STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> CO		COMPL	ODATE SURVEY COMPLETED 03/25/2025		
	PROVIDER OR SUPPLIER		<u> </u>	11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	IN00454469, and In Complaint IN00454 to the allegations ar Complaint IN00455 to the allegations ar Survey date: March Facility number: 01 Residential Census: These State Resider accordance with 416	1469 - State deficiencies related e cited at R351, and R358. 1309 - State deficiencies related e cited at R273.  24, and 25, 2025  2263  63  attial Findings are cited in	R 00	000			
R 0273 Bldg. 00	Based on observation failed to ensure diet utilized proper hand preparation. This depotential to affect 6 food prepared for the Findings include:  A confidential concept.	on and interview, the facility ary staff covered hair and I precautions during food efficient practice had the lout of 63 residents who had them from the kitchen.	R 02	273	R273  1 What corrective action(s will be accomplished for the 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 a what corrective action will be taken;	se n ng y nd	05/01/2025
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				<del></del>	TITLE		(X6) DATE

Lily Price Executive Director 04/11/2025

Any defiency statement 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 disclodays 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.

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 1 of 8

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/25/2025	
NAME OF PROVIDER OR SUPPLIER  GRAND VICTORIAN OF ZIONSVILLE				11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD /ILLE, IN 46077			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	During a random of 3/24/25 at 11:05 a.r. moving around the different food prep putting food into a p was not wearing gld her hands, and was asked if she had a h her pocket and indication. The cook indication include spart During an interview Culinary Manager is had been educated a staff knew they were and gloves during in On 3/25/25 at 3:55 there had been 2 restacility around lunch on 3/24/25.  On 3/25/25 at 2:45 (ED) provided a Cure Requirements policity the policy was the country of the facility. The policy was the country of the country	pservation of the kitchen on m., the cook was observed kitchen between tasks, and areas. The cook was observed pot boiling on the stove, she oves, was not seen washing not wearing a hair net. When air net, she pulled one out of cated she should have put it ated she was preparing food for aghetti and fish.  If on 3/24/25 at 11:12 a.m., the indicated the dietary employees on multiple occasions, and are required to wear hair nets aneal preparation.  In m., the Receptionist indicated sidents that signed out of the h time on 3/24/25. Licensed (N) 3 indicated she was not not sthat had signed out for p.m., the Executive Director clinary Dress Code & y, dated 7/2024, and indicated one currently being used by itey indicated, "Long hair must back. Caps/hats or hairnets to kitchen while preparing food p.m., the ED indicated, the cy regarding the need for in the kitchen while preparing			a All residents had the potent to be affected by the alleged deficient practice. ED and/or designee will ensure that dieta staff cover hair and utilize prophand precautions during food preparation. Employees found be out of compliance with thes guidelines will receive addition education and corrective action.  3 What measures will be printo 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 and utilize proper hand precautions during food preparation. Any staff member of compliance with facility's policies and protocols will receiprogressive corrective action, including termination. The Culinary Manager, or designee educate all newly hired dietary staff, on policies and protocols during employee job-specific orientation moving forward.  4 How the corrective action, will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place;	ntial  ry  per  to e al n.  ut  hair  e will		

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 2 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED	
			B. WING 03/25/2			2025
NAME OF PROVIDER OR SUPPLIER  GRAND VICTORIAN OF ZIONSVILLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 11755 N MICHIGAN RD ZIONSVILLE, IN 46077			
				PROVIDER'S PLAN OF CORRECTION		(X5)
				CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION DATE
Requirements," effet 138. indicated, "(a subsection (b), food restraints, such as heard restraints, and hair, that are design keep their hair from (2) clean equipment unwrapped single-s410 IAC 7-24-246 (a) If used, single-u only one (1) task, stready-to-eat food or This citation relates	extive November 13, 2004, Sec.  a) Except as provided in employees shall wear hair ats, hair coverings or nets, a clothing that covers body ed and worn to effectively contacting: (1) exposed food; t, utensils, and linens; and (3) ervice and single-use articles of Gloves; use limitation Sec. 246. see gloves shall be: (1) used for ach as working with with raw animal food"		IAU	a This process will be review by ED/designee on a weekly be for 8 weeks, monthly for 4 morand as needed thereafter as profithe QA process.  b Results will be reviewed a part of the QA process in order identify any anomalies or poter patterns. If indicated, an action plan will be implemented by Queen and reviewed as needed resolved.	easis onths eart es ontial	DATE
	•					
failed to maintain a residents records an information for 3 of Findings include:  A confidential conc indicated the facility that had patient info access the room.  On 3/24/25 at 10:24 room labeled "comp but not locked. A deresident records that On 3/24/25 at 12:29	system of securing all current d personal identifying 3 observations.  ern during the survey process y had a room on the 3rd floor formation, and anyone could a.m., observation of a 3rd floor mon room". The door was shut tesk was in the room piled with t were not secured.	R 03	351	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 a what corrective action will be taken;  a All residents had the potent to be affected by the alleged deficient practice. ED and/or	se n ng y nd e	05/01/2025
	ROVIDER OR SUPPLIER VICTORIAN OF ZIC  SUMMARY S (EACH DEFICIEN REGULATORY OR Requirements," effet 138. indicated, "(a subsection (b), food restraints, such as heard restraints, and hair, that are design keep their hair from (2) clean equipment unwrapped single-s410 IAC 7-24-246 (a) If used, single-u only one (1) task, su ready-to-eat food on This citation relates  410 IAC 16.2-5-8. Clinical Records - Based on observation failed to maintain a residents records an information for 3 of Findings include:  A confidential concindicated the facility that had patient information for 3 of Signature	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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 articles410 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.  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	ROVIDER OR SUPPLIER  VICTORIAN OF ZIONSVILLE  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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 articles410 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.  At 10 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	ROVIDER OR SUPPLIER  **ROVIDER OR SUPPLIER  **ROVIDER OR SUPPLIER  **SUMMAY STATEMENT OF DEFICIENCIE**  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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 articles410 IAC 7-24-246 Gloves; use limitation Sec. 246. 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On 3/24/25 at 12:29 p.m., the 3rd floor common	PROVIDER OR SUPPLIER  VICTORIAN OF ZIONSVILLE  SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY PULL  REGULATORY OR IX: DIBARTIPYING INFORMATION  Requirements," effective November 13, 2004, Sec. 138, indicated, "(a) Except as provided in subsection (b), food employees shall wear hair restraints, and clothing that covers body hair, that are designed and worm to effectively keep their hair from contacting; (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles410 IAC 7-24-246 Gloves; use limitation Sec. 246. (a) if used, single-use gloves shall be; (1) used for only one (1) lasks, such as working with ready-to-eat food or with raw animal food"  This citation relates to Complaint IN00455309.  ROSSI RASSINGS SUMPLES STATES, CITY, STATE, ZIP COD 111755 N MICHIGAN RD ZIONSVILLE, IN 46077  IN 50 MICHIGAN RD ZIONSVILLE, IN 46077  TAG  This process will be review by ED/designee on a weekly by	ROYIDER OR SUPPLIER  ROYIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  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 articles410 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-ear food or with raw animal food"  This citation relates to Complaint IN00455309.  R 0351  R 351/R358  1 What corrective action(s) will be completed; a May 1, 2025  R 351/R358  1 What corrective action(s) will be accomplished for those residents records and personal identifying information for 3 of 3 observations.  Findings include:  R 0351  R 351/R358  1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; and what corrective action will be taken;  A confidential concern during the survey process indicated the facility hall a room on the 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 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

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 3 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
			B. W	B. WING			03/25/2025	
					-			
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
			11755 N MICHIGAN RD					
GRAND	VICTORIAN OF ZIC	DNSVILLE		ZIONS	VILLE, IN 46077			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DE CLUDEDIG DE ANI CE CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE .	DATE	
		with unsecured resident			records are stored in accordar	nce		
		es and loose papers. A smaller			with the company Medical			
	· ·	with 2 separate stacks of			Records Storage Policy.			
		ne resident records included,			Employees found to be out of			
		dentifying information of birth			compliance with medication			
		numbers, insurance numbers,			documentation will receive			
		ents, physician progress			additional education and corre	ctive		
		rders for medications and			action.	Olive		
		plinary team notes. There were			dollori.			
		ng cabinets with 4 and 5			3 What measures will be p			
		resident records, those were			into place or what systemic	"		
	_	naintenance cart with painting			changes the facility will make	<u> </u>		
	and repair supplies was observed sitting among				to ensure that the deficient			
	the filing cabinets.				practice does not recur;			
	the ming caomets.				practice does not recui,			
	On 3/25/25 at 11:27	7 a.m., the 3rd floor common			a ED and/or designee will			
		to remain unlocked with			ensure that medical records a	re		
	unsecured resident	medical records, unlocked			stored in accordance with the			
	filing cabinets conta	aining resident medical			company Medical Records			
		tenance cart sitting among the			Storage Policy. Any staff men	nber		
	filing cabinets.				out of compliance with facility's			
					policies and protocols will rece			
	During an interview	on 3/25/25 at 1:57 p.m., the			progressive corrective action,			
	Executive Director	(ED) indicated that the			including termination. The			
		or nurse thinning charts were			Director of Nursing, or designe	e l		
		g and managing medical			will educate all newly hired clir			
		was currently without a			staff, including any agency sta			
	Wellness Director.				on policies and protocols durir			
					employee job-specific orientati	_		
	During an interview	on 3/25/25 at 2:28 p.m., the			moving forward.	• •		
	_	for indicated he was newer to			] "			
		ast few months. He had a grand			4 How the corrective			
		s every door in the facility to			action(s) will be monitored to	,		
		artments, offices, and the			ensure the deficient practice			
	_	etrical rooms. The 3rd floor			will not recur, i.e., what quali			
		appeared to be an old office			assurance program will be p	-		
		es in it, filing cabinets, a			into place;			
		and he stored his maintenance			into piaco,			
	1	ne Maintenance Director			a This process will be review	wed		
		no key code panel on the 3rd			by ED/designee on a weekly b			
	marcaica mere was	no key code paner on the 31d			by ED/designee on a weekly b	asis		

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 4 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/25/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR floor common area access. He did not k common area room  During an interview indicated she was ne month and had not k area room since she hired. To her knowl nursing office, but k a storage area for re ED indicated she ke required to be locke the 3rd floor common and resident records thinned from curren resident files were a the door. The Welln charts were respons medical records. All employees were res medical records wer  On 3/25/25 at 2:45 p Community Record 2/2025, and indicate currently being used indicated, "Archiv maintained in a lock	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION room, it required a key to mow how long the 3rd floor door had been unlocked.  on 3/25/25 at 3:15 p.m., the ED ewer to the facility in the past been in the 3rd floor common was toured before being edge, the room used to be a mad since been converted into sident medical records. The new resident records were d up, and had not been aware on area room was unlocked, so to include documents at resident files, and discharged accessible to anyone opening mess Director or nurse thinning ible for filing and managing Il management and nursing ponsible for making sure			nths eart  as er to ential n eA I until			
	This citation relates	to Complaint IN00454469.						
R 0358 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -							
2.55. 00	failed to maintain a	on and interview, the facility system of securing all 'medical records and	R 0358	R351/R358  1 What corrective action(s	05/01/2025			

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 5 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLE				
			B. WI	ING		03/25/	/2025
NAME OF D	ROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					N MICHIGAN RD		
GRAND \	VICTORIAN OF ZI	ONSVILLE		ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	personal identifying information for 3 of 3				will be accomplished for tho		
	observations.				residents found to have bee	n	
	Findings include:				affected by the deficient practice;		
	i manigs merade.				practice,		
	A confidential con-	cern during the survey process			a 2 How the facility will		
	indicated the facili	ty had a room on the 3rd floor			identify other residents havi	ng	
	that had patient inf	ormation, and anyone could			the potential to be affected b	у	
	access the room.				the same deficient practice a		
					what corrective action will b	е	
		4 a.m., observation of a 3rd floor			taken;		
	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.				a All residents had the pote	ential	
	resident records the	at were not secured.			to be affected by the alleged		
	On 3/24/25 at 12:2	9 p.m., the 3rd floor common			deficient practice. ED and/or designee will ensure that med	lical	
		to be unlocked. There was a			records are stored in accorda		
		with unsecured resident			with the company Medical	IICE	
		les and loose papers. A smaller			Records Storage Policy.		
		with 2 separate stacks of			Employees found to be out of		
		he resident records included,			compliance with medication		
	but not limited to,	identifying information of birth			documentation will receive		
		y numbers, insurance numbers,			additional education and corre	ective	
		ents, physician progress			action.		
		orders for medications and					
		plinary team notes. There were			3 What measures will be p	out	
		ing cabinets with 4 and 5			into place or what systemic		
	_	resident records, those were			changes the facility will mak	e	
		maintenance cart with painting was observed sitting among			to ensure that the deficient		
	the filing cabinets.	was observed sitting among			practice does not recur;		
	are ming enomets.				a ED and/or designee will		
	On 3/25/25 at 11:2	7 a.m., the 3rd floor common			ensure that medical records a	re	
		to remain unlocked with			stored in accordance with the		
	unsecured resident	medical records, unlocked			company Medical Records		
		taining resident medical			Storage Policy. Any staff mer	mber	
		ntenance cart sitting among the			out of compliance with facility		
	filing cabinets.				policies and protocols will rec		
		2/27/27			progressive corrective action,		
	During an interview	w on 3/25/25 at 1:57 p.m., the			including termination. The		

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 6 of 8

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/25/2025				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	Executive Director or responsible for filing records. The facility Wellness Director.  During an interview Maintenance Direct the facility in the parameter key to access include resident aparamechanical and elect common area room that had resident filter frigerator, desks, a cart in the room. The indicated there was floor common area access. He did not know that the common area access. He did not know the common area room did area room since she hired. To her known nursing office, but he a storage area for ree ED indicated, she know the sident floor common area room and resident records thinned from current resident files were at the door. The Wellst charts were responsimedical records. Al	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION (ED) indicated that the r nurse thinning charts were g and managing medical r was currently without a  r on 3/25/25 at 2:28 p.m., the or indicated he was newer to st few months. He had a grand s every door in the facility to rtments, offices, and the extrical rooms. The 3rd floor appeared to be an old office es in it, filing cabinets, a and he stored his maintenance e Maintenance Director no key code panel on the 3rd room, it required a key to mow how long the 3rd floor door had been unlocked.  r on 3/25/25 at 3:15 p.m., the ED ewer to the facility in the past been in the 3rd floor common was toured before being edge, the room used to be a had since been converted into sident medical records. The new resident records were d up, and had not been aware on area room was unlocked, at to include documents t resident files, and discharged accessible to anyone opening less Director or nurse thinning ible for filing and managing I management and nursing ponsible for making sure re secure.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Director of Nursing, or design will educate all newly hired cli staff, including any agency state on policies and protocols durit employee job-specific oriental moving forward.  4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be printo place;  a This process will be reviet by ED/designee on a weekly of for 8 weeks, monthly for 4 monand as needed thereafter as profit of the QA process.  b Results will be reviewed as part of the QA process in order identify any anomalies or potential plan will be implemented by Compatterns. If indicated, an action plan will be implemented by Compatterns and reviewed as needed resolved.  5 By what date the system changes will be completed;  a May 1, 2025	ee nical aff, ng tion  o e ity out  wed basis onths bart as er to ential n QA d until			
			1					

State Form Event ID: K4YP11 Facility ID: 012263 If continuation sheet Page 7 of 8

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/25/2025	
NAME OF PROVIDER OR SUPPLIER  GRAND VICTORIAN OF ZIONSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 11755 N MICHIGAN RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  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.			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΠΈ	(X5) COMPLETION DATE

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