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	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLASSWATER CREEK OF LAFAYETTE, LLC	208 BECK LANE LAFAYETTE, IN 47909

(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. Survey dates: January 14, 15 and 16, 2025. Facility number: 014148 Residential Census: 104 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 24, 2025.	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure dementia education was completed for 2 of 10 staff members reviewed for dementia training. (Staff Member 5 and 6) Findings include: 1. The employee record for Staff Member 5 was reviewed on 1/15/25 at 1:05 p.m. The employee's dementia training was not completed. 2. The employee record for Staff Member 6 was reviewed on 1/15/25 at 1:25 p.m. The employee's dementia training was not completed. During an interview, on 1/15/25 at 1:32 p.m., the Executive Director indicated Staff Member 5 and 6 did not have dementia training in their files. She indicated the Human Resources Department did	R 0120	1 1. Staff #5 & 6 will complete dementia training by 2.16.2025. 2 2. The facility audited personnel records for dementia training completion. Dementia training due per regulation will be completed by 2.16.2025. 3 3. The Executive Director/designee will run report monthly to ensure all new employees have completed dementia training. The Executive Director/designee will audit employee completion reports monthly x 6 months. 4 4. Audits will be reviewed at monthly x 6 months in the QA meetings and QA committee will make recommendations as	02/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori L Lindsey-Clarkston	Executive Director	02/06/2025

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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	not release the dementia training for Staff Member 5 and 6 for the year. The facility did not have a policy and procedure and she was not aware the training had not been completed.		appropriate.	