132 about his concerns and was told I'm not talking to you today. LSW #41 then informed FA #132 that Resident #90 wanted to speak with her and the reasons why and FA #132 abruptly stood up and said, I'm done with this and stormed out of her office and into his room. A few minutes later LSW #41 heard FA #132 yelling at Resident #90 while she was standing in the front copy room. Resident #90 told LSW #41 on 02/13/25 that she had told him You deserve to be in a mental institution. Review of [NAME] President of Risk Management (VPRM) #501 undated written statement revealed a telephone statement was conducted with FA #132 on 02/13/25. FA #132 stated LSW #41 came to her in reference to Resident #90 not discharging as previously discussed and Resident #90 stated he was not leaving until he made sure FA #132 was fired. FA #132 stated she went to the DON and asked her to witness the conversation between her and Resident #90 because She was not going to keep doing this with him. FA #132 stated there had been previous discussions about Resident #90 going to another facility and he was aware. FA #132 stated she took the DON with her, and they went to Resident #90's room and FA #132 stated her tone was firm and direct because she already knew how Resident #90 was and he was going to want to try and get into it with her. FA#132 stated when Resident #90 does that there was a lot of time spent trying to educate, explain and redirect him. Resident #90 gets aggressive with FA #132. FA #132 stated she went with a no nonsense type of approach but in no way was she speaking to him in any type of abusive manner nor was that her intent. FA #132 stated she had been an Administrator for over [AGE] years, and no one had ever made an allegation against her. FA #132 stated she would not do that, and she felt she was speaking loudly but was not yelling. FA #132 never stated he was despicable, that it's time for you to pack your bags or that she was going to go off on him. The conversation was short and to the point and Resident #90 was engaging back with FA #132, but FA #132 would not say it was an argument but more like he just didn't agree with what I was saying which was not anything unusual. Resident #90 did not appear upset other than disagreement with what FA #132 was saying, and he made it his mission to try and get FA #132 fired and he told many people that. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the police report dated 02/12/25 at 11:39 A.M. revealed the incident was reported on 02/12/25 at 11:39 A.M. The police report stated the DON called to report FA #132 told Resident #90 that he was mental, he didn't deserve to be there, and he was a despicable human being on 02/11/25 at approximately 5:00 P.M. The DON stated she witnessed the encounter and was not certain why FA #132 would say but stated Resident #90 wanted to get FA #132 fired for some unknown reason. The DON reported Resident #90 was visibly upset and emotional about the comments FA #132 stated. The DON stated FA #132 was placed on suspension until their investigation was completed. The DON reported she had to contact the police in regard to verbal abuse. Review of FA #132's personnel file revealed FA #132 was hired by the facility on 04/11/23 and was terminated on 02/14/25. FA #132 was educated on abuse on 02/23/24. FA #132's employee corrective action form dated 02/14/25 revealed FA #132 was terminated for performance or a policy violation. The form stated FA #132 was failing to operationally manage the building effectively as evident by staffing challenges, facility morale issues and recent complaint surveys. Interview with Resident #90 on 04/14/25 at 10:30 A.M. revealed FA #132 came into his room and yelled and screamed at him related to a sexual abuse allegation that was made against him by another resident. Resident #90 stated FA #132 told him that there was something wrong with him and she cursed at him. Resident #90 reported FA #132 berated him and told him that he should not be here. Resident #90 stated FA #132 asked him if there was anything he had to say for himself before she left the room and he stated, thank you for your time. Resident #90 stated he felt he was verbally abused by FA #132. Interview with LSW #41 on 04/15/25 at 11:02 A.M. revealed Resident #90 came to her office on an unknown date. LSW #41 stated Resident #90 was complaining that he wanted to talk with FA #132, but she was not listening to him. LSW #41 reported she talked to Resident #90 about discharge, and she spoke with FA #132 related to Resident #90's complaints. LSW #41 stated she was not present for the alleged verbal abuse incident. LSW #41 reported Resident #90 told her that he was not going to leave until after FA #132 got terminated after the incident occurred. Interview with CNA #115 on 04/14/25 at 2:28 P.M. revealed CNA #115 was across the hall in another resident's room on a unknown date. CNA #115 stated she heard a lot of yelling, and she stood in the other resident's doorway and listened. CNA #115 reported she heard FA #132 say You shouldn't even be here. You need psychological help. I don't care what you have to say. CNA #115 reported she could not hear any cursing, but FA #132's voice was raised. CNA #115 stated LPN #23 was going to go into Resident #90's room and CNA #115 went back into the other resident's room to provide care. CNA #115 reported LPN #23 was sitting at the nurse's station later that night, and she asked CNA #115 if she heard about the incident. LPN #23 told CNA #115 the DON came out of Resident #90's room with FA #132. CNA #115 stated she felt FA #132 verbally abused Resident #90, but she did not intervene because the DON was in the room. CNA #115 reported the DON did not try to stop FA #132 from verbally abusing Resident #90 and the DON did not try to get FA #132 out of Resident #90's room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #23 on 04/14/25 at 2:39 P.M. revealed LPN #23 was walking up the 400 hallway when she heard FA #132's voice screaming at Resident #90. LPN #23 stated she heard FA #132 telling Resident #90 that she doesn't care what doctors diagnosed him with that there was something wrong with him. LPN #23 stated FA #132 told Resident #90 that he does not belong at the facility. LPN #23 reported she saw FA #132, the DON and RN UM #29 leave Resident #90's room. LPN #23 stated she felt the incident between FA #132 and Resident #90 was extremely abusive. LPN #23 reported Resident #90 was in tears after the incident. LPN #23 stated she did not intervene or attempted to separate FA #132 and Resident #90 and no other staff members tried to intervene. Interview with Divisional Director of Clinical Operations (DDCO) #131 on 04/14/25 at 12:08 P.M. revealed FA #132's employment was terminated for staffing challenges and complaint survey findings. Interview with the DON on 04/15/25 at 8:23 A.M. revealed she was coming down the 400 hallway and FA #132 was coming in the other direction towards her. FA #132 asked if she could witness a conversation with Resident #90. The DON stated she put down her stuff and went with FA #132 into Resident #90's room. The DON reported FA #132 told Resident #90 that he was a despicable human and he didn't deserve to be here. The DON reported FA #132 was yelling at Resident #90 and it could be heard throughout the building. The DON stated, people heard it and came down to see what was going on. The DON reported she stepped out of the room and into the hallway and asked for RN UM #29. FA #132 was still in the room yelling at Resident #90 for a minute or two. The DON stated Resident #90 did not say anything during it and at the end of the conversation FA #132 asked Resident #90 if he had anything to say for himself and he said, nope have a good day. The DON reported FA #132 stormed out of the room and went back to her office and the DON asked what was going on. The DON stated FA #132 told the DON about the conversation with LSW #41 and Resident #90 was not going to stop pestering FA #132 until she was out of the building. The DON reported the incident occurred on an evening in February around 4:00 P.M. or 5:00 P.M. The DON stated she did not try to separate Resident #90 or FA #132 because it happened so fast. The DON reported she was also in shock, but she reported the incident to Regional Director of Clinical Operations (RDCO) #130 the following morning. The DON stated FA #132 left for the day after the incident and she knew she was going to be taking the morning off the following day. The DON reported FA #132 was suspended after she notified RDCO #130, and FA #132 never returned to work at the facility except to pick up her things with human resources (HR) present at the facility. When asked if FA #132 verbally abused Resident #90, the DON stated, it could be perceived as abuse. Interview with RN UM #29 on 04/15/25 at 8:40 A.M. revealed LSW #41 was in FA #132's office sometime before Valentine's Day. RN UM #29 stated she went to FA #132 to tell her something and FA #132 all the sudden got up from her desk and grabbed the DON who was coming down the hallway. RN UM #29 reported she, the DON and FA #132 went to Resident #90's room but RN UM #29 was called out of the room by a nurse as she was entering the doorway. RN UM #29 stated she was down the hallway talking to the nurse and she heard a loud conversation. RN UM #29 reported that it was heated, but she could not tell who was talking. RN UM #29 stated the DON and F/a #132 were coming out of the room by the time she got back to Resident #90's room. RN UM #29 reported she could not tell what was said in the room but reported the door to the room was open. RN UM #29 stated she did not see Resident #90 after the interaction, and she did not know what happened. RN UM #29 verified she did not report or intervene in the situation. RN UM #29 stated the DON reported the incident the next day. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview with VPRM #501 on 04/15/25 at 4:04 P.M. revealed VPRM #501 completed the SRI investigation regarding an allegation of verbal abuse of Resident #90 by FA #132. VPRM #501 stated there was a lot of turmoil with the facility with disgruntled staff and VPRM #501 wanted a non-biased investigation. VPRM #501 reported the DON was the only staff member present in the room during the incident and VPRM #501 completed telephone call interviews with FA #132, the DON and LSW #41. VPRM #501 reported she also attempted to call LPN #23 but was not successful with telephone attempts. VPRM #501 reported the DON told her that LPN #23 was the only person in the hallway and Resident #90 went to LSW #41 and stated he was not going to discharge until FA #132 got fired. The DON told VPRM #501 that FA #132 was emotional and asked the DON if she could come with her to be a witness and she stated, I am going to go off. The DON reported that she went with FA #132 to Resident #90's room and Resident #90 and FA #132 were talking over each other. The DON told VPRM #501 that FA #132 was loud, and she felt it was inappropriate. VPRM #501 reported the DON stated FA #132 was loud enough that LPN #23 could hear her. VPRM #501 asked the DON if she felt she could remove FA #132 from the situation and the DON stated it happened so fast and FA #132 was emotional. VPRM #501 reported the DON stated she did not think FA #132 was trying to be abusive to Resident #90 and Resident #90 was being Resident #90. The DON reported to VPRM #500 that Resident #90 did not like FA #132. VPRM #501 asked the DON why she did not stop the incident or remove FA #132, and the DON stated FA #132 was not near Resident #90, but she was loud. VPRM #501 confirmed the DON reported that the word despicable was used but FA #132 denied using the word or saying she was going to go off on Resident #90. VPRM #501 stated FA #132 reported Resident #90 was engaging back with her and FA #132 did not feel it was an argument. FA #132 told VPRM #501 that the facility had another facility for Resident #90 to discharge and Resident #90 was not going to go there because he was going to get FA #132 fired before discharged from the facility. FA #132 also informed VPRM #501 that she was direct, firm and loud, but she was not yelling. VPRM #501 confirmed no discharge notice was given to Resident #90 but stated It was my understanding that she had found placement. VPRM #501 stated she did not know why FA #132 had to go to speak with Resident #90, be firm and take a no-nonsense approach since a discharge notice was never given. VPRM #501 reported she spoke to the DON by telephone but she did not have her handwritten statement so VPRM #501 could not ask why the DON's statements did not match or why the DON reported the incident if she did not think the conversation was abuse. VPRM #501 reported she received a copy of LSW #41's statement but was told that the interviews were guided. VPRM reported LSW #41 told her on 02/13/25 that LSW #41 could hear FA #132's voice raised but could not tell what she was saying. LSW #41 reported to VPRM #501 It was loud. I didn't think she should be speaking that loudly to him. VPRM #501 stated FA #132 was not intending to abuse Resident #90 and that was the reason why she unsubstantiated the SRI. VPRM #501 reported she made her decision based on FA #132 and the DON's statement because she did not feel like FA #132 was trying to be abusive towards him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview with FA #132 and VPRM #501 on 04/16/25 at 11:29 A.M. revealed FA #132 wanted to be interviewed with VPRM #501 on the telephone. FA #132 stated the incident occurred late in the day and the DON was outside the door. FA #132 talked with Resident #90 about the opening of an assisted living where Resident #90 wished to live. FA #132 stated the assisted living did not have a lot of openings there and she wanted to see what the facility and Resident #90 could do before the opening was no longer available. FA #132 stated Resident #90 started to get belligerent and argumentative and wanted to bring up other topics. FA #132 reported Resident #90 did not want to hear what she wanted to say. FA #132 stated she never yelled at Resident #90 and FA #132 never had a resident accuse her of abusing them before. FA #132 reported she did not abuse Resident #90 and that staff at the facility never liked her. FA #132 reported it was a typical conversation, and she was not upset about Resident #90 making a statement about getting her fired because that was the running joke at the facility that he told everyone. FA #132 stated she was a little scared of Resident #90 and felt she had to be extra careful because he had staff telephone numbers and would call and text them. FA #132 denied calling Resident #90 despicable or telling him he didn't deserve to be there, he needed to be in a mental institution, that he needed mental help or calling the resident sick. FA #132 stated the conversation was about congratulating Resident #90 that he was able to walk because that had always been his goal and that he was able to go to an assisted living. FA #132 confirmed a discharge notice had not been given to Resident #90. FA #132 stated he was becoming argumentative and asked FA #132 to leave. FA #132 reported Resident #90 was not crying. FA #132 stated LPN #23 was standing at the nurse's station and LPN #23 hated FA #132 from day one. Review of the facility's undated Abuse, Neglect and Misappropriation policy revealed verbal abuse was any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to the resident or their families or within their hearing distance to describe residents regardless of their age, disability or ability to comprehend. The policy defined willful as means the individual must have acted deliberately and not that the individual must have intended to inflict injury or harm. This deficiency represents non-compliance investigated under Complaint Number OH00162743, OH00162758, OH00162691 and OH00162461.

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	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on staff interview and record review, the facility failed to ensure the resident's Minimum Data Set (MDS) assessments were accurately coded for falls and discharge location. This affected two (#90 and #109) of 23 residents reviewed for MDS accuracy. The facility census was 110. Findings include: 1. Review of Resident #90's medical record revealed Resident #90 admitted to the facility on [DATE]. Diagnoses included focal traumatic brain injury with loss of consciousness of thirty minutes or less and functional quadriplegia. Review of Resident #90's post fall evaluation dated 10/18/24 revealed Resident #90 fell at the facility on 10/18/24 at 9:00 P.M. Resident #90 was moving in his wheelchair in his room and Resident #90's wheelchair slid out from under him. Resident #90's wheelchair was not locked. Review of Resident #90's quarterly MDS assessment dated [DATE] revealed Resident #90 had no falls since the prior assessment. Interview with MDS Registered Nurse (MDS RN) #34 on 04/16/25 at 3:39 P.M. verified Resident #90's fall on 10/18/24 was not coded accurately on the 11/28/24 MDS assessment. 37447 2. Review of the closed record for Resident #109 revealed he was admitted [DATE] and discharged [DATE]. Review of the Medicare five-day MDS assessment dated [DATE] revealed Resident #109 had an unplanned discharge to the hospital. Review of a progress note dated 02/26/25 revealed Resident #109 signed out to visit his daughter and chose not to return to the facility. Interview on 04/16/25 at 4:15 P.M. with MDS Nurse #34 verified Resident #109 discharged home with his daughter and the notation in the MDS assessment dated [DATE] reporting a discharge to the hospital was an error.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review and staff interview, the facility failed to notify the state mental health authority with a significant change Preadmission Screening and Resident Review (PASARR) for a resident that had a change in their mental health condition. This affected one (#90) of two residents reviewed for significant change PASARR. The facility census was 110. Findings include: Review of Resident #90's chart revealed Resident #90 admitted to the facility on [DATE]. Diagnosis included unspecified focal traumatic brain injury with loss of consciousness of thirty minutes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 was cognitively intact. Review of Resident #90's diagnosis list dated 04/21/25 revealed Resident #90 had a new diagnosis of major depressive disorder recurrent added on 12/26/24. Review of Resident #90's chart from 08/26/24 to 04/15/25 revealed Resident #90 did not have a significant change PASARR or notification to the state mental health authority of Resident #90's new diagnosis of major depressive disorder recurrent on 12/26/24. Interview with Licensed Social Worker (LSW) #41 on 04/15/25 at 11:13 A.M. verified Resident #90 did not have a significant change PASARR completed on 12/26/24 after Resident #90 was given a new diagnosis of major depressive disorder recurrent on 12/26/24.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on review of facility policy, staff interview, and record review, the facility failed to develop care plans to address a resident's use of an anticoagulant and a resident's vision needs. This affected two (#67 and #90) of 23 residents reviewed for care planning. The facility census was 110. Findings include: 1. Review of Resident #90's chart revealed Resident #90 admitted to the facility on [DATE]. Diagnosis included paroxysmal atrial fibrillation. Review of Resident #90's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and received an anticoagulant during the review period. Review of Resident #90's physician order dated 08/21/24 revealed Resident #90 was ordered Apixaban (anticoagulant) oral tablet five milligrams (mg) give one tablet by mouth every morning and bedtime for peripheral vascular disease. Review of Resident #90's care plan dated 04/15/25 revealed Resident #90 did not have a care plan for Resident #90's anticoagulant use and to monitor the side effects of Resident #90's anticoagulant use. Interview with MDS Registered Nurse (MDS RN) #34 on 04/15/25 at 3:28 P.M. verified Resident #90 did not have a care plan for the use of an anticoagulant and to monitor the side effects of Resident #90's anticoagulant use. 44070 2. Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, and failure to thrive. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively impaired. Review of Resident #67's eye exam notes dated 10/11/24 revealed new orders or recommendations for cataract surgery with ophthalmology consult with follow up with the eye provider in five to six months. Review of Resident #67's care plan on 04/17/25 found no evidence of vision impairment or follow up recommendations for cataract procedure included in the care plan. Interview on 04/14/25 at 3:33 P.M. with Resident #67's family revealed Resident #67 was supposed to see the eye doctor and had not heard about any appointment. Interview on 04/17/25 at 10:00 A.M. with MDS Nurse #34 confirmed Resident #67 did not have a care plan in place for vision impairment. (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Plan of Care overview policy dated 03/03/25 revealed the facility will provide resident centered care plans that meet the psychosocial, physical and emotional needs and concerns of the residents.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, interview and record review, the facility failed to ensure residents were given the opportunity to participate in the development of their care plans and the care plan meetings had a interdisciplinary team present. This affected three (#16, #63, and #90) of six residents reviewed for resident participation in care planning. The facility census was 110. Findings include: 1. Review of Resident #63's chart revealed Resident #63 admitted to the facility on [DATE]. Diagnoses included with type two diabetes mellitus with hyperglycemia, major depressive disorder, non-pressure chronic ulcer of back limited to break down of skin, and cellulitis of right lower limb. Review of Resident #63's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #63's progress notes from 09/30/24 to 04/15/25 revealed Resident #63 did not have any care conferences or an opportunity to participate in the development of his care plan. Interview with Resident #63 on 04/14/25 at 9:29 A.M. revealed Resident #63 had not attended or been offered a care conference in the past six months. Interview with Licensed Social Worker (LSW) #41 on 04/15/25 at 10:52 A.M. verified Resident #63 had not been offered or attended a care conference or was given an opportunity to participate in care planning from 09/30/24 to 04/15/25. 2. Review of Resident #90's chart revealed Resident #90 admitted to the facility on [DATE]. Diagnoses included focal traumatic brain injury with loss of consciousness of thirty minutes or less, functional quadriplegia, polycystic kidney adult type, bipolar disorder, chronic pain syndrome, major depressive disorder, insomnia, and mood disorder. Review of Resident #90's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #90's progress notes from 08/21/24 to 04/15/25 revealed Resident #90 had a care conference on 09/13/24. Resident #90 did not have any additional care conferences or opportunities to participate in the development of his care plan from 09/13/24 to 04/15/25. Interview with Resident #90 on 04/14/25 at 10:37 A.M. revealed Resident #90 had not attended or been offered a care conference in the past six months. Interview with Licensed Social Worker (LSW) #41 on 04/15/25 at 10:53 A.M. verified Resident #90 had not been offered or attended a conference or was given an opportunity to participate in care planning since 09/13/24. 36303 (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #16's medical record revealed an admitted [DATE]. Diagnoses included chronic kidney disease, anxiety disorder, type two diabetes mellitus, hypertension, and diabetic neuropathy. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact. Review of a care conference note dated 12/18/24 revealed attendees were social services and Resident #16's daughter by telephone. Resident #16 was invited but declined. No other attendees were noted. The care conference note dated 03/27/25 revealed attendees were social services and a unit manager. Family was invited, but did not attend. No other attendees were noted. Interview on 04/15/25 at 5:55 P.M. with Divisional Director of Clinical Services (DDCS) #131 confirmed member of the facility's interdisciplinary team (IDT) should be present at resident care conferences. DDCS #131 confirmed Resident #16's care conferences on 12/28/24 and 03/27/25 did not include IDT members. Review of the facility's policy titled, Plan of Care Overview dated 03/03/25 revealed an IDT that participates in the planning and implementation of care may include but is not limited to: clinical team, licensed and non-licensed personnel, the MDS Coordinator will oversee and coordinate the care team and plan of care (POC); nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants; therapy team; xocial services and activities team; nutritional dietary team; medical providers; pharmacists or other ad hoc consultants, when appropriate; business team, where applicable; Administrative team, where applicable; and family, resident, resident representative or other individual the resident requests to be present. Members of the care planning team will coordinate care to meet resident preferences and care needs utilizing a holistic approach to care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident and staff interview, and record review, the facility failed to ensure staff communicated with residents in a language or manner they could understand. This affected one (Resident #94) of one resident reviewed for communication and language. The facility census was 110. Findings include Review of the medical record for Resident #94 revealed an admitted [DATE]. Diagnoses included cerebral infarct, hemiplegia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had cognitive impairments. Review of Resident #94's care plan dated 10/02/24 revealed resident only spoke Haitian Creole with interventions including utilize language line for interpreter and provide the following tools to aide in communication in primary language (interpreter, communication board etc.) and offer interpretation services. Observation and interview on 04/14/25 at 11:15 A.M. with Resident #94 without use of interpreter revealed the resident responded wi to all questions which means yes in his language even when that was not an appropriate answer. The sign on the resident's room door revealed a translation telephone number that should be used for communication in various languages. Observation and interview on 04/14/25 at 4:34 P.M. with Resident #94 (while using the interpretive service) revealed staff did not typically use translation devices or interpretive services. He confirmed he spoke Haitian Creole and he did not feel staff were understanding him and his needs. Observation and interview on 04/17/25 at 8:50 A.M. with Certified Nursing Aide (CNA) #108 revealed CNA picked up food from Resident #94 and was talking with him in English. Observation and interview on 04/17/25 at 9:36 A.M. with Licensed Practical Nurse (LPN) #103 revealed during medication pass, LPN #103 took the resident's blood pressure and handed the resident his medication and stated I have your meds. She instructed the resident to sit up and he did not, so she assisted him while saying it a second time. Resident #94 did not fight back and went along with her motions. LPN #103 acknowledged afterwards upon interview she did not use a translator to explain what she was doing (taking blood pressure and passing medication). LPN #103 stated she did not explain what medications she was providing and stated resident knows his medications. LPN #103 stated Resident #94 could tell staff if he was not feeling well. She also acknowledged he did not speak English but was able to ask for a drink without use of translator. Interview on 04/17/25 at 9:45 A.M. with Divisional Director of Clinical Operations #131 confirmed staff should be using the translation devices offered for resident to be an active member of his care and staff should check on residents condition in a way he can understand.

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	365514	A. Building B. Wing	04/21/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39967 Based on observation, resident, family and staff interview, review of facility policy, and record review, the facility failed to ensure residents who required assistance with activities of daily living (ADL) were provided regular assistance with showers and grooming. This affected four (#4, #63, #67, and #263) of four residents reviewed for ADLs. The facility census was 110. Findings include: 1. Review of Resident #63's chart revealed Resident #63 admitted to the facility on [DATE]. Diagnoses included morbid obesity due to excess calories, muscle weakness, non-pressure chronic ulcer of back limited to break down of skin, and cellulitis of right lower limb. Review of Resident #63's activities of daily living (ADL) care plan dated 10/01/24 revealed Resident #63 had an ADL self care performance deficit. Resident #63 occasionally refused showers. Interventions included offer bed bath if a shower is refused and Resident #63 required supervision with shower transfers. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 was cognitively intact. Resident #63 was dependent on staff with showering, and required moderate assistance with upper body dressing and personal hygiene. Review of Resident #63's shower documentation from 01/01/25 to 01/31/25 revealed there were nine opportunities for Resident #63 to receive bathing on his scheduled days on Monday and Friday. Resident #63 was given a bed bath or shower twice on 01/06/25 and 01/20/25 and refused bathing on 01/10/25 and 01/24/25. There was no documentation any other days. The shower documentation from 02/01/25 to 02/28/25 revealed there were eight opportunies for Resident #63 to receive bathing as scheduled. Resident #63 received five bed baths or showers on 02/03/25, 02/10/25, 02/21/25, 02/24/25, and 02/28/25. There was no documentation Resident #63 refused bathing and no other documentation any other days. The shower documentation from 03/01/25 to 03/31/25 revealed there were nine opportunities for Resident #63 to recive bathing as scheduled. Resident #63 recieved five bed baths or showers on 03/07/25, 03/10/25, 3/18/25, 03/22/25, and 03/25/25. Resident #63 refused showers on 03/14/25 and no other documentation any other days. Observation of Resident #63 on 04/14/25 at 9:27 A.M. revealed Resident #63 was lying in his bed. Resident #63's hair and skin appeared oily and did not appear clean. Interview with Resident #63 on 04/14/25 at 9:27 A.M. stated he was not receiving his scheduled shower or bed bath two times a week and he did not receive a shower or bed bath for over 10 days in March 2025. (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Divisional Director of Clinical Operations (DDCO) #131 on 04/17/25 at 9:16 P.M. revealed Resident #63's shower days were on Mondays and Fridays. DDCO #131 verified Resident #63 did not receive a shower or bed bath and there was no documented shower or bed bath refusals from 01/11/25 to 01/19/25, from 01/25/25 to 02/03/25, from 02/04/25 to 02/09/25, from 02/11/25 to 02/20/25, from 03/01/25 to 03/06/25, from 03/26/25 to 03/31/25, from 04/09/25 to 04/14/25. 36303 2. Review of Resident #263's medical record revealed an admitted [DATE]. Diagnoses listed included suicidal behavior, mood disorder, renal disease, hypertension, and type two diabetes mellitus. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #263 was moderately cognitively impaired and required partial to moderate assistance with bathing. Review of the shower sheets and shower logs from 03/08/25 through 04/16/25 revealed Resident #263 had a total of four offered showers/baths on 03/08/25, 03/18/25, 03/22/25, and 03/25/25. Resident #263 refused two (03/08/25 and 03/22/25) of those four showers/baths offered. Interview on 04/17/25 on 11:25 A.M. with Divisional Director of Clinical Operations (DDCO) #131 confirmed Resident #263 did not have enough baths/showers. Resident #263 should have had a minimum of two baths/showers per week. 44070 3. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included paranoid schizophrenia, hemiplegia and hemiparesis, muscle weakness and vascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively impaired and was dependent on staff with bathing. Review of the care plan dated 02/10/25 revealed Resident #4 had an activity of daily living self-care deficit related to Resident #4 was totally dependent on staff with shower and baths and personal hygiene. If the resident refused a shower, staff should offer a bath. Review of shower and bath documentation from 02/17/25 to 04/17/25 revealed Resident #4 was offered and provided a shower/bath on 02/19/25, 02/22/25, 02/26/25, 03/01/25, 03/05/25, 03/08/25, 03/12/25, 03/15/25, 03/19/25, 03/22/25, 04/02/25, 04/05/25, 04/09/25 and 04/16/25. Showers were missed on 03/26/25, 03/29/25 and 04/12/25. Observation and interview on 04/14/25 at 10:40 A.M. with Resident #4 revealed she does not get showers per her preference. She stated sometimes the staff will give her bed baths but confirmed it was not regular and not twice weekly as scheduled. She stated she felt dirty and her hair appeared greasy and matted. Resident #4 scratched her scalp and her hair moved and appeared matted. Observation and interview on 04/17/25 at 8:36 A.M. with Resident #4 revealed she would like her hair to be washed and it was sticking out in all directions. Resident #4 also had long chin hair and stated staff typically would shave them but had not shaved her chin area in several weeks. (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/17/25 at 8:40 A.M. with Certified Nurse Aide (CNA) #108 confirmed Resident #4's hair appeared greasy and matted and she had several chin hairs. CNA #108 stated she would provide care to Resident #4. 4. Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, failure to thrive, heart disease, kidney failure, and subdural hemorrhage. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively impaired and was dependent on staff with bathing. Review of the care plan dated 02/19/25 revealed Resident #67 had an activity of daily living self-care deficit related to impaired cognition, impaired mobility and weakness with interventions for shower and baths, the resident required total dependence from staff and for personal hygiene resident required total dependence from staff. Review of the shower and bath documentation from 02/17/25 to 04/17/25 revealed Resident #67 was offered and provided a shower/bath on 02/18/25, 02/21/25, 02/25/25, 03/04/25, 03/11/25, 03/14/25, 03/18/25, 03/21/25, 03/25/25, 04/04/25, and 04/08/25. Showers were missed on 02/28/25, 03/07/25, 03/28/25, 04/01/25, 04/11/25 and 04/15/25. Observation on 04/14/25 at 3:20 P.M. of Resident #67 revealed the resident appeared disheveled with blood droppings on his mouth and blanket. Interview on 04/14/25 at 3:34 P.M. with Resident #67's family stated they have come to visit and they have noticed Resident #67 looked and smelled bad and had to request staff bathe the resident. Family reported staff do no offer or complete at least two baths or showers weekly. Interview on 04/17/25 around 10:00 A.M. with Divisional Director of Clinical Operations #131 confirmed issues with showers and confirmed the facility had no evidence Resident #67 was offered or provided showers twice weekly. Review of facility's undated policy titled Routine Resident Care revealed the facility shall provide routine care including bathing to maintain dignity and quality of life. This deficiency represents non-compliance investigated under Complaint Number OH00162691.

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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** 44070 Based on observations, medical record review, staff interview, resident interview and policy review, the facility failed to ensure skin checks were completed weekly as care planned, wound treatments were completed as order and physician orders were clarified for skin impairment treatments. This affected one (#18) of three reviewed for non-pressure skin impairments. The facility census was 110. Findings include: Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included post procedural hematoma, unspecified open wound of the left arm, end stage renal disease, renal dialysis, malnutrition and heart disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact and the resident had a stage four pressure wound and a non-pressure wound. Review of the plan of care dated 04/09/25 revealed resident was at risk for skin impairment with interventions to follow with wound provider, nursing to monitor skin impairments, administer treatments as ordered and complete weekly skin checks. Review of physician orders dated 03/25/25 revealed an active order to cleanse surgical incision to left shoulder with normal saline, pat dry, cover with ABD pad and secure in place with tape daily until resolved. Dressing change to be completed on night shift. Review of physician orders dated 03/25/25 revealed an active order to monitor 10 sutures to left shoulder surgical site daily until resolved. Order ordered for monitoring on night shift. Review of physician order dated 04/07/25 revealed an active order for left shoulder surgical dehiscence with instructions to cleanse with normal saline and pat dry, pack with hydrogel impregnated gauze and cover with Calcium alginate with silver Ag, secure with border dressing. Change daily and as needed. Dressing change to be completed on night shift. Review of general surgery hospital follow-up progress notes dated 04/09/25 revealed Resident #18 was seen for a hospital follow up from surgical repair of left shoulder hematomas. The note states sutures were removed by orthopedic surgery team on 04/03/25 and the wound had opened up and was draining old hematoma without signs of infection. The plan included a treatment recommendation for daily wet to dry dressing changes with saline dampened gauze packed into the wound and covered with ABD, wrapped with kerlix and gentle ace wrap from hand to shoulder. Review of medical record revealed no documentation of weekly skin checks had been completed from 03/07/25 to 04/16/25. (continued on next page)

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	04/21/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 04/14/25 at 4:37 P.M., with Resident #18 revealed his left arm wound dressing was saturated with wound discharge. Resident #18 revealed staff are supposed to change the dressing every night shift and revealed staff were not doing wound care as ordered. Resident #18 stated sometimes he sees the facility wound nurse practitioner and other weeks he sees an outpatient wound provider. Review of the Treatment Administration Record for April 2025 revealed the 03/25/25 and 04/07/25 physcian orders were being signed off as completed. Interview on 04/16/25 at 10:00 A.M., with RN Divisional Director of Clinical Operations #131 confirmed weekly skin checks were not completed weekly since 03/07/25 per the care planned intervention. She revealed facility should be completing weekly skin checks for all residents even if they have wound treatments as the wound providers are only reviewing the known wound for treatment and healing status. Observation on 04/17/25 at 8:53 A.M. to 9:58 A.M. of wound treatment for Resident #18 completed by Nurse Practitioner (NP) #600 and Registered Nurse #29. The left upper arm surgical incision was debrided by NP and packed with hydrogel gauze and was covered with calcium alginate. Interview on 04/21/25 at 11:20 A.M., with RN Divisional Director of Clinical Operations (RDO) #131 confirmed facility had two different active wound orders one dated 03/25/25 and another dated 04/07/25. RDO #131 confirmed facility orders also did not match the follow up from the surgeon from 04/09/25 and confirmed facility was signing off as if they were completing all orders. RDO #131 also confirmed facility staff were signing off they were monitoring sutures on the left arm as recent as 04/20/25 while confirming from the surgeon follow up note, the sutures were removed 04/03/25. Review of the undated policy titled Physician Orders, revealed the facility shall provide resident centered care. Provider shall give a medical order and nursing staff were responsible for following the order. Review of the undated policy titled Wound Care, undated, revealed facility shall provide wound care as indicated. Review of the undated policy titled Skin Care and Wound Management Overview, revealed facility shall strive to promote healing of wounds. Wound treatments shall be reviewed and facility shall select the appropriate treatment for the identified skin impairment.

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	365514	A. Building B. Wing	04/21/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, family interview, staff interview and policy review, the facility failed to ensure vision services were provided as recommended by vision specialist. This affected one (#67) of one resident reviewed for vision services. The facility census was 110. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, failure to thrive, dysphasia, heart disease, kidney failure, and subdural hemorrhage. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively impaired and was dependent on staff mobility and activities of daily living. Review of eye exam notes dated 10/11/24 revealed new orders or recommendations for cataract surgery with ophthalmology consult with follow up with the eye provider in five to six months. The medical record contained no other information about cataract surgery or eye provider follow ups. Review of the care plan on 04/17/25 found no evidence of vision impairment or follow up recommendations for cataract procedure included in the care plan. Interview on 04/14/25 at 3:33 P.M., with Resident #67's family revealed the resident was supposed to see the eye doctor and had not heard about any appointment. Interview on 04/16/25 at 11:20 A.M., with Registered Nurse Divisional Director of Clinical Operations #131 who confirmed the facility found the visit note and paperwork he was seen in 10/11/24 but confirmed the facility had no evidence staff followed up with recommendations for ophthalmology consult for cataracts or with follow up in five to six months. Review of the undated policy titled Social Service, revealed the facility shall provide care and services related to social services according to regulations. The social Services department shall make necessary referrals for eye care services.

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	365514	A. Building B. Wing	04/21/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record reviews, staff interviews and policy review, the facility failed to ensure falls were thoroughly investigated to determine potential cause of the falls to prevent future falls. This affected one (#67) of three residents reviewed for falls. The facility census was 110. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, failure to thrive, dysphasia, heart disease, kidney failure, and subdural hemorrhage. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively impaired and was dependent on staff mobility and activities of daily living. Review of the care plan with initiated date of 05/19/24 revealed the resident was at risk of falls with interventions for bed in lowest position, perimeter mattress, floor mats at bedside to prevent injury from fall, toileting upon rise, and after meals and as needed at night, educate resident how to use bed remote control, educate resident to use call light for assistance. Review of the fall detailed report dated 11/30/24 revealed Resident #67 had a fall 11/30/24 at 11:00 P.M. The preventative measures documented as being in place at the time of fall included a low bed. Review of the post fall evaluation dated 12/01/24 revealed on 11/30/24, Resident #67 had a fall out of bed. The resident was unable to explain what he was doing when he fell but was found incontinent with bowel and bladder. It stated the bed was in a low position and was a foot off the ground. The immediate intervention was to clean resident and provide incontinence care. It was documented as unknown the last time resident was toileted. Review of the detailed fall report dated 12/22/24 at 7:20 P.M. revealed preventative no measures were marked as being in place at the time of fall (low bed marked no.) Review of the post fall eval dated 12/23/24 revealed fall on 12/22/24 Resident #67 had a fall out of bed with a bump on his head. The resident was unable to explain what he was doing when he fell but was found incontinent of bowel and bladder. It stated the bed was in a low position and was a foot off the ground. The immediate intervention was to send the resident to hospital. Review of the detailed fall report dated 02/23/25 at 3:40 A.M., revealed preventative measures in place at time of fall including a low bed. (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

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Allen View Healthcare Center	2615 Derr Road Springfield, OH 45503

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the post fall evaluation dated 02/23/25 revealed Resident #67 had a fall out of bed with skin tear injury. The resident was unable to explain what he was doing when he fell but was found incontinent with bowel and bladder. It stated the bed was in a low position and was a foot off the ground. The immediate intervention was to keep the bed lowered and add pillow to his hip to help with comfort. It was documented as unknown the last time the resident was last toileted. Review of the progress note dated 02/24/25 revealed the new intervention was bed mats to be placed on the floor. Review of the detailed fall report dated 02/25/25 at 7:20 A.M., revealed preventative measures in place at time of fall including low bed and mattress on floor. Review of the post fall eval dated 02/25/25 revealed Resident #67 had a fall out of bed. The resident was unable to explain what he was doing when he fell but was found incontinent. It stated the bed was in a low position and was a foot off the ground. The immediate intervention was to change the resident. Review of progress note dated 02/25/25 revealed an IDT team meeting intervention for purposeful rounding to ensure resident comfort. Interview on 04/16/25 at 5:30 P.M., with Registered Nurse (RN) #69 and Director of Nursing confirmed Resident #67 had a fall from bed on 11/30/24, 12/22/24, 02/23/25, and 02/25/25. The falls occurred in the late evening to early morning. Each time the resident was incontinent and there was no documentation of when the resident was last provided toileting or incontinence care. The post fall investigations included no information about when the resident was provided incontinence assistance. The staff revealed the facility had no tracking system in place to check how often staff offered toileting and when a resident was last seen or changed prior to falls. The staff revealed after the fourth fall a care plan was updated to include toileting upon rise, before and after meals and during night shift as needed. The staff acknowledged all the fall were within 20 minutes of night shift and toileting intervention (before and after meals) would not have prevented many of the falls that occurred. Interview on 04/17/25 at 10:00 A.M., with RN Divisional Director of Clinical Operations #131 stated if falls are at night and the resident was found incontinent, the interventions should be based on the reason for the fall. She also verified the facility should identify last time seen and last time toileted if resident was found incontinent as potential cause of the fall. Review of the undated facility policy titled Fall Prevention and Management, revealed the facility shall identify risks factors to minimize potential for falls. The care plan shall include interventions that address risk factors and environmental factors resulting from dementia and other medical diagnosis, putting the residents at higher risk for falls. After a fall an investigation should be conducted including talking with residents and seeing if there were any witnesses and a post fall intervention should be put in place based on the cause of the previous fall.

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	365514	A. Building B. Wing	04/21/2025

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

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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** 36303 Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure a resident's urinary catheter collection bag was properly maintained to prevent potential infections. This affected one (#211) of two residents reviewed for urinary catheters. The census was 110. Findings include: Review of Resident #211's medical record revealed an admitted [DATE]. Diagnoses listed included type two diabetes mellitus, hypertension, hyperlipidemia, atrial fibrillation, and malnutrition. Observation on 04/15/25 at 7:38 A.M., revealed Resident #211's urinary catheter collection bag was observed on the floor beside the bed. Resident #211 was lying in bed. Interview on 04/15/25 at 7:49 A.M., with Certified Nurse Aide (CNA) #30 confirmed Resident #211's urinary catheter collection bag was on the floor. CNA #30 stated Resident #211's family requested the urinary catheter collection bag remain on the floor due to his confusion. Interview with on 04/15/25 at 8:00 A.M., with Divisional Director of Clinical Services (DDCS) #131 confirmed Resident #211's urinary catheter collection bag should not be on the floor. Interview with on 04/15/25 08:15 A.M. Registered Nurse (RN) #126 confirmed Resident #211's urinary catheter collection bag should not be on the floor. RN #126 stated the Director of Nursing (DON) had messaged her on 04/14/25 to change the care plan per family request. On 04/16/25 at 7:20 A.M. Resident #211 was observed ambulating per self in a wheelchair. Resident #211 urinary catheter collection bag was hanging from the back of the seat of the wheelchair. The urinary collection bag was at approximately at Resident #211's shoulder level, above bladder level. Interview on 04/16./25 at 7:25 A.M. with Licensed Practical Nurse (LPN) #23 confirmed Resident #211's urinary catheter collection bag was hanging from the back of the wheelchair seat above bladder level. Review of the facility's undated policy titled, Catheter Care revealed that a collection bag is not to be on the floor and and should be draining properly and secured allowing for no reflux of urine back to the bladder.

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	365514	A. Building B. Wing	04/21/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, resident interview, staff interview and policy review, the facility failed to ensure a resident received routine dental care. This affected one (#63) of two residents reviewed for dental care. The facility census was 110. Findings include: Review of Resident #63's medical record revealed Resident #63 admitted to the facility on [DATE], with diagnoses of type two diabetes mellitus with hyperglycemia, morbid obesity due to excess calories, obstructive and reflux uropathy, calculus of ureter, presence of urogenital implants, muscle weakness, iron deficiency anemia, hypothyroidism, hyperlipidemia, major depressive disorder, tachycardia, localized edema, non-pressure chronic ulcer of back limited to break down of skin, and cellulitis of right lower limb. Review of Resident #63's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #63 was independent with eating. Resident #63 required set up assistance with eating and oral hygiene. Review of Resident #63's medical record from 09/30/24 (admission) to 04/15/25 revealed Resident #63 did not receive any routine dental care from 09/30/24 to 04/15/25. Interview on 04/14/25 at 9:30 A.M., with Resident #63 revealed Resident #63 had not received any routine dental care since he was admitted to the facility. Interview on 04/15/25 at 11:15 A.M., with Medical Records #75 verified Resident #63 had not received any routine dental care services from 09/30/24 to 04/15/25. Review of the undated policy titled Dental Services revealed the facility will assist residents in obtaining routine dental services.

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	365514	A. Building B. Wing	04/21/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, policy reviews and staff interviews, the facility failed to ensure the accuracy and thoroughness of the documentation in the resident medical record. This affected two (#18 and #107) of 23 sampled resident records reviewed. Facility census was 110. Findings include: Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included post procedural hematoma, unspecified open wound of the left arm, end stage renal disease, renal dialysis, malnutrition and heart disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact and revealed the resident had a stage four pressure wound and a non-pressure wound. Review of the plan of care dated [DATE] revealed resident was at risk for skin impairment with interventions to follow with wound provider, nursing to monitor skin impairments, administer treatments as ordered and complete weekly skin checks. Review of physician orders dated [DATE] revealed an active order to cleanse surgical incision to left shoulder with normal saline, pat dry, cover with ABD pad and secure in place with tape daily until resolved. The dressing change was to be completed on night shift. Review of physician orders dated [DATE] revealed an active order to monitor 10 sutures to left shoulder surgical site daily until resolved, to be completed on the night shift. Review of physician order dated [DATE] revealed an active order for left shoulder surgical dehiscence with instructions to cleanse with normal saline and pat dry, pack with hydrogel impregnated gauze and cover with Calcium alginate with silver Ag, secure with border dressing. Change daily and as needed. Dressing change to be completed on night shift. Review of general surgery hospital follow-up progress notes dated [DATE] revealed Resident #18 was seen for a hospital follow up from surgical repair of left shoulder hematomas. The note stated sutures were removed by orthopedic surgery team on [DATE]. Review of the Treatment Administration Record for [DATE] revealed the [DATE] and [DATE] physcian orders were being signed off as completed. Interview on [DATE] at 11:20 A.M., with Registered Nurse (RN) Divisional Director of Clinical Operations (RDO) #131 confirmed the facility had two different active wound orders one dated [DATE] and another dated [DATE]. RDO #131 confirmed the facility wound treatment orders did not match, and both were being marked off as being completed for the night shift daily wound care. RDO #131 also confirmed facility staff were signing off monitoring sutures on the left arm as recent as [DATE] while confirming from the Surgeon follow up note, the sutures were removed [DATE]. (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled Physician Orders, revealed the facility shall provide resident centered care. Provider shall give a medical order and nursing staff were responsible for following the order. 37447 2. Review of the closed record for Resident #107 revealed he was admitted on [DATE] and discharged [DATE]. Review of his Minimum Data Set (MDS) quarterly dated [DATE] revealed his Brief Interview of Mental Status (BIMS) score was 14 indicating he was cognitively intact. He was independent with eating and dependent for activities of daily living (ADLs). Review of an MDS dated [DATE] revealed Resident #107 died in the facility. Review of the Care Plan for Resident #107 dated [DATE] revealed his code status as full code. Review of a progress note dated [DATE] revealed Resident #107 was educated regarding his medical condition, offered the hospital which he refused and stated he wanted to remain full code status. Review of his Physician's Orders revealed an order dated [DATE] for Do Not Resuscitate Comfort Care Arrest (DNR CC A). There were no further notes in the medical record regarding a code status discussion or documentation of Resident #107 agreeing to or requesting a change of code status in his record. Interview on [DATE] at 1:40 P.M., with the Nurse Practitioner (NP) #132 verified there was no documentation of a discussing regarding change of code status with Resident #107 and verified there should have been documentation of a discussion at the time of the change in status. Review of the undated policy titled Advance Directives revealed discussions regarding a residents advance directives would be held periodically to determine if the resident wanted to make any changes to their instructions. Any decisions or changes would be documented in the resident's medical record.

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	04/21/2025

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

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review and staff interview, the facility failed to ensure arbitration agreements provided for the selection of a venue that was convenient to both parties. This affected three (#90, #98 and #99) of three residents reviewed for arbitration agreements. The facility census was 110. Findings include: 1. Review of Resident #90's chart revealed Resident #90 admitted to the facility on [DATE], with diagnoses of unspecified focal traumatic brain injury with loss of consciousness of thirty minutes or less, unspecified viral hepatitis c without hepatic coma, paroxysmal atrial fibrillation, anemia, functional quadriplegia, polycystic kidney adult type, bipolar disorder, chronic pain syndrome, major depressive disorder, insomnia, glaucoma, hypertension, mood disorder, alcohol dependence, acute kidney failure, and seborrheic dermatitis. Review of Resident #90's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #90 was independent with eating, oral hygiene, toileting, showering, upper body dressing, lower body dressing, putting on and taking footwear, personal hygiene, roll left and right, sitting to lying, lying to sitting, sitting to standing, chair transfers, toilet transfers, tub transfers, and walking ten feet. Review of Resident #90's arbitration agreement dated 08/22/24 revealed the venue would be in the county in which the facility was located unless the parties agreed otherwise. The agreement was signed by Resident #90 on 08/22/24. 2. Review of Resident #98's chart revealed Resident #98 admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, metabolic encephalopathy non traumatic chronic subdural hemorrhage, epilepsy, hemiplegia unspecified affecting left non dominant side, lymphangioma, muscle weakness, anemia, hypomagnesemia, delirium due to known physiological condition and gastro esophageal reflux disease without esophagitis. Review of Resident #98's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #98 required set up with eating. Resident #98 was dependent with oral hygiene, toileting, showering, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, lying to sitting, chair transfers, and tub transfers. Resident #98 moderate assistance with rolling left and right and maximal assistance with sitting to lying. Review of Resident #98's arbitration agreement dated 01/08/25 revealed the venue would be in the county in which the facility was located unless the parties agreed otherwise. The agreement was signed by Resident #98 on 01/08/25. 3. Review of Resident #99's chart revealed Resident #99 admitted to the facility on [DATE] with diagnoses of liver cell carcinoma, liver transplant status, type two diabetes mellitus without complications, anemia in chronic kidney disease, hypertension, muscle weakness, acute kidney failure, adult failure to thrive, hyperlipidemia, generalized anxiety disorder, and gastro esophageal reflux disease without esophagitis. (continued on next page)

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	04/21/2025

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

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #99's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #99 required set up assistance with eating, and oral hygiene. Resident #99 was dependent with toileting, lower body dressing, and putting on and taking off footwear. Resident #99 required maximal assistance with upper body dressing, lying to sitting, sitting to lying and chair transfers and supervision with personal hygiene. Resident #99 required moderate assistance with rolling left and right. Review of Resident #99's arbitration agreement dated 01/16/25 revealed the venue would be in the county in which the facility was located unless the parties agreed otherwise. The agreement was signed by Resident #99 on 01/16/25. Interview on 04/17/25 at 3:07 P.M.,with Divisional Director of Clinical Operations (DDCO) #131, verified Resident #90, Resident #98 and Resident #99's arbitration agreement stated the venue would be in the county in which the facility was located unless the parties agreed otherwise. DDCO #131 also confirmed the arbitration agreements did not provide for the selection of a venue that was convenient to both parties.

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	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, medical record review, water management plan review, water management plan log review, staff interviews, and policy reviews, the facility failed to update their Legionella water management plan and complete the routine monitoring of the Legionella water management plan. This affected 110 out of 110 residents that resided at the facility. The facility failed to follow enhanced barrier precautions and contact precautions. This affected three (#10, #63 and #82) of three residents reviewed for infection control precautions. The facility census was 110. Findings include: 1. Review of the facility's water management program plan, dated 01/26/18, revealed the facility's prior name was scratched out on the plan and the facility's current name was handwritten on the plan. The water management plan listed the names and phone numbers of a Administrator, a Maintenance Director and Infection Control Preventionist that no longer worked at the facility. The plan stated that fixture flushing logs would be completed twice a week, and hot water system temperatures and point of use water temperatures would be completed weekly. The plan also stated eye wash flushing, shower flushing, water service main monitoring, point of use disinfectant, and the cooling tower service would be monitored monthly, and the facility would complete mixing valve cleaning and water management team meeting notes quarterly. Review of the facility's undated water management plan logs revealed the facility had not completed any weekly, monthly, or quarterly water management plan monitoring since 08/15/24. This included no documentation of monitoring including fixture flushing logs, hot water system temperatures, point of use water temperatures, eye wash flushing, shower flushing, water service main monitoring, point of use disinfectant, the cooling tower service, mixing valve cleaning and water management team meeting notes. Interview on 04/21/25 at 11:12 A.M., with Divisional Director of Clinical Operations (DDCO) #131 verified the facility's water management program plan had not been updated since 01/26/18. DDCO #131 verified the facility had not completed any weekly, monthly, or quarterly water management plan monitoring since 08/15/24. Review of the facility's undated policy titled, Legionella or Legionnaire's Disease, revealed the maintenance performed routine water monitoring services. 36303 2. Review of Resident #82's medical record revealed an admitted [DATE]. Diagnoses listed included anemia, major depressive disorder, dysphagia, malnutrition, and metabolic encephalopathy. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #82 was severely cognitively impaired. Review of laboratory results dated [DATE] revealed Resident #82 was positive for clostridium difficile (C. Diff). (continued on next page)

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	365514	A. Building B. Wing	04/21/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of physician orders revealed an order dated 04/02/25 for metronizadole (antibiotic) oral tablet 500 milligrams (mg). Give one tablet by mouth three times a day for C. Diff for 15 days. Further review of Resident #82's medical record revealed no orders for any contact or isolation precautions. Interview on 04/14/25 at 3:04 P.M., with Licensed Practical Nurse (LPN) #126 confirmed Resident #82 tested positive for C. Diff on 03/26/25 and was not ordered and contact/isolation precautions. Observation on 04/14/25 at 3:12 P.M., of Resident #82's room entrance, with LPN #126 confirmed there was not a sign informing staff of any contact/isolation precautions and that there was not any personal protective equipment (PPE) and the entrance. Review facility's policy titled, Enteric Contact Precautions, dated 02/24/22, revealed high level contact precautions will be initiated in addition to standard precautions for residents with C. Diff or Norovirus. Staff will use proper PPE including gloves, and gown. Goggles/facemask should be added when performing tasks that require direct contact with fecal matter or the potential for spray. 3. Review of Resident #63's medical record revealed an admitted d of 09/30/24. Diagnoses listed included malnutrition, major depressive disorder, anemia, muscle weakness, morbid obesity, and type two diabetes mellitus. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #63 was cognitively intact and had an indwelling urinary catheter. Review of physician orders revealed an order dated 11/13/24 for enhanced barrier precautions (EBP) related to: Foley (urinary catheter) when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. Observation on 04/16/25 at 2:06 P.M., of Resident #63's urinary catheter care, revealed Certified Nurse Aide (CNA) #155 wore gloves but did not wear a gown. Interview on 04/16/25 at 2:12 P.M., with CNA #115 confirmed she did not wear a gown when completing Resident #63's urinary catheter care. CNA #115 was unaware Resident #63 was in EBP, but acknowledged a sign was posted on the entrance door informing of EBP. 4. Review of Resident #10's medical record revealed and admitted [DATE]. Diagnoses listed included kidney failure, type two diabetes mellitus, malnutrition, dementia, and dysphagia. Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #10 is rarely understood, severely cognitively impaired, and received nutrition per a feeding tube. Review of physician orders revealed an order dated 07/17/24 for EBP related to: Trach (tracheostomy) and G-tube (feeding tube) when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/16/25 at 12:24 P.M. revealed a sign posted on Resident #10's entrance door informing staff of EBP. Observation on 04/16/25 at 12:30 P.M., of medication administration, revealed Licensed Practical Nurse (LPN) #23 wore gloves but did not wear a gown while administering medications per Resident #10's feeding tube. Interview on 04/16/25 at 12:38 P.M., with LPN #23 confirmed she did not wear a gown or follow EBP when administering Resident #10's medication per feeding tube. Review of the facility's undated policy titled, Enhanced Barrier Precautions revealed EBP refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms (MDRO) that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. EBP are indicated for residents with wounds and/or indwelling medical devices (even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO). Indwelling medical device examples include central lines including peripherally inserted central catheters (PICC), urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous (IV) line is not considered an indwelling medical device for the purpose of EBP.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44070 Based on observations and staff interviews, the facility failed to maintain resident rooms in a clean and homelike manner. This affected 14 residents (#4, #5, #6, #11, #15, #32, #34, #37, #47, #51, #80, #85, #94, and #101) of 15 residents reviewed for environment. The facility census was 110. Findings include 1. Observation on 04/14/25 at 10:27 A.M. revealed Resident #11's room door did not shut property and did not latch to stay closed. Subsequent observation and interview on 04/15/25 at 10:49 A.M. with Maintenance Director #60 confirmed Resident #11 had broken door that would not secure and stay closed. 2. Observation on 04/14/25 at 10:43 A.M. revealed Resident #37 and #47's room door was chipped on the outside edges. The resident's door was hard to close and took two hands and pulling and tugging on the door to get it to partially close. Subsequent observation and interview on 04/15/25 at 10:50 A.M. with Maintenance Director #60 confirmed Resident #37 and #47's room door had broken door that would not close easily. 3. Observation on 04/14/25 at 10:50 A.M. revealed Resident #5 and #94's room had a wet shine on the floor, next to Resident #94's bed was a splattering on the wall with chunks of unknown material and dried evidence of the splatter to be running down the wall. Resident's dresser was broken with a drawer missing. Near Resident #94's bed, there were several pieces of broken and missing flooring with several pieces loose and easily movable. Observation and interview on 04/15/25 at 10:49 A.M. with Maintenance Director #60 confirmed Resident #5 and #94's room had broken/missing flooring. He confirmed floor tiles were not secured and could be moved by one's foot. He also confirmed the shine on the floor was from an unknown substance and the splatter on the wall was of an unknown substance as well. He also confirmed a dresser drawer was missing and the furniture was broken. Observation and interview on 04/15/25 at 11:00 A.M. with Housekeeping Director #134 confirmed Resident #5 and #94's room had a shine on the floor from the resident's urine on the floor that dried. She revealed staff try to keep up with cleaning, but provided no reasoning why the floor had not been cleaned since 04/13/25. She also confirmed the wall had a splatter and believed it to be vomit from the chunks on the wall and the dripping nature of dried liquid running down the wall. 4. Observation on 04/14/25 at 11:30 A.M. revealed Resident #4 and #101's room had several pieces of broken and missing flooring. Subsequent observation and interview on 04/15/25 at 10:48 A.M. with Maintenance Director #60 confirmed Resident #4 and #101's room had broken/missing flooring. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation and interview on 04/15/25 at 10:47 A.M. with Maintenance Director #60 confirmed Resident #6 and #85's room had broken/missing flooring. Observation and interview on 04/15/25 at 10:47 A.M. with Maintenance Director #60 confirmed Resident #15 and #32's room had broken/missing flooring. Observation and interview on 04/15/25 at 10:49 A.M. with Maintenance Director #60 confirmed Resident #34 and #51's room had broken/missing flooring. Observation and interview on 04/15/25 at 10:47 A.M. with Maintenance Director #60 confirmed Resident #80's room had broken/missing flooring. Maintenance Director #60 stated he had the flooring and all materials needed to fix the flooring issues but had not gotten around to it. He also stated he was unaware of all the rooms that had flooring missing/damaged and needed replaced and had not done an audit for repairs.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, medical record review, policy review, pest control invoice review and staff interviews, the facility failed to ensure a pest free environment. This affected two (#5 and #94) of two residents reviewed for pest control. Facility census was 110. Findings include Review of the medical record for Resident #94 revealed an admitted [DATE]. Diagnoses included malnutrition, diabetes, cerebral infarct, hemiplegia, dysphasia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 was cognitively intact and would ambulate with use of a walker. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, hemiplegia, diabetes, dysphasia, and unspecified psychosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively impaired and would ambulate with use of a wheelchair. Observation and interview on 04/15/25 at 10:49 A.M., with Maintenance Director #60 confirmed Resident #5 and #94 had broken/missing flooring and floor tiles that moved easily. He confirmed when the loose floor tile was moved over a dozen gnats flew up from the flooring. Observation and interview on 04/15/25 at 11:00 A.M., with Housekeeping Director #134 confirmed when the loose tiles on the floor moved and gnats flew up from the floor. Review of pest control work invoices dated 02/03/25 to 04/14/25 revealed resident rooms had not been treated for or monitored for gnats and no pest treatments had been completed for Resident #5 and #94's room. Review of the policy titled Pest control, dated 09/15/21, revealed the facility had a contracted pest control company and revealed all areas would be sprayed monthly. If a problem shall develop, the Maintenance Director shall contact pest control services for an additional visit.