STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G745	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

(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: 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 0000		
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION 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 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2's formal training objectives were documented. Findings include: 1. Client #1's record was reviewed on 6/11/24 at 10:21 AM. Client #1's ISP (Individual Support Plan) dated 11/29/23 indicated the following: -"OBJECTIVE: Will do some type of chore around the house daily with staff assistance 75% of the opportunities for 12 months by 11/29/2024." Client #1's Outcome/Objective Progress Notes	W 0252	The Area Supervisor will ensure that the staff will be retrained on proper documentation of goals. The Area Supervisor will ensure that the staff will be retrained on reporting any issues with goal documentation will be reported immediately to the QIDP The QAM will ensure that the QIPD is retrained on checking the tracking of the goals weekly to make sure they are tracking properly.	07/11/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G745	A. BUILDING 00 B. WING	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

(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
	from May 2024 through the June 11, 2024 date of review did not indicate documentation of goal attempts regarding client #1's daily chore goal. 2. Client #2's record was reviewed on 6/11/24 at 11:19 AM. Client #2's ISP dated 8/23/23 indicated the following: -"OBJECTIVE: Will bathe daily with two verbal prompts 90% of the opportunities for 12 consecutive months by 8/23/24." -"OBJECTIVE: [client #2] will learn to utilize coping skills so that he may independently reduce feelings of anxiety/obsession 90% of opportunities for 12 consecutive months by 8/23/24." Client #2's Outcome/Objective Progress Notes dated from May 2024 through the June 11, 2024 date of review did not indicate documentation of goal attempts regarding client #2's daily bathing goal or coping skills goal. QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 6/11/24 at 10:21 AM. QIDP indicated clients #1 and #2's goal data should be completed as described by the goal. 9-3-4(a)		The Program Manager will ensure that the Area Supervisor will be retrained on checking TMP daily to ensure that the goals are tracking properly and if not, she will notify the QIPD immediately. The Area Supervisor will ensure that the staff are retrained on how to properly track goals and will report to Area Supervisor immediately if there are any issues. A weekly meeting IDT will be held to discuss any issue that may arise. **PERSONS RESPONSIBLE:** AED, Nurse, Director of Nursing, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support Lead, DSP **DATE OF COMPLETION:** August 10, 2024	