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	07/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on record review, observation, staff interview, and review of facility policy, the facility failed to ensure residents were provided with dignity and respect. This affected two (#17 and #33) residents of the five residents reviewed for dignity and respect. The facility census was 52. Findings included: 1. Review of the medical record for Resident #33 revealed the resident was admitted on [DATE]. Diagnoses included type two diabetes, schizophrenia, candidiasis, cerebral infarction, and overactive bladder. Review of the plan of care dated 05/06/24, revealed Resident #33 had an indwelling catheter related to obstructive and reflux uropathy. Interventions included change catheter bag as needed, document urine output, observe catheter for any kinks, and staff to provide catheter care every shift. Review of Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #33 had Brief Interview Mental Status (BIMS) of 15 which indicated he was cognitively intact. Observation of Resident #33 in his bed on 07/08/24 at 1:50 P.M., revealed a very full urinary Foley bag hanging on right side of bed and visible from the hallway where other residents were walking by. Interview State tested Nursing Assistant (STNA) #308 on 07/08/24 at 1:58 P.M., verified Resident #33's urinary catheter Foley bag was full, was visible by other residents and it did not have a dignity bag covering it. 2. Review of medical record for Resident #17 revealed the resident was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), paranoid schizophrenia, major depression, and schizoaffective disorder. Review of MDS assessment dated [DATE] revealed Resident #17 had a BIMS of 10 which indicated she was cognitively impaired. Resident #17 required substantial maximal assistance for activities of daily living (ADLs). (continued on next page)

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	07/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care for Resident #17 dated 06/20/24, revealed the resident had a risk for decline in ADLs related to paranoid schizophrenia, COPD, heart disease, and osteoarthritis. Interventions included allowing time for rest breaks, encourage resident to participate while performing ADLs, staff to anticipate needs, and encourage the resident to attend activities and assist as needed. Observation of Resident #17 on 07/11/24 at 1:47 P.M., revealed the resident was seated in a wheelchair talking on the phone at the nurse's station with a blue hospital type gown on and it was not tied at the neck. Resident #17's hospital gown was draped low on her shoulders revealing her entire bare back. Resident #17's buttocks were also exposed and sticking out the back open side of the wheelchair. Other residents were observed passing by the nurse's station. Interview with Licensed Practical Nurse (LPN) #385 on 07/11/24 at 1:50 P.M., verified Resident #17 was seated in her wheelchair in the common area with her back and buttocks exposed. LPN #385 she would get an Aide to assist Resident #17. Continued observation of Resident #17 on 07/11/24 at 2:00 P.M., revealed the resident was seated in a wheelchair in the hallway with her back and buttocks still exposed as LPN #385 was brushing the resident's hair. Interview with LPN #385 at the same time, revealed she was waiting on an Aide to get Resident #17 and take her back to her room to get her dressed. Review of the facility document titled Residents Rights dated 10/03/23 revealed that the resident had the right to be treated at all times with courtesy, respect, dignity and individuality. This deficiency represents non-compliance investigated under Complaint Numbers OH00155134, OH00155040 and OH00154641. .

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	07/23/2024

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 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. 44080 Based on observations, resident and staff interviews, and review of facility policy, the facility failed to ensure a clean, safe, comfortable environment for all residents. This affected 32(#01, #02, #03, #05, #06, #08, #09, #10, #12, #17, #18, #19, #22, #23, #27, #29, #30, #31, #32, #35, #36, #37, #41, #42, #44, #46, #47, #49, #50, #51, #53, and #54) of the 52 residents observed for environment. The facility census was 52. Findings include: 1. Observation of the secured Memory Care Unit (MCU) on 07/08/24 at 10:20 A.M. with State tested Nursing Assistant (STNA) #341, revealed a very dirty, upswept, light brown laminate wood floors that were 80 percent (%) stained with black coloring throughout the middle of the hall. The entire floor had food crumbs scattered throughout the halls, soda cans and other trash debris in the floor. Interview with STNA #341 on 07/08/24 at 10:28 A.M., verified the environmental conditions of the secured MCU. 42731 2. Observation of Resident #44's room on 07/08/24 at 11:40 A.M., revealed the resident's room felt warm. Interview with Resident #44 at the same time, stated her room had been warm for a few days. Resident #44 stated there was no air conditioning in her room and woke up that morning and her head was soaked from sweat. Resident #44 was observed laying on her bed. Observation on 07/08/24 at 12:54 P.M., Housekeeping Assistant (HA) #306 utilized a hand-held thermometer to check the temperature of Resident #44's room. The room temperature was observed to be 82 degrees Fahrenheit (F) by the resident's bed and the ceiling vent in the center of the room was observed at 83 degrees Fahrenheit. HA #306 adjusted the thermostat in the resident's room, stating it was set at 75 degrees Fahrenheit and he turned it down to 50 degrees Fahrenheit. A second check of the ceiling vent was conducted immediately following and the room was observed at 85 degrees Fahrenheit. Interview on 07/08/24 at 12:55 P.M., HA #306 confirmed the temperature in Resident #44's room felt warm and the temperature should be maintained between 71 and 81 degrees Fahrenheit. HA #306 further stated he checked the temperature in Resident #44's room earlier that day and it was 76 degrees Fahrenheit. (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	07/23/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the common area between the 400 and 500 halls on 07/16/24 at 8:00 A.M. with Licensed Practical Nurse (LPN) #385, revealed five large buckets on the floor, all containing water. The ceiling panels above the buckets were observed to be brown-stained, bulging, and actively leaking water into the buckets. Further observation revealed the open room adjacent to the common area had two trash cans sitting on top of the table. Both trash cans contained water and the ceiling panels directly above the trash cans were brown-stained, bulging, and actively leaking water into the trash cans. Interview with LPN #385 at the same time stated the ceiling had been leaking for several months and the trash cans collected the water. LPN #385 stated it always leaked following a rain. LPN #385 affirmed the room adjacent to the common area where trash cans were sitting on the tables, was a common area for residents to congregate as desired. Observation on 07/16/25 at 8:05 A.M., STNA #332 walked by the common area, observed the buckets and trash cans, and stated, Oh, that's leaking again, and continued to walk down the hall. Interview on 07/16/24 at 8:09 A.M., Maintenance Supervisor (MS) #363 confirmed the ceiling in the common area and adjacent room was brown stained, bulging, and actively leaking water into the buckets and trashcans. MS #363 stated the observed areas had been leaking for approximately one to two weeks. MS #363 stated he had been chasing leaks throughout the building and the areas in the roof needed to be repaired. 47988 3. Observation of the facility's outdoor environment on 07/11/24, 07/15/2024 and 07/16/24, revealed unkept lawn, patio (smoking area), empty plastic bottles, black plastic/fabric pieces strewn across the patio area, decaying tree branches above the patio and seating area with residents wheeling/walking across areas of tree bark on the concrete of the patio area. Overgrown landscaping with tall weeds making the pathway difficult to navigate because of the height, and the vegetation in the pathway of the walking path. Interview on 07/16/24 at approximately 1:48 P.M. with STNA #341, revealed concerns over the lack of landscaping and lawn care provided to the outdoor space for the residents. STNA #341 verified that the vegetation from overgrown grass, weeds and decaying tree branch materials covered areas on the walking pathways. Further verified a large dead tree branch that was over top of the seating area for residents. Stated a concern for branch to fall and cause injury to residents or staff. STNA #341 stated the lawn was about a foot high and did not know the last time it was mowed. Interview with Resident #29 on 07/16/24 at 10:40 A.M. stated that when she is outside on the smoking area (outdoor patio), she is unable to propel herself around the outdoor space because of the weeds and grass covering the pathway. While looking out the window to the patio area, Resident #29 gestured towards the grass, and vegetation covering the sidewalks. Further pointing to the trash allover gesturing toward empty plastic bottles, back plastic/fabric pieces laying in the sidewalk areas and non-organic debris in landscaping and in grass. Interview with administrator on 07/16/24 at approximately 2:40 P.M., verified the conditions outside and stated the facility should provide a safe and homelike environment for all their residents. Review of the facility policy titled Housekeeping Services Policy & Procedure, dated 01/01/16, revealed residents would be provided with housekeeping services on a regularly scheduled basis. (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	07/23/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency is a recite to complaint surveys completed on 04/11/24 and 06/06/24. This deficiency represents non-compliance investigated under Complaint Numbers OH00155134 and OH00154641.

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	07/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on medical record review, staff and Guardian interview, observations, review of emergency room (ER) records, review of witness statements, review of Self-Reported Incidents (SRI's) and review of the facility policy, the facility failed to provide adequate supervision to prevent resident-to-resident sexual abuse. This affected two (#29 and #43) of the ten residents reviewed for abuse. The facility census was 52 residents. Findings include: 1. Review of the medical record for Resident #29 revealed the resident was admitted on [DATE]. Diagnoses included, but not limited to, hemiplegia and hemiparesis following a cerebrovascular disease, paranoid schizophrenia, schizoaffective disorders old myocardial infarction, seizure disorder, Bechet's disease, generalized anxiety, insomnia, bipolar disorder and major depression. Review of 2018 court documents titled Appointment of Guardian for Incompetent Person revealed Resident #29 was identified by the [NAME] County Probate Court as being incompetent of person and had a court appointed Guardian. Review of a behavior note for Resident #29 dated 03/08/24 at 2:30 A.M. and recorded as a late entry by an unknown nurse, revealed the Director of Nursing (DON) was notified that a male resident (facility identified Resident #42) was in Resident #29's room. The male resident was caught in the resident's room again while the nurse was passing medications in another hall. Resident #29's dentures were out and attempting to give oral sex to the male resident. Resident #29 progress notes revealed no documented evidence that the resident's guardian and the physician were notified. Review of facility document, titled Am I Ready for Sex signed by Resident #29 on 03/11/24 and witnessed by Social Services Designee (SSD) #376 indicated sex is a choice and, revealed some residents are not able to give informed consent, which means they do not understand the potential risks of the behavior. If a resident is not able to give informed consent, you are not permitted to be intimate with a resident, including hugging kissing or any other type of intimacy. If you continue to be intimate with such a resident, even after you have been informed, it's not appropriate and you may be given a discharge notice and assisted to find another facility. It is also possible the family or legal representative of the other resident will notify the police that they believe you are taking advantage of the other resident. Review of plan of care for Resident #29 revised on 04/06/24, revealed the resident has potential for behavior problems related to preferred to engage in sexual activity with other male residents and the resident makes false allegations against staff and other residents at times. Resident #29 has history of stripping clothing in the common area and the resident will perform oral stimulation to male residents in exchange for money and cigarettes. Interventions in place for staff to redirect resident as able, one-on-one (1:1) observation as needed, and educate the resident to remain clothed in common areas. (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	07/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had a Brief Interview Mental Status (BIMS) score of 11 indicating cognitive impairment. The assessment revealed no physical behavior symptoms, verbal behavior symptoms, or other behavior symptoms were indicated. Interview with Resident #29's Guardian on 07/11/24 at approximately 12:37 P.M., revealed after the resident had an acute illness, it caused damage to the resident's brain, and the resident was left with the inability to make or understand decisions about her care or her body. Resident #29's Guardian stated she had concerns with the facility allowing Resident #29 to have sexual encounters with other residents on a regular basis and the lack of investigating those incidents. Resident #29's Guardian stated the resident could not make sexual decisions with other residents, nor did he want her to have any sexual contact with any other persons because of her inability to make the appropriate decisions which was determined by the court. Interview with SSD #376 on 07/15/24 at approximately 1:00 P.M., revealed after the sexual incident between Residents #42 and #29 on 03/08/24, she provided Resident #29 with a guide titled, Am I ready for sex to which she had Resident #29 sign. SSD #376 verified Resident #29's guardian did not want her to have any sexual contact with any resident. SSD #376 also verified she witnessed the document. Interview with State tested Nursing Assistant (STNA) #332 on 07/16/24 at 8:54 A.M., revealed Resident #29 had multiple sexual encounters with a variety of different residents. STNA #332 stated that almost on a weekly basis, Resident #29 was caught or suspected of a sexual encounter with other residents. STNA #332 stated she has even caught Resident #42 back in Resident #29's room after he was placed off of the secured unit because he knew the code to the door. STNA #332 stated she reports the incidents every time to the nurse as required to do per policy. Interview with the Director of Nursing (DON) on 07/16/24 at approximately 1:35 P.M., revealed the police were never notified of the sexual incident between Residents #29 and #42 on 03/08/24. The DON stated Resident #29 had the mental capacity of a [AGE] year old girl and she could not consent to sexual activities. The DON stated they could not watch Resident #29 all the time and she has had previous sexual encounters with other Residents. The DON verified the investigation subsequent to SRI #245069 created on 03/11/24 as physical abuse, did not contain police notification or sexual assault assessment, or investigation consisting of sexual in nature to like residents. The DON also verified an SRI was not created until 03/11/24 despite the incident on 03/08/24. Interview with the Administrator on 07/16/24 at approximately 2:40 P.M., revealed any allegations of abuse should be reported and investigated immediately, and that any allegation of sexual abuse should have law enforcement notified, other residents questioned and provide safety to the residents as well as creating an SRI. Review of the medical record for Resident #42 revealed the resident was admitted on [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, major depressive disorder, major depressive disorder, muscle weakness, type two diabetes mellitus, alcohol abuse, adult failure to thrive, hypertension, depression, alcohol abuse and anemia. (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	07/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care for Resident #42 dated 02/26/24 revealed the resident was at risk for behavior problems, resident will touch himself inappropriately in public areas, around other residents for other people to see. Resident #42 will accept oral stimulation from other female residents in exchange for cigarettes and/or money. Resident #42 makes poor decisions regarding sexual behaviors. Interventions in place include staff to redirect resident as able, staff to perform 15-minute checks on resident, staff to give 1:1 as needed and a goal to have fewer episodes of behavior though the next review. Review of a progress note for Resident #42 dated 03/08/24 revealed no documented evidence of an incident involving Resident #29. Review of a progress note for Resident #42 dated 03/11/24 at 10:24 A.M., revealed the team met for a behavior follow up. Resident #42 has been smoking in his room and common area. Resident #42 has been argumentative and still displays sexual behaviors. Review of a Social Services note for Resident #42 dated 03/12/24, revealed SSD #376 met with the resident to discuss his sexual behaviors and to talk about the pros and cons of having unprotected sex. Resident #42 stated he knew what he was doing and signed the paper. Review of a Social Services note for Resident #42 dated 03/14/24 at 5:00 P.M. and recorded as a late entry by SSD #376, revealed the resident was moved back to the Memory Care Unit because of sexual behavior. The resident was threatening to knock everybody's head off. Review of a quarterly MDS assessment for Resident #42 dated 05/06/24 revealed a BIMS score of 15 indicating cognitively intact and no behaviors were assessed. 2. Review of a closed record for Resident #43 revealed admitted [DATE]. Diagnoses included, but not limited to, schizoaffective disorder bipolar type, spinal stenosis, intracranial injury with loss of consciousness, anxiety disorder, depression, mild neurocognitive disorder, hyperlipidemia and post cholecystectomy syndrome. Resident #43 was discharged home on 06/29/24. Review of a nursing progress note for Resident #43 dated 05/10/24 at 10:44 A.M. and authored by the DON, revealed the DON was notified from Human Resources (HR) that Resident #43's power of attorney (POA) called the facility and stated she was notified by and an unnamed source that Resident #43 was witnessed by an STNA in another male resident's room (facility identified as Resident #42) and inappropriately touching one another in a sexual manner. Resident #43 was immediately removed from the room, her hands were washed and taken back to room. (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	07/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ER records for Resident #43 dated 05/10/24 revealed the resident presented to the ER at 1:37 P.M. per Emergency Medical Services (EMS), for complaints of possible sexual assault. According to the EMS, Resident #43 was found having sexual intercourse with another resident. the resident's family was contacted, and they wanted a sexual assault kit to be done as they do not think patient could consent. Resident #43 denied having intercourse. Resident #43 states that she was there to get food from the restaurant for her brother. Resident #43 does have a history of traumatic brain injury (TBI), some chronic problems with memory and dementia as well as a history of agitation. The resident does not provide a reliable history as she was pleasantly confused. The ER called the nursing home, and they reported the resident was found a lot in other resident's beds. There is no documented evidence that Resident #43 had any sexual intercourse due to no one at the facility visualizing anything. No pelvic examination was completed due to history of dementia and agitation, and it was in the best interest of the resident to not put the resident through this examination with a low suspicion and the family members were in agreement. A urinalysis, chlamydia, and gonorrhea test were documented as being provided and the resident returned to the facility. The final impression included worried well examination and a possible STD exposure. Review of the SRI (tracking #247360) created 05/10/24 at 11:36 A.M., revealed Resident #43 and Resident #42 were found inappropriately touching each other while visiting together. The residents were immediately separated and head to toe assessments were completed. Resident #43 was placed on 1:1 supervision to ensure the residents remained separated. The DON notified the physician and the resident's family. Resident #43 has a baseline behavior of wandering in and out of other resident's rooms due to her history of a TBI. Resident #43 is easily redirected by staff. No other residents were involved in the incident. The physician was notified. The residents were interviewed with no recall of the event and no further incident noted between the residents. Staff reported no changes in residents' daily function. The staff were in-serviced on the abuse policy and the procedures. The facility unsubstantiated the allegations of sexual abuse due Resident #43 not able to understand that she is not to go into other resident's room at night or have inappropriate contact with the residents. Also, Resident #42 did not mind Resident #43 coming in his room. Resident #43's family requested for the resident to be sent to the hospital for further evaluation. The resident returned with no clinical concerns. Review of a witness statement dated 05/10/24 authored by STNA #398, revealed she had Resident #43 sitting in the common area. STNA #398 went to get briefs to change another resident and noticed Resident #43 was not located in the common area. STNA #398 went to look for Resident #43 and started in room [ROOM NUMBER], where she found Resident #43 sitting in a chair next to Resident #42 and inappropriately touching Resident #42. STNA #398 removed Resident #43 from Resident #42's room, washed her hands and took Resident #43 back to her room. Review of nursing progress notes for Resident #42 dated 05/10/24, revealed no documentation regarding an incident with Resident #43. Review of Social Services note for Resident #43 dated 5/14/24 at 4:06 P.M. and authored by SSD #376, revealed Resident #43 was found in a male resident's rooms. Resident #43 was asked to come out of the room, she states that her momma drop her off here and where is she supposed to stay. SSD #376 took the resident for a walk and tried explaining that Resident #43 was not allowed to go into male rooms under no circumstance. Resident #43 states that she can go where she wants and proceeded to try to enter another male patient's room, but the resident was able to be redirected. (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	07/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS dated [DATE] revealed Resident #43 had a BIMS score of 08 indicating severe cognitive impairment. Interview with SSD #376 on 07/15/24 at approximately 1:00 P.M. verified Resident #43 was found going in other male rooms after the incident on 05/10/24. Resident#43 was not placed on 1:1 observation after the incident on 05/10/24. SSD #376 noted Resident #43's responsible party expressed concerns before the incident on 05/10/24, of her being on a unit with predominately male residents, and placement on the unit was continued because of a previous elopement. SSD #376 verified Resident #43 would not have been able to consent to any sexual encounters because of her cognition. Interview with STNA #332 on 07/16/24 at 8:54 A.M., revealed a concern over the lack of investigations/care provided after incidents involving abuse allegations were made. STNA #332 stated she reports all incidents of abuse to the nurse but knows nothing about them after that because they never fill out a witness statement about what happened. Interview with the DON on 07/16/24 at approximately 1:35 P.M., verified that Resident #43 was placed back on the secured unit after she returned from the hospital on 05/10/24. The DON verified Resident #43's behavior of wandering into others room continued throughout her stay. The DON stated Resident #42 was placed on the secured unit because of a sexual abuse allegation from another resident. The DON stated the secured unit was for increased supervision but was unable to always provide 1:1 to make sure Resident #43 did not go back into Resident #42's room or other residents rooms. Review of Residents #43's progress notes and physician orders revealed no documented evidence of any increased supervision such as 1:1 supervision, or other safety measures provided immediately following the sexual abuse incident on 05/10/24. Review of facility policy abuse neglect exploitation and misappropriation of resident's property dated 08/10/23 defines sexual abuse as non-consensual sexual contact of any type with a resident. Further review states staff should report all incidents/allegations immediately to the administrator or designee. Residents will be free from sexual abuse. The residents will be assessed and documented of incident in the resident's record. Review of the facility document titled Residents Rights dated 10/03/23 revealed that the resident had the right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, dignity and individuality. This deficiency represents non-compliance investigated under Complaint Number OH00155040.

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	07/23/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observations, record review, resident interview, staff interviews, review of witness statements and policy review, the facility failed to timely implement their abuse policy during allegations of staff-to-resident verbal abuse. This affected one (#18) of the 10 residents sampled for abuse. The facility census was 52. Findings include: Review of the medical record for Resident #18 revealed the resident was admitted to the facility on [DATE]. Diagnoses included unspecified bipolar disorder, unspecified hemiplegia affecting left dominant side, unspecified anxiety disorder, uncomplicated opioid dependence and marijuana abuse, and unspecified Chronic Obstructive Pulmonary Disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact, had verbal behaviors, did not wander, and occasionally rejected care. Review of a witness statement dated 07/17/24 and authored by State tested Nurse Aide (STNA) #360, revealed she went into Resident #18's room at 5:47 A.M. to change Resident #46 (roommate of Resident #18). Resident #18 began cursing and yelling at State tested Nursing Assistant (STNA) #360 to get out because she was too loud. Resident #18 got out of bed, tried to hit STNA #360, and continued yelling racial slurs. STNA #360 said something back to Resident #18 and reported the incident to the nurse. Resident #18 kept cursing and making racial slurs. STNA #360 said something to her again. Review of a witness statement dated 07/17/24 at 8:30 A.M., revealed Registered Nurse (RN) #406 stated around 6:00 A.M., STNA #360 went into Resident #46 and Resident #18's room for patient care. STNA #360 was loud and rude waking up Resident #46. Resident #18 told STNA #360 she was tired of her being rude and told her to shut up. STNA #360 responded by telling Resident #18 not to disrespect her and to shut up. Resident #18 began name-calling. STNA #360 name-called back. Resident #18 tried to hit STNA #360. STNA #360 pushed Resident #18's chair aggressively. In the process, RN #406 asked STNA #360 to calm down and leave the room. RN #406 removed Resident #18 from the room and asked her if she was ok. STNA #360 proceeded to threaten Resident #18 and stated something about losing her job. RN #406 again asked STNA #360 to leave. STNA #360 insisted on writing a witness statement before she left. Resident #18 threatened to report the incident to the State. STNA #360 reported the incident as she was leaving. RN #406 reported the incident to the DON and explained to STNA #360 how to handle the situation in the future, but STNA #360 was not receptive and threatened to quit. Observation of Resident #18 on 07/17/24 at 6:38 A.M., revealed the resident appeared visibly upset. Interview with Resident #18 at the same time, revealed STNA #360 came into her room, turned the lights on and started yelling at her roommate, Resident #46, about being dirty. STNA #360 stated to Resident #46 I just changed you at midnight, why are you dirty again? Resident # 18 stated she got out of bed and confronted STNA #360. Resident #18 stated STNA #360 cursed at her, threatened her, and kept pushing her wheelchair aggressively when the nurse came in the room and pulled Resident #18 out of the room. (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	07/23/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with STNA #360 on 07/17/24 at 7:07 A.M., revealed she went into the room to do patient care on Resident #46. The STNA turned the light on. Resident #18 was yelling, started cussing at her for being too loud, and told her to get out of the room. Resident #18 jumped out of bed, came over, and started swinging at her. STNA #360 indicated she was in the middle of a total bed change and could not leave Resident #46 covered in poop. STNA #360 stated she had last changed Resident #46 at midnight, and when she checked on her at 2:00 AM, Resident #46 was dry. STNA #360 stated she was explaining this to Resident #46. STNA #360 stated her voice is loud and it carries but denied yelling at either resident. STNA #360 stated Resident #18 always jumped in and did this during resident care for Resident #46, like she was being protective of her mother. Resident #18 did this before when STNA #360 worked with her at another facility. Interview with RN #406 on 07/17/24 at 7:18 A.M., revealed she witnessed the entire incident which happened around 6:00 A.M. STNA #360 went into the shared room to give care to Resident #46. STNA #360 went in, turned the light on, and Resident #46 was completely dirty. Resident #46 had not been changed all night long. STNA #360 was changing Resident #46, and her voice was kind of loud. RN #406 stated she had many patient complaints about an STNA but never knew who they were talking about until now. RN #406 stated this night was her first night meeting STNA #360. RN #406 stated Resident #18 was half asleep. Resident #18 was very rude and said, I don't like the way you're talking to her and shut the expletive up. STNA #360 said something back along the lines of ,I was not talking to you. Resident #18 then called her foul names. STNA #360 responded and called Resident #18 foul names back. RN #406 stated she told STNA #360 not to respond to the Resident #18 and offered to take her place to take over care when STNA #360 refused. RN #406 stated she stayed there at the medication cart outside of the room to supervise. Resident #18 got in her chair to go to the bathroom. Resident #18 swung at the STNA but made no physical contact. STNA #360 said, I don't care about my job, I will beat your expletive. At that point RN #406 asked STNA #360 to step out of the room and clock out, which she refused to do. STNA #360 wanted to tell her side of the story. As she was telling her side of the story, STNA #360 threatened Resident #18 again. STNA #360 said to the Resident #18, You are too young to be in the nursing home, you are a crackhead, and no one wants to take care of you. That upset Resident #18 and she started yelling at STNA #360 and calling her names. RN #406 asked STNA #360 to leave again when the STNA said, that isn't right how Resident #18 talked to her. RN #406 stated she educated STNA #360 about her responsibility to remain professional and not participating in verbal abuse. STNA #360 was not receptive. STNA #360 asked if it was ok to write her statement before she left, and RN #406 asked her to write it in her car. RN #406 verified she did not intervene to remove Resident #18 from the room promptly after initially identifying verbal abuse had occurred when STNA #360 responded to Resident #18 with name-calling and profanity. RN #406 verified she did not remove Resident #18 from the room until after Resident #18 tried to make physical contact with STNA #360 and after STNA #360 aggressively pushed Resident #18's wheelchair. RN #406 verified she took no further actions to remove STNA #360 from the property after Resident #306 refused twice to leave or notify the Administration of the abuse situation. Review of policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property dated 08/10/23 revealed: the facility provided supervision of staff to identify inappropriate behaviors such as using derogatory language, immediately remove from the building any staff member who was accused or suspected of abuse of a resident and would respond to protect the resident. This deficiency represents non-compliance investigated under Complaint Number OH00155040.

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	07/23/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on record review, staff interview, observation, review of witness statements, review of the facility policy, and review of Self-Reported Incident (SRI), the facility failed to thoroughly investigate allegations of sexual abuse. This affected one (#29) of the ten residents reviewed for abuse. The facility census was 52. Findings included: Review of the medical record for Resident #29 revealed the resident was admitted on [DATE]. Diagnoses included, but not limited to, hemiplegia and hemiparesis following a cerebrovascular disease, paranoid schizophrenia, schizoaffective disorders old myocardial infarction, seizure disorder, Bechet's disease, generalized anxiety, insomnia, bipolar disorder and major depression. Review of 2018 court documents titled Appointment of Guardian for Incompetent Person revealed Resident #29 was identified by the [NAME] County Probate Court as being incompetent of person and had a court appointed Guardian. Review of a behavior note for Resident #29 dated 03/08/24 at 2:30 A.M. and recorded as a late entry by an unknown nurse, revealed the Director of Nursing (DON) was notified that a male resident (facility identified Resident #42) was in Resident #29's room. The male resident was caught in the resident's room again while the nurse was passing medications in another hall. Resident #29's dentures were out and attempting to give oral sex to the male resident. Resident #29 progress notes revealed no documented evidence that the resident's guardian and the physician were notified and the allegations were investigated. Review of facility document, titled Am I Ready for Sex signed by Resident #29 on 03/11/24 and witnessed by Social Services Designee (SSD) #376 indicated sex is a choice and, revealed some residents are not able to give informed consent, which means they do not understand the potential risks of the behavior. If a resident is not able to give informed consent, you are not permitted to be intimate with a resident, including hugging kissing or any other type of intimacy. If you continue to be intimate with such a resident, even after you have been informed, it's not appropriate and you may be given a discharge notice and assisted to find another facility. It is also possible the family or legal representative of the other resident will notify the police that they believe you are taking advantage of the other resident. Review of plan of care for Resident #29 revised on 04/06/24, revealed the resident has potential for behavior problems related to preferred to engage in sexual activity with other male residents and the resident makes false allegations against staff and other residents at times. Resident #29 has history of stripping clothing in the common area and the resident will perform oral stimulation to male residents in exchange for money and cigarettes. Interventions in place for staff to redirect resident as able, 1:1 observation as needed, and educate the resident to remain clothed in common areas. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #29 had a Brief Interview Mental Status (BIMS) score of 11 indicating cognitive impairment. The assessment revealed no physical behavior symptoms, verbal behavior symptoms, or other behavior symptoms were indicated. (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	07/23/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #29's Guardian on 07/11/24 at approximately 12:37 P.M. revealed after the resident had an acute illness, it caused damage to the resident's brain, and the resident was left with the inability to make or understand decisions about her care or her body. Resident #29's Guardian stated she had concerns with the facility allowing Resident #29 to have sexual encounters with other residents on a regular basis and the lack of investigating those incidents. Resident #29's Guardian stated the resident could not make sexual decisions with other residents, nor did he want her to have any sexual contact with any other persons because of her inability to make the appropriate decisions which was determined by the court. Interview with SSD #376 on 07/15/24 at approximately 1:00 P.M., revealed after the sexual incident between Residents #42 and #29 on 03/08/24, she provided Resident #29 with a guide titled, Am I ready for sex to which she had Resident #29 sign. SSD #376 verified Resident #29's guardian did not want her to have any sexual contact with any resident. SSD #376 also verified she witnessed the document. Interview with State tested Nursing Assistant (STNA) #332 on 07/16/24 at 8:54 A.M., revealed Resident #29 had multiple sexual encounters with a variety of different residents and there was a lack of investigations after the incidents. STNA #332 stated that almost on a weekly basis, Resident #29 was caught or suspected of a sexual encounter with other residents. STNA #332 stated she has even caught Resident #42 back in Resident #29's room after he was placed off of the secured unit because he knew the code to the door. STNA #332 stated she reports the incidents every time to the nurse as required per policy but unknown if the allegations were investigated because the facility never fills out a witness statement about what happened. Interview with DON on 07/16/24 at approximately 1:35 P.M., revealed the police were not notified of the sexual incident between Residents #29 and #42 on 03/08/24. The DON stated Resident #29 had the mental capacity of a [AGE] year old girl and she could not consent to sexual activities. The DON stated they could not watch Resident #29 all the time and she has had previous sexual encounters with other residents. The DON verified the investigation subsequent to SRI #245069 created on 03/11/24 as physical abuse, did not contain police notification or sexual assault assessment, or investigation consisting of sexual abuse in nature to like residents. The DON also verified an investigation, and an SRI was not started until 03/11/24 and should have been started immediately. Interview with the Administrator on 07/16/24 at approximately 2:40 P.M. revealed any allegations of abuse being reported should be investigated immediately, and that any allegations of sexual abuse should have law enforcement notified, resident's representatives/Guardians notified, other residents questioned and ensure safety to the residents as well as creating an SRI. Review of the facility policy dated Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 08/10/23 revealed that all incident and allegations of abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property and all injuries of unknown source must be reported immediately to the Administrator or designee. The investigation must be started immediately and completed within five working days, if there are special circumstances causing the investigation to continue beyond five working days. This deficiency represents non-compliance investigated under Complaint Number OH00155040.

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	07/23/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on resident interviews, staff interviews, review of the medical record, and policy review, the facility failed to hold quarterly care conferences with residents and/or resident's representatives. This affected three (#29, #49 and #51) of the three residents sampled for care conferences. The facility census was 52. Findings include: 1. Review of medical record for Resident #29 revealed the resident was admitted on [DATE]. D diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebrovascular disease, paranoid schizophrenia, schizoaffective disorders old myocardial infarction (heart attack), seizure disorder, Bechet's disease, generalized anxiety, insomnia, bipolar disorder and major depression. Review of 2018 court documents titled Appointment of Guardian for Incompetent Person revealed Resident #29 was identified by the [NAME] County Probate Court as being incompetent of person and had a court appointed Guardian. Review of the Minimum Data Set (MDS) assessment for Resident #29 dated 05/08/24 revealed a Brief Interview Mental Status (BIMS) score of 11 indicating cognitive impairment. Further review of the medical record of Resident #29 revealed the last Interdisciplinary Team (IDT) care conference was held with Resident #29's and Guardian on 03/30/22. Resident #29 medical record revealed no documented evidence a care conferences were completed for the years of 2023 and 2024. There was no documented evidence of notification of scheduled care conferences, refusals to participate in care conferences and /or resident assessments. Interview with Resident #29's Guardian on 07/11/24 at approximately 12:37 P.M., revealed care conferences had not been held for years. Resident #29's Guardian stated he had requested care conferences on multiple occasions to multiple different facility personnel, that he wanted to participate, and schedule a care conference so that he could help to dictate Resident #29's plan of care, but all requests went unanswered. Resident #29's Guardian stated he was unaware of what Resident #29's plan of care said. Interview with Social Services Designee (SSD) #376 on 07/15/24 at approximately 1:00 P.M. verified the only documented care conference with Resident #29 and Guardian was on 03/30/22. SSD #376 verified that Resident #29 and/or her Guardian had not been scheduled or contacted for a care plan conference since she had begun working at the facility, which is about six months. SSD #376 further verified care plan conferences should be held quarterly with each resident's quarterly MDS assessment or as needed as per policy. 42492 (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	07/23/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident # 49 revealed an admitted [DATE] with diagnoses including morbid obesity with alveolar hypoventilation, moderate persistent asthma, and acute diastolic heart failure. Review of the medical record for Resident #49 revealed the resident had a care conference during which the resident's family was present by telephone. There were no other care conferences documented for Resident #49 from 03/07/23 to 07/11/24. Review of the MDS assessment for Resident #49 dated 06/07/2024 revealed the resident was cognitively intact. Interview on 07/11/24 at 2:00 P.M. with Social Services Designee (SSD) #376 confirmed Resident #49 had only one care conference from 03/07/23 to 07/11/24. 3. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), type two diabetes, mild protein calorie malnutrition, ischemic cardiomyopathy, unspecified anxiety disorder, and adjustment disorder with depressed mood. Review of the MDS assessment for Resident #51 dated 06/14/2024 revealed the resident had moderately impaired cognition. Review of the medical record for Resident #49 revealed the resident had care conferences on 10/11/23 and 04/15/24. There were no other care conferences documented for Resident #49 from 09/07/23 to 07/11/24. Review of the medical record revealed Resident #51 had care conferences documented on 10/11/2023 and 04/15/2024. Interview on 07/11/2024 at 2:02 P.M. with SSD #376 confirmed resident care conferences should be held at least quarterly and further confirmed Resident #51 had not received quarterly care conferences. His next care conference was scheduled to occur August 2024. Review of facility policy, Resident participation-assessment/care plans dated 2001 states, social services is responsible for notifying the resident/representative and maintaining records of such notices. Further stated resident or representative's right to participate in the development and implantation of the plan of care including, request meetings, participate in the planning process, be informed in advance of the risks and benefits of care or treatment proposed and have access to and review the care plan.

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	07/23/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42731 Based on medical record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure residents did not have access to knives, razors, and smoking materials and smokers were supervised while smoking. This affected Residents #50, #29, #48 and #107. The facility identified 28 Residents (#01, #03, #04, #07, #09, #16, #18, #19, #20, #21, #22, #24, #27, #30, #31, #34, #35, #37, #38, #40, #41, #42, #44, #48, #50, #51, #53, and #54) who smoked. The facility census was 52. Findings include: 1. Review of the medical record of Resident #50 revealed an admitted [DATE]. Diagnoses included alcoholic cirrhosis of liver with ascites, chronic obstructive pulmonary disease, anxiety, hypertension, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had intact cognition and was independently mobile. Review of the Smoking Assessment for Resident #50 dated 06/12/24 revealed the resident needed the facility to store her lighter and cigarettes. Review of the care plan for Resident #50 dated 09/17/23, revealed the resident was at risk for injury and health risks related to smoking. Interventions included for staff to keep cigarettes, lighters, and matches in a designated area. Review of the medical record of Resident #29 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side, nicotine dependence, paranoid schizophrenia, conversion disorder with seizures or convulsions, behcet's disease, anxiety, cerebral infarction, depression, and bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #29 had moderately impaired cognition and was independently ambulatory. Review of the Smoking Assessment, dated 08/16/23 revealed Resident #29 was unable to light her own cigarette, required supervision, and needed the facility to store lighters and cigarettes. Review of the plan of care for Resident #29 dated 11/19/21, revealed the resident was at risk for injury related to smoking. Interventions included providing supervision while smoking and for staff to keep cigarettes lighter and matches in a designated area. Observation on 07/08/24 at 3:17 P.M. revealed Resident #50 was observed lighting a cigarette for Resident #29 on the facility's smoking patio. Resident #50 then placed the lighter in her walker basket and entered the building. Further observation revealed there were no staff present in the facility's smoking patio to supervise the residents who were smoking. (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	07/23/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 07/08/24 at 3:20 P.M., verified Resident #50 had two lighters and two empty packs of cigarettes in her walker basket. The DON further verified there was no staff present on the facility's smoking patio to supervise residents who were smoking. 2. Review of the medical record of Resident #48 revealed an admitted [DATE]. Diagnoses included repeated falls, bradycardia, chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, senile degeneration of brain, and type 2 diabetes mellitus. Review of the quarterly MDS assessment dated [DATE] revealed Resident #48 had severely impaired cognition and was independently mobile. Review of the Smoking Assessment for Resident #48 dated 05/25/24 revealed the resident required supervision and required the facility to store his lighter and cigarettes. Review of the plan of care for Resident #48 dated 02/12/24, revealed the resident was at risk for injury related to smoking. Interventions included providing supervision at all times for smoking and keeping smoking items at the nurse's station. Observation on 07/11/24 at 8:45 A.M. revealed Resident #48 standing inside the common area next to the outdoor smoking patio. Resident #48 reached in his walker basket and took a cigarette out of a pack he had in the basket and placed it in his mouth. Interview on 07/11/24 at 8:47 A.M. Housekeeping Assistant (HA) #325 verified Resident #48 had cigarettes in his walker basket. Further observation revealed Resident #48 had an additional pack of cigarettes in his walker basket. HA #325 verified Resident #48 was not supposed to carry his own cigarettes. 3. Review of the medical record of Resident #107 revealed an admitted [DATE]. The resident transferred to the hospital on 07/11/24 and did not return to the facility. Diagnoses included right humerus fracture, major depressive disorder, low back pain, chronic bronchitis, suicidal ideations, nicotine dependence, age-related osteoporosis, and hypocalcemia. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #107 had intact cognition. The resident exhibited verbal behavioral symptoms directed towards others during the assessment period. The resident had impaired range of motion on one side of his upper extremities and utilized a wheelchair for mobility. The resident required partial/moderate assistance for transfers. Review of the care plan for Resident #107 dated 06/26/24, revealed the resident was at risk for suicide related to a history of suicidal ideation. Interventions included to allow the resident to express his feelings and offer support. Review of the care plan for Resident #107 dated 06/18/24 revealed the resident was at risk for injury related to smoking. Interventions included for staff to keep cigarettes, lighters, and matches in a designated area. Review of the Smoking Assessment for Resident #107 dated 07/05/24, revealed the resident needed the facility to store his lighter and cigarettes. (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	07/23/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note for Resident #107 dated 06/26/24, revealed the resident voiced concerns of feeling down and depressed. Psychiatric (psych) services had been consulted. The DON and physician were notified, and no new orders were received. Interview on 07/09/24 at 11:06 A.M., Resident#107 stated he smoked cigarettes and kept his cigarettes in his drawer. Resident #107 stated his daughter brought him his cigarettes. Observation on 07/09/24 at 11:09 A.M., State tested Nursing Assistant (STNA) #354 opened Resident #107's dresser drawers and found a large pocketknife, three razors, and a carton of cigarettes, which contained nine packs of cigarettes. Interview with STNA #354 at the same time, verified Resident #107 had a large pocketknife, three razors, and nine packs of cigarettes in his drawers. Interview on 07/09/24 at 11:10 A.M., Resident #107 stated he used his pocketknife to open milk cartons and cut the meat on his meal tray. Resident #107 further stated, What am I going to do? Slit my neck with the razors? Review of the facility policy titled, Smoking, dated 11/04/22, revealed any resident with supervised smoking privileges requiring monitoring shall always have the supervision of a staff member, family member, visitor, or volunteer worker while smoking. Supervision shall be direct supervision with the person providing the supervision in the direct vicinity of the resident. All smoking materials will be stored in a secure location by facility staff. The staff member providing the supervision will distribute the material, while maintaining control of the lighting device. At the end of the smoke break, all material distributed will be collected by the staff member and returned to the secure location. Residents who are assessed and demonstrate the ability to smoke independently must keep smoking materials secured with the nurse in a locked container. Residents are not permitted to supervise or assist other residents with smoking. 4. Review of medical record revealed Resident #21 was admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, major depressive disorder, seizures, and bipolar disorder. Review of MDS assessment dated [DATE] revealed Resident #21 had a BIMS of 12 that indicated he was cognitively intact. Review of plan of care for Resident #21 dated 04/15/24, revealed the resident did not have a smoking care plan. Resident #21 was at risk for activity of daily living related to episodes of depression severe, with psychotic features, and major depressive disorder. interventions included allow time for rest breaks, encourage resident participation in care, encourage activities, and encourage resident to participate in care. Observation on 07/12/24 at 10:00 A.M. through 10:20 A.M. revealed Resident #21 was smoking outside of the designated smoking area. Resident #21 was alone and had a cigarette, and a lighter in his hand. Interview on 07/12/24 at 10:01 A.M. with Resident #21 who stated he was leaving today and was not going to be at the facility any longer. Resident #21 stated he had his lighter since he had got to the facility on admission day. Resident #21 stated he was upset someone was taking his lighter away. (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	07/23/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/12/24 at 10:10 A.M. with DON, revealed Resident #21 was not leaving the facility for a discharge. The DON verified Resident #21 was a supervised smoker and was not to have a lighter without staff supervising the lighter. This deficiency represents non-compliance investigated under Complaint Number OH00154641. This deficiency is a recite to the complaint surveys dated 05/13/24 and 06/06/24.

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	07/23/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review and staff interview, the facility failed to ensure dietary supplements were administered per the physician's order. This affected one (#106) of two residents reviewed for nutrition. The facility census was 52. Findings include: Review of the medical record of Resident #106 revealed an admitted [DATE]. The resident transferred to the hospital on 06/10/24 and did not return. Diagnoses included acute gastroenteritis and colitis, post-traumatic stress disorder (PTSD), major depressive disorder, cerebral infarction, adult failure to thrive, colon cancer, diabetes mellitus, emphysema, mild protein-calorie malnutrition. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 had adequate short and long-term memory. The resident required supervision or touching assistance for eating, weighed 103 pounds, had no known significant weight changes, and received a mechanically altered diet. Review of the physician orders for Resident #106 dated 06/02/24 revealed the resident was ordered Boost (oral supplement) three times a day. Review of the June 2024 Medication Administration Record (MAR) for Resident #106 revealed the resident received Boost three times a day beginning on 06/02/24. The MAR indicated the resident did not receive the Boost as ordered twice on 06/03/24 and once on 06/07/24. Review of the medical record revealed no progress notes on 06/03/24 nor 06/07/24 regarding the administration of the Boost supplement. Interview on 07/17/24 at 9:39 A.M., the Director of Nursing (DON) verified there were holes in the MAR of Resident #106 for Boost administration twice on 06/03/24 and once on 06/07/24. The DON further verified there were no progress notes regarding the Boost administration for the aforementioned dates. The DON confirmed Resident #106's medical record lacked evidence of Resident #106's Boost being administered per the physician's order. This deficiency represents non-compliance investigated under Complaint Number OH00154796.

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	07/23/2024

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 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** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure residents received medications as ordered. This affected one (#39) of four residents reviewed for pain. The facility census was 52. Findings include: Review of the medical record of Resident #39 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), constipation, insomnia, hypertension, pain, emphysema, anxiety disorder, major depressive disorder, polycythemia vera, alcohol dependence with withdrawal delirium. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had intact cognition. The resident did not display behaviors during the assessment period. Review of the physician orders for Resident #39 dated 10/23/23 revealed the resident was ordered to receive Celebrex 100 milligrams (mgs) two times a day for pain. Physician orders dated 10/24/23, revealed Aspirin 81 mgs daily for prevention, folic acid 1 mg daily for supplement, omeprazole 20 mg daily for heartburn and indigestion, multi-vitamins daily for supplement, thiamine 100 mg daily for supplement, metoprolol tartrate 25 mg twice daily for hypertension, Seroquel 25 mg twice a day for behaviors related to anxiety and depression. Physician orders dated 02/17/24 revealed Norco 5-325 mg twice daily for pain. Physician orders dated 02/20/24 revealed promethazine 25 mg daily for nausea. Physician orders dated 06/03/24 re revealed lorazepam 0.5 mg twice daily for anxiety. Review of the June 2024 medical Medication Administration Record (MAR) for Resident #39 revealed no documentation to support Resident #39 received aspirin, folic acid, omeprazole, multivitamin, thiamine, lorazepam, and Seroquel as ordered on 06/19/24, promethazine as ordered on 06/25/24 and 06/28/24, and Celebrex, metoprolol, and Norco as ordered on 06/19/24 and 06/25/24. Review of Resident #39's progress notes revealed no documentation regarding the administration of the medications on 06/19/24, 06/25/24, nor 06/28/24. Interview on 07/15/24 at 1:30 P.M., the Director of Nursing (DON) verified the medical record for Resident #39 did not contain documentation to support the medications were administered as ordered on 06/19/24, 06/25/24, and 06/28/24. Review of the facility policy titled, Medication Administration-General Guidelines, dated 01/2018, revealed medications are administered as prescribed. The individual who administers the medication records the administration on the resident's MAR directly after the medication is given by initialing the MAR in the space provided. If a dose of a regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, it is documented on the MAR and an explanatory note is also entered in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00155040. (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	07/23/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency is a recite to complaint surveys dated 04/11/24, 05/13/24, and 06/06/24.

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	07/23/2024

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, resident interview, and staff interview, the facility failed to obtain radiology services per physician's order. This affected one (Resident #107) of one reviewed for constipation. The facility census was 52 residents. Findings include: Review of the medical record of Resident #107 revealed an admitted [DATE] with diagnoses including humerus fracture, major depressive disorder, low back pain, chronic bronchitis, suicidal ideations, nicotine dependence, age-related osteoporosis, and hypocalcemia and a discharge date of [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #107 dated 06/25/24 revealed the resident had intact cognition and required partial/moderate assistance for transfers. Review of the medical record revealed Resident #107's last bowel movement was a medium, formed stool on 07/04/24. Review of a progress note for Resident #107 dated 07/08/24 timed at 9:56 P.M. revealed the resident complained of lower abdominal pain and stated he had not had a bowel movement in five days. The physician was notified and ordered an x-ray of the kidneys, ureters, and bladder (KUB.) Review of physician's orders for Resident #107 revealed an order dated 07/09/24 timed at 6:56 A.M. for the resident to have a KUB x-ray. Review of the medical record for Resident #107 revealed it did not include documentation of KUB x-ray being completed or KUB x-ray results. Interview on 07/08/24 at 11:22 A.M. with Resident #107 confirmed the resident had not had a bowel movement in six days although he had been given medications to promote bowel movements with no results. Resident #107 complained of stomach cramping. Interview on 07/15/24 at 1:30 P.M. with the Director of Nursing (DON) confirmed the KUB x-ray was not completed for Resident #107 and the chart did not include documentation regarding the rationale for not completing the KUB x-ray.

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	07/23/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation, staff interview, and review of the dishwasher manual, the facility failed to ensure the dishwasher was functioning to clean and sanitize dishes appropriately. This had the potential to affect 51 of 52 residents in the facility. The facility identified one resident (#15) who did not receive food from the kitchen. The facility census was 52. Findings include: Interview on 07/11/24 at 8:51 A.M. with Dietary Supervisor (DS) #502 confirmed she had called for the dishwasher to be serviced on 07/08/24 and the sanitizer concentration levels had read 0 parts per million (ppm) for a few weeks. DS #502 further confirmed the dishwasher remained in use during the time the sanitizer levels read 0 ppm. DS #502 stated the sanitizer level should be at 50 ppm for safe use. Observation on 07/11/24 at 9:00 A.M. revealed there was a sign on the dish machine indicating the sanitizer level should be 50 ppm for proper use. Observation on 07/11/24 at 9:01 A.M. revealed DS #502 tested the sanitizer level with a test strip and the test strip did not change color indicating the machine did not contain the proper level of sanitizer. Interview on 07/11/24 at 9:02 A.M. with DS #502 confirmed the sanitizer level tested at 0 ppm and should test at 50 ppm for proper use. Interview on 07/11/24 at 2:03 P.M. with Service Technician (ST) #507 confirmed he came to the facility to service the dishwasher because the sanitizer was not testing at the appropriate level. ST #507 verified the sanitizer was reading 0 ppm and stated the bucket of sanitizer was empty, causing the sanitizer levels to read at 0 ppm. ST #507 stated the machine should run with a sanitizer level of 50 ppm to ensure proper cleaning and sanitation of dishes. Observation on 07/11/24 at 2:05 P.M. revealed the sanitizer bucket was empty. Further observation revealed the sanitizer bucket had a delivery date of 02/12/24. There was no date observed on the bucket to indicate when the bucket was opened. Interview on 07/11/24 at 2:09 P.M. with DS #502 confirmed the sanitizer bucket that was being used for the dishwasher was empty and had a delivery date of 02/12/24. DS #502 stated she was unsure when the bucket had been opened and stated [NAME] #334 managed all of the chemicals in the kitchen. DS #502 stated when chemicals in the kitchen needed refilled [NAME] #334 was responsible for ordering the chemicals. DS #502 stated [NAME] #334 had been off since 07/08/24 and would not return to work until 07/25/24. DS #502 estimated the sanitizer needed to be replaced every 45-60 days. DS #502 confirmed she was unable to locate any invoices showing when sanitizer for the dish machine had last been ordered. (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	07/23/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the manufacturer's instructions for the dish machine dated 06/07/13 provided by ST #507 revealed sanitizer concentrations should be 50 ppm for safe and proper use.

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	07/23/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, observation, and staff interview, the facility failed to ensure resident records adequately reflected resident status. This affected one (Resident #107) of one resident reviewed for constipation. The facility census was 52 residents. Findings include: Review of the medical record of Resident #107 revealed an admitted [DATE] with diagnoses including right humerus fracture, major depressive disorder, low back pain, chronic bronchitis, suicidal ideations, nicotine dependence, age-related osteoporosis, and hypocalcemia and a discharge date of [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #107 dated 06/25/24 revealed the resident had intact cognition and required partial/moderate staff assistance for transfers. Observation on 07/15/24 at 9:00 A.M. revealed Resident #107 was not in his room and was unable to be located by the Surveyor. Review of the medical record for Resident #107 revealed it did not include documentation of resident's location. Interview on 07/15/24 at 1:30 P.M. with the Director of Nursing (DON) confirmed Resident #107 was sent to the hospital on 07/11/24 and had not returned to the facility, but this was not documented in the resident's medical record. The DON further confirmed staff should document resident transfers to the hospital in the medical record.

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	07/23/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure residents with wounds and indwelling medical devices were placed in enhanced barrier precautions (EBP). This affected five (#14, #15, #16, #28, and #33) of five residents reviewed for EBP. The facility census was 52 residents. Findings include: 1. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including congestive heart failure, osteomyelitis, alcohol dependence, open wound right ankle, systemic lupus, schizoaffective disorder, major depressive disorder. Review of the quarterly Minimum Data Set (MDS) for Resident #14 assessment dated [DATE] revealed the resident had intact cognition, refused care daily, and required supervision or touching assistance with activities of daily living (ADLs.) Review of the non pressure skin grid for Resident #14 dated 07/05/24 revealed the resident had an unstageable vascular ulcer to his right lower extremity. Review of the medical record for Resident #14 revealed no physician orders for EBP. Observations on 07/08/24 at 10:49 A.M. and 07/09/24 at 10:25 A.M. revealed the door to Resident #14's room did not contain any type of notification of the resident being in EBP. There was no personal protective equipment (PPE) observed outside of Resident #14's room. Interview on 07/09/24 at 10:30 A.M. with Registered Nurse (RN) #368 confirmed Resident #14 had a wound and the door to his room did not contain any signage for EBP. RN #368 further confirmed there were no gowns or gloves outside Resident #14's room for staff to utilize when necessary. 2. Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including hemiplegia, chronic obstructive pulmonary disease (COPD), bladder neoplasm, congestive heart failure, bipolar disorder, cerebral infarction, gastrostomy status. Review of the MDS assessment for Resident #15 dated 06/10/24 revealed the resident had severely impaired cognition and was dependent on staff for ADLs. Review of the physician orders for Resident #15 revealed the resident had an enteral feeding tube with physician orders to verify tube placement prior to medication administration, flush the tube with water before and after each med pass, flush tube with water every four hours, and to administer tube feeding from 6:00 P. M. to 10:00 A.M. daily. There were no physician orders for EBP. Observations on 07/08/24 at 10:39 A.M. and 07/09/24 at 8:20 A.M. revealed the door to Resident #15's room did not contain any signage to indicate Resident #15 was on EBP. There was no personal protective equipment (PPE) observed outside of Resident #15's room. (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	07/23/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/09/24 at 8:23 A.M. with RN #368 confirmed Resident #15 had a feeding tube and did not have any orders for isolation precautions, nor did Resident #15's door contain any signage for EBP nor were any gowns or gloves available outside the room for staff use. 3. Review of the medical record of Resident #28 revealed an admitted [DATE] with diagnoses including COPD, peripheral vascular disease, chronic venous hypertension with ulcer of right lower extremity. Review of the MDS assessment for Resident #28 dated 05/16/24 revealed the resident had intact cognition. Review of the non pressure skin grid for Resident #28 dated 07/09/24 revealed the resident had vascular ulcers to his right and left lower extremities. Review of the medical record for Resident #28 revealed no physician orders for EBP. Observations on 07/08/24 at 10:11 A.M. and 07/09/24 at 10:25 A.M. revealed the door to Resident #28's room did not contain any type of notification of the resident being in EBP. There was no personal protective equipment (PPE) observed outside of Resident #28's room. Interview on 07/09/24 at 10:30 A.M., Registered Nurse (RN) #368 confirmed Resident #28 had a wound and the door to his room did not contain any signage for EBP. RN #368 further verified there were no gowns or gloves outside Resident #28's room for staff to utilize when necessary. 44080 4. Review of medical record for Resident #33 revealed an admitted [DATE] with diagnoses including type two diabetes, morbid obesity, other sites of candidiasis, carrier of suspected carrier of methicillin resistant staphylococcus aureus, and chronic kidney disease. Review of physician orders for Resident #33 revealed an order dated 04/22/24 revealed for the resident to have catheter care every shift. There were no orders for EBP. Review of the plan of care for Resident #33 dated 04/23/24 revealed the resident had an indwelling catheter related to obstructive and reflux uropathy. Interventions included the resident should be placed in EBP. Review of the Minimum Data Set (MDS) assessment for Resident #33 dated 06/21/24 revealed the resident #33 was cognitively intact and required staff assistance with activities of daily living (ADLs.) 5. Review of medical record for Resident #16 revealed an admitted [DATE] with diagnoses including mood disorder, schizophrenia, presence of artificial hip, Huntington's disease, and dementia. Review of MDS for Resident #16 dated 04/23/24 revealed the resident severely cognitively impaired and required moderate assistance with ADLs. (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	07/23/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders for Resident #16 revealed an order dated 06/25/24 revealed to cleanse the left hip wound, apply Santyl and cover with moistened gauze and a border dressing. There were no physician orders for EBP. Review of the wound progress note for Resident #16 dated 07/09/24 revealed the resident had a full thickness wound with slough tissue which showed clinical signs of infection. Observations on 07/09/24 at 9:55 A.M. revealed Residents #16 and #33 had no signs posted indicating they were in EBP and there was no personal protective equipment (PPE) available outside the residents' rooms. Interview on 07/09/24 at 10:00 A.M. with the Director of Nursing (DON) confirmed Residents #16, and #33 were not in EBP but both residents should have been placed in EBP. The DON further confirmed Resident #16 should have been in EBP because of his full thickness hip wound, and Resident #33 should have been in EBP because he had an indwelling catheter. Review of the facility policy titled Enhanced Barrier Precautions dated 04/01/24 revealed the facility would utilize EBP to prevent broader transmission of multidrug-resistant organisms and to help protect patients with chronic wounds and indwelling devices. EBP was described as the use of gowns and gloves during high contact resident care activities. Residents who required EBP included residents with open wounds and indwelling medical devices. Physician orders would be obtained and reflected in the resident's medical record.

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	07/23/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were offered pneumococcal and influenza vaccinations. This affected five (Resident #2, #5, #16, #33, and #47) of five residents reviewed for vaccinations. The facility census was 52 residents. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE]. Further review of the record revealed it did not include documentation regarding receipt or refusal of the pneumococcal or influenza vaccines. Review of the medical record for Resident #5 revealed an admitted [DATE]. Further review of the record revealed it did not include documentation regarding receipt or refusal of the pneumococcal or influenza vaccines. Review of the medical record for Resident #16 revealed an admitted [DATE]. Further review of the record revealed it did not include documentation regarding receipt or refusal of the pneumococcal or influenza vaccines. Review of the medical record for Resident #33 revealed an admitted [DATE]. Further review of the record revealed it did not include documentation regarding receipt or refusal of the pneumococcal or influenza vaccines. Review of the medical record for Resident #47 revealed an admitted [DATE]. Further review of the record revealed it did not include documentation regarding receipt or refusal of the pneumococcal or influenza vaccines. Interview on 07/13/24 at 8:45 P.M. with the Administrator confirmed the facility had no documentation of receipt or refusal of pneumococcal or influenza vaccines for Residents #2, #5, #16, #33, and #47.

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	07/23/2024

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 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** 44080 Based on medical record review, observation, and staff interview, the facility failed to ensure residents had functioning call lights. This affect three (Residents #2, #47, #53) of three residents reviewed for call lights. The facility census was 52 residents. Findings include: 1. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including schizophrenia, dementia, chronic pulmonary disease, and delusional disorder. Review of care plan for Resident #2 dated 05/06/24 revealed that the resident was at risk for falls and interventions included keeping the call light within reach. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 05/16/24 revealed the resident was cognitively intact and required supervision with light touch assistance for transfers, bathing, meals, personal hygiene, dressing, and oral care. Observation on 07/08/24 at 10:05 A.M. through 10:35 A.M. revealed Resident #2 was in bed and the call light was sounding. There was no call light cord in the resident's room for the resident to summon assistance and for the staff to turn off the call light. Interview on 07/08/24 at 10:36 A.M. with State tested Nursing Assistant (STNA) #341 confirmed Resident #2 did not have a call light in the room to summon assistance and there was no way to turn off the call light. Interview on 07/08/24 at 11:55 A.M. with Maintenance Supervisor (MS) #363 confirmed Resident #2 did not have a functional call light to summon staff assistance. Observation on 07/09/24 at 11:18 A.M. revealed Resident #2 did not have a functional call light or alternate means such as a bell to summon assistance. Interview on 07/09/24 at 11:19 A.M. with MS #363 confirmed Resident #2 did not have a functional call light or other means to summon staff assistance. 2. Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including schizoaffective bipolar disorder, and anxiety disorder. Review of the MDS assessment for Resident #53 dated 06/08/24 revealed the resident was severely cognitively impaired and required supervision and touch assistance with transfers, toileting, dressing and bathing. Review of plan of care for Resident #53 dated 06/19/24 revealed that resident was at risk for falls related to medications and interventions included keeping the call light within reach. (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	07/23/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/09/24 at 11:17 A.M. revealed Resident #53's room had a call light cord wrapped around the call light box on the wall. The call light was not plugged into the hole for the call light box on the wall. Interview on 07/09/24 at 11:20 A.M. with MS #363 confirmed Resident #53's room did not have a functional call light or means to summon staff assistance. 3. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including Huntington's disease, mood disorder, anxiety disorder, and dementia. Review of the MDS assessment for Resident #47 dated 06/05/24 revealed the resident was severely cognitively impaired required substantial assistance with transfers, dressing, bathing, personally hygiene, and toileting. Review of plan of care for Resident #47 dated 06/24/24 revealed the resident at risk for falls related to decreased mobility, medications, and Huntington's disease and interventions included keeping the call light within reach. Observation on 07/09/24 at 10:59 A.M. revealed Resident #47 was in bed and the call light cord was wrapped around the box on the wall, and the call light was not functional. Interview on 07/09/24 at 11:00 A.M. with MS #363 confirmed Resident #47's room did not have a functional call light or means to summon staff assistance. This deficiency is a recite to complaint surveys completed 05/13/24 and 06/06/24.