DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2024 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		3) DATE SURVEY COMPLETED
RES CARE SOUTHEAST INDIANA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (W 000) INITIAL COMMENTS This visit was for the PCR (Post Certification Revisit) to the investigation of complaint #IN00431589 completed on 4/3/24. Complaint #IN00431589: Corrected. Survey Dates: 5/13/24 and 5/14/24 Facility Number: 011595 Provider Number: 200905630 Res Care Southeast Indiana was found to be in compliance with 42 CFR, Part 483, Subpart I and 460 IAC 9 in regard to the PCR to the investigation of completed by STREETADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126 PREFIX TAG PREFIX T			15G749	B. WING			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) {W 000} INITIAL COMMENTS This visit was for the PCR (Post Certification Revisit) to the investigation of complaint #IN00431589: Corrected. Survey Dates: 5/13/24 and 5/14/24 Facility Number: 011595 Provider Number: 15G749 AIMS Number: 200905630 Res Care Southeast Indiana was found to be in compliance with 42 CFR, Part 483, Subpart I and 460 IAC 9 in regard to the PCR to the investigation of complaint #IN00431589. Quality Review of this report completed by					16613 SIMA GRAY RD	ATE, ZIP CODE	03/14/2024
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		Revisit) to the investig #IN00431589 comple Complaint #IN004315 Survey Dates: 5/13/2 Facility Number: 0115 Provider Number: 150 AIMS Number: 20090 Res Care Southeast compliance with 42 Cd 460 IAC 9 in regard to investigation of comp Quality Review of this	gation of complaint sted on 4/3/24. 589: Corrected. 4 and 5/14/24 595 G749 5630 Indiana was found to be in FR, Part 483, Subpart I and to the PCR to the laint #IN00431589.				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA	LADODATORY						(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.