STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365364	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Court Nursing and Rehabilitation Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on record review observations, staff and resident interviews, and policy review, the facility failed to ensure the call light was within a resident's reach. This affected one (#47) out of three residents reviewed for call lights. The facility census was 55. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus with chronic kidney disease, chronic obstructive pulmonary disease (COPD), depression, dementia with behavioral disturbances. Review of the medical record revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #47 had moderately impaired cognition and required substantial staff assistance with toilet hygiene, bathing, and bed mobility. The MDS also noted Resident #47 had highly impaired vision. Observation and interview on 06/04/24 at 10:34 A.M. of Resident #47 revealed the call light was resting on the headboard of Resident #47's bed and was not within her reach or line of vision. Interview with Resident #47 stated she was not able to reach her call light and that her call light did not work. Observation and interview on 06/04/24 at 10:36 A.M. with Licensed Practical Nurse (LPN) #277 confirmed Resident #47's call light was not within reach and not in her line of vision. LPN #277 confirmed Resident #47 did not have any other means to notify staff if she needed assistance. Review of the facility policy titled, Call Light, dated December 2020 stated the facility would ensure timely response to resident's call light to ensure needs are being met. The policy stated the call light is used by a resident to notify staff of the nursing facility that the resident has a need that they would like addressed. The policy further stated that the call light would be left within the reach of the resident before leaving the resident's room. This deficiency represents non-compliance investigated under Complaint Numbers OH00154373 and OH00153975.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46613 Based on observations and staff interviews, the facility failed to provide a comfortable, clean, and homelike environment by not ensuring comfortable air temperatures on 100 Hall. This had the potential to affect 11 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11) residents residing on the 100 Hall. Additionally, the facility failed to ensure the facility was free of pervasive odors on 500 Hall. This had the potential to affect 10 (#46, #47, #48, #49, #50, #51, #52, #53, #54, and #55) residents residing on the 500 Hall. The facility census was 55. Findings include: Observation on 06/04/24 at 8:26 A.M. of 500 Hall revealed the pervasive urine odor. Observation on 06/04/24 at 1:21 P.M. revealed the air temperature on 100 Hall to feel very warm. The observation revealed multiple residents walking in the hallways and into rooms on the unit. None of the residents observed appeared to be in any distress. The observation revealed one portable air conditioning unit which was pumping cool air on to the unit. Observation with interview on 06/04/24 at 1:24 P.M. with Maintenance #201 revealed Maintenance #201 used the facility's handheld digital thermometer to take the temperature of the air on 100 Hall. The observation revealed the thermometer read 85.5 degrees Fahrenheit (F). Interview with Maintenance #201 confirmed the 100 Hall's temperature felt very warm and the thermometer read 85.5 degrees F on the unit. Maintenance #201 confirmed the facility had multiple portable air conditioning units in the facility to help keep the temperatures comfortable for staff and residents in the facility. The facility confirmed 11 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11) residents reside on the 100 Hall. Observation and interview on 06/05/24 at 8:12 A.M. with Licensed Practical Nurse (LPN) #229 revealed 500 Hall to have a pervasive urine odor. LPN #229 confirmed 500 Hall had a pervasive odor and stated the hall usually had a strong urine odor. The facility confirmed 10 (#46, #47, #48, #49, #50, #51, #52, #53, #54, and #55) residents reside on the 500 Hall. This deficiency represents non-compliance investigated under Complaint Number OH00154503. This deficiency represents ongoing noncompliance from the survey dated 04/11/24.

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	365364	A. Building B. Wing	06/06/2024

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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 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** 46613 Based on medical record review, observations, staff and resident interviews, and policy review, the facility failed implement their smoking policy to ensure a resident who smokes was assessed upon admission. Additionally, the facility failed to provide adequate interventions and/or supervision to ensure resident's smoking materials were properly secured per the facility smoking policy. This affected two (#51 and #46) out of three residents reviewed for smoking. The facility census was 55. Findings include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] with medical diagnoses of paraplegia, anxiety, bipolar disorder, chronic hepatitis C, schizoaffective disorder, and congestive heart failure. Review of the medical record for Resident #51 revealed an admission Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #51 was cognitively intact and was dependent upon staff for toilet hygiene, requires substantial staff assistance for bathing and moderate staff assistance for bed mobility and transfers. The MDS indicated Resident #51 used tobacco. Review of the medical record for Resident #51 revealed a care plan dated 05/15/24 which stated resident was at risk for injury related to smoking and that resident had history of burning himself with cigarettes. The care plan indicated an intervention for staff to keep cigarettes, lighters, and matches in designated area. Review of the medical record for Resident #51 revealed a nurse progress note dated 05/25/24 at 2:26 A.M. stated at approximately 11:30 P.M., the fire alarm was activated. This nurse followed fire protocol to ensure the safety of residents by checking all rooms for visible smoke or fire. Visible smoke observed from resident's room. Doors were closed per fire alarm activation. Upon entering the room, Resident #51's bed linen had a small flame upon it with resident's hand within reach. Resident #51 admitted to this nurse that he had been smoking in room but forgot cigarette was still lit. This nurse removed linen with flames to floor and smothered object until State tested Nursing Assistant (STNA) retrieved fire extinguisher to further douse flame. Resident #51 observed sleeping, unaware of flames in bed. Resident #51 had no obvious sign/symptoms of injury or inhalation during this event. Resident #51 transferred self into wheelchair but adamantly refused to leave smoke-filled room until obtaining other objects needed to smoke. Emergency Medical Services (EMS) notified, and fire EMS arrived to further evaluate and make scene safe. Director of Nursing (DON) notified. Resident #51 unwilling to cooperate with fire EMS to ensure safety of room. Fire EMS notified police to help further secure the scene. This nurse confiscated smoking objects from the resident and put them away for safe keeping. Resident #51 transferred to a new room due to smoke. Review of the medical record for Resident #51 revealed no documentation to support the facility completed a smoking assessment upon admission on 05/14/24. Review of the medical record revealed a smoking assessment, dated 05/25/24, which indicated Resident #51 was a supervised smoker and the facility was to store Resident #51's cigarettes and lighters. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed a Social Service note dated 05/27/24 at 12:45 P.M. which stated the nurse notified her that Resident #51 had a lighter. The note stated the Social Service staff recovered the lighter and had the nurse to secure. Observation on 06/05/24 at 10:15 A.M. revealed Resident #51 had a cigarette in his hand and was entering his room. Interview on 06/05/24 at 12:18 P.M. with Administrator and Director of Nursing (DON) confirmed there was a fire in Resident #51's room on 05/25/24. DON stated staff and resident education was done on 05/25/24 on the smoking policy and procedures, stated the rooms of the residents who smoke were searched smoking materials and any items found were confiscated, and staff were notified that all smokers were to be supervised during designated smoking times. The Administrator and DON confirmed Resident #51 should not have any smoking materials in his possession per the facility smoking policy. DON stated Resident #51's mother would bring him in cigarettes and lighters without notifying the staff. Administrator stated Resident #51's mother was educated on the smoking policy and procedures and the facility issued Resident #51 a 30-day discharge notice. Interview on 06/05/24 at 1:50 P.M. with Resident #51 confirmed he smoked in his room on 05/25/24 and a washcloth caught on fire. Resident #51 stated he thought he put the lite cigarette out in the washcloth, and he fell asleep. Resident #51 stated he was awakened by a nurse and notified him the washcloth was on fire. Resident #51 stated the nurse was able to put out the small flame and he did not sustain any injuries. Resident #51 stated the facility provided education on smoking policy and procedures. Resident #51 confirmed the facility confiscated a lighter from his room on 05/27/24. 2. Review of the medical record for Resident #46 revealed an admitted [DATE] with medical diagnoses of anxiety, depression, hypertension and hyperlipidemia. Review of the medical record for Resident #46 revealed a quarterly MDS assessment dated [DATE] which indicated the resident was cognitively intact and was independent with mobility. Further review of Resident #46's medical record revealed the resident was identified as a supervised smoker and smoking material was to be in a secured in a designated area. Observation on 06/05/24 at 12:39 P.M. noted that Resident #46 was observed placing cigarette packs into the basket of her walker. Interview on 06/05/24 at 12:42 P.M. with Maintenance #201 confirmed Resident #46 had packs of cigarettes stored in the basket portion of her walker. Maintenance #201 confirmed Resident #46 was a supervised smoker and all smoking materials should be kept in a designated area per the facility policy. Review of the facility policy titled, Smoking,, revised 11/04/22 stated the facility would make every best effort to establish and maintain safe resident smoking practices that accommodate the resident's needs. The policy stated residents would be evaluated upon admission and routinely to determine if he or she is able to smoke safely with or without supervision (per smoking assessment). The policy also stated smoking is only permitted in designated smoking areas and all smoking materials, including e-cigarettes would be stored in a secure location by the facility staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency is based on incidental findings discovered during the course of this complaint investigation. This deficiency represents ongoing noncompliance from the survey dated 05/13/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected two (#23 and #47) residents out of the three residents reviewed for medications administered as ordered. The facility census was 55. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE] with medical diagnoses of COPD, hypertension (HTN), convulsions, anxiety, liver disease, and depression. Review of the medical record for Resident #23 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #23 was cognitively intact and was independent with toileting, bed mobility, transfers, and required supervision with showers. Review of the medical record for Resident #23 revealed physician orders dated 10/23/23 for Celebrex 100 milligram (mg) one capsule by mouth two times per day and for Elavil sleep tablet 25 mg one tablet by mouth at bedtime, orders dated 10/24/23 for melatonin 3 mg one tablet by mouth at bedtime, metoprolol 25 mg one tablet by mouth two times per day, and Seroquel 25 mg one tablet by mouth two times per day and an order dated 02/17/24 Norco 5-325 mg one tablet by mouth two times per day. Review of the medical record for Resident #23 revealed the May 2024 Medication Administration Record did not contain documentation to support Resident #23 received Celebrex, Elavil, melatonin, metoprolol, Seroquel, or Norco as ordered on 05/08/24. 2. Review of the medical record for Resident #47 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus with chronic kidney disease, chronic obstructive pulmonary disease (COPD), depression, dementia with behavioral disturbances. Review of the medical record revealed a quarterly MDS assessment dated [DATE] which indicated Resident #47 had moderately impaired cognition and required substantial staff assistance with toilet hygiene, bathing, and bed mobility. The MDS also noted Resident #47 had highly impaired vision. (continued on next page)

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	365364	A. Building B. Wing	06/06/2024

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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	Review of the medical record for Resident #47 revealed physician orders dated 10/02/23 for Dorzolamide-timolol ophthalmic solution 22.3-6.6 mg per milliliter (ml) to install one drop in both eyes two times per day, fluticasone-salmeterol inhalation 250-50 microgram per actuation one puff every 12 hours, carvedilol 3.125 mg one tablet by mouth two times per day, pregabalin 75 mg one capsule by mouth two times per day, Brimonidine Tartrate Ophthalmic solution 0.2% instill one drop to both eyes three times per day, Tylenol 650 mg one tablet by mouth every eight hours, physician orders dated 10/03/23 for cholecalciferol 25 micrograms (mcg) one tablet by mouth daily, duloxetine 60 mg one tablet by mouth daily, escitalopram oxalate 10 mg one tablet by mouth daily and to take with 5 mg tablet for total of 15 mg, escitalopram oxalate 5 mg one tablet by mouth daily and to take with 10 mg tablet for total of 15 mg, and folic acid 1 gram by mouth daily, orders dated 10/16/23 for cefadroxil 500 mg one capsule by mouth two times per day and furosemide 20 mg one tablet by mouth two times per day, an order dated 01/24/24 for metformin 1000 mg one po two times per day, and an order dated 02/17/24 Basaglar Kwikpen (insulin) 100 unit/ml to inject 18 units subcutaneously every morning at 6:00 A.M. Review of the medical record for Resident #47 revealed the May 2024 MAR revealed Resident #47 did not contain documentation to support Resident #47 received the dorzolamide-timolol ophthalmic solution eye drops, fluticasone-salmeterol inhaler, carvedilol, pregabalin, brimonidine tartrate eye drops, Tylenol, cholecalciferol, duloxetine, escitalopram, folic acid, cefadroxil, furosemide, metformin, and Basaglar Kwikpen as ordered on 05/21/24. Interview on 06/05/24 at 10:30 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #23 did not contain documentation to support medications were administered as ordered on 05/08/24 and the medical record for Resident #47 did not contain documentation to support medications were administered as ordered on 05/21/24. Review of the facility policy titled, Medication Administration, revised November 2018, the policy stated medications are to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. This deficiency represents non-compliance investigated under Complaint Number OH00153942. This deficiency represents ongoing noncompliance from the survey dated 04/11/24 and 05/13/24.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observation, and staff interview, the facility failed to ensure resident's medications were administered as ordered resulting in two medication errors out of 30 opportunities or a 6.66 percent (%) medication error rate. This affected one (#53) out of two residents observed for medication administration. The facility census was 55. Findings include: Review of the medical record for Resident #53 revealed an admitted [DATE] with medical diagnoses of cerebral infarction, right sided hemiparesis, paranoid schizophrenia, and bipolar disorder. Review of the medical record for Resident #53 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #53 had moderate cognitive impairment and was independent with eating, toileting, transfers, and bed mobility and required supervision with bathing. Review of the medical record for Resident #53 revealed a physician order dated 09/22/23 for Gabapentin 300 milligram (mg) one tablet by mouth daily, orders dated 09/23/23 for Gabapentin 600 mg one tablet by mouth daily, Azathioprine 50 mg three tablets by mouth daily, Colcrys 0.6 mg one tablet by mouth daily, and Cymbalta 60 mg one tablet by mouth daily, an order dated 09/26/23 for Ziprasidone 80 mg one tablet by mouth two times per day, orders dated 09/29/23 for Buspirone 5 mg one tablet by mouth two times per day and Clonidine 0.1 mg one tablet by mouth two times per day, an order dated 09/29/23 for Keppra 1000 mg by one tablet by mouth two times per day, orders dated 09/30/23 for Prednisone 10 mg one tablet by mouth daily and Budesonide inhalation aerosol powder 90 micrograms per actuation for one puff orally two times per day, an order dated 09/30/23 for Vitamin D3 one tablet by mouth daily, an order dated 10/24/23 for Lidocaine 4% patch one apply to right shoulder topically daily, an order dated 04/06/24 for MiraLAX 17 gram/scoop one scoop mix with water by mouth daily and an order dated 06/01/24 for hydrochlorothiazide 12. 5 mg one tablet by mouth daily. Observation on 06/05/24 at 8:15 A.M. of Licensed Practical Nurse (LPN) #229 administer medications to Resident #53. The observation revealed LPN #229 did not apply Lidocaine patch or administer MiraLAX as ordered. Interview on 06/05/24 at 8:20 A.M. with LPN #229 confirmed she had not applied Resident #53's Lidocaine patch and had not administered MiraLAX as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00153942.

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	365364	A. Building B. Wing	06/06/2024

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview and policy review, the facility failed to obtain laboratory work as ordered. This affected one (#65) out of the three residents reviewed for nutrition. The facility census was 55. Findings include: Review of the medical record for Resident #65 revealed an admitted [DATE] with medical diagnoses of depression, rhabdomyolysis, severe protein calorie malnutrition, dementia, and schizophrenia. Review of the medical record revealed Resident #65 discharged to the hospital on 05/06/24. Review of the medical record for Resident #65 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/01/24, which indicated Resident #65 had severe cognitive impairment and was independent with transfers and bed mobility but required substantial staff assistance for toileting hygiene and bathing. Review of the medical record for Resident #65 revealed a physician order dated 04/30/24 for the following blood work to be done: comprehensive metabolic panel (CMP), complete blood count (CBC), and thyroid stimulating hormone (TSH). Review of the medical record revealed a lab report dated 04/30/24 which stated the lab was unable to obtain the specimen and on the first attempt the phlebotomist was unable to obtain an adequate sample. The form stated a second phlebotomist would be sent out. Further review of the lab report revealed documentation that the facility nurse was to call the lab to schedule the date for redraw. Review of the medical record for Resident #65 revealed no documentation to support the lab work was drawn as ordered. Interview on 06/05/24 at 10:30 A.M. with Director of Nursing (DON) stated Resident #65 readmitted to the facility from the hospital on 04/29/24. DON stated Resident #65 was lethargic and was not eating well upon readmission. DON stated the facility notified the physician of Resident #65's condition and lab work was ordered on 04/30/24. DON stated Resident #65 did not have a guardian or power of attorney in place to make medical decisions. Interviews on 06/05/24 at 12:30 P.M. with Administrator and DON confirmed the medical record for Resident #65 did not contain documentation to support the facility obtained the lab work that was ordered on 04/30/24. DON stated she was not aware that the nurse was to call to schedule a date and time for the lab company to redraw the labs for Resident #65. DON stated Resident #65 was sent back out to the hospital on 05/06/24 due to change in medical condition and for poor intake and the hospital was able to get emergency guardianship for Resident #65. DON stated the hospital inserted a gastrointestinal tube (g-tube) to provide Resident #65 with enteral nutrition. Review of the facility policy titled, Lab and Diagnostic Test Results- Clinical Protocol, revised November 2018 stated the physician would identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs, staff would process test requisitions and arrange for test. This deficiency represents non-compliance investigated under Complaint Number OH00153991.

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	365364	A. Building B. Wing	06/06/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on record review, observations, staff and resident interviews, and policy review, the facility failed to ensure the call light system was functioning properly. This affected two (#23 and #47) out of the three residents reviewed for call lights not functioning properly. The facility census was 55. Findings include: 1. Review of the medical record for Resident #47 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus with chronic kidney disease, chronic obstructive pulmonary disease (COPD), depression, dementia with behavioral disturbances. Review of the medical record revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #47 had moderately impaired cognition and required substantial staff assistance with toilet hygiene, bathing, and bed mobility. The MDS also noted Resident #47 had highly impaired vision. Observation and interview on 06/04/24 at 10:34 A.M. of Resident #47 revealed the call light was resting on the headboard of Resident #47's bed and was not within her reach or line of vision. Interview with Resident #47 stated she was not able to reach her call light and that her call light did not work. Observation and interview on 06/04/24 at 10:36 A.M. with Licensed Practical Nurse (LPN) #277 confirmed Resident #47's call light was not within reach and not in her line of vision. LPN #277 was observed to press Resident #47's call light button and the call light signal box in Resident #47's room indicated the call light had been turned on. Observation with LPN #277 revealed the call light located outside of Resident #27's room above the door did not indicate the call light had been turned on. LPN #277 confirmed Resident #47 did not have any other means to notify staff if she needed assistance. 2. Review of the medical record for Resident #23 revealed an admitted [DATE] with medical diagnoses of COPD, hypertension (HTN), convulsions, anxiety, liver disease, and depression. Review of the medical record for Resident #23 revealed a quarterly MDS assessment dated [DATE] which indicated Resident #23 was cognitively intact and was independent with toileting, bed mobility, transfers, and required supervision with showers. Observation and interview on 06/04/24 at 11:49 A.M. with Resident #23 stated the call in his room did not work and had not worked for a long time. Resident #23 was observed pressing the call light button in his room. The call light signal box on the wall in Resident #23's room did not indicate the call light had been turned on. Observation of the call light outside of Resident #23's room above the door did not indicate the call light had been turned on. The observation did not reveal any other means for Resident #23 to notify staff if he needed assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365364	A. Building B. Wing	06/06/2024

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/24 at 12:02 P.M. with Registered Nurse (RN) #236 confirmed the call light for Resident #23's room did not work, and that Resident #23 did not have any other means to notify staff if he needed assistance. Review of the facility policy titled, Call Light, dated December 2020 stated the facility would ensure timely response to resident's call light to ensure needs are being met. The policy stated the call light is used by a resident to notify staff of the nursing facility that the resident has a need that they would like addressed. The policy further stated if a resident's call light is not functioning it should be replaced with an alternative device to notify staff unit it is repaired. This deficiency represents non-compliance investigated under Complaint Numbers OH00154373 and OH00153975. This deficiency represents ongoing noncompliance from the survey dated 05/14/24.