

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/11/2024
NAME OF PROVIDER OR SUPPLIER  Doverwood Village		STREET ADDRESS, CITY, STATE, ZIP CODE  4195 Hamilton Mason Road Hamilton, OH 45011	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702</b></p> <p>Based on medical record review, staff interview, review of the transportation schedule, and review of the facility statement form the facility failed to ensure a resident had an adequate supply of oxygen when leaving the facility for a medical appointment. This affected one (#91) resident of three residents reviewed for respiratory care and services. The facility census was 90.</p> <p>Findings include:</p> <p>Medical record review for Resident #91 revealed an admitted [DATE]. Diagnoses included hemiplegia, hemiparesis following stroke, narcolepsy, type two diabetes mellitus, chronic heart failure, hypertension, pulmonary embolism, kidney failure and a history of covid.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 had significant cognitive impairment, required moderate to maximum assistance from staff for eating, toileting, transfers and bed mobility. Resident #91 had oxygen usage during the assessment period.</p> <p>Review of the plan of care revealed Resident #91 had shortness of breath related to acute respiratory failure. Interventions included to monitor breathing patterns and report abnormalities to the physician, position the resident with proper body alignment for optimal breathing pattern and the use of pain management as needed.</p> <p>Review of the physician orders for Resident #91 revealed an order dated 08/20/24 for oxygen at two to five liters per minute (l/m) via nasal cannula to keep oxygen saturation rate above ninety-two percent every day and night shift related to acute respiratory failure.</p> <p>Review of the facility's transportation schedule dated 11/08/24 revealed Resident #91 had an medical appointment at 10:15 A.M. and had a scheduled picked up for 9:30 A.M.</p> <p>Interview on 12/09/24 at 3:08 P.M. with Certified Nurse Assistant (CNA) #84 stated Resident #91 was sent to the medical appointment with an almost empty oxygen tank and without oxygen on. CNA #84 verified when Resident #91 returned from the appointment the resident did not have oxygen on and that oxygen tubing was on the back of the wheelchair, but there was no oxygen tank. CNA #84 stated Resident #91 did not appear to be short of breath and when the nurse checked Resident #91 oxygen saturation, it was in the nineties.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366040
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/09/24 at 3:19 P.M. with CNA #34 stated she was assigned to the Resident #91 on 11/08/24. CNA #34 stated the nurse did not advise her of Resident #91's appointment and when transportation arrived Resident #91 was not ready. CNA #34 stated she rushed to get him ready for departure and noted that the portable oxygen tank was almost empty but in the rush to get Resident #91 ready the oxygen tank was not exchanged and should have been.</p> <p>Interview on 12/09/24 at 3:45 P.M. with the Assistant Director of Nursing (ADON) denied any knowledge of the incident.</p> <p>Interview on 12/09/24 at 5:26 P.M. with the facility transportation Driver #402 verified Resident #91 was picked up at the facility and dropped off at a physicians office on 11/08/24, where Resident #91's family member was waiting for the resident. Driver #402 verified Resident #91 had an oxygen tank on the wheelchair with oxygen tubing connected to the tank, but not to Resident #91. Driver #402 stated upon arrival to the appointment the family member advised that Resident #91 was to have oxygen on at all times. When leaving the appointment Driver #402 stated the family member was angry the oxygen tank was empty and took the oxygen tank. Driver #402 stated the incident was reported to the nurse caring for Resident #91 upon returning to the facility with Resident #91 after the appointment.</p> <p>Interview on 12/09/24 at 5:35 P.M. with facility Administrator verified no knowledge of the incident.</p> <p>Interview on 12/10/24 at 11:16 A.M. with Transportation Supervisor #403 verified Driver #402 notified her of the 11/08/24 incident with Resident #91 and the family member. Driver #402 wrote a statement regarding the incident and submitted the statement to the office. Transportation Supervisor #403 verified the facility nurse assigned to Resident #91 was informed of the incident.</p> <p>Review of the facility statement form dated 11/13/24 at 1:30 P.M. completed by Driver #402 revealed when Driver #402 arrived at the facility on 11/08/24 to pick up Resident #91 for a medical appointment, Resident #91 was not ready. CNA's #34 and #84 assisted getting Resident #91 and informed Driver #402 when Resident #91 was ready. The statement also contained information Resident #91 had no oxygen and the family member was angry Resident #91 was sent to an appointment with an empty oxygen tank, again.</p> <p>Additional interview on 12/11/24 at 3:00 P.M. with the Administrator verified the incident had occurred and the management team was not aware of Driver #402's statement or of the oxygen tank not being returned to the facility with Resident #91 after the medical appointment on 11/08/24.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159795.</p>		