STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a focused fundamental recertification and state licensure survey. Survey Dates: February 10, 11, 12 and 13, 2020 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/20/20.	W 0000		
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. Based on record review and interview for 1 of 3 clients in the sample (#1), the Qualified Intellectual Disabilities Professional/QIDP failed to integrate, coordinate and monitor the communication between the outside services day program and the group home. Findings include: On 2/10/20 from 11:23 AM to 12:48 PM, an observation was conducted at the outside services day program. On 2/10/20 at 12:18 PM, day program staff #1 indicated the day program communicated with the group home using client #1's communication book however the group home was not providing documentation regarding client #1. Staff #1 indicated client #1 arrived on 2/10/20 with bruising on his back however there	W 0159	Qualified Intellectual Disabilities Professional/QIDP, Area Supervisor and Residential staff will be training in regards to providing updated communication to day services. QIDP and Area Supervisor will review communication book weekly to ensure completion QIDP will conduct a monthly visit to day program site to review programming and communication needs. Documentation of visit will be provided to Program Manager for review Person Responsible: QIDP, Area Supervisor, Program Manager,	03/14/2020

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

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	was no documentation in the communication book about the injury. Client #1 pulled up his shirt and showed the surveyors a 5 inch in diameter black, blue and purple bruise on the lower middle of his back. On 2/10/20 at 12:20 PM, client #1 indicated the bruising was caused by a fall he had over the weekend while adjusting his radio. On 2/10/20 at 12:20 PM, a review of client #1's communication book was conducted. There was no documentation in the communication book informing the day program staff about his bruise. The February 2020 entries in the communication book contained minimal documentation from the group home to the day program regarding client #1's evenings, mornings and weekends. On 2/11/20 at 11:52 AM, the Area Supervisor/AS indicated there should be two way communication between the group home and the day program. The AS indicated the group home staff should have documented in the communication book about client #1's fall over the weekend. On 2/11/20 at 11:55 AM, the Home Manager/HM indicated the staff at the group home should provide information to the day program using the communication book. 9-3-3(a)		Residential Staff	
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.			

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	Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had plans to address the use of a PICC (Peripherally inserted central catheter) line and his refusals to wear a sling. Findings include: On 2/10/20 from 3:54 PM to 5:50 PM and 2/11/20 from 6:00 AM to 8:15 AM, observations were conducted at the group home and the following issues were noted: 1) Throughout the observation on 2/10/20, client #1 had a PICC line in right arm. The access cap and tubing were not secured. The access cap and tubing were dangling throughout the observation. On 2/11/20 from 6:00 AM to 7:48 AM when the Home Manager secured client #1's PICC line, the PICC line was dangling from his arm. The PICC line bandaging/adhesive/dressing around the PICC line was loose and starting to peel off client #1's arm. The PICC line dressing was off on 2/11/20 and the PICC line was dangling even farther than on 2/10/20. On 2/11/20 at 6:23 AM, the surveyors requested the Home Manager to secure client #1's PICC line on 2/11/20. On 2/11/20 at 7:48 AM, the Home Manager secured client #1's PICC line to his arm so the line was no longer dangling from his arm using tape. On 2/11/20 at 9:22 AM, a review of client #1's record was conducted. There was no documentation in client #1's record regarding the PICC line. There was no documentation when the line was inserted. There was no documentation of the care the PICC line required. There was no documentation the PICC line needed to be flushed	W 0227	Training will be conducted with Residential Nurse,Qualified Intellectual Disability Professional(QIDP) , Area Supervisor and residential staff on programs in regard to medical procedures and forming risk plans per individual needs,following plans in regards to areas of client programming. QIDP will review all discharges with Residential Nurse to ensure all programming and training needs are met. Observations will be conducted weekly by QIDP and/or Area Supervisor to ensure these program plans are adhered to. Persons responsible: QIDP, Residential Staff, Residential Manager, Area Supervisor, Residential Nurse, Associate Executive Director	03/14/2020

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	on a weekly basis. There was no documentation of what staff was to do if there were issues with the PICC line. There was no documentation of the care required to ensure the PICC line remained intact. There was no documentation of a risk plan. On 2/11/20 at 12:17 PM, the Home Manager indicated client #1 was discharged from the hospital on 1/3/20 with the PICC line. The Home Manager indicated she did not receive written instructions regarding the care required for the PICC line. The Home Manager indicated she was verbally told the instructions about getting the PICC line flushed weekly and he needed daily infusions. The Home Manager indicated she did not have documentation related to the PICC line. On 2/11/20 at 12:37 PM, the nurse indicated he did not have a risk plan for staff to implement regarding client #1's PICC line. The nurse stated "I think there was an order in the discharge summary." The nurse stated "I can call up there and get something." The nurse indicated the staff was not supposed to get the PICC line wet. The nurse indicated if the PICC line was pulled out, the staff needed to take him to the hospital. The nurse indicated these instructions were not in a plan. The nurse indicated this information should have been included in a plan. The nurse stated, "Should have been a plan. It's my fault. Didn't get one in there." The nurse indicated although he was at the group home on 2/10/20, he did not assess client #1's PICC line. The nurse indicated the PICC line was fine on Friday (2/7/20). The nurse indicated if the dressing fell off the staff should take client #1 to the infusion lab to get the dressing changed. The nurse indicated there was no plan instructing staff to do this. 2) On 2/11/20 at 1:14 PM, a review of the facility's			

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	incident reports was conducted and indicated the following: On 1/9/20 at 2:00 PM, client #1 went to a follow up appointment regarding a shoulder injury. The 1/10/20 Bureau of Developmental Disabilities Services incident report indicated, "It was reported [client #1] went for follow up appointment with the orthopedic surgeon after a surgery on [client #1's] shoulder. The Dr (doctor) discovered that [client #1's] shoulder was dislocated. Dr attempted to do a shoulder reduction, but it was too painful. Dr instructed staff to take [client #1] to ER (emergency room) to have shoulder reduction completed, so he could be sedated. At ER [client #1's] shoulder was x rayed and [client #1] was given sedation. ER Dr was able to perform shoulder reduction. [Client #1] was released with discharge instructions stating to wear left shoulder sling 24 hours daily until re-evaluated by ortho." During the observation on 2/10/20 from 11:23 AM to 12:48 PM at the outside services day program, client #1 was not wearing a sling. Client #1 was not prompted to wear a sling. Client #1's sling was not observed at the day program. During the observation on 2/10/20 from 3:54 PM to 5:50 PM at the group home, client #1 was not wearing a sling. Client #1 was not asked to wear a sling. Client #1 was not provided a sling. During the observation on 2/11/20 from 6:00 AM to 7:53 AM, client #1 was not wearing a sling. Client #1 was not asked or provided his sling. At 7:53 AM, during his medication administration, the Home Manager asked client #1 to wear his sling. Client #1 agreed to wear his sling. The Home Manager assisted client #1 to wear his sling.			

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	On 2/11/20 at 9:22 AM, a review of client #1's record was conducted. There was no plan in client #1's record regarding his refusals to wear his sling. Client #1 did not have a risk plan for the use of the sling. There was no plan regarding his refusals to wear the sling. Client #1's Narrative Section Progress Notes for January 2020 indicated the following (no times were documented): -1/5/20: "...took off arm sling a couple of times, asked to put it back on...." -1/6/20: "...sling was on his arm - may not have been on exactly right but it was on. Sometime after staff left at 10pm [client #1] took off his sling - was not on this morning...." -1/11/20: "...had arm sling off, said that it fell off, got it back on the best we could...." -1/11/20: "Took off arm sling." -1/11/20: "...just before going to bed (recliner) takes off the sling he is suppose (sic) to be wearing...." -1/12/20: "...took off arm sling at 3:40 A, claimed it fell off...." -1/12/20: "....will not keep his sling on, has taken it off multiple times...." -1/13/20: "...He refuses to leave his arm brace alone." -1/14/20: "...took off the arm sling, put back on the best we could...." -1/14/20: "Took off arm sling...." -1/16/20: "...in his room w/ (with) his sling off changing his clothes...." -1/17/20: "...took off arm sling at 2:30 A...." -1/17/20: "Took off arm sling and shirt...." -1/17/20: "...take off sling and ace wrap...." -1/17/20: "...Took off sling...." -1/17/20: "...took off his sling and would not put it back on...." -1/18/20: "...Would not let staff put his arm sling back on him...."			

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	-1/18/20: "Told everyone - guardian, [Area Supervisor], [Area Supervisor], and nurse about [client #1] changing clothes and take (sic) off sling...." (Note from Home Manager) -1/18/20: "Will not keep sling on...." -1/19/20: "...Wouldn't wear arm sling." -1/25/20: "...Took off arm sling when asked about it. Said that it was broken...." -1/25/20: "When staff asked about putting arm sling back on was told not to worry and mess with it, didn't want staff to put it back on." -1/29/20: "Note: Was not wearing his sling when he went to bed." -1/31/20: "...Did not have cast (sling) on." -1/31/20: "No sling...." On 2/10/20 at 2:31 PM, the Home Manager indicated client #1 was refusing to wear his sling. She indicated the staff put on the sling and he took it off when he wanted to. The Home Manager indicated the doctor was made aware of his refusals. On 2/11/20 at 10:05 AM, the nurse indicated he was aware of client #1's refusals to wear his sling on 2/10/20 when he refused to wear it while sleeping. The nurse indicated he told client #1 he needed to wear the sling while he was up during the day. The nurse indicated client #1 refused to put it on. The nurse indicated the staff was to apply an ACE bandage over the sling to keep client #1 from removing the sling. The nurse indicated he did not develop a plan to address client #1's refusals to wear his sling. On 2/11/20 at 10:07 AM, the Area Supervisor/AS indicated she was not aware client #1 was refusing to wear his sling. The AS indicated she should have been notified. The AS stated "need to put something in place to address his refusals."			

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	The AS indicated she was not told about his refusals. The AS stated, "would not let it go with all the things we have gone through with that guy." The AS indicated the Area Supervisor over the home should have reviewed the daily notes to see he was refusing to wear the sling. 9-3-4(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 clients in the sample (#1) and one additional client (#5), the facility failed to ensure the clients' plans included relevant interventions for staff to implement regarding: 1) client #1's fall risk plan and 2) client #5's behavior support plan. Findings include: 1) On 2/11/20 from 6:00 AM to 8:15 AM, an observation was conducted at the group home. On 2/11/20 at 6:20 AM, client #1 was in the bedroom. Client #1 stood up from his wheelchair and appeared to be doing something up above his head. The surveyor notified the Home Manager of client #1's standing in his bedroom. The Home Manager asked client #1 from the dining room if his wheels were locked. Client #1 answered the wheels were locked and he wanted to get his coat on. The Home Manager and staff #3 did not go into client #1's room to provide stand by assistance. Client #1 used a wheelchair during the observation at the group home. Client #1 did not use a walker.	W 0240	Training will be conducted with Residential Nurse,Qualified Intellectual Disability Professional(QIDP) , Area Supervisor and residential staff on programs in regard to medical procedures and forming risk plans per individual needs,following plans in regards to areas of client programming. QIDP will review all discharges with Residential Nurse to ensure all programming and training needs are met. Observations will be conducted weekly by QIDP and/or Area Supervisor to ensure these program plans are adhered to. Persons responsible: QIDP, Residential Staff, Residential Manager, Area Supervisor, Residential Nurse, Associate Executive Director	03/14/2020

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	On 2/11/20 at 7:32 AM, client #1 stood up from his wheelchair while in the living room. The Home Manager told client #1 to be careful. The Home Manager did not go over to client #1 to ensure he did not fall. On 2/11/20 at 9:22 AM, a review of client #1's record was conducted. Client #1's 10/15/19 Fall Risk plan indicated, "Staff will monitor [client #1] closely to prevent injury... Staff will aide (sic) in making sure rolling walker is used as needed...." On 2/11/20 at 12:02 PM, the Area Supervisor indicated client #1's risk plan needed to include specific instructions to staff to define closely. The Area Supervisor indicated the plan needed to be revised. On 2/11/20 at 12:00 PM, the Home Manager indicated client #1 needed to be assisted when he stood up from his wheelchair. The Home Manager indicated client #1 was not currently using a walker. The Home Manager indicated the risk plan needed to be revised to include the use of the wheelchair. 2) On 2/11/20 from 6:00 AM to 8:15 AM, an observation was conducted at the group home. At 6:37 AM while client #6 was receiving his medications from the Home Manager in the medication room, client #5 became agitated. Client #5 yelled, pushed items on the counter, spit and banged on the walls. The Home Manager prompted client #5 out of the medication room. Client #5 started to leave the medication area but refused to leave. The Home Manager prompted client #5 to go out to listen to music. Client #5 did not go out. The Home Manager escorted client #5 to the hallway and attempted to close the door. Client #5 attempted to open the door. The Home			

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	Manager used her body and eventually closed and locked the medication room door. Staff #3 came to intervene with client #5. Client #5 yelled and hit the walls. Client #5 calmed down and stopped hitting the walls and stopped yelling. On 2/11/20 at 6:40 AM, the Home Manager stated, "[Client #5] hasn't done that here (at the group home) in a long time." On 2/11/20 at 12:08 PM, a focused review of client #5's record was conducted. Client #5's 5/7/19 Behavior Support Plan/BSP indicated he had a targeted behavior of physical aggression, property destruction and agitation. The plan indicated in the Preventative Measures section, "If [client #5] becomes upset staff need to prompt him to use these strategies. Ex (example): [Client #5] is denied access to something he wants and he starts pacing and becoming agitated. Staff could ask him if he wants to take a walk to regain his composure, if there are enough staff to make this possible or if weather permits. Talk with [client #5] about preferred topics, his clothing, hats, country music...." On 2/11/20 at 12:12 PM, the Area Supervisor indicated client #5's BSP needed to be revised to include additional strategies staff could use to address his agitation. The AS indicated the plan did not include a sufficient amount of strategies for staff to use to address his agitation. The AS indicated the plan needed to clearly indicate the strategies staff was to use when he was agitated. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has			

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	formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #3) and one additional client (#4), the facility failed to ensure the staff implemented the clients' program plans as indicated. Findings include: 1) On 2/11/20 from 6:00 AM to 8:15 AM, an observation was conducted at the group home. On 2/11/20 at 6:20 AM, client #1 was in the bedroom. Client #1 stood up from his wheelchair and appeared to be doing something up above his head. The surveyor notified the Home Manager of client #1's standing in his bedroom. The Home Manager asked client #1 from the dining room if his wheels were locked. Client #1 answered the wheels were locked and he wanted to get his coat on. The Home Manager and staff #3 did not go into client #1's room to provide stand by assistance. Client #1 used a wheelchair during the observation at the group home. Client #1 did not use a walker. On 2/11/20 at 7:32 AM, client #1 stood up from his wheelchair while in the living room. The Home Manager told client #1 to be careful. The Home Manager did not go over to client #1 to ensure he did not fall. On 2/11/20 at 9:22 AM, a review of client #1's record was conducted. Client #1's 10/15/19 Fall Risk plan indicated, "Staff will monitor [client #1]	W 0249	Training will be conducted with Residential Nurse,Qualified Intellectual Disability Professional(QIDP) , Area Supervisor and residential staff on programs in regard to medical procedures and forming risk plans per individual needs,following plans in regards to areas of client programming. QIDP will review all discharges with Residential Nurse to ensure all programming and training needs are met. Observations will be conducted three times weekly weekly for one month, then twice weekly on going by QIDP, Residential Manager, and/or Area Supervisor to ensure these program plans are adhered to. Persons responsible: QIDP, Residential Staff, Residential Manager, Area Supervisor, Residential Nurse, Associate Executive Director	03/14/2020

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	closely to prevent injury... Staff will aide (sic) in making sure rolling walker is used as needed...." On 2/11/20 at 11:57 AM, the Area Supervisor/AS indicated client #1 had a fall risk plan requiring supervision when he stood up. The AS indicated the staff should implement the plan as written. On 2/11/20 at 12:00 PM, the Home Manager indicated client #1 should be assisted when he stood up to prevent him from falling. 2) On 2/10/20 from 3:57 PM to 5:50 PM, an observation was conducted at the group home. At 4:44 PM, client #3 exited his bedroom. His door alarm sounded an audible alert. Client #3 returned to his room one minute later and the alarm sounded again when his door was opened. The staff did not disable the alarm once the staff was aware the alarm was activated. On 2/10/20 at 4:45 PM, staff #6 indicated the alarm was due to client #3's food seeking. On 2/10/20 at 4:45 PM, the Home Manager indicated the alarm was due to his food seeking. On 2/11/20 at 10:40 AM, a review of client #3's record was conducted. Client #3's 3/11/20 (correct date) Individualized Support Plan/ISP indicated, "Sensory Alarm placed on his bedroom door to alert staff when he is exiting his bedroom during sleep hours. Reason the modification is needed: To alert staff of possible elopement, food hoarding and personal safety...." On 2/11/20 at 10:03 AM, the Area Supervisor indicated the staff failed to implement client #3's plan as written. The AS stated "[Client #3's] door alarm only to be used at night."			

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	15G194	A. BUILDING 00 B. WING	02/13/2020

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	3) On 2/11/20 from 6:00 AM to 8:15 AM, an observation was conducted at the group home. From 6:48 AM to 7:03 AM, client #4 sat unsupervised by staff at the dining room table eating his breakfast. The Home Manager was passing medications in the medication room and staff #3 was assisting client #3 in his bedroom. The staff did not encourage him to take small bites and chew his food thoroughly before swallowing. The staff did not encourage him to not have consecutive drinks. On 2/11/20 at 11:28 AM, a focused review of client #4's record was conducted. Client #4's 3/13/20 (correct date) Individualized Support Plan indicated, "[Client #4] will take small bites and chew food thoroughly. Staff will encourage [client #4] to take small bites and chew food thoroughly before swallowing...." The plan indicated, "Staff will follow [client #4's] Dining Plan... Staff will encourage [client #4] to not have consecutive drinks, one sip at a time when drinking... RISK OF NO SUPPORT: Possible choking...." Client #4's 2/4/19 risk plan for choking indicated, in part, "...Staff will monitor for signs/symptoms of choking during all food intake...." On 2/11/20 at 11:58 AM, the Home Manager/HM stated staff should have supervised client #4 "at all times while eating." The HM indicated staff #4 should have been implementing the plan as written for prompts regarding sips and bites. 9-3-4(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing			

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	services in accordance with their needs. Based on observation, interview and record review for 1 of 3 clients in the sample (#1) and one additional client (#8), the facility's nursing services failed to ensure: 1) former client #8's weight gain in one month was communicated to the doctor and 2) a plan was developed and implemented for the care of client #1's PICC (Peripherally inserted central catheter) line. Findings include: 1) On 2/11/20 at 10:49 AM, a focused review of former client #8's record was conducted. Client #8's Monthly Weight & Vital Sign Record for October 2019 indicated client #8 weighed 122.6 pounds on 10/8/19. Client #8's November 2019 weight was 127.7 on 11/10/19. Client #8 gained 5.1 pounds from 10/8/19 to 11/10/19. The bottom of the Monthly Weight form indicated, "Weight fluctuations of 5 pound (+/- up/down due to facility policy) should be immediately reported to the nurse. There was no documentation the nurse was notified. The Nurses Signature and Date of Review section was blank from March 2019 to December 2019. On 2/11/20 at 11:51 AM, a review of client #8's Physician's Standing Orders was conducted. The orders indicated, in part, in the Nurse Orders section, "...Notify physician if +/- 5 pounds in 1 month." There was no documentation the nurse notified client #8's physician of his weight gain. On 2/11/20 at 12:26 PM, the Area Supervisor indicated the nurse and client #8's physician should have been notified of his weight gain from November to December 2019. On 2/13/20 at 11:13 AM, the nurse indicated he was not notified of client #8's weight gain. He	W 0331	Training will be conducted with Residential Nurse,Qualified Intellectual Disability Professional(QIDP) , Area Supervisor and residential staff on programs in regard to medical procedures and forming risk plans per individual needs,following plans in regards to areas of client programming. QIDP will review all discharges with Residential Nurse to ensure all programming and training needs are met. Observations will be conducted weekly by QIDP and/or Area Supervisor to ensure these program plans are adhered to. Persons responsible: QIDP, Residential Staff, Residential Manager, Area Supervisor, Residential Nurse, Associate Executive Director	03/14/2020

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	should have been notified. The nurse stated, "I might not have (reviewed the weight record) in those months. I do it now." The nurse indicated he did not contact client #8's physician to notify him of the weight gain. The nurse indicated he should have notified the doctor. The nurse stated, "...that's what our policy says." 2) Throughout the observation on 2/10/20 from 3:54 PM to 5:50 PM at the group home, client #1 had a PICC line in right arm. The access cap and tubing were not secured. The access cap and tubing were dangling throughout the observation. On 2/11/20 at 7:48 AM, the Home Manager indicated client #1 had 3 bandages to cover the PICC line however no one could find them. The Home Manager indicated she was taking client #1 to the infusion center on this date to get the dressing changed and the PICC line flushed. On 2/11/20 from 6:00 AM to 7:48 AM when the Home Manager secured client #1's PICC line, the PICC line was dangling from his arm. The PICC line bandaging/adhesive/dressing around the PICC line was loose and starting to peel off client #1's arm. The PICC line dressing was off on 2/11/20 and the PICC line was dangling even farther than on 2/10/20. The surveyors requested the Home Manager to secure client #1's PICC line on 2/11/20. On 2/11/20 at 7:48 AM, the Home Manager secure client #1's PICC line to his arm so the line was no longer dangling from his arm. On 2/11/20 at 9:22 AM, a review of client #1's record was conducted. There was no documentation in client #1's record regarding the PICC line. There was no documentation when the line was inserted. There was no documentation of the care the PICC line required. There was no			

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	documentation the PICC line needed to be flushed on a weekly basis. There was no documentation of what staff was to do if there were issues with the PICC line. There was no documentation of the care required to ensure the PICC line remained intact. There was no documentation of a risk plan. On 2/11/20 at 12:17 PM, the Home Manager indicated client #1 was discharged from the hospital on 1/3/20 with the PICC line. The Home Manager indicated she did not receive written instructions regarding the care required for the PICC line. The Home Manager indicated she was verbally told the instructions about getting the PICC line flushed weekly and he needed daily infusions. The Home Manager indicated she did not have documentation related to the PICC line. On 2/11/20 at 12:37 PM, the nurse indicated he did not have a risk plan for staff to implement regarding client #1's PICC line. The nurse stated "I think there was an order in the discharge summary." The nurse stated "I can call up there and get something." The nurse indicated the staff was not supposed to get the PICC line wet. The nurse indicated if the PICC line was pulled out, the staff needed to take him to the hospital. The nurse indicated these instructions were not in a plan. The nurse indicated this information should have been included in a plan. The nurse stated, "Should have been a plan. It's my fault. Didn't get one in there." The nurse indicated although he was at the group home on 2/10/20, he did not assess client #1's PICC line. The nurse indicated the PICC line was fine on Friday (2/7/20). The nurse indicated if the dressing fell off the staff should take client #1 to the infusion lab to get the dressing changed. The nurse indicated there was no plan instructing staff to do this.			

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	9-3-6(a)			