STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/09/2022

NAME OF PROVIDER OR SUPPLIER **RES-CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1306 S BLOOMINGTON STREET** **GREENCASTLE, IN 46135**

(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 000	**INITIAL COMMENTS** This visit was for the investigation of complaint #IN00384682. Complaint #IN00384682: Unsubstantiated, due to lack of sufficient evidence. This visit was done in conjunction with the Post Certification Revisit (PCR) to the pre-determined full annual recertification and state licensure survey completed on 6/9/2022. Survey dates: August 1, 2, 3, 4, 5, 8, and 9, 2022. Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570 Res-Care Inc. was found to be in compliance with 42 CFR Part 483, Subpart I and 410 IAC 16.2-5 in regard to the investigation of complaint #IN00384682. Quality Review of this report completed by #15068 on 8/17/22.	W 000		

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