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	11/04/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00446213 Complaint IN00446213 - State deficiencies related to the allegations are cited at R0052, R0090, R0116 and R0119. Survey date: November 4, 2024. Facility number: 012263 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 14, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to ensure a resident had the right to be free from physical and verbal abuse for 1 of 3 residents reviewed for abuse, and had the potential to effect 23 of 69 residents who resided in the specialized memory care unit (Resident B). Findings include: On 10/28/24 the facility self-reported an allegation of abuse which involved Resident B and Certified Nursing Aide (CNA) 58 and indicated, " ...[CNA 58] was seen and heard speaking vulgar to the resident and she took both of his wrists and hit his face with his own hands [before] pulling the	R 0052	**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 will be taken** a All residents that reside in the memory care unit had the potential to be affected by the	12/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	residents pillow out from under his head and hitting him in the head with his pillow ...." The report indicated preventative measures were taken, " ...the DON [Director of Nursing] and ED [Executive Director] immediately began staff in-services concerning resident abuse and the reporting required when there is a situation involving resident abuse ...." During an entrance conference on 11/4/24 at 9:40 a.m., with the ED and DON present, a copy of the abuse allegation investigation was requested and provided. The Investigation included the following witness statements: CNA 29 Witness Statement, "we were changing [Resident B], and I was getting ready to clean him and put the brief under him. He was being a little combative, so we took a second before attempting to change him. When we got ready to proceed to change him, she [CNA 58] was holding his hands so he wouldn't hit us, one of his hands slipped out of hers so he then reached up and punched her in the chin. She then paused, I had told her I would get someone else to help me change him. She looked back at the door and said "no, cause this Mother F***** just hit me." Then she took his hand and punched himself in the face, then she grabbed the pillow from under his head and hit him in the face twice ...." CNA 58 Witness Statement, "Assisting with [Resident B] who is always combative. Hit me in my chin and I reported it. I restrained his hands but not too hard because I know elders bruise easy but I didn't hit poor man back he doesn't knows what he doing. Definitely throwing a pillow or whatever we wasn't in there long at all. I was		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 systemic changes the facility will make to ensure that the deficient practice does not recur:** a The ED and/or DON or designee, will educate all newly hired clinical staff on policies and protocols relating to abuse and neglect during employee job-specific orientation moving forward. All residents and staff will be educated to alert the ED and/or DON to any potential abuse or neglect **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:** a ED and/or DON or designee, will review all incidents twice weekly for two months, once a week for two months and monthly thereafter. Results to be reviewed	

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	trying to distract him saying, [Resident B] you don't hit women and bright-eyed he said, a woman LOL [laugh out loud]. But I know Karma and abuse is that I wouldn't dare do that ...." The investigation lacked documentation of interviews and/or assessments of additional residents who were on Resident B's assignments for potential signs/symptoms of abuse. The investigation lacked documentation of interviews of other staff members who worked with CNA 58 that day, or previous days. The investigation lacked documentation of follow-up in service related to abuse preventions and/or reporting. During a confidential interview, it was indicated, Resident B could become combative with care, especially during brief changes as he was very modest. It was indicated, this staff member never had trouble when they worked with Resident B because they understood his triggers and it depended on how he was approached that would set the tone for his cooperation. It was indicated, if this staff person attempted to change his brief and he became combative, they would ensure he was in a safe position, before they gave him time and space to calm down, then they would reapproach him after some time, and maybe with additional help to ensure he felt safe and comfortable as they continued his care. During a confidential interview, it was indicated, Resident B could become combative at times, but they had never experienced behaviors from him which escalated to him hitting. Resident B was usually fine if he was reapproached at a later time, but the most important thing was how he was		at monthly QI meetings for 6 months and make further recommendations based on audit results. **5 By what date will the systematic changes be completed** a Education and in-service will be provided to staff and residents between now and concluding on 12/25/2024. **Informal Dispute Resolution:** Based on the information below, we respectfully request the removal of “offense” of tag R 052 410 IAC 16.2-5-1.2(v)(1-6) Resident Rights – Offense -According to regulation 410 Ind.Admin.Code IAC 16.2-5-1.2 – Resident Rights **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.** -The facility acted immediately in suspending the alleged staff member. -The facility acted immediately to keep the residents, and all other residents safe from harm.	

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	approached. If staff were calm and patient, he was really sweet most of the time. On 11/4/24 at 11:30 a.m., Resident B's medical record was reviewed. He was a long-term care resident who resided on the specialized secured memory care unit with diagnoses which included, but were not limited to, severe dementia, senile degeneration of the brain, Post Traumatic Stress Disorder (PTSD), anxiety and full incontinence. Resident B was admitted to Hospice on 8/22/24 and his hospice nursing progress notes were reviewed. The Hospice Coordinated Care Nurse notes lacked documentation of aggression and/or combativeness. The Hospice CNA care log lacked documentation of aggression and/or combativeness. The facility's nursing progress notes were requested, but not provided by the time of exit, nor were they provided by the agreed date of 11/5/24 by 3:00 p.m. During an interview on 11/4/24 at 11:27 a.m., the DON indicated the charge nurse contacted her immediately after it was reported to her, that CNA 58 had been witnessed to the mistreatment of Resident B. The DON came in, and immediately assessed Resident B who she found to be calm and cooperative, at his baseline and had no injuries at that time. Resident B was a war veteran and had Post Traumatic Stress Disorder (PTSD) from his time in the service and would often be triggered with close, personal incontinent and hygiene care. After the DON assessed Resident B, she found out the accused CNA, had already left		-The facility acted immediately to assess the resident in question. -The facility acted immediately to gain witness statements. The facility acted immediately to terminate the alleged staff member after investigating. The facility acted immediately to self report. -The facility acted immediately to in-service staff on the “Abuse, Neglect and Financial Exploitation Prevention” policy **We are requesting the level of severity be changed, as it does not meet the criteria of “Offense”.**	

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	the campus after her shift ended. So she was contacted via phone and put on suspension pending an investigation. The DON indicated, the reporting CNA, CNA 29, was very upset over what she witnessed and was determined to be a credible witness. Her story remained consistent throughout the investigation, and she did exactly what the DON expected of her. CNA 58 however, had not returned for an interview, and would likely be let go as the investigation concluded. When asked what should have been done, the DON indicated, if CNA 58 had become upset, or injured during care, she should have accepted CNA 29's suggestion to get another staff member to help finish getting him ready. Staff members should never hit a resident, with their hands or a pillow, and staff should not use vulgar language or behavior to mock and/or intimidate a resident. When asked if there was any additional pieces or documentation from the investigation to add to the previously provided file, the DON indicated there may have been some nursing in-service documentation in the Business Office Manager's (BOM) office, but the BOM was on vacation and the DON did not have access to the documents. The DON indicated, she thought the ED might have interviewed other residents in the Assisted Living side, but she did not have that documentation. The DON indicated, no other memory care residents who had been in CNA 58's care had not been assessed or interviewed, and no other staff members had been interviewed. On 11/4/24 at 12:52 p.m., the DON provided 4 additional resident interviews and indicated they had been completed by the ED. The Resident Interviews were from 4 residents who did not reside on the specialized memory care unit. The interviews were not initialed or signed by the residents, ED or BOM and had not been included			

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	in the original investigation file reviewed above. A copy of the facility's Alzheimer's/Dementia Special Care Unit disclosure form was provided. The Disclosure form was dated 6/17/24. The Disclosure form indicated, the mission/philosophy of the specialized unit as follows: "At the heart of our communities is a belief built upon a foundation centered on our residents, family, staff and communities. Our value system nurtures, inspires and supports the mind, body and spirit throughout life's journey." The Disclosure Form indicated, the specialized unit did have special requirements for initial and continuing staff education and staff who worked on the unit were based on the "interview process, experience, background checks and observation during training." During an interview on 11/4/24 at 1:00 p.m., the ED indicated the DON notified him that morning about the abuse allegations. By the time he arrived, CNA 58 had already left, but she was immediately contacted and suspended pending the investigation. The ED indicated he and the BOM "interviewed different residents throughout the day as we could catch them," but had not interviewed memory care residents and/or their family/representatives. The ED indicated, the investigation would officially conclude on 11/5/24 after a final interview with CNA 29, and he would most likely not continue CNA 58's employment given the credibility and consistency of CNA 29's witness statement. The ED indicated the allegation of abuse had not been reported to the police. On 11/4/24 at 2:00 p.m., the DON provided a copy of current facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention," revised			

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	2/2021. The policy indicated, "Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times ... all staff will undergo a criminal background check through [name of organization] and be checked against the Indiana Professional Licensing Agency website. In addition, all staff will be checked through the Indiana State Nurse Aide Registry. All employees must receive favorable results from the screening in order to join the staff or continue employment ... the community will make every effort to prevent abuse, neglect, or financial exploitative staff behavior through staff training. In-Service education for all staff will be provided at the time of hire and every six months thereafter ... The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator ... if a resident alleges or an investigation uncovers possible abuse ... the administrator or designee shall conduct local law enforcement authorities immediately after the allegation ...." This residential tag relates to Complaint IN00446213.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on interview and record review, the facility failed to ensure an unusual occurence of abuse was thoroughly investigated to ensure no other residents were affected after Resident B was	R 0090	Plan of Correction 12/5/24 Facility ID: 012263 Survey Event ID: IC0E11	12/25/2024

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	physically and mentally/emotionally abused, and failed to ensure all staff received in-service/education on abuse prevention/reporting after the alleged incident occurred. This deficient practice had the potential to affect 69 of 69 residents who resided in the facility. Findings include: On 10/28/24 the facility self-reported an allegation of abuse which involved Resident B and Certified Nursing Aide (CNA) 58 and indicated, " ...[CNA 58] was seen and heard speaking vulgar to the resident and she took both of his wrists and hit his face with his own hands [before] pulling the residents pillow out from under his head and hitting him in the head with his pillow ...." The report indicated preventative measures were taken, " ...the DON [Director of Nursing] and ED {Executive Director] immediately began staff in-services concerning resident abuse and the reporting required when there is a situation involving resident abuse ...." During an entrance conference on 11/4/24 at 9:40 a.m., with the ED and DON present, a copy of the abuse allegation investigation was requested and provided. The investigation lacked documentation or interviews and/or assessments of additional residents who were on Resident B's assignments for potential signs/symptoms of abuse. The investigation lacked documentation or interviews of other staff members who worked with CNA 58 that day, or previous days. The investigation lacked documentation of		R090 **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 will be taken** a All residents that reside in the community 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 have since been 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 systemic changes the facility will make to ensure that the deficient practice does not recur:** a ED and/or DON or designee will thoroughly investigate each report or suspicion of abuse. The ED and/or DON or designee will interview, at a minimum, 3 residents, 3 witnesses and 3 staff.	

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	follow-up in service related to abuse preventions and/or reporting. During a confidential interview, it was indicated this nursing staff member had not received abuse prevention and/or reporting training since the alleged allegation. During a confidential interview, it was indicated this second staff nursing staff member had not received abuse prevention and/or reporting training since the alleged allegation. During a confidential interview, it was indicated that a 3rd and 4th nursing staff members had not received abuse prevention and/or reporting training since the alleged allegation. During a confidential interview, it was indicated that a Housekeeping (HK) staff member had not received abuse prevention and/or reporting training since the alleged allegation. During a confidential interview, it was indicated that a 2nd HK staff member had not received abuse prevention and/or reporting training since the alleged allegation. During a confidential interview, it was indicated that a 3rd HK staff member had not received abuse prevention and/or reporting training since the alleged allegation. During an interview on 11/4/24 at 11:27 a.m., the DON indicated there may have been some nursing in-service documentation in the Business Office Manager's (BOM) office, but the BOM was on vacation and the DON did not have access to the documents. The DON indicated only nursing staff would have received the in-service.		All residents and staff will be educated to alert the ED and/or DON to any potential abuse or neglect **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:** a ED and/or DON or designee, will review training platform to ensure all Residents Rights and Abuse training are completed upon hire and every 6 months thereafter. ED and/or DON or designee, will review all incidents twice weekly for two months, once a week for two months and monthly thereafter. Results to be reviewed at monthly QI meetings for 6 months and make further recommendations based on audit results. **5 By what date will the systematic changes be completed** a Education and in-service will be provided to staff and residents between now and concluding on 12/25/2024.	

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	During the survey exit conference on 11/4/24 at 3:00 p.m., the ED and DON indicated only nursing staff would have received in-service training on abuse prevention/reporting after the allegation because it had been between a resident and nursing staff member. The DON indicated all staff had the potential to be reporters and all staff should be in-serviced. The ED and DON indicated the allegation of abuse had not been reported to the police. On 11/4/24 at 2:00 p.m., the DON provided a copy of current facility policy titled, "Abuse, Neglect, and Financial Exploitation Prevention," revised 2/2021. The policy indicated, "Residents of the community have the right to be free of abuse, neglect and financial exploitation. Staff members will conduct themselves in a manner that is respectful and courteous at all times ... all staff will undergo a criminal background check through [name of organization] and be checked against the Indiana Professional Licensing Agency website. In addition, all staff will be checked through the Indiana State Nurse Aide Registry. All employees must receive favorable results from the screening in order to join the staff or continue employment ... the community will make every effort to prevent abuse, neglect, or financial exploitative staff behavior through staff training. In-Service education for all staff will be provided at the time of hire and every six months thereafter ... The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator ... if a resident alleges or an			

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	investigation uncovers possible abuse ... the administrator or designee shall conduct local law enforcement authorities immediately after the allegation ...." Cross Reference R52. This residential tag relates to Complaint IN00446213.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure a staff member was thoroughly screened prior to beginning their employment and failed to ensure they were appropriately trained to work with a specialized population before being assigned to a special memory care unit. This deficient practice had the potential to affect 23 of 69 residents who resided in the specialized memory care unit. Findings include: On 10/28/24 the facility self-reported an allegation of abuse which involved Resident B and Certified Nursing Aide (CNA) 58 and indicated, " ...[CNA 58] was seen and heard speaking vulgar to the resident and she took both of his wrists and hit his face with his own hands [before] pulling the residents pillow out from under his head and hitting him in the head with his pillow ...." The report indicated preventative measures were taken, " ...the DON [Director of Nursing] and ED {Executive Director] immediately began staff in-services concerning resident abuse and the reporting required when there is a situation involving resident abuse ...."	R 0116	**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 will be taken** a All residents that reside in the memory care unit 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 have all been in-serviced by the ED and DON regarding Resident Rights and Abuse and Neglect as well as, reporting alleged abuse and neglect. ED, DON and BOM have been educated on company	12/25/2024

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	On 11/4/24 at 12:00 p.m., Certified Nursing Aide (CNA) 58's employee file was reviewed. She was hired on 9/16/24. The record lacked a background check. The record lacked reference checks. The records lacked job-specific orientation. The record lacked specialized population/special unit dementia-specific training. The record lacked documentation of "observations during training." On 11/4/24 at 12:50 p.m., the DON provided a copy of CNA 58's actual worked schedule which indicated she worked a total of 58 hours between the dates of 9/16/24 and 10/28/24. The schedules indicated CNA 58 worked before the above pre-hire requirements were completed, and she worked in the specialized memory care unit before she started or received dementia-specific training. On 11/4/24 at 12:50 p.m., the DON provided a copy of CNA 58's background check. The State Police background check indicated the search was requested on 10/29/24 with inconclusive results and that follow-up fingerprints were recommended. A copy of the facility's Alzheimer's/Dementia Special Care Unit disclosure form was provided. The Disclosure form was dated 6/17/24 and indicated, staff who worked on the unit were based on the "interview process, experience, background checks and observation during training."		practices to ensure thorough screening of all staff. **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 DON or designee will check and heed advice from background checks regarding further steps to take for screening applicants. ED, DON or BOM will also screen applicants through the IN PLA and Nurse Aide Registry. The ED and/or DON or designee, will educate all newly hired clinical staff on policies and protocols relating to abuse and neglect during employee job-specific orientation moving forward. All residents and staff will be educated to alert the ED and/or DON to any potential abuse or neglect. **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:** a ED and/or DON or designee, will review all potential new hires prior to scheduling first shift to ensure backgrounds and licenses are viable. ED and/or DON or designee, will review all incidents	

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	11/04/2024

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	During an interview on 11/4/24 at 1:00 p.m., the ED indicated new employees should not be allowed to work with residents before the results of their background checks were complete. Staff should have all hire-paperwork such as background checks and references completed before the on-boarding process would continue. The ED indicated, due to the recent acquisition from one company to another, he would be unable to verify if CNA 58's background check was submitted and/or completed before she was hired and could not verify if reference checks were completed. On 11/4/24 at 2:00 p.m., the DON provided a copy of current facility policy titled, " ...all staff will undergo a criminal background check through [name of organization] and be checked against the Indiana Professional Licensing Agency website. In addition, all staff will be checked through the Indiana State Nurse Aide Registry. All employees must receive favorable results from the screening in order to join the staff or continue employment ...." On 11/5/24 at 1:27 p.m., the DON provided a copy of current facility policy, via e-mail. The policy was titled, "Introductory Period," and dated 1/2022. The policy indicated, " ... the Department Head of Supervisor shall provide an orientation for all new Employees specific to the job description, the function of the department, benefits, policies and the community ...." Cross reference R52. This residential tag relates to Complaint IN00446213.		twice weekly for two months, once a week for two months and monthly thereafter. 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** a Education and in-service will be provided to staff and residents between now and concluding on 12/25/2024.	

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R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on record reviews and interviews, the facility failed to ensure the state required dementia training was provided upon hire and annually for staff working at the facility for 5 of 5 staff members (Employees 20, 53, 29, 56, and 58). Findings include: 1. Employee 20 was hired on 10/10/23. Her file lacked documentation of the required annual 3 hours of dementia training. 2. Employee 53 was hired on 2/23/24. The employee record lacked documentation of any dementia training. 3. Employee 29was hired on 10/1/24. Her employee record lacked documentation of any dementia training. 4. Employee 56 was hired on 11/20/23. Her employee file lacked documentation of the required annual 3 hours of dementia training. 5. Employee 58 was hired on 9/16/24. Her employee record lacked documentation of any dementia training. During an interview with the Executive Director (ED) on 11/4/24 at 2:10 p.m., he indicated a past employee threw all the documentation for dementia training away. If it had the old management's name on it, it was destroyed. A policy was requested for dementia training on 11/4/24 and not received at the time of exit.	R 0119	**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 will be taken** a All staff, on both Memory Care and assisted living, including nursing, dietary, maintenance, housekeeping and administrative are to be in-serviced by the ED and DON regarding state required dementia training before 12/25/2024. **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 DON or designee will physically and digitally store all dementia training signature pages and forms. The ED and/or DON or designee, will educate all newly hired staff and educate annually for all current staff. **4 How the corrective**	12/25/2024

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	This residential tag relates to Complaint IN00446213.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:** a ED and/or DON or designee, will review training at monthly QI meetings for 6 months and make further recommendations based on audit results. ED and/or DON or designee will monitor weekly for 2 months, bi-weekly for 2 months and monthly for the last 2 months to ensure deficient practice will not recur. **5 By what date will the systematic changes be completed** a Education and in-service will be provided to staff and residents between now and concluding on 12/25/2024	