

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
NAME OF PROVIDER OR SUPPLIER Garden Court Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 Covenant House Drive Dayton, OH 45426	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, staff interviews, and policy review, the facility failed to provide adequate interventions and/or supervision to ensure a resident who was assessed as being at risk for elopements did not elope from the facility. This affected one (#26) out of three residents reviewed for elopement. The facility census was 58.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #26 revealed an admitted [DATE] with medical diagnoses of chronic obstructive pulmonary disease, schizoaffective disorder, spinal stenosis, psychosis, and mild neurocognitive disorder.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 05/02/24, indicated Resident #26 had moderate cognitive impairment, had delusions, and had verbal behavioral symptoms towards others. The MDS indicated Resident #26 required set-up assistance with eating, moderate staff assistance with toilet hygiene and dressing, and maximum staff assistance with bathing. The MDS indicated Resident #26 required supervision with transfers and bed mobility.</p> <p>Review of the medical record for Resident #26 revealed an Elopement Risk Screen, completed 04/26/24 at 10:25 A.M. which indicated Resident #26 was at high risk for elopement.</p> <p>Review of the medical record for Resident #26 revealed a nurse progress note dated 04/25/24 at 7:55 P.M. which stated resident was walking around and trying to leave the facility, agitation, having word salad, and flight of ideas. The note stated the physician was notified and an order was received for Haldol 1 milligram (mg) intramuscular every two hours as needed and the Director of Nursing (DON) was notified. Review of the medical record revealed a Social Service note, dated 04/26/24 at 5:17 P.M. which stated met with the resident, daughter, and son upon admission. The note stated Resident #26 did not want to be in the facility and was a flight risk. The note stated Resident #26 was to be one-on-one observation for the weekend. Further review of the medial record revealed a nurse progress note dated 04/26/24 at 11:00 P.M. which stated Resident #26 had an elopement and the DON, Administrator, and Assistant Director of Nursing (ADON) were notified immediately by staff. The note stated the police notified to assist with the search and family were notified. The note stated the Administrator located Resident #26 at a nearby store/gas station and was returned to the facility. The note continued to state Resident #26 was placed back on one-on-one observation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #26 revealed a Interdisciplinary Team (IDT) note dated 04/29/24 at 2:48 P.M. which stated IDT met for follow up to Resident #26's elopement on 04/26/24. Resident #26 was admitted on [DATE]. Resident #26 was able to get a ride from another visitor to go to the nearby store/gas station. Staff immediately identified that the resident was missing. Staff notified DON, ADON and Administrator. Police and family were notified. Resident #26 was found at the store/gas station. Resident #26 agreed to get in the car with the Administrator and returned to facility. A head-to-toe assessment was completed, no marks, bruises or scratches identified. The IDT note stated Resident #26 was happy with her return, however, still did not want to be placed in a nursing home. Facility staff discussed with family the need to be placed on a secured unit, family okay with placement. Physician aware of elopement, referral made to psychiatric services for medication management. Resident #26 remained on one-on-one observation as the facility helped the resident adjust to her new placement in a nursing facility. The IDT note stated Resident #26 was placed on the secured unit.</p> <p>Interview on 05/13/24 at 8:10 A.M. with State tested Nursing Assistant (STNA) #131 confirmed Resident #26 eloped from the facility on 04/26/24 and was found at a nearby store/gas station. STNA #131 stated the nurse who was responsible for providing the one-on-one supervision for Resident #26 left her unattended for a short period of time and Resident #26 eloped from the facility.</p> <p>Interview on 05/13/24 at 8:30 A.M. with DON confirmed Resident #26 had an elopement from the facility on 04/26/24 when the resident was to be on one-on-one observation by staff. The DON stated Resident #26 asked a visitor for a ride. The DON stated Resident #26 did not receive any injuries or had any negative effects from the elopement. DON stated the employee who was responsible for providing the one-on-one supervision was terminated.</p> <p>Review of the facility policy titled, Elopement, revised 09/03/19, stated the facility was to ensure that a resident's environment was safe while using the least restrictive measures possible. The policy also stated if a resident was at risk for elopement, an individualized care plan would be implemented to prevent elopement.</p> <p>The deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review and staff interview, the facility failed to ensure proper disposal of medications after a resident was discharged from the facility. This affected one (#60) out of three residents reviewed for medication disposition after discharge from the facility. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #60 revealed an admitted [DATE] with medical diagnoses of pneumonia, severe protein calorie malnutrition, Human Immunodeficiency Virus (HIV), Hepatitis C, and asthma. Review of the medical record revealed Resident #60 was discharged to the hospital on 09/16/23 and did not return to the facility.</p> <p>Review of the medical record for Resident #60 revealed an admission Minimum Data Set (MDS) assessment, dated 07/17/23, which indicated Resident #60 was cognitively intact and required supervision with bed mobility, transfers, toileting, and bathing. The MDS indicated Resident #60 required extensive staff assistance with eating.</p> <p>Review of the medical record for Resident #60 revealed a physician order dated 08/30/23 for hydroxyzine 25 milligram (mg) tablet give one tablet via gastrostomy tube (g-tube) three times per day for anxiety; physician orders dated 08/31/23 for Bictegravir-emtricitab-Tenofovir oral tablet 50-200-25 mg give one tablet via g-tube daily for HIV; sertraline 25 mg tablet give 0.5 tablet via g-tube daily for depression; and a physician order dated 09/15/23 for doxycycline hyclate 100 mg tablet give one tablet by mouth two times per day for pneumonia. Review of the Medication Administration Record (MAR) for September 2023 revealed Resident #60 received his medications as ordered. Review of the MAR revealed Resident #60 refused to take his medications often.</p> <p>Review of the medical record for Resident #60 revealed no documentation related to the disposition of the Resident #60's medications upon discharge to the hospital and not returning to the facility.</p> <p>Interview on 05/09/24 at 10:22 A.M. with Director of Nursing (DON) stated when a resident discharged to the hospital and did not return to the facility, the resident's medications are sent back to the pharmacy and the narcotics are destroyed by two licensed nurses.</p> <p>Interview on 05/13/24 at 2:00 P.M. with DON confirmed the facility did not have any documentation to support Resident #60's medications were sent back to the pharmacy, or any documentation related to the disposition of Resident #60's medications upon discharge. DON stated the facility did not have a policy for the disposition of a resident's medications upon discharge from the facility.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153557. This deficiency represents ongoing noncompliance from the survey dated 04/11/24.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on record review, observations, staff and resident interviews, and facility policy review, the facility failed to ensure a resident's call light was functioning properly. This affected one (#02) out of the three residents reviewed for call lights. The facility census was 58.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #02 revealed an admitted [DATE] with medical diagnoses of chronic respiratory failure, cirrhosis of the liver, cerebral infarction, and anemia.</p> <p>Review of the medical record for Resident #02 revealed an annual Minimum Data Set (MDS) assessment, dated 04/15/24, which indicated Resident #02 had moderate cognitive impairment and required supervision with eating, toilet hygiene, transfer, bed mobility, and bathing.</p> <p>Interview and observation on 05/09/24 at 9:10 A.M. with Resident #02 revealed his call light had not worked for a few weeks. Resident #02 was observed to press his call light button. The observation revealed the call light indication box in Resident #02's room signaled the call light turned on, but the call light located outside Resident #02's room above his door did not turn on and there was no sound alerting staff the call light had been turned on. Resident #02 stated the facility had not provided him with alternate device to use to notify staff he needed assistance.</p> <p>Interview and observation on 05/09/24 at 9:11 A.M. with State tested Nursing Assistant (STNA) #101 confirmed Resident #02's call light signaled as on in the room, but the light located outside of Resident #02's room above the door was not signaling the call light as on. STNA #101 stated Resident #02's call light had not been working for a while and that maintenance was aware of the issue. STNA #101 stated the facility's call light system does not sound but the light outside of Resident #02's rooms turn on when the resident pushes the call light button. STNA #101 confirmed Resident #02 did not have an alternate device to notify staff he needed assistance.</p> <p>Interview on 05/09/24 at 10:09 A.M. with Maintenance Director #124 stated he had not received any work orders recently for call light repair. Maintenance Director #124 stated he was not aware the call light in Resident #02's room was not working properly.</p> <p>Interview on 05/09/24 at 10:21 A.M. with Director of Nursing (DON) confirmed she was aware the facility had issues with the call light system and stated a new call light system was to be placed soon. DON stated all residents were to be given a bell to use to call staff for assistance when needed if their call light was not working.</p> <p>Review of the facility policy titled, Call light, dated December 2023, stated the facility would ensure timely response to resident's call light to ensure needs are being met. The policy stated the call light was to be used by a resident to notify the nursing facility that the resident has a need that they would like addressed. The policy also stated that if a resident's call light was not functioning it should be replaced with an alternative device to notify staff until it was repaired.</p> <p>(continued on next page)</p>		

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