

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>01/19/2024</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 the Investigation of Complaints IN00416271 and IN00423904.</p> <p>Complaint IN00416271 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00423904 - No deficiencies related to the allegations are cited.</p> <p>Survey date: January 19, 2024</p> <p>Facility number: 014015</p> <p>Residential Census: 85</p> <p>Five Star Residences of Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00416271 and IN00423904.</p> <p>Quality review was completed on January 31, 2024.</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE