STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135, GREENWOOD, , 46143

(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 Intakes 469622 and 469746. Intake 469622 - No deficiencies related to the allegations are cited. Intake 469746 - State deficiencies related to the allegations are cited at R297. Survey date: June 3, 2026 Facility number: 005722 Residential Census: 120 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 4, 2026.	R 0000		
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1)	R 0297	1. What corrective action(s) will be accomplished for those residents found to	06/10/2026

	(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a pharmacy delivery of narcotic pain medication was verified before the nurse signed for them. A resident's narcotic pain medication was unaccounted for for 1 of 3 residents reviewed for medication administration. Findings include: During an interview on 6/3/26 at 8:18 a.m., Qualified Medication Aide (QMA) 1 indicated on 5/14/26 at approximately 12:00 p.m., she administered Resident B's last oxycodone/acetaminophen (medication used to treat pain) 7.5 milligrams (mg)/325 mg. QMA 1 took the empty packet to the nurse to order a refill but the refill was not delivered for two days. Resident B did not receive her oxycodone/acetaminophen 7.5 mg/325 mg for two days. During an interview on 6/3/26 at		have been affected by the deficient practice -Promptly ordered medications to rectify situation. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken -All residents that receive narcotic medication administration had the potential to be affected by the deficient practice. Educated staff on pharmacy delivery, narcotic counting, their responsibilities, and the 5 Rights of Medication Administration. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Pharmacy boxes are opened and verified prior to the driver leaving the community. 2 QMA’s, 1 QMA and 1 Nurse, or 2 nurses will sign the narcotic count sheet that	

	8:28 a.m., Licensed Practical Nurse (LPN) 1 indicated she was notified on 5/15/26, that the pharmacy couldn't refill Resident B's oxycodone/acetaminophen 7.5 mg/325 mg because the had already filled the prescription on 5/5/26. The staff were unable to locate the medication. The clinical record for Resident B was reviewed on 6/3/26 at 8:52 a.m. The diagnoses included, but were not limited to, chronic pain, opioid dependence, and Alzheimer's disease. A current physician's order started on 7/15/25, indicated oxycodone/acetaminophen 7.5 mg/325 mg administer one tablet orally 4 times daily at 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. A progress note, dated 5/15/26 at 9:00 a.m., indicated on 5/15/26, the pharmacy notified the facility that Resident B's prescription of oxycodone/acetaminophen 7.5 mg/325 mg could not be filled because it had just been delivered on 5/5/26. The staff were unable to locate the medication so the police were notified. A pharmacy delivery slip, dated 5/5/26, indicated the pharmacy delivered 120 tablets of		the medications have been received. Logging all narcotics, counting cards and sheets to make sure everything matches at the end of each shift, or any time someone different takes over the cart. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Audit medication delivery narcotic sheets for 2 signatures: 3 per week for the first month, 3 every other week for a month, and then 3 for the following month. 5. By what date the systemic changes will be completed 6.24.2026	

	oxycodone/acetaminophen 7.5 mg/325 mg for Resident B. The slip was signed by LPN 2. During an interview on 6/3/26 at 12:01 p.m., LPN 2 indicated she was the nurse that signed the delivery slip on 5/5/26. When the pharmacy delivered the box of medications, LPN 2 did not open the box to verify the contents before signing the slip and sending it back to the pharmacy. During an interview on 6/3/26 at 12:30 p.m., the Director of Nursing (DON) indicated LPN 2 should have verified the contents of the pharmacy delivery before she signed the delivery slip on 5/5/26. The DON was unable to locate a policy on the pharmacy delivery process. On 6/3/26 at 12:35 p.m., the facility was unable to provide a policy regarding the pharmacy delivery process. This citation relates to Intake 469746.			

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 SIGNATUREThomas Turner	TITLEExecutive Director	(X6) DATE06/19/2026