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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 00 B. WING	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 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 pre-determined recertification and state licensure survey. Dates of Survey: 8/28/23, 8/29/23, 8/30/23 and 8/31/23. Facility Number: 011595 Provider Number: 15G749 AIMS Number: 200905630 This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 9/7/23.	W 0000		
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review, observation and interview for 1 of 2 sampled clients (#1), the facility failed to update client #1's dining plan and Individual Support Plan to include adaptive equipment needed during meal times. Findings: An observation was conducted on 8/29/23 from 3:42 PM to 5:53 PM. At 4:27 PM, client #1 ate from a plate suctioned to the table and drank from a cup with a lid.	W 0227	1 Facility updated client #1's dining plan and Individual Support Plan to include adaptive equipment needed during meal times. 2 During random monthly administrative review BSP/ISP Dining Plans and HRP will be reviewed by member of management. The facility will monthly at a minimum meet as IDT and will review client progress and make changes to plans from	09/22/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Slaughter	AED	09/22/2023

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.

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	The PM (Program Manager) was interviewed on 8/29/23 at 4:27 PM. The PM indicated client #1 used a suctioned plate and cup with a lid to prevent him from throwing the plate and cup. An observation was conducted on 8/30/23 from 6:54 AM to 9:16 AM. At 7:50 AM client #1 drank water from a cup with a lid. At 8:04 AM client #1 ate breakfast from a plate that was suctioned to the table and drank from a cup with a lid. Client #1's record was reviewed on 8/29/23 at 10:41 AM. The dining plan, dated 6/14/23, indicated no adaptive equipment was needed during meal time. The ISP (Individual Support Plan), dated 6/15/23, did not indicate the need for a suctioned plate or cup with lid in the adaptive equipment section. The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 8/29/23 at 2:46 PM. The QIDP indicated client #1 used a suctioned plate and cup with a closed lid to prevent him from throwing his plate and cup. The QIDP indicated several types of plates and cups have been tried. The BC (Behavior Consultant) was interview 8/29/23 at 3:48 PM. The BC indicated client #1 had difficulty drinking from an open cup. The BC indicated client #1 previously ate using his fingers. The plate with higher sides makes it easier for him to scoop food onto his spoon. The BC indicated client #1 needs a sturdy cup because he has thrown cups. The LPN (Licensed Practical Nurse) was		the recommendations made by the IDT. 3 The Facility will retrain all staff responsible for client care in the facility on plan changes based on recommendations by the IDT. 4 Observations will be complete weekly by the DSL, and Monthly by area supervisor, random observation will be conduced by a member of the administrative team monthly. **Persons Responsible**: Program Manager, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP. **DATE OF COMPLETION:** September 22, 2023	

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	interviewed on 8/30/23 at 9:31 AM. The LPN indicated dining plan revisions will be made to add suctioned bowl/plate and cup with a lid at client #1's next quarterly meeting. Client #1's nursing quarterly assessment, dated 7/18/23, was reviewed 8/30/23 at 9:31 AM. The LPN noted weighted/suctioned bowl and sippy cup were working well. 9-3-4(a)			