STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING			COMPLETED	
			B. WI	NG		04/16/	2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER				STATE ROAD 135			
GRAND \	/ICTORIAN OF GR	EENWOOD		GREEN	IWOOD, IN 46143			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0000								
Bldg. 00								
Diag. 00	This visit was for a Survey.	State Residential Licensure	R 00	000				
	Survey dates: April	15 and 16, 2025						
	Facility number: 00	5722						
	Residential Census:	91						
	These State Resident accordance with 410	ntial Findings are cited in 0 IAC 16.2-5.						
	Quality review com	pleted April 21, 2025.						
R 0092	410 IAC 16.2-5-1.3	3(i)(1-2)						
	Administration and							
Bldg. 00	Noncompliance							
		and record review, the facility	R 00)92	Facility ID 005722		06/05/2025	
		9 of the 12 total required			R92-Administration and			
		ere conducted for the calendar			Management Nonompliance-			
	year for 2024.				(Fire Drills)			
	Finding includes:				What corrective action(s) will be accomplished for those residents found to have beer			
	On 4/16/25 at 11:30	a.m., the ED (Executive			affected by the alleged			
		documentation of fire drills			deficient practice:			
		alendar year for 2024. A review			No residents were adversely	v		
		ated that there were three fire			affected by the deficient	'		
	drills conducted on	12/27/24, one drill each on 1st,			practice			
	2nd, and 3rd shifts.				How the facility will identify			
					other residents having the			
	_	on 4/16/25 at 11:30 a.m., the			potential to be affected by the	е		
	-	g the calendar year 2024, the			same deficient practice and			
	-	hree fire drills during the The facility was to conduct at			what corrective action will be	;		
	least 12 fire drills pe				taken: N/A All Fire Dille Up to date 5.6.2	5		
	reast 12 me arms pe	or your.			Fire Drill Schedule – Fire Dril			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Suzanne Dille Interim Executive Director 05/13/2025

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.

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 04/16/2025	
	PROVIDER OR SUPPLIER		2339 \$	FADDRESS, CITY, STATE, ZIP COD S STATE ROAD 135 ENWOOD, IN 46143		
(X4) ID PREFIX TAG	(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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
		•		Monthly QA Maintenance Manager of designee monthly to assure Fire Drill procedures are completed x 12 months Fire Department Invited to observe a fire drill on site M 2025		
R 0116 Bldg. 00	410 IAC 16.2-5-1. Personnel - Nonco	, ,				
	failed to maintain and documentation of reconducted for 2 of 3 reviewed for employ Aide 5) Finding includes: On 4/16/25 at 10:00 provided a list of cubire and associated 1. On 4/16/25 at 10: Aide (QMA) 7's per QMA 7 was hire on employed at the fact. The personnel file lies.	215 a.m., Qualified Medication resonnel file was reviewed. 4/7/25 and was currently ility.	R 0116	Facility ID: 005722 R116-Personnel- Noncomplia 1 What Corrective action(will be accomplished for the s found to have been affected be alleged deficient practice a 2 How the facility will identify other staff having the potential to be affected by the same deficient practice and w corrective will be taken An audit of all employee files be completed by the Busines. Office Manager. The employee files found to be out of compliationing the audit will have Reference checks completed or before 6/5/2025	s) staff by the e c what will s ee fance	
	QMA 7's applicable been conducted. 2. On 4/16/25 at 10: personnel file was r	e employee references had 20 a.m., Dietary Aide 5's eviewed. Dietary Aide 5 was was currently employed at the		3 What measures will be printo place or what systemic changes the facility will make ensure that the deficient practions not recur:	to	

State Form Event ID: P03111 Facility ID: 005722 If continuation sheet Page 2 of 9

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/16/2025		
NAME OF PROVIDER OR SUPPLIER GRAND VICTORIAN OF GREENWOOD (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 2339 S STATE ROAD 135 GREENWOOD, IN 46143				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	(X5) COMPLETION DATE		
	Dietary Aide 5's applied been conducted. During an interview Executive Director unable to locate any QMA 7 and Dietary should have contains showed the employ completed. On 4/16/25 at 12:20 provided a copy of dated January 2023 current policy in ust the policy indicated employees will be k communitythe followed.	acked documentation that plicable employee references. 7 on 4/16/25 at 11:20 a.m., the indicated that the facility was 7 documented references for 7 Aide 5. The employee files are documentation that ee references had been 9 p.m., the Executive Director the Personnel Records policy, and indicated it was the e by the facility. A review of , "Personnel records on all teept in a central location in the lowing documents will be onnel filereference inquiry"		a .The Business Office Manager will conduct an audit employee files weekly for 4 we and monthly for 3 months. Variances will be corrected at time of observation 4 How the corrective action will be monitored to ensure the deficient practice will not recur what quality assurance progra will be put into place: a BOM and/ or ED to Results to be reviewed at mo QI meetings and make further recommendations based off a results. 5 By what date will the systematic changes be completed _ 6/5/2025	the n(s) e r, i.e nm		
R 0120 Bldg. 00	410 IAC 16.2-5-1. Personnel - Nonce						
9. 33	failed to ensure the dementia training we employee records refinding included: On 4/16/25 at 10:33 were reviewed. The dementia training for the employee records.	and record review, the facility required three hours annual vas completed for 2 of 5 eviewed. (QMA 8, QMA 9) 8 a.m., the employee records e employee records lacked or the following staff: ord of QMA (Qualified indicated the date of hire was	R 0120	Facility ID: 005722 R120- Personnel Noncomplian 1. What corrective action(s) w accomplished for those reside found to have been affected b deficient practice? No residents experienced adv effects from the alleged deficie practice 2. How the facility will identify other residents having the potential to be affected by the	ill be ents y the erse ent		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 04/16/2025		
	NAME OF PROVIDER OR SUPPLIER GRAND VICTORIAN OF GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 2339 S STATE ROAD 135 GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE		
IAU	8/1/19. The employ three hours of annu - The employee rec date of hire was 3/2 lacked the required dementia training. During an interview Executive Director unable to provided annual dementia trainidicated the facilit to dementia training	ree record lacked the required al dementia training. ord of QMA 9 indicated the 1/22. The employee record three hours of annual or on 4/16/25 at 12:25 p.m., the indicated the facility was documentation of the required tining. The Executive Director y did not have a policy related g but followed the State g the required dementia	IAC	same deficient practice and corrective action will be take Alleged deficiency had the potential to affect all residen residing in the community. No residents had adverse effect related to the alleged deficiency practice 3. What measures will be purpliace or what systematic changes be completed? Director or Designee will notify staff of a required training. Executive Director or Designee will notify staff of a required training. Executive Director or Designee will remany employees from the school who failed to comply with the requirement by the date set. 4. How the corrective action be monitored to ensure the deficient practice will not recipie: What Quality Assurance program will be put in place? The Executive Director or designee will audit employed training weekly to ensure ce staff have completed require training on a timely basis. Quality Assurance Committee (QA review audits monthly and more commendations as needed. By what date will the system changes be completed? 06/05/2025	what n? ts lo s nt t in to langes re the lecur? any nove ledule s forth. (s) will lur, or extified led lad lad lad lad lad lad lad lad lad la		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00 COMPLE		ETED	
			B. WI	NG		04/16/	04/16/2025	
				CTREET	ADDRESS SITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135			
CDANDA	/ICTORIAN OF CR	PEENWOOD						
GRAND	/ICTORIAN OF GR	EENWOOD		GREEN	NWOOD, IN 46143			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0121	410 IAC 16.2-5-1.4	4(f)(1-4)						
	Personnel - Nonco	ompliance						
Bldg. 00								
	Based on interview	and record review, the facility	R 0	121			06/05/2025	
	failed to maintain ac	ccurate personnel records and			Facility ID: 005722			
	documentation of a	physical health screening for			R121-Personnel Noncomplian	ce		
	3 of 3 newly hired e	employees. (Dietary Aide 5,			1.What Corrective action(s) wi	ll be		
	CNA 6, and QMA 7	7)			accomplished for the staff four	nd to		
					have been affected by the alle	ged		
	Finding includes:				deficient practice			
		a.m., the Executive Director			a b An audit of all			
	•	rrent employees with date of			employee files will be complete	ed		
	hire and associated	position titles.			by the Business Office Manag			
					The employee files found to be			
		a.m., the three newly hired			of compliance during the audit	will		
		were reviewed. The employee			have Physical Health screen			
	record documentation	on indicated the following:			completed checks on or befor 06/05/2025	e		
	1. Dietary Aide 5 w	as hired on 2/7/25 and was						
	currently employed	at the facility.						
					3.What measures will be put ir	nto		
	2. CNA 6 was hired	on 2/21/25 and was currently			place or what systemic change			
	employed at the fac	ility.			the facility will make to ensure			
					that the deficient practice does	not		
	3. QMA (Qualified	Medication Aide) 7 was hired			recur:			
	on 4/7/25 and was c	currently employed at the						
	facility.				a .The Business Office			
					Manager will conduct an audit	of		
		rds of an employee physical			employee files weekly for 4 we	eeks		
	health screening for	Dietary Aide 5, CNA 6, or			and monthly for 3 months.			
	QMA 7.				Variances will be corrected at	the		
					time of observation			
	-	on 4/16/25 at 11:30 a.m., the						
		e physical health screenings						
	-	CNA 6, or QMA 7 could not be			4.How the corrective action(s)	will		
		employees should have had			be monitored to ensure the			
	0.7.	l health screenings with their			deficient practice will not recur			
	employee files.				what quality assurance progra	m		
					will be put into place:			

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>00</u> COM		ETED
					04/16/	2025	
NAME OF PROVIDER OR SUPPLIER GRAND VICTORIAN OF GREENWOOD				2339 S	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 IWOOD, IN 46143		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	they lacked a policy screens for newly h	is a.m., the ED indicated that a specific to physical health ired employees and the facility lations and guidelines.			a BOM and/ or ED to Results to be reviewed at mon QI meetings and make further recommendations based off at results. 5.By what date will the system changes be completed 06/05/2	udit atic	
R 0123 Bldg. 00	410 IAC 16.2-5-1. Personnel - Nonco	, . , .					
	failed to maintain addocumentation of go job orientations, or	and record review, the facility eccurate personnel records and eneral orientations, specific job descriptions for 2 of 3 rees. (Dietary Aide 5, CNA 6)	nd R123-Personnel Noncompliance 1 What Corrective action(s) will be accomplished for the staff) will	06/05/2025		
	provided a list of cu hire and associated On 4/16/25 at 10:55 employees' records record documentation 1. Dietary Aide 5 w currently employed	is a.m., the three newly hired were reviewed. The employee on indicated the following: as hired on 2/7/25 and was at the facility.			2 How the facility will identice other staff having the potential be affected by the same deficipal practice and what corrective with be taken a An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out compliance during the audit will be provided to the same of the same	I to ent iill of	
	The employee files indicated the general orientations, or job	lacked documentation that al orientations, specific job descriptions for Dietary Aide 5 n provided to the employee.			have 3 What measures will be puinto place or what systemic		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 04/16/2025	
NAME OF PROVIDER OR SUPPLIER GRAND VICTORIAN OF GREENWOOD (VALID SUMMARY STATEMENT OF DEFICIENCIE)			2339 S	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 NWOOD, IN 46143	
(X4) ID PREFIX TAG	(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)	(X5) COMPLETION DATE
	During an interview on 4/16/25 at 11:30 a.m., the ED indicated that the job orientations and job descriptions for Dietary Aide 5 and CNA 6 could not be located and that the employees should have had the missing documentation with their employee files. On 4/16/25 at 11:33 a.m., the ED provided a copy of a policy titled "General Orientation", dated effective April 2021, and indicated it was the policy currently in use by the facility. A review of the policy indicated that the general orientation process included job descriptions and both general and specific orientation to be completed no later than the 30th day of employment.			changes the facility will make ensure that the deficient pract does not recur: a .The Business Office Manager will conduct an audit employee files weekly for 4 we and monthly for 3 months. Variances will be corrected at time of observation 4 How the corrective action will be monitored to ensure the deficient practice will not recur what quality assurance prograwill be put into place: b BOM and/ or ED to Results to be reviewed at mor QI meetings and make further recommendations based off a results. 5 By what date will the systematic changes be completed: 06/05/2025	of eeks the n(s) e r, i.e im
R 0273 Bldg. 00	410 IAC 16.2-5-5. Food and Nutrition	1(f) al Services - Deficiency			
Diag. 00	review, the facility f served in a sanitary kitchen observations	on, interview, and record ailed to ensure foods were and safe manner for 1 of 3 s. Staff hair was not covered food preparation area. (Cook	R 0273	R273-Personnel- Noncomplian 1.What Corrective action(s) with accomplished for those reside found to have been affected by deficient practice /p>	ill be nts

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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 04/16/2025		
NAME OF PROVIDER OR SUPPLIER GRAND VICTORIAN OF GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 2339 S STATE ROAD 135 GREENWOOD, IN 46143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	from 9:15 a.m. to 9 hanging on the kitc the sign indicated, ' kitchen at all times. During a follow-up	kitchen observation on 4/15/25			2.How the facility will identify or residents having the potential be affected by the same defici practice and what corrective with be taken a.All residents that dine from the kitchen had the potential to be affected by the alleged deficie	to ent vill he	
	from 12:45 p.m. to 12:50 p.m., the following was observed: - Cook 2 was observed at the food preparation table located near the steam table where the noon				practice. The Dietary Manager designee will provide an in-ser to all kitchen staff regarding th use of facial hair coverings	or vice	
	preparing the meat was observed wear from the top of his Cook 2's hair, appre length, from below	ted. Cook 2 was observed for the evening meal. Cook 2 ing a hair net that covered hair ears to the top of his head. oximately one-half inch in the hair net to the neckline was covered. Cook 2 was observed			3.What measures will be put in place or what systemic change the facility will make to ensure that the deficient practice does recur:	es	
	to have hair, approximately one-half inch in length, in front of both ears and had facial hair that covered the cheek bone area to the jaw line, including hair above and below the lips. Cook 2's facial hair was observed to not be covered. During an interview on 4/15/25 at 12:55 p.m., the Dietary Manager indicated Cook 2's hair should have been covered. During an interview on 4/15/25 at 12:57 p.m., Cook				a An in-service will be held the Dietary Manager or design to include all kitchen staff. An staff member out of compliand with facility's policies and protocols relating to facial	iee y	
					coverings will receive progres corrective action. The Dietary Manager or designee will educ all newly hired clinical staff on policies and protocols relating	cate	
	kitchen. On 4/15/25 at 1:30 provided a copy of Requirements, date	p.m., the Executive Director the Culinary Dress Code and d July 2024, and indicated it			hair coverings 4.How the corrective action(s) be monitored to ensure the deficient practice will not recur what quality assurance progra	, i.e	
	review of the docur	icy in use by the facility. A ment indicated, "hair must be must be worn in the kitchen			will be put into place: a The Dietary Manager or		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/16/2025	
NAME OF PROVIDER OR SUPPLIER GRAND VICTORIAN OF GREENWOOD			2339 S	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 NWOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
	On 4/15/25 at 3:30 Food Establishmer Title 410 IAC 7-24 indicated, "food restraints, such as netsthat are design	while preparing foodbeardnets must be worn" On 4/15/25 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "food employees shall wear hair restraints, such as hats, hair coverings or netsthat are designed and worn to effectively keep their hair from contactingexposed food"		designee will audit the use of facial coverings daily for two (2) weeks, then two (2) times a wrong for two (2) weeks, and then we for three (3) weeks, then as needed to ensure that the propercedure is properly executed. Results to be reviewed at more QI meetings and make further recommendations based on a results. 5 By what date will the systematic changes be completed to the complete of the c	eek eekly per d. nthly	

State Form Event ID: P03111 Facility ID: 005722 If continuation sheet Page 9 of 9