STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VICTORIAN OF ZIONSVILLE	11755 N MICHIGAN RD, ZIONSVILLE, , 46077

(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 Complaints IN00454469, and IN00455309. Complaint IN00454469 - State deficiencies related to the allegations are cited at R351, and R358. Complaint IN00455309 - State deficiencies related to the allegations are cited at R273. Survey date: March 24, and 25, 2025 Facility number: 012263 Residential Census: 63 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 31, 2025.	R 0000		
R 0273	Food and Nutritional Services - Deficiency	R 0273	**R273**	05/01/2025

	410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure dietary staff covered hair and utilized proper hand precautions during food preparation. This deficient practice had the potential to affect 61out of 63 residents who had food prepared for them from the kitchen. Findings include: A confidential concern during the survey process indicated dietary workers were not wearing gloves or hair nets in the kitchen. During a random observation of the kitchen on 3/24/25 at 11:05 a.m., the cook was observed moving around the kitchen between tasks, and different food prep areas. The cook was observed putting food into a pot boiling on the stove, she was not wearing gloves, was not seen washing her hands, and was not wearing a hair net. When asked if she had a hair net, she pulled one out of her pocket and indicated she should have put it on. The cook indicated she was preparing		**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a **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;** a All residents had the potential to be affected by the alleged deficient practice. ED and/or designee will ensure that dietary staff cover hair and utilize proper hand precautions during food preparation. Employees found to be out of compliance with these guidelines will receive additional education and corrective action.	

	food for lunch to include spaghetti and fish. During an interview on 3/24/25 at 11:12 a.m., the Culinary Manager indicated the dietary employees had been educated on multiple occasions, and staff knew they were required to wear hair nets and gloves during meal preparation. On 3/25/25 at 3:55 p.m., the Receptionist indicated there had been 2 residents that signed out of the facility around lunch time on 3/24/25. Licensed Practical Nurse (LPN) 3 indicated she was not aware of any residents that had signed out for lunch on 3/24/25. On 3/25/25 at 2:45 p.m., the Executive Director (ED) provided a Culinary Dress Code & Requirements policy, dated 7/2024, and indicated the policy was the one currently being used by the facility. The policy indicated, "Long hair must be restrained or tied back. Caps/hats or hairnets must be worn in the kitchen while preparing food ..." On 3/25/25 at 3:28 p.m., the ED indicated, the facility had no policy regarding the need for gloves to be worn in the kitchen while preparing food. "Retail Food Establishment Sanitation Requirements," effective November 13, 2004,		**3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** a ED and/or designee will ensure that dietary staff cover hair and utilize proper hand precautions during food preparation. Any staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Culinary Manager, or designee will educate all newly hired dietary staff, on policies and protocols during employee job-specific orientation moving forward. **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;**	

	Sec. 138. indicated, "...(a) Except as provided in subsection (b), food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles ...410 IAC 7-24-246 Gloves; use limitation Sec. 246. (a) If used, single-use gloves shall be: (1) used for only one (1) task, such as working with ready-to-eat food or with raw animal food ...." This citation relates to Complaint IN00455309. Based on observation and interview, the facility failed to ensure dietary staff covered hair and utilized proper hand precautions during food preparation. This deficient practice had the potential to affect 61out of 63 residents who had food prepared for them from the kitchen. Findings include: A confidential concern during the survey process indicated dietary workers were not wearing gloves or hair nets in the kitchen. During a random observation of		a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed;** a May 1, 2025	

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R 0351	Clinical Records - Noncompliance	R 0351	**R351/R358**	05/01/2025

	410 IAC 16.2-5-8.1(c)(d) (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation and interview, the facility failed to maintain a system of securing all current residents records and personal identifying information for 3 of 3 observations. Findings include: A confidential concern during the survey process indicated the facility had a room on the 3rd floor that had patient information, and anyone could access the room. On 3/24/25 at 10:24 a.m., observation of a 3rd floor room labeled "common room". The door was shut but not locked. A desk was in the room piled with resident records that were not secured. On 3/24/25 at 12:29 p.m., the 3rd floor common room was observed to be unlocked. There was a large desk piled up with unsecured resident medical		**1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a **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;** a All residents had the potential to be affected by the alleged deficient practice. ED and/or designee will ensure that medical records are stored in accordance with the company Medical Records Storage Policy. Employees found to be out of compliance with medication documentation will receive additional education and corrective action.	

	records, files and loose papers. A smaller desk was observed with 2 separate stacks of resident records. The resident records included, but not limited to, identifying information of birth date, social security numbers, insurance numbers, diagnoses, assessments, physician progress notes, physician's orders for medications and care, and interdisciplinary team notes. There were also 7 tall metal filing cabinets with 4 and 5 drawers containing resident records, those were also not locked. A maintenance cart with painting and repair supplies was observed sitting among the filing cabinets. On 3/25/25 at 11:27 a.m., the 3rd floor common room was observed to remain unlocked with unsecured resident medical records, unlocked filing cabinets containing resident medical records, and a maintenance cart sitting among the filing cabinets. During an interview on 3/25/25 at 1:57 p.m., the Executive Director (ED) indicated that the Wellness Director or nurse thinning charts were responsible for filing and managing medical records. The facility was currently without a Wellness Director. During an interview on 3/25/25 at 2:28 p.m., the Maintenance		**3** **What** **measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** a ED and/or designee will ensure that medical records are stored in accordance with the company Medical Records Storage Policy. Any staff member out of compliance with facility's policies and protocols will receive progressive corrective action, including termination. The Director of Nursing, or designee will educate all newly hired clinical staff, including any agency staff, on policies and protocols during employee job-specific orientation moving forward. **4 How the corrective action(s) will be** **monitored to ensure the deficient practice will not recur, i.e., what quality**	

	Director indicated he was newer to the facility in the past few months. He had a grand master key to access every door in the facility to include resident apartments, offices, and the mechanical and electrical rooms. The 3rd floor common area room appeared to be an old office that had resident files in it, filing cabinets, a refrigerator, desks, and he stored his maintenance cart in the room. The Maintenance Director indicated there was no key code panel on the 3rd floor common area room, it required a key to access. He did not know how long the 3rd floor common area room door had been unlocked. During an interview on 3/25/25 at 3:15 p.m., the ED indicated she was newer to the facility in the past month and had not been in the 3rd floor common area room since she was toured before being hired. To her knowledge, the room used to be a nursing office, but had since been converted into a storage area for resident medical records. The ED indicated she knew resident records were required to be locked up, and had not been aware the 3rd floor common area room was unlocked, and resident records to include documents thinned from current resident files, and discharged resident files were accessible to anyone opening		**assurance program will be put into place;** a This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as needed thereafter as part of the QA process. b Results will be reviewed as part of the QA process in order to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved. **5** **By** **what date the systemic changes will be completed;** a May 1, 2025	

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R 0358	Clinical Records - Nonconformance 410 IAC 16.2-5-8.1(k) (k) The facility shall store inactive clinical records in accordance with applicable state and federal laws in a safe and accessible manner. The storage facilities shall provide	R 0358	**R351/R358** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	05/01/2025

	protection from vermin and unauthorized use. Based on observation and interview, the facility failed to maintain a system of securing all discharged residents' medical records and personal identifying information for 3 of 3 observations. Findings include: A confidential concern during the survey process indicated the facility had a room on the 3rd floor that had patient information, and anyone could access the room. On 3/24/25 at 10:24 a.m., observation of a 3rd floor room labeled "common room". The door was shut but not locked. A desk was in the room piled with resident records that were not secured. On 3/24/25 at 12:29 p.m., the 3rd floor common room was observed to be unlocked. There was a large desk piled up with unsecured resident medical records, files and loose papers. A smaller desk was observed with 2 separate stacks of resident records. The resident records included, but not limited to, identifying information of birth date, social security numbers, insurance numbers, diagnoses, assessments, physician progress notes,		**practice;** a **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;** a All residents had the potential to be affected by the alleged deficient practice. ED and/or designee will ensure that medical records are stored in accordance with the company Medical Records Storage Policy. Employees found to be out of compliance with medication documentation will receive additional education and corrective action. **3** **What** **measures will be put into place or what systemic changes the facility will make**	

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Based on observation and interview, the facility failed to maintain a system of securing all discharged residents' medical records and personal identifying information for 3 of 3 observations.

Findings include:

A confidential concern during the survey process indicated the facility had a room on the 3rd floor that had patient information, and anyone could access the room.

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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 SIGNATURE	TITLE	(X6) DATE