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 _____	**03/09/2020**

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident was administered [MED]gen as ordered by the Physician, related to an empty portable [MED]gen machine for 1 of 3 residents reviewed for [MED]gen therapy. (Resident C) Finding includes: During an observation on [DATE]20 at 8:51 a.m., Resident C was sitting in a wheelchair in her room. She had a portable [MED]gen machine on the back of the wheelchair set at 3 liters and [MED]gen was administered through a nasal cannula. Employee 1 checked the portable [MED]gen machine and indicated it was 1/2 full. During an observation on [DATE]20 at 1:05 p.m., the resident was sitting in the wheelchair in the Dining Room. The Administrator was sitting next to her, and there were no other residents in the Dining Room. The nasal cannula was present in the nares and connected to the portable [MED]gen machine, which was set at 3 liters. Employee 2 checked the portable [MED]gen machine and indicated it was empty. Employee 2 indicated the portable [MED]gen was usually checked every two hours and she had not checked it since after breakfast (served between 7 a.m. and 7:30 a.m.). She was unaware how long the resident had been without [MED]gen. Normally she would have checked it before the resident was assisted to the Dining Room. She had not assisted her to the Dining Room for lunch. During observations on [DATE]20 at 1:10 p.m., the portable [MED]gen machine was re-filled and brought back to the resident in the Dining Room. The Director of Nursing (DON) then connected the nasal cannula tubing to the [MED]gen. The [MED]gen administration rate was set to 3 liters. At 1:12 p.m., the DON obtained an [MED]gen saturation from the left ear lobe, which read 67%. The DON then used a finger oximeter and obtained [MED]gen saturations of 60-85%. At 1:15 p.m. the DON used another finger oximeter and the results were 63-82%. The respirations were 28. The resident was assisted to her room and the nasal cannula was attached to the [MED]gen concentrator in the room and set at 3 liters. At 1:20 p.m., the [MED]gen saturation was 92%. Resident C's record was reviewed on [DATE]20 at 11:33 a.m. The [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set assessment, dated 12/10/19, indicated a severely impaired cognitive status and [MED]gen was used. A Care Plan, dated 11/[DATE]7, indicated [MED]gen was used due to shortness of breath. The interventions included, [MED]gen was to be administered as ordered and the [MED]gen saturations were to be maintained at 90% or above. A physician's orders [REDACTED]. During an interview on [DATE]20 at 2:01 p.m., the DON indicated per the (Oxygen Company Name), the portable [MED]gen machine at 3 liters would have lasted 5 hours. She indicated with the portable [MED]gen machine at 1/2 full at 8:51 a.m., the resident would have been without [MED]gen for a little while. The [MED]gen was now being administered with an [MED]gen concentrator and the [MED]gen saturations would be monitored. There was no facility policy that indicated when the portable [MED]gen machines were to be checked for the amount of [MED]gen in the machine. This Federal tag related to Complaint IN 828. 3.1-47(a)(6)

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.