STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155686	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-KNOX	**300 E CULVER RD KNOX, IN 46534**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident with an identified injury was transferred to the Emergency Department in a timely manner for 1 of 3 residents reviewed for quality of care. (Resident B) Finding includes: Record review for Resident B was completed on 8/28/20 at 10:10 a.m. [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) assessment, dated 6/8/20, indicated the resident was cognitively intact. The resident required an extensive assistance for bed mobility, transfers, dressing, personal hygiene, and toilet use. A Care Plan indicated the resident was on hospice care related to end of life care. An intervention included to notify hospice of any changes in condition. A Progress Note, dated 7/23/20 at 6:27 a.m., indicated during the morning care, the CNA noted the resident's left leg was not in the right place and the resident was in increased pain. Assessment of the resident's left leg indicated it was rotated inward. When touched the resident would yell out in pain. The resident and the CNA indicated it was not like that at the beginning of the night. The CNA indicated at the beginning of the night, she was able to assist the resident with turning in bed to be changed without difficulty. The nurse notified hospice. Hospice notified the resident's son and agreed to stop Hospice services so the resident could be transferred to the hospital. The nurse attempted to call the resident's Physician with no answer. The facility Medical Director was then called and gave an order to send the resident to the hospital. Emergency Medical Transport (EMT) was called and the resident departed the facility at 5:45 a.m. Review of statements from facility staff related to the incident indicated: CNA 1 indicated on the morning of 7/23/20 at 4:00-4:15 a.m., she was providing care to the resident. The resident was alert and oriented and was able to use the quarter side rail as an enabler to help her position and roll herself during personal care. The resident used the rail and turned herself on her side so that the CNA could provide personal care. Once the care was finished, the resident released the grip on the rail and rolled back into position on her back. The CNA indicated the resident's leg did not look right and the resident indicated her leg hurt. The CNA then left the room to notify the nurse. RN 1 indicated a little after 4:00 a.m., CNA 1 reported to her that something was not right with the resident's leg. The RN went to assess the resident's leg and it appeared to be bent in an odd way. The resident indicated she was in pain. She was then administered her [MEDICATION NAME] (medicated pain patch). The nurse then notified the hospice company. Hospice then called back and indicated the son gave permission to send the resident to the emergency room (ER). The resident's Physician was then called. The resident was given her scheduled [MEDICATION NAME] (pain medication) to manage the pain. The resident's Physician did not return the call, so the facility Medical Director was paged. He returned the call at around 5:15 a.m., with an order to send the resident to the ER. Emergency Medical Services (EMS) was called at 5:48 a.m., and arrived at the facility at 5:52 a.m. An Overall General Timeline provided by the Director of Nursing (DON) related to the incident on 7/23/20 indicated the following: - 4:00 a.m.,: CNA 1 provided care to Resident B - 4:15 a.m.,: CNA 1 noticed Resident B's leg did not look right and notified RN 1 - 4:15 a.m., RN 1 observed Resident B's condition - Between 4:15 a.m., and 4:30 a.m., hospice was called and informed of resident's condition - 4:27 a.m., resident received her [MEDICATION NAME] for pain - 4:30 a.m., hospice returned a call with son's consent to send the resident to the ER. - 5:00 a.m., the resident's Physician was called for an order to send the resident to the ER. No answer from the Physician. - 5:00 a.m., resident received [MEDICATION NAME] for pain management - 5:15 a.m., Medical Director paged and called back with order to send the resident to the ER. - 5:48 a.m., EMS was called - 5:52 a.m., EMS arrived at the facility - 6:13 a.m., EMS left the facility with resident en route to the ER. Interview with the Medical Director on 8/28/20 at 1:10 p.m., indicated the nurse should have sent the resident to the ER as soon as she received the order from the hospice company. The nurse did not need to wait and get an ok from the resident's Physician. The nurse did try and manage the resident's pain until the EMT's arrived, but he had a concern that EMS was not called right away after the nurse got the order to send the resident out from the hospice provider. Interview with the DON on 8/28/20 at 1:19 p.m., indicated the nurse should have called EMS at 4:30 a.m., when she received the order from hospice. The nurse was trying to make the resident comfortable and manage her pain until the EMT's arrived to the facility. The nurse was getting all necessary paperwork together to send the resident to the hospital. She should have just sent the resident out to the hospital and then faxed all necessary paperwork to the ER after the resident left the facility. A Hospice Care Services Agreement for the resident's hospice company was received as current from the facility on 8/28/20. The agreement indicated, .5. Services Provided by Hospice. a. Hospice shall provide the following services (the Hospice Services) to each Hospice Patient, provided that such services are in accordance with the patient's Plan of Care: i. Providing medical direction and management of the patient . .6. Responsibilities of Facility. d. Facility shall obtain Hospice approval prior to any relocation of a Hospice Patient This Federal Tag relates to Complaint IN 721. 3.1-37(a)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.