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	03/25/2025

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 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 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency 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.	R 0273	**R273** **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;**	05/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lily Price	Executive Director	04/11/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 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		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. **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;**	

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	Requirements," effective November 13, 2004, 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.		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	
R 0351 Bldg. 00	410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance 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	R 0351	**R351/R358** **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	05/01/2025

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	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, 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 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		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 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 assurance program will be put into place;** a This process will be reviewed by ED/designee on a weekly basis	

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	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 the door. The Wellness Director or nurse thinning charts were responsible for filing and managing medical records. All management and nursing employees were responsible for making sure medical records were secure. On 3/25/25 at 2:45 p.m., the ED provided a Community Record Retention Policy, dated 2/2025, and indicated the policy was the one currently being used by the facility. The policy indicated, "...Archived records must be maintained in a locked area and should be stored in banker boxes, storage tubs, and/or filing cabinets ..." This citation relates to Complaint IN00454469.		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	
R 0358 Bldg. 00	410 IAC 16.2-5-8.1(k) Clinical Records - Nonconformance Based on observation and interview, the facility failed to maintain a system of securing all discharged residents' medical records and	R 0358	**R351/R358** **1 What corrective action(s)**	05/01/2025

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	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, 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		**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. **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	

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	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 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 the door. The Wellness Director or nurse thinning charts were responsible for filing and managing medical records. All management and nursing employees were responsible for making sure medical records were secure.		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 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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	On 3/25/25 at 2:45 p.m., the ED provided a Community Record Retention Policy, dated 2/2025, and indicated the policy was the one currently being used by the facility. The policy indicated, "...Archived records must be maintained in a locked area and should be stored in banker boxes, storage tubs, and/or filing cabinets ...." This citation relates to Complaint IN00454469.			