

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 03/26/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080</p> <p>Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to administer medications per physicians orders. There were two medication errors out of 31 opportunities resulting in a 6.45 percent (%) medication error rate. This affected two (Residents #40 and #47) of three residents reviewed for medication administration. The facility census was 45.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included chronic obstructive disease, cystocele, overactive bladder, depression, cognitive communication, and anxiety disorder.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. Resident #40 required setup or clean up assistance for meals, and oral care. Resident #40 required supervision or touching assistance for bathing, dressing upper and lower body, toilet hygiene, personal hygiene, and placing shoes on and off feet.</p> <p>Review of physician orders for Resident #40 revealed there was no current order for medication Pyridium 100 mg.</p> <p>Review of the medication administration record for March 2025 revealed Resident #40 had a discontinued order for Phenazopyridines 100 mg take three times a day. The end date was 03/04/25.</p> <p>Observation and interview on 03/26/25 at 7:58 A.M. revealed Licensed Practical Nurse (LPN) #252 administered Pyridium 100 mg to Resident #40.</p> <p>Interview on 03/26/25 at 11:42 A.M. with LPN #252 verified no active order for Pyridium 100 mg.</p> <p>Interview on 03/26/25 at 1:00 P.M. with Regional Nurse (RN) #300 verified Resident #40 had an older order of Pyridium 100 mg. RN #300 stated it should not have been administered.</p> <p>2. Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, paranoid schizophrenia, major depressive disorder, type diabetes, and asthma.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment dated [DATE] revealed Resident #47 was cognitively intact. Resident #47 required supervision or touching assistance meals, dress upper body, and oral care. Resident #47 required partial moderate assistance, dress lower body, putting on and off shoes, and bathing. Resident #47 required substantial to maximal assistance for toileting hygiene, and personal hygiene, and toileting hygiene.</p> <p>Review of physician orders revealed an order for Linagliptin 5 mg take one tablet for diabetes at 8:00 A.M.</p> <p>Observation on 03/26/25 at 8:05 A.M. with LPN #252 did not administer Lingliptin 5 mg during medication administration.</p> <p>Interview on 03/26/25 at 11:42 A.M. LPN #252 verified she did not administer Lingliptin 5 mg as ordered.</p> <p>Review of facility document titled, Medication Administration-General Guidelines, dated 11/2018 revealed medication is administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00163987 and Complaint Number OH00163208.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on observation, medical record review, interview, and policy review, the facility failed to ensure medications were stored in a safe manner. This affected one (Resident #19) of one resident observed for medication storage. The facility census was 45.</p> <p>Findings include,</p> <p>Medical record review for Resident #19 revealed he was admitted to the facility on [DATE]. His diagnoses included alcohol dependent withdrawal, emphysema, anxiety disorder, major depressive disorder, polycythemia, chronic obstructive pulmonary disease (COPD), asthma, hypokalemia, foot drop, irritable bowel syndrome, delusional disorder, acute respiratory failure, acute kidney failure, pleural effusion, and acute respiratory failure with hypoxia.</p> <p>Review of Minimum Data Set (MDS) assessment, dated 03/18/25, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) of 15 and this indicated he was cognitively intact. Resident #19 required set up, clean up assistance for meals, and oral care. Resident #19 required supervision or touching with dressing upper and lower body, placing shoes on and off feet, bathing, personal hygiene, and toileting. Resident #19 was dependent on staff for medication administration.</p> <p>Interview and observation on 03/26/25 at 8:43 A.M. with Resident #19 in his room revealed he was seated in his wheelchair. Resident #19 had the following bottles of medication in his room; milk [NAME], St. [NAME]-[NAME], two bottles of zinc, a large bottle of B Vitamins, and a large container of soy lectin.</p> <p>Interview and observation on 03/26/25 at 8:53 A.M. with Registered Nurse (RN) #213 confirmed Resident #19 had the following medications and fertilizer in his room; Resident #19 had the following bottles of medication in his room; milk [NAME], St. John's-[NAME], two bottles of zinc, a large bottle of B Vitamins, and a large container of soy lectin.</p> <p>Review of the facility policy titled, Storage Medications, dated 2001, confirmed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Further review of the policy confirmed the nursing staff shall be responsible for maintain medication storage.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on observation, interview, and facility policy review, the facility failed to provide a clean, homelike environment with working showers. This had the potential to affect all residents. The facility also failed to provide a clean floor for Resident #36. The facility census was 45.</p> <p>Findings include:</p> <p>1. Interview and observation on 03/26/25 at 9:00 A.M. with Licensed Practical Nurse (LPN) #255 confirmed the 500-hallway shower room was the only shower room used by all residents in the facility. LPN #255 confirmed the first two shower room stalls were not functioning. She confirmed the dirt, debris, and trash scattered all over the floor of the shower room. LPN #255 confirmed the lights in the 500-hall shower room contained multiple brown items that appeared to be bugs. LPN #255 confirmed the bathroom stall had a sign that read, Do Not Use, dated 01/22/25. LPN #255 opened the bathroom stall door next to the shower stall and the toilet had various pieces of colored tape on it. The toilet contained black water.</p> <p>Interview and observation on 03/26/25 at 9:05 A.M. with the Maintenance Supervisor (MS) #231 confirmed the first shower room on the 200-hall did not have a handle on it and was unlocked. The sign on the door read, Out of Order-Use 500 hall shower. He confirmed when you opened the shower door, a bag with trash all around it was lying on the floor in water. The floor was approximately 50% covered with a foot of stagnated water. Across from the shower stall a fountain of running water from the ceiling was running down. The wall was covered with a brown stain and black dotted substance all along the wall. Active gnats were flying around the water. Water was pouring from the ceiling and down the wall. The ceiling had brown stains and black dotted substance all over it. MS #231 confirmed the second 200-hallway bathroom had lights; however, the electric was turned off. MS #231 used a flashlight to confirm the bathroom was full of various chairs and the walk-in tub had dried brown debris and dirt all over it. MS #231 confirmed the 200-hall bathroom had the water turned off all the equipment in the bathroom.</p> <p>Review of the facility policy titled, Maintenance Policy and Procedure, dated 01/01/18, confirmed all maintenance repairs and request need a work order filled out and submitted to maintenance. Maintenance will attempt to make repairs and if unable will use an outside contractor. Maintenance will follow up on the status of repairs.</p> <p>44080</p> <p>2. Review of the medical record revealed Resident #36 was admitted [DATE]. Diagnoses included type two diabetes, major depressive disorder, chronic obstructive pulmonary disease, anxiety disorder, and adjustment disorder with depressed mood.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively impaired. Resident #36 required supervision or touching assistance for meals, oral care, dress upper body, and personal hygiene. Resident #36 required partial moderate assistance toileting hygiene, personal hygiene, bathing, dressing lower body, and putting on and off shoes.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 03/26/25 at 8:45 A.M. with Resident #36 during a medication pass, revealed Licensed Practical Nurse (LPN) #252 was walking around in the resident's room, shoes were sticking to the floor, and made a very loud sticking noise.</p> <p>Interview on 03/26/25 at 8:50 A.M. with LPN #252 verified her shoes were sticking to Resident's #36 floor. LPN #252 stated she will let someone know.</p> <p>Interview and observation on 03/26/25 at 5:30 P.M. with Regional Nurse (RN) #300 verified Resident #36's floor was was sticky and made a loud noise when walking on. RN #300 walked around the bed, and the room to understand why floor was so sticky. RN #300 stated it was possibly the chemical cleaner.</p> <p>Review of the facility document, CDC Environment Checklist for Monitoring Terminal Cleaning, undated, revealed facility check off list required floor to be cleaned and disinfection by sweeping the floor before wet mopping, then with wet mop, start to the furthest from the door, half of room first, then the other half to complete.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00163987.</p>		