STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/15/2026

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 467900 and 469164. Intake 467900 - No deficiencies related to allegations are cited. Intake 469164 - State deficiencies related to the allegations are cited at R52. Survey date: April 14 and 15, 2026 Facility number: 005722 Residential Census: 121 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 17, 2026.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	1. **What Corrective action(s) will be accomplished for those**	04/23/2026

(v) Residents have the right to be free from:

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 3 residents reviewed for elopement. A cognitively impaired resident left the facility without staff knowledge. (Resident B)

Findings include:

During an interview on 4/14/26 at 8:43 a.m., Visitor 1 indicated Resident B had been found outside the facility knocking on doors to get back in multiple times. On 3/25/26, the facility was notified by another resident's family that Resident B was seen walking north on South State Road 135. The staff found her in front of a random home, lying in a mulch bed because she had fallen.

The clinical record for Resident B was reviewed on 4/14/26 at 10:21 a.m. The diagnosis

residents found to have been affected by the deficient practice

1. 1 of 3 residents with cognitive decline residing in assisted living experienced adverse effects from the alleged deficient practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken**
   1. All residents that reside in assisted living that have a cognitive decline diagnosis had the potential to be affected by the alleged deficient practice. All staff, on both Memory Care and assisted living, including nursing, dietary, maintenance, housekeeping and administrative were immediately in-serviced by the ED and DON regarding Resident Rights and Abuse and Neglect as well as, reporting alleged abuse and neglect.

3. **What measures will be put into place or what**

included, but was not limited to, cognitive decline.

A Saint Louis University Mental Status (SLUMS) exam, dated 2/27/26, indicated Resident B had symptoms of dementia.

A Service Plan Assessment, dated 3/4/26, indicated Resident B was moderately cognitively impaired, had been asking repetitive questions such as "where do I go" and "what do I do" on a daily or almost daily basis during the previous 30 days, was easily annoyed, had anger at placement in a facility, or anger at care received during the previous 30 days, and had a history of wandering and had been resistive to care in the previous six months.

A Service Plan, dated 9/3/25, indicated Resident B was disoriented to staff member's names, where to go outside to smoke, and sometimes to the location of her apartment. Interventions included, but were not limited to, Resident B would be safe and secure in the community.

The progress notes included, but were not limited to:

- On 1/8/26 at 1:51 p.m., Resident B had been found outside attempting to smoke. When she was asked what she was doing, Resident B could not

systemic changes the facility will make to ensure that the deficient practice does not recur:

1. Elopement binder for AL residents
2. Review at-risk residents weekly
3. Review Memory Care transfer list weekly
4. Elopement Drill education conducted and ongoing
5. Monthly meeting with POA/Family of at-risk residents

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:**
   1. ED and/or DON or designee will monitor audit results to be reviewed at monthly QI meetings for 6 months and make further recommendations based from audit results.
5. **By what date will the systematic changes be completed**

1. 05/08/26

remember where she was nor what she was doing. Writer redirected Resident B back inside the building.

- On 2/9/26 at 1:00 p.m., Resident B was found outside in the back of the facility by the dumpster. Resident B was confused, did not know where she was. Resident B had been let back into the building by another resident's family member.

- On 3/25/26 at 5:00 p.m., writer was informed by Executive Director (ED) that another resident's family member notified the facility that Resident B was walking down the sidewalk on South State Road 135. Resident B was located in front of residence on South State Road 135, lying on her back in a mulch bed next to the walkway to the front door of the home.

During an interview on 4/14/26 at 2:50 p.m., the Director of Nursing (DON) indicated, on 3/25/26, the facility was notified by a visitor that they saw Resident B walking on State Road 135. Resident B was located north of the facility two houses away. She had walked up someone's driveway and must have tipped her walker as she walked to the door.

On 3/14/26 at 12:50 p.m., the

	DON provided a copy of a facility policy, titled Elopement Risk and Missing Resident Policy, dated 5/2021, and indicated this was the current policy used by the facility. A review of the policy indicated the goal of the community is to provide a safe environment for all residents. This citation relates to Intake 469164.			

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) DATE05/04/2026