

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 08/21/2024	
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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00434693 completed on June 13, 2024. Complaint IN00434693- Corrected. Survey date: August 21, 2024 Facility number: 014094 Residential Census: 86 West Lafayette ALF Operations was found to be in compliance with 410 IAC 16.2-5 in regard to the Post Survey Revisit Investigation of Complaint IN00434693. Quality review was completed on August 22, 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			TITLE			(X6) DATE	

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FORM APPROVED

OMB NO. 0938-0391

SIGNATURE		
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