

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 06/11/2025
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and resident and staff interviews, the facility failed to ensure residents were treated with dignity and respect. This affected one (#10) out of three reviewed for dignity and respect. The facility census was 49.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #10 revealed an admission date of 05/30/25 with diagnoses of chronic obstructive pulmonary disease, edema, post-traumatic stress disorder, and essential (primary) hypertension.</p> <p>Review of the Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] revealed resident was cognitively intact. Resident required supervision assistance with all activities of daily living (ADL's).</p> <p>Review of the care plan dated 06/09/25 revealed resident had a potential for behavior problems related to anxiety and depression with interventions of administer medication as ordered, allow resident to discuss feelings, and approach/speak to resident in a calm voice.</p> <p>Interview on 06/10/25 at 2:23 P.M. with Resident #10 stated Certified Nursing Assistant (CNA) #235 was disrespectful while she was on the phone yesterday, 06/09/25. Resident #10 stated CNA #235 kept insisting she had to take a shower right then. Resident #10 told CNA #235 should would take a shower later. CNA #235 left and came back yelling at her again to take a shower. Resident #10 told CNA #235 she wanted to take her shower at a later time because she was on the phone. Resident #10 stated CNA #235 yelled at her to get off the phone, because it wasn't important. Resident #10 stated CNA #235 continued to yell and tell her to get a shower, so Resident #10 stated she started yelling back. Resident #10 stated Resident #10 tried to tell the Administrator but he said he would come and talk to her later. Resident #10 sated the Administrator never did talked to her about the incident.</p> <p>Interview on 06/10/25 at 3:15 P.M. with the Administrator stated he was not aware of Resident #10's accusations of a CNA #235 being rude, yelling and disrespectful to her. The Administrator stated Resident #10 did ask to speak with him earlier in the day and he told her not right now, that he would talk to her later. The Administrator stated Resident #10's case manager was in the facility and she didn't report any concerns during the meeting.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/11/25 at 8:35 A.M. with CNA #235 confirmed she was yelling at Resident #10 on 06/09/25 because she was far away from Resident #10 and wanted to know about her shower. CNA #235 stated she did tell Resident #10 to hang up the phone. CNA #235 confirmed she didn't believe Resident #10, so she told Resident #10 to get off the phone and told Resident #10 that the phone call wasn't important.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166394.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observations, resident and staff interviews, and policy review, the facility failed to maintain a comfortable and home-like environment by ensuring heating/air conditioning units in resident rooms were properly functioning. This affected five (#10, #12, #35, #36, and #43) out of ten residents reviewed for complaints of air conditioning not working. The facility census was 49.</p> <p>Findings include:</p> <p>Interview on 06/10/25 at 8:36 A.M. with Resident #12 stated the heating/air conditioner unit does not work in her room.</p> <p>Interview on 06/10/25 at 9:25 A.M. with Maintenance Supervisor (MS) #212 stated the heating/air conditioning units in all residents rooms are working. MS #212 confirmed resident could control the heating/air conditioning in their rooms.</p> <p>Interview on 06/10/25 at 9:31 A.M. with Resident #35 stated the heating/air conditioner unit does not work in his room.</p> <p>Interview on 06/10/25 at 9:43 A.M. with Resident #10 stated the heating/air conditioner unit does not work in her room.</p> <p>Interview on 06/10/25 at 10:04 A.M. with Resident #36 stated the heating/air conditioner unit does not work in his room.</p> <p>Interview on 06/10/25 at 10:46 A.M. with Resident #43 stated the heating/air conditioner unit does not work in her room.</p> <p>Observations and interview on 06/11/25 at 11:53 A.M. with MS #212 confirmed the heating/air unit conditioning units in the Resident #10, #12, #35, and #43's room was not properly functioning. MS #212 confirmed the heating/air conditioning unit in Resident #36's room is working but not blowing strong enough and needs repaired as well.</p> <p>Review of the Room Temperatures policy dated 07/2020 revealed air conditioning repairs and/or modifications will be completed as soon as possible.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00166394 and Complaint Number OH00166394. This deficiency represents ongoing noncompliance from the survey dated 06/04/25.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medication record review, staff interview, and policy review, the facility failed to ensure a resident's pain was adequately control. This affected one (#19) out of three residents reviewed for pain. The facility census was 49.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #19 revealed an admission date of 05/22/25 with diagnoses of quadriplegia, essential (primary) hypertension, type 2 diabetes mellitus with hypoglycemia without coma, polyneuropathy and chronic obstructive pulmonary disease.</p> <p>Review of the care plan dated 05/22/25 revealed resident is at risk for pain related to diagnoses of polyneuropathy, history of displaced Bimalleolar fracture of the right lower extremity with interventions of administer medication as ordered, monitor for pain every shift, and notify physician as needed.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #19 had moderate cognitive impairment. Resident required supervision assistance with eating, oral hygiene, wheelchair mobility, required substantial assistance with bathing, personal hygiene, bed mobility, and transfers and resident was dependent on staff assistance with toileting hygiene and dressing.</p> <p>Review of Resident #19's physician order dated 05/22/25 revealed an order for Acetaminophen Tablet 325 mg give 2 tablet by mouth every 6 hours as needed for pain/discomfort.</p> <p>Review of Resident #19's physician order dated 05/23/25 revealed an order for Aspirin Oral Tablet 325 mg give 1 tablet by mouth one time a day for pain.</p> <p>Review of Resident #19's physician order dated 06/04/25 revealed an order for an appointment with the Pain Center on 06/26/25 at 2:15 P.M. for pain.</p> <p>Review of the progress note dated 06/04/25 at 3:57 P.M. revealed the Pain Center called facility stating Resident #19 has been accepted as a new patient and may now be scheduled. Appointment scheduled for 06/26/25 at 2:15 P.M.</p> <p>Review of the pain levels revealed on 06/09/25 at 9:51 A.M. revealed Resident #19 reported a pain level of a seven out of 10. On 06/10/25 at 8:11 A.M. Resident #19 reported a pain level of eight out of 10.</p> <p>Review of the Medication Administration Record (MAR) for June 2025 revealed Resident #19 did not receive any pain medication on 06/09/25 at 9:51 A.M. and resident did not received pain medication 06/10/25 at 8:11 A.M. Further review of Resident #19's medical record revealed there was no documentation on non-pharmacological pain interventions being offered/implemented.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/11/25 at 1:28 P.M. with the Director of Nursing (DON) confirmed Resident #19 had a pain level on 06/09/25 at 9:51 A.M. of seven and did not receive any pain medication. The DON also confirmed on 06/10/25 at 8:11 A.M. had a pain level of eight and did not receive any pain medication. The DON confirmed there was no documentation on non-pharmacological pain interventions being offered/implemented. The DON confirmed Resident #19 is receiving a daily Aspirin 325 mg but that is not for pain and should not be listed with a diagnoses of pain. The DON confirmed Resident #19 has not received any pain medication since admission. The DON confirmed Resident #19 has pain and is going to be seen at the pain clinic on 06/26/25.</p> <p>Review of the Pain Assessment and Management Policy dated March 2015 revealed the purposes is to help the staff identify pain in the resident, and to develop interventions to meet the resident's goals.</p> <p>This 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** Based on medical record review, staff interviews, and policy review, the facility failed to ensure Resident #10's medications were administered as ordered and failed to ensure Resident #46's pain medication was timely reordered/available for administration. This affected two (#10 and #46) out of six residents reviewed for medication administration. The facility census was 49.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #10 revealed an admission date of 05/30/25 with diagnoses of chronic obstructive pulmonary disease, edema, post-traumatic stress disorder, and essential (primary) hypertension.</p> <p>Review of the care plan dated 05/30/25 revealed Resident #10 is at risk for altered cardiac output related to diagnosis of hypertension with interventions of administer medication as ordered and obtain Vital signs as ordered and as needed (PRN). Notify physician as needed.</p> <p>Review of the Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively intact. Resident required supervision assistance with all activities of daily living (ADL's).</p> <p>Review of Resident #10's hospital Continuity of Care form for discharge back to the facility dated 06/05/25 revealed and order for Olmesartan Medoxomil Oral Tablet 20 mg give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure of 100 or less.</p> <p>Review of Resident #10's physician orders revealed an order dated 06/06/25 at 6:00 A.M. for Olmesartan Medoxomil Oral Tablet 20 mg give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure of 100 or less.</p> <p>Review of the documented blood pressures for Resident #10 revealed on 05/30/25 at 12:52 P.M. the resident's blood pressure was 129/75, on 06/06/25 at 4:42 A.M. the resident's blood pressure was 136/73, and on 06/10/25 at 11:11 A.M. the resident's blood pressure was 136/73.</p> <p>Review of the medication administration record for June 2025 revealed on Resident #10's Olmesartan Medoxomil Oral Tablet 20 mg 1 tablet was administered to the resident with no blood pressure listed on 06/06/25 at 6:00 A.M., on 06/07/25 at 6:00 A.M., on 06/08/25 at 6:00 A.M., on 06/09/25 at 6:00 A.M. and on 06/10/25 at 6:00 A.M.</p> <p>Interview on 06/11/25 at 1:28 P.M. with the Director of Nursing (DON) confirmed Resident #10 had an order when she returned from the hospital dated 06/06/25 for Olmesartan Medoxomil Oral Tablet 20 mg give 1 tablet by mouth one time a day for hypertension hold for systolic blood pressure of 100 or less. The DON confirmed that blood pressures were not monitored when medication was administered.</p> <p>2. Review of the medical record for Resident #46 revealed a re-admission date of 05/31/25 with diagnoses of right lower quadrant pain, schizoaffective disorder, bipolar type, anxiety disorder, and essential (primary) hypertension.</p> <p>(continued on next page)</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>Review of the care plan dated 04/18/24 revealed Resident #46 was at risk for pain related to hemiplegia with interventions of administer medication as ordered monitor for pain every shift, and notify physician as needed.</p> <p>Review of the Discharge Return Anticipated MDS dated [DATE] revealed Resident #46 was independent regarding tasks of daily life. Resident #46 required supervision assistance with eating, oral hygiene, bed mobility, transfers, and wheelchair mobility and required partial assistance with toileting hygiene, bathing, dressing, and personal hygiene. Resident #46 received scheduled pain medication regimen and received as needed pain medications.</p> <p>Review of Resident #46's physician order dated 05/21/25 revealed an order for Norco Oral Tablet 5-325 mg give one tablet by mouth every six hours for Pain.</p> <p>Review of the progress notes revealed a note dated 06/06/25 at 1:52 P.M. revealed Tylenol Oral Capsule 325 mg two tablets given due to complaints of pain in back.</p> <p>Review of the progress notes revealed a note dated 06/06/25 at 6:41 P.M. revealed Norco Oral Tablet 5-325 mg medication on order, contacted physician and pharmacy for estimated time of arrival (ETA).</p> <p>Review of the progress notes revealed a note dated 06/06/25 at 10:38 P.M. revealed Tylenol Oral Capsule 325 mg two tablets given for pain. Ineffective, follow-up pain level six out of 10.</p> <p>Review of the progress notes revealed a note dated 06/06/2025 at 11:00 P.M. revealed Norco Oral Tablet 5-325 mg medication not available.</p> <p>Review of the progress notes revealed a note dated 06/07/25 at 05:11 A.M. revealed Norco Oral Tablet 5-325 mg medication not available.</p> <p>Review of the progress notes revealed a note dated 06/09/25 at 12:28 P.M. regarding Norco Oral Tablet 5-325 mg, left a message for physician regarding the need for a new script.</p> <p>Review of the progress notes revealed a note dated 06/09/25 at 1:24 P.M. revealed Tylenol Oral Capsule 325 mg two tablets given for complaints of pain.</p> <p>Review of the progress notes revealed a note dated 06/09/25 at 4:52 P.M. revealed Tylenol Oral Capsule 325 mg two tablets given was effective with a follow up pain level of three out of 10.</p> <p>Review of the progress notes revealed a note dated 06/09/25 at 5:00 P.M. regarding Norco Oral Tablet 5-325 mg, awaiting new order from the physician.</p> <p>Review of the progress notes revealed a note dated 06/10/25 at 2:58 A.M. regarding Norco Oral Tablet 5-325 mg, awaiting medication delivery.</p> <p>Review of the progress notes revealed a note dated 06/10/25 at 6:34 A.M. regarding Norco Oral Tablet 5-325 mg, awaiting medication delivery.</p> <p>Review of the progress notes revealed a note dated 06/10/25 at 1:07 P.M. regarding Norco Oral Tablet 5-325 mg, medication unavailable awaiting delivery from pharmacy.</p> <p>(continued on next page)</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>Review of the Controlled Drug Record for Resident #46 revealed the last Norco 5-325 mg tablet was last administered on 06/05/25 at 12:21 P.M.</p> <p>Interview on 06/10/25 at 1:38 P.M. with Registered Nurse (RN) #293 confirmed Resident #46 has been without Norco 5-325 mg for a week and the resident has stomach pain.</p> <p>Interview on 06/10/25 at 1:40 P.M. with Nurse Practitioner (NP) #289 confirmed she was not aware of Resident #46 being out of Norco 5-325 mg tablets since 06/05/25.</p> <p>Review of the Administering Medications policy dated 12/2012 revealed medications will be administered in a safe and timely manner, and as prescribed.</p> <p>This deficiency represents non-compliance investigated under Master Complaint OH00166390 and Complaint OH00166394.</p>		