STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011595	A. BUILDING: _____ B. WING _____	C 11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE SOUTHEAST INDIANA	16613 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) COMPLETE DATE
S 000	INITIAL COMMENTS An investigation of Complaint Number IN00277386 was conducted by the Indiana State Department of Health. Complaint Number: IN00277386 Substantiated, No deficiencies related to allegations Survey Date: 10/31/18 Facility Number: 011595 Provider Number: 15G749 AIM Number: 200905630 Census: 4 Res Care Southeast Indiana was found in compliance with 42 CFR Part 483, Subpart I and 410 IAC 16.2 in regard to the investigation of Complaint Number IN00258084. Quality Review completed on 11/07/18 - DA	S 000		