STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR RESIDENCES OF LAFAYETTE	250 SHENANDOAH DRIVE, 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 Intake 465137. Intake 465137-State deficiencies related to the allegations are cited at R214. Survey dates: November 5 and 7, 2025 Facility number: 014015 Residential Census: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 18, 2025	R 0000		
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known	R 0214	In order to correct this deficiency, all nurses and QMA's will be educated on the importance of the assessment policy by 12/5/25. If a nurse is not scheduled during a shift, when an assessment is needed, staff will contact the DON and the ED to ensure that a nurse is dispatched, and an assessment	11/20/2025

	substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure a licensed nurse was available to complete an assessment when a resident had experienced a change in condition and showed signs of confusion for 1 of 3 residents reviewed for assessments. (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/7/25 at 11:27 a.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, insomnia, chronic kidney disease, and peripheral vascular disease. A facility fax to the physician, dated 9/28/25, indicated Resident B went to the store and was confused about how to get back to the facility. The resident had no visible injuries and was assisted back to the facility. A nursing progress note, dated 9/29/25, indicated Resident B had signed out of the facility on 9/27/25 and returned on 9/28/25. After returning, the resident had gone to the store		is completed as soon as possible.	

next door to buy snacks and was confused on how to return to the facility. The store notified staff at the facility Resident B was present in their store and was confused. QMA 3 and QMA 4 went to the store and returned Resident B to the facility.

A nursing progress note, dated 9/29/25, indicated Resident B had signed out of the facility on 9/27/25 with family and was dropped off by the family in front of the building on 9/28/25. Resident B then went to the store to buy snacks and was confused on the way to return to the facility. Resident B indicated she was shopping for snacks and had asked the store attendant which way to the facility. A skin assessment was completed.

A nursing progress note, dated 9/29/25, indicated LPN 2 called and notified the physician Resident B that left the facility, went to the store, and became confused about how to return to the facility. Resident B had stopped and asked for assistance at the store. The resident complained of a foggy memory. Lab work and a medication review were requested.

During an interview, on 11/5/25 at 3:00 p.m., QMA 3 indicated the Director of Nursing (DON) was notified of the incident and

Resident B's increased confusion. The resident was not assessed until the next day by the DON.

During an interview, on 11/5/25 at 3:10 p.m., QMA 4 indicated the Director of Nursing (DON) was notified of the incident and Resident B's increased confusion. The resident was not assessed until the next day by the DON.

During an interview, on 11/5/25 at 3:30 p.m., the DON indicated she was made aware the resident had left the facility at the time the incident occurred. The resident usually did not leave the facility without letting the staff know where she was going. The resident was assessed on 9/29/25. She did not assess the resident on 9/28/25 when the incident occurred. The resident had a change of condition, and she should have been assessed by a nurse at the time of the incident.

During an interview, on 11/5/25 at 2:48 p.m., Resident B indicated the staff told her she was confused and had gone to the store shopping by herself. She did not usually go to the store alone.

During an interview, on 11/5/25 at 4:15 p.m., Resident B's son indicated he had signed

Resident B out, on 9/27/25, for a family wedding out of the state. After she returned, he received a phone call Resident B had left the facility and walked to the store without notifying staff. He thought the trip out of state might have confused the resident.

A current facility policy, titled "Change in Resident Condition," dated as revised 4/1/19 and received from the DON on 11/7/25 at 11:30 a.m., indicated "...The DRC, or designee, performs an evaluation of the resident and contacts the resident's healthcare provider if indicated, and determines if a change in the resident's level of service needs has occurred...."

This citation relates to Intake 465137.

Based on interview and record review, the facility failed to ensure a licensed nurse was available to complete an assessment when a resident had experienced a change in condition and showed signs of confusion for 1 of 3 residents reviewed for assessments. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 11/7/25 at 11:27 a.m. The diagnoses included, but were not limited to, dementia, anxiety disorder,

	insomnia, chronic kidney disease, and peripheral vascular disease. A facility fax to the physician, dated 9/28/25, indicated Resident B went to the store and was confused about how to get back to the facility. The resident had no visible injuries and was assisted back to the facility. A nursing progress note, dated 9/29/25, indicated Resident B had signed out of the facility on 9/27/25 and returned on 9/28/25. After returning, the resident had gone to the store next door to buy snacks and was confused on how to return to the facility. The store notified staff at the facility Resident B was present in their store and was confused. QMA 3 and QMA 4 went to the store and returned Resident B to the facility.			

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	Resident B's increased confusion. The resident was not assessed until the next day by the DON. During an interview, on 11/5/25 at 3:30 p.m., the DON indicated she was made aware the resident had left the facility at the time the incident occurred. The resident usually did not leave the facility without letting the staff know where she was going. The resident was assessed on 9/29/25. She did not assess the resident on 9/28/25 when the incident occurred. The resident had a change of condition, and she should have been assessed by a nurse at the time of the incident. During an interview, on 11/5/25 at 2:48 p.m., Resident B indicated the staff told her she was confused and had gone to the store shopping by herself. She did not usually go to the store alone.			

	During an interview, on 11/5/25 at 4:15 p.m., Resident B's son indicated he had signed Resident B out, on 9/27/25, for a family wedding out of the state. After she returned, he received a phone call Resident B had left the facility and walked to the store without notifying staff. He thought the trip out of state might have confused the resident. A current facility policy, titled "Change in Resident Condition," dated as revised 4/1/19 and received from the DON on 11/7/25 at 11:30 a.m., indicated "...The DRC, or designee, performs an evaluation of the resident and contacts the resident's healthcare provider if indicated, and determines if a change in the resident's level of service needs has occurred...." This citation relates to Intake 465137.			

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 SIGNATURETiffany Tribble	TITLEExecutive Director	(X6) DATE11/26/2025