STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING _____ B. WING _____	C 05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 #IN00351051. This visit was in conjunction with the pre-determined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Complaint #IN00351051: Unsubstantiated, due to a lack of sufficient evidence. Survey dates: 5/11/21, 5/12/21, 5/13/21 and 5/14/21. Facility Number: 000775 Provider Number: 15G255 AIMS Number: 100248960 ResCare Community Alternatives SE IN was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the investigation of complaint #IN00351051. Quality Review of this report completed by #15068 on 5/27/21.	W 000		

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