

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FIVE STAR RESIDENCES OF LAFAYETTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 SHENANDOAH DRIVE</b> <b>LAFAYETTE, IN 47905</b>
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(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
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00440426</p> <p>Complaint IN00440426 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 16, 19 and 20, 2024.</p> <p>Facility number: 014015</p> <p>Residential Census: 77</p> <p>Five Star Residences of Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00440426.</p> <p>Quality review was completed on August 21, 2024.</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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