STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366490	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vienna Springs Health Campus	2510 Vienna Pkwy Dayton, OH 45459

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interviews, and policy review, the facility failed to ensure a resident's medication allergies were verified prior to administering a new medication. This affected one (#54) out of three residents reviewed for medications given with an allergy to it. The facility census was 54. Findings include: Review of the medical record for Resident #54 revealed an admission date of 11/14/25 with diagnoses of wedge compression fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing, fracture of one rib, left side, subsequent encounter for fracture with routine healing, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and type 2 diabetes mellitus with diabetic chronic kidney disease. Review of Resident #54's allergies list revealed an allergy to gabapentin with the affect of altered mental status. Review of Resident #54's progress note dated 11/16/25 at 6:07 P.M. revealed Licensed Practical Nurse (LPN) #287 called the on call physician and request medication to focus on neuropathy. LPN #287 received a new order for Gabapentin 100 mg one capsule three times daily as needed. LPN #287 administered the first dose. Resident #54's daughter called, was made aware of the medication being ordered and administered. Resident #54's daughter reminded LPN #287 that the resident had an allergy to the medication. Review of the Medication Transaction Log revealed on 11/16/25 at 2:42 P.M. one Gabapentin 100 mg capsule was pulled and administered to Resident #54. Interview on 12/09/25 at 1:58 P.M. with LPN #287 confirmed on 11/16/25 at 2:42 P.M. she called the physician on call to request medication for Resident #54's neuropathy. LPN #287 confirmed she did not check Resident 54's allergies and she did not tell the physician of any allergies the resident had. LPN #287 also confirmed she pulled one Gabapentin 100 mg capsule from the Emergency box and administered it to Resident #54 after receiving a verbal order from an on-call physician. LPN #287 confirmed it was her fault for not following procedures, not checking allergies before administering a new medication. LPN #287 confirmed she received a write-up and education for failing to check allergies before administering a new medication. Review of the Preparation and General Guidelines HA2: Medication Administration-General Guidelines policy, dated November 2018 revealed medications are administered as prescribed in accordance with good nursing principles and practices. The deficient practice was corrected on 11/18/25 when the facility implemented the following corrective actions: On 11/17/25, the Director of Nursing (DON) reviewed residents admitted in the last 14 days to ensure no contraindications for allergies. There were no other concerns identified and this was completed on 11/17/25. On 11/16/25, the facility designee assessed like residents on LPN #287's assignment to ensure no other findings or concerns were noted with allergies. This was completed on 11/17/25. On 11/16/25, the facility designee started audits new admissions for order accuracy and contraindications due to allergies. This was completed on 11/17/25. On 11/17/25, the DON started in-service education with nurses on 5 rights of medications, double checking and reviewing allergies with provider and medications entered into matrix system prior to administering medication. This was completed on 11/18/25 On 11/18/25, LPN #287, responsible for incident of not checking medication allergies prior to administering a new medication to Resident #54 received a written verbal warning, by the DON. On 11/18/25, the DON began reviewing medication administration records and physician orders, for medication allergies five times a week for eight weeks, then twice weekly for 4 months until sustained compliance. Continues weekly at time of the survey completed on 12/10/25. This deficiency represents past non-compliance investigated under Complaint Number 2676984.