

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 05/17/2024	
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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00429232, IN00433486 and IN00434535. Complaint IN00429232 - No deficiencies related to the allegations are cited. Complaint IN00433486 - No deficiencies related to the allegations are cited. Complaint IN00434535 - No deficiencies related to the allegations are cited. Survey dates: May 14, 15, 16 and 17, 2024. Facility number: 013045 Residential Census: 98 Aster Place was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

Complaints IN00429232, IN00433486 and IN00434535. Quality review was completed on May 23, 2024.			
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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
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