

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/22/2024	
NAME OF PROVIDER OR SUPPLIER ASTER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 the Investigation of Complaint IN00447455. Complaint IN00447455-No deficiencies related to the allegations are cited. Survey date: November 22, 2024. Facility number: 013045 Residential Census: 103 Aster Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00447455. Quality review was completed on November 26, 2024.		R 0000				
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	