STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175549	A. BUILDING _____ B. WING _____	C 08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD COMMONS REHAB & HEALTH CARE CENTER	12340 QUIVIRA ROAD OVERLAND PARK, KS 66213

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00173694. The 2567 was sent electronically on 08/24/22.	F 000		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 56 residents. The sample included six residents reviewed for intravenous fluid (IV-administered directly into the bloodstream via a catheter placed in the vein) treatments and care. Based on record review, interview, and observation, the facility failed to ensure Resident (R)1 received the appropriate orders, treatment, care and services related to IV care when R1's peripherally inserted central catheter (PICC-a form of intravenous access that can be used for a prolonged period of time) dressing did not get changed and R1 lacked flushes per the standards of PICC care. This placed R1 at risk increased risk of infection, clotting, and IV related complications. Findings included: - R1's electronic medical record (EMR) under the "Diagnosis" tab documented renal (kidney) dialysis (procedure performed to remove toxins, drugs or other wastes in the blood normally	F 694		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/24/2022

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.

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excreted by the kidney), heart failure (a condition with low heart output and the body), peripheral vascular disease (PVD- abnormal condition affecting the blood vessels), and chronic kidney disease.

The "Entry Minimum Data Set" (MDS) assessment dated 08/12/22 documented R1 admitted to the facility on 08/12/22.

The "IV Access Care Plan" revised on 08/15/22 directed staff to monitor, document and report to the physician signs and symptoms of infiltration at the site. It further directed staff to check the dressing at the site daily.

The "Physician Order" dated 08/12/22 ordered staff to document the appearance of the IV site every shift.

The "Physician Order" dated 08/12/22 ordered nursing staff to flush the PICC with 10 milliliters (mL) of normal saline (NS) prior to medication infusion.

The "Physician Order" dated 08/12/22 ordered nursing staff to change IV dressing as needed for soiling or break in integrity.

The "Physician Order" dated 08/12/22 ordered nursing staff to change needle less connector as needed.

The "Physician Order" dated 08/13/22 ordered Daptomycin (antibacterial agent of a new class of antibiotics) solution reconstituted (process of mixing and diluting solutions) 500 milligrams (mg) use 500 mg intravenously every 48 hours for right heel wound infections until 08/13/22.

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The clinical record lacked orders to flush the PICC line upon completion of medication being administrated, lacked orders for scheduled dressing change related to the PICC line, scheduled needleless connector change, or maintenance order for the PICC line upon completion of IV medication.

Review of the "Medication Administration Record" (MAR) of August 2022 documented ten out of ten opportunities of the physicians order to flush the PICC line with 10 mL of NS prior to medication infusion.

The August 2022 MAR lacked evidence that the PICC line was flushed after the medication was infused.

The "Health Status Note" dated 08/13/22 at 05:07 PM documented R1 required skilled services of IV therapy following hospitalization.

The progress notes lacked any further documentation related to R1's PICC line insertion site.

On 08/16/22 at 01:05 PM R1 laid in bed with her eyes closed, and her covers pulled up to her chest. R1's single lumen PICC line on her left upper extremity had, blood in the tubing up to the hub. The PICC dressing was dated 08/07/22 (nine days old). R1 confirmed that staff flushed her PICC site before the antibiotics were administered, but could not recall if the line was flushed after the antibiotics were completed.

On 08/16/22 at 01:40 PM Licensed Nurse (LN) G stated that she checked the orders when she

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administered R1's IV medications and stated R1 did have an order to flush prior to IV antibiotic administration, but there was no order to flush the IV after the antibiotic. LN G confirmed there was no order to flush the PICC line once the antibiotic stopped. LN G stated there should be daily maintenance flush order and a 10 mL NS flush after the medication is administrated.

On 08/16/22 at 03:00 PM Administrative Nurse D stated expected orders to be transcribed from the hospital discharge orders and standing orders placed when a resident admitted to the facility. Administrative Nurse D further stated that nursing management went over the admission orders at the morning meetings to assure that the orders had been entered from the admission. She revealed that depending on the type of IV, standing orders existed and were entered for maintenance orders, flushes, and dressing changes. She said sometimes residents admitted without IV orders. Administrative Nurse D stated when that happened, she expected the nurse doing the admission to call the physician for clarification. Administrative Nurse D revealed that there had not been a second nurse checking the admission orders lately. Administrative Nurse D stated that the nurses should check the IV orders to see what needed to be done and follow the physicians order. Administrative Nurse D stated she expected the nurse to notify the physician for clarification on IV orders if necessary and if a resident was missing orders, get those orders before doing anything for a resident with an IV.

The facility's "Infusion Therapy: Flushing a Peripheral Intravenous Catheter" revised 12/2016 documented flushing was performed to ensure and maintain catheter patency, and to prevent the

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mixing of incompatible medications or solution. The policy documented all peripheral venous catheters must be flushed with the prescribed flushing agent following conversion of a continuous intravenous therapy to an intermittent intravenous therapy.

The facility's "Infusion Therapy: Dressing Change, Peripheral Inserted Central Catheter (PICC)" revised 01/2012 documented the catheter insertion site was a potential entry site for bacteria that may cause a catheter related infection. The policy documented dressing changes using transparent dressings were to be changed 24 hours after insertion of the PICC line or upon admission, every seven days thereafter, or if the integrity of the dressing had become compromised. The policy further documented that upon completion of the dressing change the licensed nurses were to document in the medical records to include, but not limited to: date and time, site assessment, length of external catheter, upper arm circumference, residents response to the procedure and/or medication, and resident/significant other teaching.

The facility's "Infusion Therapy: Changing a Needle less Access Device, PICC" revised 01/2012 documented needle less access devices were changed upon admission, every seven days, after blood was drawn through the needle less access device, anytime the integrity of the needle less access device was in question, or anything the needle less access device was removed for any reason. The policy documented licensed nurses documented in the medical record the date and time, site assessment, residents response to procedure and/or medication, and resident/significant other

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F 694	Continued From page 5 teaching. The facility failed to ensure R1 received appropriate cares and services in accordance with the standards of care and the facility policy for a PICC line. This placed R1 at increased risk for infections and PICC related complications.	F 694		