STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER PLACE	741 PARK EAST BLVD, LAFAYETTE, , 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00458300. Complaint IN00458300-State deficiencies related to the allegations are cited at R217. Survey dates: May 2, 5, 6, and 7, 2025. Facility number: 013045 Residential Census: 147 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 19, 2025.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using	R 0217	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?As resident D has been discharged,	05/31/2025

appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:

(1) The services offered to the individual resident shall be appropriate to the:

(A) scope;

(B) frequency;

(C) need; and

(D) preference;

of the resident.

(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

no further corrective action can be taken regarding the applicable service plan.

HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN?

The service plans of all current residents have been audited to confirm a current, accurate service plan is in place and had been signed by the resident or representative. Any service plans that have been reviewed verbally with the resident representative via phone have been sent through mail for a physical signature.

WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

All resident service plans to be reviewed, signed, and dated by resident or representative upon admission, semi-annually, and change in condition. Executive Director review/re-education with IDT team on 05/23/25 to ensure re-training on requirement for service plans to be reviewed, signed, and dated by resident or representative including documentation of communication attempts as needed.

HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED?

A QAPI monitoring tool for service plans, including but not limited to obtaining resident or representative signature, will be utilized monthly x 4 months then bi-monthly x 3

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE