

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/14/2022
NAME OF PROVIDER OR SUPPLIER WEST LAFAYETTE ALF OPERATIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 3575 SENIOR PLACE, WEST LAFAYETTE, , 47906			
(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 IN00389818. Complaint IN00389818 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 13 and 14, 2022 Facility number: 014094 Residential Census: 61 Wickshire West Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00389818. Quality review was completed on September 19, 2022.	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			TITLE	(X6) DATE	

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SIGNATURE		
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