

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for the investigation of complaint #IN00346328.</p> <p>Complaint #IN00346328: Substantiated, federal and state deficiency related to the allegation(s) was cited at W149.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 3/4/21 and 3/5/21.</p> <p>Facility Number: 011664 Provider Number: 15G746 AIM Number: 200902010</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 3/19/21.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 3 of 11 incidents affecting clients A, B and D, the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment or violation of an individual's rights to prevent 1) former staff #1's use of intimidation toward client A, 2) former staff #2's use of retaliation toward client A and 3) client D's physical aggression toward client B on 1/7/21, hitting him in the face with a metal thermos.</p>	W 0149	<p>1. The Facility will retrain staff at the site on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor and Residential Manager to ensure all</p>	04/04/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>On 3/4/21 at 11:43 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated:</p> <p>1)-BDDS report dated 12/18/20 indicated, "It was reported [client A] told Area Supervisor [name] that staff [former staff #1] came to the group home on 12/17/20 and threatened [client A] concerning an attempt [client A] made to hurt staff".</p> <p>Investigation summary dated 12/18/20 through 12/28/20 indicated, "Introduction: An investigation was initiated when [client A] reported to Area Supervisor that staff, [former staff #1] was verbally abusive toward [client A]. Scope of Investigation: Determine if [former staff #1] was verbally abusive toward [client A]. Determine if [former staff #1] made threatening/intimidating statements ... Conclusion: Unsubstantiated [former staff #1] was verbally abusive toward [client A]. Substantiated [former staff #1] has made blanketed intimidating statements in reference to staff/clients. Recommendations: Term (terminate) [former staff #1]. Retrain staff on [client A's] BSP (behavior support plan) ...".</p> <p>2)-BDDS report dated 1/22/21 indicated, "[Client A] reported to staff that on 1/20/21 staff, [former staff #2] was using YSIS (You're Safe I'm Safe) to put [client A] in a hold and held [client A's] head against the wall. [Client A] stated his head hurt. Nurse was contacted and did skin assessment on [client A]. Nurse reported that the left side of [client A's] head appeared</p>		<p>incidents of possible abuse, neglect and exploitation are reported to the QA department.</p> <p>2. The facility will retrain the staff at the site on all clients Behavior Support Plan (BSP) specific engaging in active treatment with clients. Staff will be retrained on providing opportunities for active treatment. Staff will be retrained on following the "Meaningful Day" schedule.</p> <p>3. All Staff will be retrained on Consumer Specific Training for all clients at the site.</p> <p>4. The Program Manager will ensure retraining for all staff at the site is completed by April 4, 2020</p> <p>5. The Area Supervisor and Residential Manager will ensure all new staff receive initial training and retraining as needed.</p> <p>Persons Responsible, Program Manager, Behavior Clinician, QIDP, Nurse, Area Supervisor, Residential Manager, Direct Support Lead and Direct Support Professional.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>slightly swollen with a small amount of redness and was hot to the touch. Nurse advised staff to transport [client A] to [hospital name] ER (emergency room) for evaluation. [Client A] was evaluated and released with discharge paperwork for Contusion of Scalp. Plan of Resolve: During the course of the investigation, [client A] stated to numerous people, including the investigator, that he lied regarding the allegation of abuse ...".</p> <p>Investigation report dated 1/22/21 through 1/27/21 indicated, "Introduction: An investigation was initiated when [client A] reported [former staff #2] put [client A's] head against the wall during a behavior on 1/20/21 causing swelling and pain on right side of [client A's] head. Conclusion: Unsubstantiated [former staff #2] pushed [client A's] head into the wall during a behavior".</p> <p>-BDDS report dated 1/30/21 indicated, "Allegations were received of staff (former staff #2) antagonizing [client A]. The staff member in question was placed on administrative leave pending investigation".</p> <p>Investigation report dated 1/30/21 through 2/5/21 indicated, "Introduction: An investigation was initiated when it was reported staff, [former staff #2] was witnessed being retaliatory toward [client A] by refusing to participate in active treatment with [client A] due to a previous allegation of ANE (Abuse, Neglect and Exploitation) [client A] made against [former staff #2]. Scope of Investigation: Determine if [former staff #2] was retaliating against [client A] due to a previous allegation of ANE [client A] made against [former staff #2]. Conclusion: Substantiated [former staff #2] was retaliating against [client A] due to a previous ANE</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>allegation [client A] made against [former staff #2]. Recommendations: Term (terminate) [former staff #2] ...".</p> <p>3)-BDDS report dated 1/8/21 indicated, "It was reported [client D] had been in the bathroom when he came out and picked up a metal water jug and threw it at [client B]. The jug hit [client B] in the face causing his nose to bleed. Staff was able to verbally redirect [client D]. [Client B] reported to staff that he was feeling dizzy and that his vision was affected. [Client B] was transported to [hospital name] ER (emergency room) for eval (evaluation). X-ray (electromagnetic imagine) showed no fractures. No concussion was reported. [Client B] is to use ibuprofen as needed for pain. [Client B] sustained no bruising".</p> <p>Investigation report dated 1/7/21 indicated, "Briefly describe the incident: For some unknown reason, [client D] rushed out of the bathroom shouting, picked up a full metal water jug and threw it at [client B], striking him in the face. [Client B] fell to his knees and had a bloody nose ... Interview staff involved: [Staff #5] I was in the kitchen working on breakfast, standing in the window looking towards [client D's] bedroom ... [Staff #4] I was getting ready to pass medications for the clients. I heard [client D] yell and heard [client B], when I came out of the office, [client B] was on his knees ... Was there sufficient staff at the time of the incident? No".</p> <p>On 3/5/21 at 12:47 PM, the Interim Program Manager (IPM) was interviewed. The IPM was asked about the above noted incident history. The IPM indicated she had started at the tail end of this incident history, but was aware of them. The IPM stated, "They (staff) need to keep them safe.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0186 Bldg. 00	<p>We're retraining all staff and starting fresh. I'm retraining on the consumer specific and ANE policy. I need to be confident all staff are trained. It's never bad to retrain". The IPM indicated former staff #1's use of intimidation toward client A, former staff #2's use of retaliation toward client A and client D's physical aggression toward client B on 1/7/21, hitting him in the face with a metal thermos, all of these incidents had occurred. The IPM indicated the ANE policy should be implemented at all times.</p> <p>On 3/5/21 at 1:08 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the above noted incident history. The QAM indicated former staff #1's use of intimidation toward client A, former staff #2's use of retaliation due to a previous ANE allegation alleged by client A and client D's physical aggression toward client B on 1/7/21, hitting him in the face with a thermos, all of these incidents had occurred. The QAM was asked if the ANE policy should be implemented at all times. The QAM stated, "Yes, absolutely".</p> <p>On 3/5/21 at 12:38 PM, the ANE policy dated 10/16/20 was reviewed. The ANE policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights".</p> <p>This federal tag relates to complaint #IN00346328.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 2 incident/investigative reports reviewed affecting clients B and D, the facility failed to ensure there was sufficient direct care staff to manage and supervise clients B and client D according to their program plans.</p> <p>Findings include:</p> <p>Observation was completed on 3/4/21 from 2:00 PM to 3:25 PM. Present at the home were clients A, B, C and D along with the Area Supervisor, staff #4 and staff #5. Clients A and B were seated at the dining room table eating a banana each. Client C was in his bedroom and client D was seated at a table in a common living room eating a banana.</p> <p>-At 2:32 PM, client A and client B went with the Area Supervisor to a basketball court. Client C and staff #5 remained on one side of the home while client D remained on another side of the home with staff #4. Client C proceeded to take a shower and client D remained seated in a common living area watching television after eating his banana.</p> <p>-At 2:25 PM, staff #5 was asked about client D's physical aggression toward client B. Staff #5 indicated he was present when client D used a metal water jug to hit client B in the face. Staff #5 indicated client D came out of the bathroom and at that time client B was coming out of his</p>	W 0186	<p>1. The Program Manager will conduct a weekly meeting to project needs and plan coverage for open shifts. All Area Supervisors in the New Albany Program and All ESN Direct Support Leads, and Residential Managers will attend if available.</p> <p>2. ResCare New Albany Operation has brought in staff from out of town and, increased wages for DSPs outside of the ESN System including paid travel time bonuses, and mileage.</p> <p>3. Human Resources has made filling ESN Open shifts a priority, this will continue until vacancies are filled.</p> <p>4. The Area Supervisor will coordinate with ESN Residential Managers to ensure shift coverage. All unfilled shift will be reported to the Program Manager.</p> <p>5. DSP Base pay has been increased for all ESN Staff hour to help fill staffing vacancies, additional bonuses are being provided for qualified staff.</p> <p>6. A weekly report is being provided to the hiring manager that will identify open positions and forecast staff gains and losses.</p>	04/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>bedroom. Client D picked up a metal "thermos" for drinking water and hit client B in the face. Staff #5 stated client B "handled" the situation well but was hurt and client B's nose was bloody from being hit by the water container. Staff #5 indicated only two staff were present at the time of the incident. Staff #5 indicated he took client B the hospital for evaluation and treatment and the metal containers for drinking water were removed for safety.</p> <p>-At 2:49 PM, staff #4 was asked about client D's physical aggression toward client B and the staffing during the incident. Staff #4 stated, "There were two of us here when that happened. I was preparing medications and [staff #5] was either in the kitchen preparing breakfast or mop water (for cleaning after breakfast). We keep the same routine". Staff #5 indicated by pointing to the kitchen his location during the incident and staff #4 then stated, "I have no idea why they (client D) had those (metal thermos) ... There was no way I could stop that".</p> <p>On 3/4/21 at 11:43 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated:</p> <p>BDDS report dated 1/8/21 indicated, "It was reported [client D] had been in the bathroom when he came out and picked up a metal water jug and threw it at [client B]. The jug hit [client B] in the face causing his nose to bleed. Staff was able to verbally redirect [client D]. [Client B] reported to staff that he was feeling dizzy and that his vision was affected. [Client B] was transported to [hospital name] ER (emergency room) for eval (evaluation). X-ray</p>			Persons Responsible: Program Manager, Human Resource, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>(electromagnetic imagine) showed no fractures.</p> <p>No concussion was reported. [Client B] is to use ibuprofen as needed for pain. [Client B] sustained no bruising".</p> <p>Investigation report dated 1/7/21 indicated, "Briefly describe the incident: For some unknown reason, [client D] rushed out of the bathroom shouting, picked up a full metal water jug and threw it at [client B], striking him in the face. [Client B] fell to his knees and had a bloody nose ... Interview staff involved: [Staff #5] I was in the kitchen working on breakfast, standing in the window looking towards [client D's] bedroom ... [Staff #4] I was getting ready to pass medications for the clients. I heard [client D] yell and heard [client B], when I came out of the office, [client B] was on his knees ... Was there sufficient staff at the time of the incident? No".</p> <p>On 3/5/21 at 10:31 AM, client B's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 1/25/21 indicated, "He (client B) relies on others to obtain his medication and their administration. [Client B] receives psychotropic medications to assist him in managing negative behaviors. He can learn most basic skills using one-on-one repetitive training. [Client B] needs significant training to generalize skills to the real world ...".</p> <p>On 3/5/21 at 10:45 AM, client D's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 10/2/20 indicated, "[Client D] requires supervision to ensure basic ADL's (adult daily living skills) are completed. He currently is in good health but requires 24- hour supervision and care...".</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>-Behavior Support Plan dated 9/3/20 indicated, "[Client D] has a history of severe aggression towards staff and peers... Target Behaviors... Physical Aggression, Property Destruction...".</p> <p>On 3/5/21 at 11:22 AM, the undated Reimbursement Guidelines for the 24-hour Extensive Support Needs Residences were reviewed. The record indicated, "Individuals living in residences under this category must be supervised at all times and the staffing pattern at full capacity should be a minimum of: three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift". From observation, interviews, and a record review on 3/5/21 at 11:18 AM of the previous 3 weeks of time records, the time records indicated staff #4 and staff #5 were the only staff members present during the 8 AM to 8 PM day shift on 1/7/21.</p> <p>On 3/5/21 at 12:47 PM, the Interim Program Manager (IPM) was interviewed. The IPM was asked about the above noted incident history and staffing coverage that time. The IPM stated she started at the "tail end" of the incident history, but aware. The IPM stated, "They (staff) need to keep them safe. We're retraining all staff and starting fresh. I'm retraining on the consumer specific and ANE (Abuse, Neglect and Exploitation) policy. I need to be confident all staff are trained. It's never bad to retrain". The IPM was asked about the staffing at the time of the incident. The IPM stated, "They were under ratio ... If they (staff #4 and staff #5) said they were under ratio, they were under ratio".</p> <p>On 3/5/21 at 1:08 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN 47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>asked about the above noted incident history. The QAM indicated the client-to-client incident occurred on 1/7/21 at 7:30 AM. The QAM was asked if the home required 3 staff at the time of the incident. The QAM stated, "Yes, that's part of our waking hours".</p> <p>9-3-3(a)</p>				