PRINTED:	07/12/2024					
FORM APPROVED						

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G745 B. WING 06/14/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE. IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE W 0000 Bldg. 00 This visit was for a focused fundamental W 0000 recertification and state licensure survey. Survey Dates: 6/10/24, 6/11/24, 6/12/24, 6/13/24 and 6/14/24. Facility Number: 011663 Provider Number: 15G745 AIMS Number: 200902020 This deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/27/24. W 0252 483.440(e)(1) **PROGRAM DOCUMENTATION** Bldg. 00 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 2 of 2 W 0252 07/11/2024 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2's formal training The Area Supervisor will objectives were documented. ensure that the staff will be retrained on proper documentation Findings include: of goals. The Area Supervisor will 1. Client #1's record was reviewed on 6/11/24 at ensure that the staff will be 10:21 AM. Client #1's ISP (Individual Support retrained on reporting any issues Plan) dated 11/29/23 indicated the following: with goal documentation will be reported immediately to the QIDP -"OBJECTIVE: Will do some type of chore around The QAM will ensure that the house daily with staff assistance 75% of the the QIPD is retrained on checking opportunities for 12 months by 11/29/2024." the tracking of the goals weekly to make sure they are tracking Client #1's Outcome/Objective Progress Notes properly.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	E TITLE	(X6) DATE
Tracy Callahan	Program Manager	07/11/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR	R MEDICARE & MEDI	CAID SERVICES				0	MB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	DNSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUI	LDING	00	COMI	PLETED
		15G745	B. WIN	G		06/14	4/2024
NAME OF F	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF FROMDER OR SUFFLIER				16611 SIMA GRAY RD			
RES CAP	RE SOUTHEAST I	NDIANA		HENRY	/VILLE, IN 47126		
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Р	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
review d attempts 2. Client 11:19 AN the follow -"OBJEC prompts	from May 2024 through the June 11, 2024 date of				The Program Manager will		
	review did not indicate documentation of goal attempts regarding client #1's daily chore goal.				ensure that the Area Superv	visor	
					will be retrained on checking	3 TMP	
					daily to ensure that the goal	s are	
	2. Client #2's record			tracking properly and if not,	she		
	11:19 AM. Client #2's ISP dated 8/23/23 indicated				will notify the QIPD immedia	itely.	
	the following: -"OBJECTIVE: Will bathe daily with two verbal				The Area Supervisor v	vill	
					ensure that the staff are retr	ained	
					on how to properly track goa	als and	
	prompts 90% of th			will report to Area Superviso	or		
	consecutive month	secutive months by 8/23/24."			immediately if there are any	/	
					issues.		
	-"OBJECTIVE: [c	lient #2] will learn to utilize			A weekly meeting IDT	will	
	coping skills so the	at he may independently reduce			be held to discuss any issue	e that	
	feelings of anxiety/obsession 90% of				may arise.		
	opportunities for 1	2 consecutive months by			-		
	8/23/24."						
	Climet #21- Onter a	Volis din Du and Nata					
		ne/Objective Progress Notes			PERSONS RESPONSIBLE:	,	
	dated from May 2024 through the June 11, 2024 date of review did not indicate documentation of				Nurse, Director of Nursing,	Juanty	
					Assurance Manager, QA		
		rding client #2's daily bathing			Coordinator/QIDP Manager		
	goal or coping skil	lis goal.			Program Manager, Area		
					Supervisor, QIDP, Direct Su	ipport	
		ntellectual Disabilities			Lead, DSP		
	· · · ·	interviewed on 6/11/24 at 10:21					
		ted clients #1 and #2's goal data			DATE OF COMPLETION: A	August	
	snould be complet	ed as described by the goal.			10, 2024		
	9-3-4(a)						

HXPR11 Facility ID: 011663

If continuation sheet

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