STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASTER PLACE	741 PARK EAST BLVD LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00458300. Complaint IN00458300-State deficiencies related to the allegations are cited at R217. Survey dates: May 2, 5, 6, and 7, 2025. Facility number: 013045 Residential Census: 147 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 19, 2025.	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure a resident's service plan was signed and dated by the resident or resident's representative for 1 of 8 residents reviewed for signed service plans. (Resident D) Findings include: The clinical record for Resident D was reviewed on 5/6/25 at 2:45 p.m. The diagnoses included, but were not limited to, dementia, anxiety, and peripheral vascular disease. A service plan was not signed by the resident or resident's representative.	R 0217	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? As resident D has been discharged, no further corrective action can be taken regarding the applicable service plan. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN?	05/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cari Branshaw	Executive Director	06/01/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	During an interview, on 5/5/25 at 1:58 p.m., Resident D's family member indicated she was not aware of the services Resident D was to receive. She expected the staff to feed, bathe, change Resident D's briefs, and to supervise him. During an interview, on 5/7/25 at 3:15 p.m., the Executive Director indicated the resident did have a service plan, but it was not signed. She indicated the form should have been signed when it was discussed with the family. A current facility policy was not provided. This citation relates to Complaint IN00458300.		The service plans of all current residents have been audited to confirm a current, accurate service plan is in place and had been signed by the resident or representative. Any service plans that have been reviewed verbally with the resident representative via phone have been sent through mail for a physical signature. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? All resident service plans to be reviewed, signed, and dated by resident or representative upon admission, semi-annually, and change in condition. Executive Director review/re-education with IDT team on 05/23/25 to ensure re-training on requirement for service plans to be reviewed, signed, and dated by resident or representative including documentation of communication attempts as needed. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED? A QAPI monitoring tool for service plans, including but not limited to obtaining resident or representative signature, will be utilized monthly x 4 months then bi-monthly x 3 months. If 100% threshold is not met, new action plan will be developed and/or	

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			disciplinary action. Director of Nursing/designee responsible for the monitoring tool.	