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 12/03/2024

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review and resident, staff and physician office staff interviews, the facility failed to provide medically-related social services by failing to provide assistance with a resident's medical appointments to an outside provider. This affected one (#21) of three residents reviewed for medical appointments. The facility census was 51. Findings include Medical record review for Resident #21 revealed an admission on 08/24/21 with diagnoses including but not limited to congestive obstructive pulmonary disease, chronic pain, hypertension, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #21 revealed the resident had intact cognition. Resident #21 required set up or clean up assistance for eating, supervision or touching assistance for toileting, bed mobility and transfers. Review of the Resident Appointment Sheet for Resident #21 revealed an appointment for unknown physician on 10/17/24 with a pickup time scheduled for 1:45 P.M. Review of the Resident Appointment Sheet for Resident #21 revealed an appointment for heart and vascular physician on 10/28/24 with a pickup time scheduled for 11:02 A.M. Review of the progress notes for Resident #21 dated 10/13/24 to 10/30/24 was silent for any appointment documentation for 10/17/24 or 10/28/24 related to departures, returns or order changes. Review of the after-visit summary for Resident #21 dated 11/04/24 revealed the resident was seen for a follow-up appointment related to post aortic aneurysm repair and to discuss next surgical procedure for a thoracic nonvascular aortic repair. Further review of the document for Resident #21 revealed the physician reviewed the computed tomography (CT) scan completed on 10/17/24. Interview on 11/12/24 at 9:47 A.M. with Facility Administrative Staff #122 assigned to complete transportation arrangements states Resident #21 went to his appointment on 10/17/24, but the physician rescheduled the appointment on 10/28/24 to 11/04/24. (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
	365364	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Court Nursing and Rehabilitation Center	4911 Covenant House Drive Dayton, OH 45426

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/12/24 at 12:20 P.M. with Resident #21 stated he must have another surgery, and the facility is messing up the appointments that need to take place before he can have his next surgery for his aneurysm repair. Interview on 11/12/24 at 1:38 P.M. with Transportation Staff #206 verified transportation was scheduled for 10/28/24 for Resident #21. Transportation Staff #206 stated the appointment was not completed as scheduled and was canceled by transportation staff on 10/29/24. Transportation Staff #206 was unable to provide any additional documentation for the cancellation as none was listed in their system regarding a reason for the cancellation. Interview on 11/12/24 at 1:59 P.M. with Registered Nurse (RN) #208 verified she was the Office Manager for the cardiologist that Resident #21 was scheduled to seen on 10/28/24. RN #208 stated she called the facility on 10/23/24 for Resident #21 to verify the appointment on 10/28/24 as they have had problems in the past with no calls and no shows. RN #208 verified the appointment was not canceled by the office or the physician and Resident #21 was a no call or no show for the appointment on 10/28/24. Interview on 11/12/24 at 4:25 P.M. with Administrator and the Director of Nursing (DON) verified the facility did not have any documentation in the medical record for the scheduled appointments for Resident #21 and should have. The Administrator and DON could not provide information as to why Resident #21's cardiologist appointment scheduled for 10/28/24 was canceled. This deficiency represents non-compliance investigated under Complaint Number OH00159497.

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NAME OF PROVIDER OR SUPPLIER Garden Court Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 Covenant House Drive Dayton, OH 45426	

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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** 39702 Based on medical record review, observations, staff and pharmacist interviews and policy review, the facility failed to ensure medications were administered according to physicians orders, failed to ensure licensed nursing staff accurately documented the administration of medications in the medical record and failed to ensure medications were re-ordered/available from the pharmacy. This affected two (#52 and #21) of three reviewed for medication administration. The facility census was 51. Findings include 1. Medical record review for Resident #52 revealed an admission on 10/02/24. Diagnoses include hydronephrosis, anemia, gastroesophageal reflux disease, benign prostatic hyperplasia, obstructive uropathy, thyroid disorder, anxiety, and schizophrenia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #52 revealed the resident had impaired cognition. Resident #52 required maximum assistance for eating, toileting, and moderate assistance for transfers and bed mobility. Review of the plan of care for Resident #52 revealed resident has potential for behavior problems related to anxiety and schizoaffective disorder (bipolar type). Interventions include administer medication as ordered, allow resident to discuss feelings, approach/speak to resident in a calm voice, encourage resident to attend activities of choice, and psych/counseling services as needed. Review of the hospital discharge medication orders for Resident #52 dated 10/02/24 revealed an order for Clonazepam one milligram (mg) take two tablets by mouth at bedtime. Additionally, the orders revealed a second order for clonazepam one mg take two tablets by mouth two times a day dated 10/02/24. Review of the facility's medication administration record (MAR) for Resident #52 for the month of October 2024 revealed an order dated 10/02/24 for Clonazepam 0.5 mg give two tablets by mouth at bedtime to treat seizures. Review of the controlled drug record for Resident #52 revealed an order for Resident #52 revealed the facility received ten tablets of clonazepam 1 mg tablets with written instructions stating to take two tablets by mouth at bedtime for five days on 10/03/24. Further review of the controlled drug record for Resident #52 revealed on 10/03/24 at 9:00 A.M., and 10/07/24 at 9:00 P.M. Resident #52 received only one tablet instead of the two prescribed for administration. Interview on 11/07/24 at 12:20 P.M. with Pharmacist #200 verified the facility was only sent ten tablets of Clonazepam on 10/03/24. Pharmacist #200 stated the pharmacy did not receive any request to remove the prescribed medication from the emergency box. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/07/24 at 3:30 P.M. with the Director of Nursing (DON) verified the admission orders for Resident #52 were not transcribed as ordered on the day of admission for the clonazepam. DON verified Resident #52 did not receive his clonazepam as ordered two times a day and only the nighttime dose was administered by the facility. DON further verified Resident #52 did not receive the correct dose of clonazepam on 10/03/24 and 10/07/24 as only one tablet was signed off on the controlled drug record. DON verified the medication administration record for Resident #52 was signed off as given eleven times, and the signatures for the nurse's documenting medication was administered on 10/05/24 at 9:00 A.M., 10/05/24 at 9:00 A.M., 10/06/24 at 9:00 A.M., 10/07/24 at 9:00 P.M., 10/08/24 at 9:00 A.M., 10/08/24 at 9:00 P.M., 10/09/24 at 9:00 A.M., 10/09/24 at 9:00 P.M., 10/10/24 at 9:00 A.M. and 10/10/24 at 9:00 A.M. were not located on any controlled drug record for Resident #52. DON verified the pharmacy sent 10 tablets of clonazepam on 10/11/24 and thirty tablets on 10/15/24 to the facility that were destroyed. DON verified the facility nurses did not contact the pharmacy for authorization for the clonazepam to be removed from the facility emergency box. Review of the facility policy titled Adverse Consequences and Medication Errors', dated 04/2014 stated a medication error is defined as the preparation or administration of drugs which is not in accordance with physicians' orders. 2. Medical record review for Resident #21 revealed an admission on 08/24/21 with diagnoses including but not limited to congestive obstructive pulmonary disease, chronic pain, hypertension, and depression. Review of the quarterly MDS assessment dated [DATE] for Resident #21 revealed the resident had intact cognition. Resident #21 required set up or clean up assistance for eating, supervision or touching assistance for toileting, bed mobility and transfers. Resident #21 is on scheduled pain medications and received as needed pain medication during the assessment period. Review of the plan of care dated 08/29/2023 and revised 08/21/24 for Resident #21 revealed resident is at risk for addiction and drug seeking behaviors related to history of polysubstance abuse. Interventions include administer medication as ordered, administer Narcan as ordered, notify physician of suspected drug or alcohol use, observe resident for signs and symptoms opioid overdose. Review of the active physician's orders for Resident #21 revealed an order dated 08/18/24 for oxycodone oral tablet five mg, give one tablet by mouth every six hours as needed for pain and methocarbamol oral tablet 750 mg give one tablet by mouth every eight hours as needed for muscle spasms. Review of the November 2024 medication administration record for Resident #21 revealed the resident received oxycodone oral tablet five mg, give one tablet by mouth every six hours as needed for pain on ten occasions starting on 11/01/24 to 11/12/24. Resident #21 received methocarbamol 750 mg one time. Review of the controlled drug record for Resident #21 dated 11/01/24 to 11/12/24 revealed resident had received oxycodone oral tablet five mg, give one tablet by mouth every six hours as needed for pain revealed facility staff signed out thirty-one oxycodone tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 11/07/24 at 3:30 P.M. verified facility staff failed to document the administration of the oxycodone oral tablet five mg on 11/01/24 at 2:37 A.M., 11/01/24 at 9:00 P.M., 11/02/24 at 4:20 A.M., 11/02/24 at 9:00 A.M., 11/02/24 at 11:00 P.M., 11/03/24 at 9:30 P.M., 11/04/24 at 9:00 A.M., 11/05/24 at 8:00 A.M., 11/05/24 at 2:00 P.M., 11/05/24 at 9:30 P.M., 11/06/24 at 9:00 A.M., 11/06/24 at 2:40 P.M., 11/06/24 at 9:30 P.M., 11/08/24 at 10:55 P.M., 11/09/24 at 7:46 A.M., 11/09/24 at 2:46 P.M., 11/09/24 at 9:00 P.M., 11/10/24 at 7:46 A.M., 11/10/24 at 2:40 P.M., 11/10/24 at 9:00 P.M., 11/11/24 at 7:19 A.M., 11/11/24 at 2:22 P.M., and 11/11/24 at 9:00 P.M. in the electronic health record and should have. The DON further verified the staff should be documenting all medication administered in the electronic health record. Interview on 12/03/24 at 2:15 P.M. with LPN #67 verified the facility does not have any methocarbamol for Resident #21 at this time. LPN #67 stated if Resident #21 would ask for it they can get it from the emergency box. LPN #67 stated a refill request was sent to the pharmacy and staff was notified that insurance was not filling it for lack of coverage. LPN #67 was unable to provide documentation of non payment. LPN #67 verified he had administered the methocarbamol previously and did not document it on the MAR. Interview on 12/03/24 at 2:22 P.M. with Pharmacist #156 verified insurance would pay for Resident #21's methocarbamol medication as it was covered previously. Pharmacist #156 further stated there have not be any requests to refill Resident #21's methocarbamol from the facility or facility notification of non payment. Pharmacist #156 stated the facility was sent 90 tablets of the methocarbamol on 08/18/24. Interview on 12/03/24 at 2:26 P.M. with Corporate Registered Nurse (RN) #154 advised that insurance communication would trigger an email to the facility staff responsible to monitoring medications and she was not sure who was receiving it at this time. RN #154 stated the medication would be paid for by insurance. RN #154 verified the facility did not have the medication available at this time and if requested the nurse would be able to pull medication from the emergency box for administration. RN #154 verified the facility MAR for Resident #21 for the months of August 2024, September 2024, October 2024 and November 2024 only contained documentation of methocarbamol being administered four times and should have been 90 times. RN #154 verified the nurses were not documenting the administration of medication correctly. Review of the facility policy titled Adverse Consequences and Medication Errors, dated 04/2014 stated a medication error is defined as the preparation or administration of drugs which is not in accordance with physicians' orders and administration documentation per accepted professional standards. This deficiency represents non-compliance investigated under Complaint Numbers OH00159863, OH00159497 and OH00158906.