STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/10/2026

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 a State Residential Licensure Survey. Survey dates: June 9 and 10, 2026 Facility number: 005722 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 12, 2026.	R 0000		
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.	R 0042	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -Survey binder will be placed in front lobby at all times for access.	06/25/2026

	Based on observation and interview, the facility failed to ensure the results of the most recent annual survey was readily available for the residents to view for 2 of 2 days. Finding includes: During an interview on 6/9/26 at 8:12 a.m., the Administrator indicated he was not aware of the location of the state survey binder. During an interview on 6/9/26 at 8:30 a.m., Resident 177 indicated he was not aware of a state survey binder or the location. On 6/9/26 at 8:35 a.m., observed the front lobby and the front desk area, the results of the most recent annual survey were not readily accessible for review. No sign was visible to indicate the location of the state survey binder. On 6/9/26 at 2:02 p.m., observed the same. On 6/10/26 at 8:08 a.m., observed the same. During an interview at that time, Receptionist 5 indicated she was not aware of the facility state survey binder that contained the most recent survey results. She indicated she was unaware of the location, where it was to be		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 -Facility will send out a notification to all current residents stating the location of the survey binder. 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 -When the survey binder is removed, a sign stating that the survey binder is being updated will temporarily be placed. -Survey binder will be in place the same business day that it is updated. 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 that the Survey	

	kept, or that it was to be accessible to the residents. During an interview on 6/10/26 at 8:20 a.m., the Administrator indicated the binder was in his office. The binder had been in his office for several days. The binder should have been easily accessible for the residents to review without having to ask. During an interview on 6/10/26 at 8:30 a.m., Resident 177 indicated he was not aware of a state survey binder or the location. During an interview on 6/10/26 at 9:00 a.m., Resident 183 indicated she was not aware of a state survey binder or the location. During an interview on 6/10/26 at 9:59 a.m., Receptionist 5 indicated she was not aware of a sign indicating the location of the state binder. During an interview on 6/10/26 at 11:45 a.m., the Administrator indicated the facility did not have a specific policy regarding residents access to the most recent annual survey.		Binder is in place: -5 times per week for the first month, 3 times per week the following month, and 1 time per week the following month 5. By what date the systemic changes will be completed 6.25.2026	
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be	R 0121	1. What corrective action(s) will be accomplished for those residents found to have been affected by	07/03/2026

	required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.		the deficient practice -No residents found to have been affected by the deficient practice. 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 -The Executive Director, or their designee, will conduct an audit of employee files 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 -The Executive Director, or their designee, will conduct an audit of all employee files. Variances will be corrected at the time of observation. -The Executive Director will audit all new employee files 4. How the corrective action(s) will be monitored to ensure the	

	(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of a physical health screening for 1 of 3 newly hired employees. (CNA 6) Finding includes: On 6/9/26 at 1:30 p.m., the Administrator provided a list of current employees with dates of hire and associated position titles. On 6/10/26 at 9:50 a.m., Certified Nurse Aide (CNA) 6's personnel record was reviewed. CNA 6 was hired on 3/25/26 and was currently employed by the facility. The personnel record lacked documentation that indicated CNA 6's employee physical health screening had occurred.		deficient practice will not recur, i.e., what quality assurance program will be put into place -Executive Director, or their designee, will review results at monthly QI meetings and make further recommendations based off audit results 5. By what date the systemic changes will be completed 7.3.2026	

	The personnel file included a copy of CNA 6's job description. A review of the document indicated " ...meet health assessment requirements ..." The document was signed by CNA 6 on 3/25/26. During an interview on 6/10/26 at 10:05 a.m., the Administrator indicated CNA 6's personnel record lacked the employee physical health screening. The screening, conducted by the physician or his designee, should have been completed at the time of hire and maintained within the employee record in accordance with the State regulations. On 6/10/26 at 11:00 a.m., the Administrator provided a copy of the Health Screening policy, dated April of 2021, and indicated it was the current policy in use by the facility. A review of the document indicated, " ...The purpose of this policy is to set a standard for health screening for current and future employees of the community ...Upon employment ...employees shall participate in the community's ...screening program ..."			
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l)	R 0155	1. What corrective action(s) will be accomplished for those residents found to have been affected by	06/26/2026

	(l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the ground surrounding the facility's dumpster area was free from debris for 2 of 2 observations. Findings include: 1. During the initial facility tour with Dietary Director on 6/9/26 at 8:55 a.m., the facility's dumpster container area, located behind the facility, was observed. There were multiple empty plastic bottles, small cardboard boxes, scattered paper and gloves on the ground beside and between the two dumpsters on site. 2. During a follow-up observation with the Dietary Director on 6/9/26 at 12:35 p.m., the dumpster area was observed. There were multiple empty plastic bottles, small cardboard boxes, scattered paper and gloves on the ground beside and between the two dumpsters on site. During an interview at that time, the Dietary Director indicated the area was to be kept clean and		the deficient practice -No residents found to have been affected by the deficient practice. 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 -Pest Control will inspect service hallway and 1st floor apartments to ensure no pests/rodents have entered the community. 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 -Environmental Services Director, or their designee, will audit the dumpster area once in the A.M. and once in the P.M. and correct any issues at time of observation. 4. How the corrective action(s) will be monitored to ensure the	

	free of debris. During an interview on 6/10/26 at 9:32 a.m., the Administrator indicated the facility lacked a dumpster policy. The dumpster container was to be kept closed and the area was to be kept free of debris. On 6/10/26 at 10:30 a.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-26, effective April 16, 2025, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables used with materials containing food residue and used outside ...must be designed and constructed to have tight fitting lids, doors or covers ...must be installed so that accumulation of debris and rodent or insect attraction or harborage or both are minimized..."		deficient practice will not recur, i.e., what quality assurance program will be put into place -Environmental Services Director will review results at monthly QI meetings and make further recommendations based off audit results 5. By what date the systemic changes will be completed 6.26.2026	

R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between one hundred (100) degrees Fahrenheit and one hundred and twenty (120) degrees Fahrenheit for 3 of 20 resident apartments reviewed for hot water temperatures. (Apartment 127, Apartment 401, Apartment 402) Findings include: During a facility tour with the Maintenance Director the following was observed: 1. On 6/10/26 at 8:22 a.m., Apartment 127's bathroom sink's hot water temperature was observed to be 132 degrees Fahrenheit (F).	R 0187	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -3 resident apartments were found to be affected by the deficient practice. 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 -Facility will take temperatures of all apartments and common areas to ascertain any potential issues 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 -Facility will install a mixing valve 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will	06/30/2026

	2. On 6/10/26 at 8:40 a.m., Apartment 401's kitchen sink's hot water temperature was observed to be 122 degrees F. 3. On 6/10/26 at 8:42 a.m., Apartment 402's bathroom sink's hot water temperature was observed to be 122 degrees F. During an interview on 6/10/26 at 8:25 a.m., the Maintenance Director indicated that the water temperatures were to be between 100 degrees and 120 degrees F. During an interview on 6/10/26 at 10:10 a.m., the Administrator indicated that the facility requirements for hot water temperatures ranged from 100 to 120 degrees F. On 4/22/26 at 8:10 a.m., the Administrator provided an undated copy of Gardant Management Solutions Maintenance Manual Preventative Maintenance Procedure and indicated it was the current guideline in use by the facility. A review of the manual indicated, "...3. Adjust temperatures according to regulations (95 to 120) ..." degrees Fahrenheit.		be put into place -Environmental Services Director, or designee, will acquire 8 water temperatures per day from an apartment and/or common area for 30 days, 6 per day the following 30 days, and 3 per day the following 30 days. 5. By what date the systemic changes will be completed 6.30.2026	

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) DATE06/24/2026