STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175513	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KANSAS SOLDIERS HOME	**200 CUSTER, UNIT 98 FORT DODGE, KS 67801**

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 0694 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 47 residents with three residents sampled for dressing changes. Based on observation, interview, and record review the facility failed to complete the order for PICC (peripherally inserted central catheter-long catheter that is inserted through a peripheral vein) line dressing changes for one Resident (R) 4 of the three residents, weekly as ordered. Findings Include: - Review of R4's [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed a brief interview for mental status (BIMS) of two, indicating severely impaired cognition. The resident required total dependence with assistance of one staff for personal hygiene. The resident received seven days of antibiotics and received intravenous (IV) medications as a resident. Review of the Cognitive loss/ Dementia Care Area Assessment (CAA) dated 06/08/20 revealed the resident had impaired cognitive function related to [MEDICAL CONDITION] ([MEDICAL CONDITION] condition of the brain) [MEDICAL CONDITION](sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). Review of the Care Plan dated 03/27/20 documented the resident received IV medications related to endocarditis and the staff were to change the PICC line dressing per orders. The Care plan further directed the staff to monitor, document, and report as needed signs and symptoms of leaking at the IV site. Review of an Admission Summary Note dated 06/01/20 at 08:01 PM documented the resident admitted from Wesley Medical Center with a PICC line to LUE with dressing in place dated 05/15/20. Review of Physician order [REDACTED]. No other orders were noted regarding PICC line dressing changes until a new order entered on 07/01/20 for PICC line dressing change every Saturday related to endocarditis. Review of Progress Note dated 06/16/20 at 07:14 PM documented the PICC line dressing change per protocol. Review of progress notes dated from 06/17/20 to 07/03/20 revealed the PICC line dressing was not changed on 06/27/20. Review of progress notes for 06/27/20 revealed no PICC line dressing change completed. Review of the Medication Administration Record [REDACTED]. Review of progress note dated 7/8/2020 at 12:30 PM documented the PICC line dressing was changed at that time by Pharmacy Staff D and Pharmacy Staff E. The resident had tolerated the procedure well. There was no redness noted at the insertion site, no skin breakdown had been noted. Observation of R4 on 07/08/20 at 11:21 AM revealed the resident sat in his recliner, PICC line with bio-patch (small antibacterial disc) noted to left upper inner arm, the date indicated the dressing had been changed on 06/16/20 (22 days prior), areas of the semipermeable dressing were lifting around the edges, no redness or signs or symptoms of infection were noted, and the area around the dressing was clean. Interview with R4 on 07/08/20 at 11:21 AM revealed R4 received IV antibiotics daily because he needed them, but he was unsure of what infection he had. R4 stated the staff change the PICC line dressing once every week, he believed by the same person. Interview with LN B on 07/09/20 at 08:24 AM revealed the nurse usually did a head to toe assessment to make sure everything they got in report was correct. On 07/08/20 she did look at R4's PICC line dressing and noted it was clean and intact, she did not notice the date on it. His last dose of medication was on 06/28/20, before she came in to work. LN B said she would have the RN's flush the PICC line due to her being newer, until she gets a bit more familiar with the residents. Interview with LN C on 07/08/20 at 02:31 PM revealed she had signed it off and then noted there were no PICC line dressings in the building, and she had called the pharmacy to get more on 07/03/20 and was informed there were none. LN C said she was unable to change it that day, but she had already charted it, and was new to the facilities charting system. Interview with Administrative Nurse A on 07/08/20 at 12:53 PM revealed LN C had signed off the PICC line dressing on 07/04/20, her second day in the facility as an agency staff. Administrative Nurse A said when it is signed off as completed, that it should have been completed. Administrative Nurse A further stated she did not know that LN C could not find PICC line dressings and expected staff to notify herself, the ADON (Assistant Director of Nursing) or the nurse on the other floor, when agency staff had a problem. Administrative Nurse A stated her understanding of R4's orders were weekly PICC line dressing changes. Interview with Pharmacy Staff D and Pharmacy Staff E on 07/09/20 at 01:10 PM revealed the PICC line dressing orders come in with the shipment that arrives weekly, and stated a shipment arrived 07/03/20, so there would have been PICC line dressings in the building on 07/04/20. Pharmacy Staff D and Pharmacy Staff E said the nurses could call down to the pharmacy and get the PICC line dressings on first shift. Interview with Administrative Nurse A on 07/13/20 at 09:06 AM revealed the PICC line dressings are in the medication rooms on each floor, there was no way you could miss them, and we don't usually run out. Administrative Nurse A said she was not told that the facility had run out, so she believed that nurse was not completely honest about not being able to find the PICC line dressings. Administrative Nurse A stated the facility used the Lippincott Nursing Procedures 8th Edition Copyright 2019 for nursing procedures, we don't write policies. Review of the facility guideline Lippincott Nursing Procedures 8th Edition Copyright 2019 Central Venous Access Catheter revealed transparent semipermeable dressings should be changed every five to seven days. The facility failed to follow guidelines for dressing changes for this resident to protect him from possible fatal blood infections, when facility staff failed to change R4's PICC line dressing for 22 days.

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.