

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 12/22/2025
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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, resident interview, staff interview and policy review, the facility failed to accommodate the residents who wanted to eat in the dining room. This had the potential to affect 25 residents who the facility identified as receiving meals from the kitchen and were able to eat in the dining room. The facility census was 33. Findings include: Review of Resident #23's medical record revealed an admission date of 10/23/20. Diagnoses included bipolar disorder, type two diabetes mellitus, schizoaffective disorder, peripheral vascular disease, hyperlipidemia, extrapyramidal and movement disorder and cardiac murmur. Review of quarterly Minimum Data Set (MDS) assessment for Resident #23 revealed she was cognitively intact, and she was independent with eating. Observation of the main entrance of the facility which included the resident's dining room during entrance on 12/17/25 at 8:36 A.M., revealed the air temperature felt very cool. Observation of the facility on 12/17/25 at 9:00 A.M. with Maintenance Director (MD) #06, revealed the MD #06 used a hand-held infrared thermometer and recorded temperatures in the main entrance between 51.2 and 56.5 degrees Fahrenheit (F). These areas included the main entrance of the facility, the administration offices, the resident's dining room, common hallways leading to the resident's rooms, the chapel and a common gathering room. Observation revealed two auxiliary fireplace looking heaters in the dining room and an additional auxiliary fireplace looking heater in the common gathering area. Interview with MD #06 at the same time verified the temperatures and verified the auxiliary heaters were being used for additional heat sources. Observation of the boiler room in the basement of the facility on 12/17/25 at 9:55 A.M. with MD #06, revealed the boiler was not in working condition. The boiler unit was permanently shut off, and the main panel was opened with exposed wires. MD #06 stated the non-functioning boiler system was linked to the main entrance of the facility which included the administration offices, Secured Behavioral Unit (100 Hall), resident's dining room, hallways leading to the resident's rooms, the chapel and a common gathering room. Interview on 12/17/25 at 1:15 P.M., Activities Aid (AA) #08 stated the facility had been having issues with facility temperatures for years and the dining room had not been used for eating or activities for two years with the exception of this year's Thanksgiving dinner with friends and family when the facility used auxiliary heaters to heat the dining room. Observation of meal services on 12/17/25 and 12/18/25, revealed the residents did not utilize the facility dining room. All the meal trays were served in the residents' rooms. Subsequent observation of the facility on 12/18/25 at 10:10 A.M. revealed MD #06 recorded a chapel temperature of 53.7 degrees F, a dining room temperature of 51.8 degrees F and a common gathering room temperature of 54.4 degrees F. Interview with MD #06 at the same time verified the temperatures. Interview on 12/18/25 at 10:25 A.M., Resident #23 stated she would enjoy eating in the dining room again; but it's too cold. Interview with Residents #12, #18, #25 and #29 at the same time, all expressed a desire to eat in the dining room if the temperatures were comfortable. Interview on 12/18/25 at 11:55 A.M. the Administrator stated the hallways, and common areas were not affecting resident care, so heating those areas was not a priority. These areas included the dining room, Secured Behavioral Unit (100 Hall), chapel, common gathering room, dietary/kitchen and the front administration offices. The Administrator stated the dining room had been closed for at least two years due to the boiler that controls these areas not being functional. The Administrator stated the costs for a replacement rooftop boiler/ Heating and Ventilation Air Conditioning (HVAC) system would be more than \$900,000, so the facility owners opted to focus on the resident rooms. This deficiency represents noncompliance investigated under Master Complaint Number 2694504.</p>		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>Based on record review, staff interviews, and review of personnel files, the facility failed to ensure the Activities Program was directed by a qualified Activity Director (AD). This had the potential to affect 32 residents interested in and/or actively participating in activities. The facility census was 33. Findings include: Review of Resident Council meeting attendance sheets revealed AD #10 did not sign the attendance forms for 09/18/25, 10/23/25 and 11/20/25. The meetings were facilitated and signed by Activities Aid (AA) #08. Interview on 12/17/25 at 12:45 P.M., Director of Nursing (DON) stated she had not been informed of any concerns expressed by the residents at the Resident Council meetings from September, October or November 2025, and it was the responsibility of the activities staff to keep the facility management informed of any resident concerns. The DON stated she had no knowledge if AD #10 met the qualifications to be the Activities Director. Interview on 12/17/25 at 1:15 P.M., AA #08 stated she attended the Resident Council meetings and had been recording the meeting minutes in a binder in the activities office. AA #08 stated she was just informed today that she was responsible for making copies of the meeting minutes and sharing them with the facility management. Review of the personnel record for the AD #10 on 12/18/25 at 3:00 P.M., revealed she was hired in February 2025 as social services staff. There was no documented evidence to verify AD #10 had a certification or the appropriate training and/or education to hold the position of AD. Interview on 12/18/25 at 3:30 P.M., AD#10 stated she was hired in February 2025 as a social services staff and was asked to take over as the Activities Director in May 2025. AD #10 stated she was going to enroll in the program for Activities Director; however, the facility changed ownership and she couldn't get enrolled. AD #10 verified she didn't meet the requirements to be the Activities Director. This deficiency represents non-compliance investigated under Complaint Number 2685159.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, facility policy review and staff interview, the facility failed to ensure all essential mechanical equipment (boiler) was maintained in a functional and safe operating condition. This had the potential to affect all 33 residents residing in the facility. Findings Include: Observation of the main entrance of the facility during entrance on 12/17/25 at 8:36 A.M., revealed the air temperature felt very cool. Observation of the facility on 12/17/25 at 9:00 A.M. with Maintenance Director (MD) #06, revealed the MD #06 used a hand-held infrared thermometer and recorded temperatures in the main entrance between 51.2 and 56.5 degrees Fahrenheit (F). These areas included the main entrance of the facility, the administration offices, the resident 's dining room, common hallways leading to the resident 's rooms, the chapel and a common gathering room. Observation revealed two auxiliary fireplace looking heaters in the dining room and an additional auxiliary fireplace looking heater in the common gathering area. Interview with MD #06 at the same time verified the temperatures and verified the auxiliary heaters were being used for additional heat sources. Observation also revealed residents were ambulating or self-propelling themselves in the main hallway. Some had winter coats, sweatshirts, hats and a few were wrapped up in blankets. Additional observations of the Secured Behavioral Unit (100 Hall), revealed temperatures in the common areas from 48.5 degrees F to 56.6 degrees F and on the 200 hall, a temperature of 61.6 degrees F was recorded. Interview at the same time with MD #06 verified the temperatures. Observation of the Secured Behavioral Unit (100 hall) on 12/17/25 at 9:40 A.M. with MD #06, revealed the main hall was 60.4 degrees F, the lounge common area at the end of the hallway was 48.5 degrees F, and the television room temperature was 56.6 degrees F. There was one portable heating unit present in the hallway near the lounge area. The residents were observed in the secure behavioral unit in coats, sweatshirts and a few wrapped in blankets. Interview at the same time with MD #06 verified the temperatures. Observation of the boiler room in the basement of the facility on 12/17/25 at 9:55 A.M. with MD #06, revealed the boiler was not in working condition. The boiler unit was permanently shut off, and the main panel was opened with exposed wires. MD #06 stated the non-functioning boiler system was linked to the main entrance of the facility which included the administration offices, Secured Behavioral Unit (100 Hall), resident's dining room, hallways leading to the resident's rooms, the chapel and a common gathering room. Interview on 12/17/25 at 1:55 P.M., the Administrator verified the boiler system in the basement was not functional and it was linked to the front portion of the facility. The ED stated that the facility addressed the lack of heat by installing Packaged Terminal Air Conditioner (PTAC) units in all the resident rooms where the residents had the option to control the temperature in their rooms; however, the facility didn't address the heat issues in the common areas where the boiler was linked. During a subsequent observation of the Secure Behavioral Unit on 12/18/25 at 9:16 A.M. with Administrator and MD #06, revealed air temperatures continued to be below 71 degrees F. A check of room air temperatures revealed a main hall temperature of 63.8 degrees F, lounge common area was 53.3 degrees F, and the television room was 59.2 degrees F. A portable heating unit was present in the rear of the hallway; however, it appeared to not be working properly. MD #06 stated he had had to keep resetting the portable unit. Interview at the same time with MD #06 and the Administrator verified the temperatures were below 71 degrees F. Observation of Resident #03's room with MD #06, revealed MD #06 recorded a temperature of 68.8 degrees F; however, the PTAC unit on the wall showed the temperature in the room was 84 degrees. MD #06 verified the discrepancy and stated the unit might need to be reset because he had to reset some of the PTAC units because they were not working correctly. Interview at the same time, Resident #03 was in his bed under a blanket and stated he had to use a blanket when he got cold. Subsequent observation of the facility on 12/18/25 at 10:10 A.M. revealed MD #06 recorded a chapel temperature of 53.7 degrees F, a dining room temperature of 51.8 degrees F and a common gathering room temperature of 54.4 degrees F. Interview with Maintenance Director #06 at the same time verified the temperatures. Subsequent interview with the Administrator on 12/18/25 at 11:55 A.M. stated the hallways, and common areas were not affecting resident care, so heating those areas was not a priority. These areas included the dining room, Secured Behavioral Unit (100 Hall), chapel, common gathering room, dietary/kitchen and the front administration offices. The Administrator stated the dining room had been closed for at least two years due to the boiler that controls these areas not being functional. The Administrator stated the costs for a replacement rooftop boiler/ Heating and Ventilation Air Conditioning (HVAC) system would be more than \$900,000, so the facility owners opted to focus on the resident rooms. Review of the facility's policy titled Room Temperature dated revised</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>(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>Based on observation, staff and resident interviews, and review of facility policy, the facility failed to ensure air temperatures were maintained within comfortable ranges for the residents. This affected all 33 residents residing in the facility. The facility census was 33. Findings include: Observation of the main entrance of the facility during entrance on 12/17/25 at 8:36 A.M., revealed the air temperature felt very cool. Observation of the facility on 12/17/25 at 9:00 A.M. with Maintenance Director (MD) #06, revealed the MD #06 used a hand-held infrared thermometer and recorded temperatures in the main entrance between 51.2 and 56.5 degrees Fahrenheit (F). These areas included the main entrance of the facility, the administration offices, the resident 's dining room, common hallways leading to the resident 's rooms, the chapel and a common gathering room. 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