

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  R-C <b>03/31/2025</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 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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00452620 completed on February 10, 2025.</p> <p>Complaint IN00452620 - Corrected.</p> <p>Survey date: March 31, 2025</p> <p>Facility number: 014015</p> <p>Residential Census: 78</p> <p>Five Star Residences of Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00452620.</p> <p>Quality review was completed on April 7, 2025.</p>	{R 000}		

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