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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 15 and 16, 2025 Facility number: 005722 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 21, 2025.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to ensure that 9 of the 12 total required annual fire drills were conducted for the calendar year for 2024. Finding includes: On 4/16/25 at 11:30 a.m., the ED (Executive Director) provided documentation of fire drills conducted for the calendar year for 2024. A review of the records indicated that there were three fire drills conducted on 12/27/24, one drill each on 1st, 2nd, and 3rd shifts. During an interview on 4/16/25 at 11:30 a.m., the ED indicated during the calendar year 2024, the facility conducted three fire drills during the month of December. The facility was to conduct at least 12 fire drills per year.	R 0092	**Facility ID 005722** **R92-Administration and Management Nonompliance-(Fire Drills)** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** **No residents were adversely affected by the deficient practice** **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: N/A** **All Fire Dille Up to date 5.6.25** **Fire Drill Schedule – Fire Drills**	06/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Dille	Interim Executive Director	05/13/2025

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.

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/16/25 at 11:55 a.m., the ED indicated that the facility lacked a policy specific to the number of fire drills and the facility followed state regulations and guidelines.		**Monthly QA Maintenance Manager or designee monthly to assure Fire Drill procedures are completed x 12 months Fire Department Invited to observe a fire drill on site May 2025**	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of references having been conducted for 2 of 3 newly hired employees reviewed for employee records. (QMA 7, Dietary Aide 5) Finding includes: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. 1. On 4/16/25 at 10:15 a.m., Qualified Medication Aide (QMA) 7's personnel file was reviewed. QMA 7 was hire on 4/7/25 and was currently employed at the facility. The personnel file lacked documentation that QMA 7's applicable employee references had been conducted. 2. On 4/16/25 at 10:20 a.m., Dietary Aide 5's personnel file was reviewed. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility.	R 0116	Facility ID: 005722 R116-Personnel- Noncompliance 1 What Corrective action(s) will be accomplished for the staff found to have been affected by the alleged deficient practice a 2 How the facility will identify other staff having the potential to be affected by the same deficient practice and what corrective will be taken An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have Reference checks completed on or before 6/5/2025 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:	06/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The personnel file lacked documentation that Dietary Aide 5's applicable employee references had been conducted. During an interview on 4/16/25 at 11:20 a.m., the Executive Director indicated that the facility was unable to locate any documented references for QMA 7 and Dietary Aide 5. The employee files should have contained documentation that showed the employee references had been completed. On 4/16/25 at 12:20 p.m., the Executive Director provided a copy of the Personnel Records policy, dated January 2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Personnel records on all employees will be kept in a central location in the community...the following documents will be retained in the personnel file...reference inquiry..."		a .The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation 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 BOM and/ or ED to Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5 By what date will the systematic changes be completed _ 6/5/2025	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure the required three hours annual dementia training was completed for 2 of 5 employee records reviewed. (QMA 8, QMA 9) Finding included: On 4/16/25 at 10:33 a.m., the employee records were reviewed. The employee records lacked dementia training for the following staff: - The employee record of QMA (Qualified Medication Aide) 8 indicated the date of hire was	R 0120	Facility ID: 005722 R120- Personnel Noncompliance 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents experienced adverse effects from the alleged deficient practice 2. How the facility will identify other residents having the potential to be affected by the	06/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/1/19. The employee record lacked the required three hours of annual dementia training. - The employee record of QMA 9 indicated the date of hire was 3/2/22. The employee record lacked the required three hours of annual dementia training. During an interview on 4/16/25 at 12:25 p.m., the Executive Director indicated the facility was unable to provided documentation of the required annual dementia training. The Executive Director indicated the facility did not have a policy related to dementia training but followed the State guidelines regarding the required dementia training.		same deficient practice and what corrective action will be taken? Alleged deficiency had the potential to affect all residents residing in the community. No residents had adverse effects related to the alleged deficient practice 3. What measures will be put in to place or what systematic changes will the facility make to ensure the deficient practice does not recur? The Executive Director or Designee will notify staff of any required training. Executive Director or Designee will remove any employees from the schedule who failed to comply with this requirement by the date set forth. 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 in place? The Executive Director or designee will audit employee training weekly to ensure certified staff have completed required training on a timely basis. Quality Assureance Committee (QA) will review audits monthly and make recommendations as needed By what date will the systematic changes be completed? 06/05/2025	

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of a physical health screening for 3 of 3 newly hired employees. (Dietary Aide 5, CNA 6, and QMA 7) Finding includes: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. On 4/16/25 at 10:55 a.m., the three newly hired employees' records were reviewed. The employee record documentation indicated the following: 1. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. 2. CNA 6 was hired on 2/21/25 and was currently employed at the facility. 3. QMA (Qualified Medication Aide) 7 was hired on 4/7/25 and was currently employed at the facility. There were no records of an employee physical health screening for Dietary Aide 5, CNA 6, or QMA 7. During an interview on 4/16/25 at 11:30 a.m., the ED indicated that the physical health screenings for Dietary Aide 5, CNA 6, or QMA 7 could not be located and that the employees should have had the missing physical health screenings with their employee files.	R 0121	Facility ID: 005722 R121-Personnel Noncompliance 1.What Corrective action(s) will be accomplished for the staff found to have been affected by the alleged deficient practice a b An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have Physical Health screen completed checks on or before 06/05/2025 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 Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation 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:	06/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/16/25 at 11:55 a.m., the ED indicated that they lacked a policy specific to physical health screens for newly hired employees and the facility followed State regulations and guidelines.		a BOM and/ or ED to Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5.By what date will the systematic changes be completed 06/05/2025	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on interview and record review, the facility failed to maintain accurate personnel records and documentation of general orientations, specific job orientations, or job descriptions for 2 of 3 newly hired employees. (Dietary Aide 5, CNA 6) Findings include: On 4/16/25 at 10:00 a.m., the Executive Director provided a list of current employees with date of hire and associated position titles. On 4/16/25 at 10:55 a.m., the three newly hired employees' records were reviewed. The employee record documentation indicated the following: 1. Dietary Aide 5 was hired on 2/7/25 and was currently employed at the facility. 2. CNA 6 was hired on 2/21/25 and was currently employed at the facility. The employee files lacked documentation that indicated the general orientations, specific job orientations, or job descriptions for Dietary Aide 5 and CNA 6 had been provided to the employee.	R 0123	Facility ID: 005722 R123-Personnel Noncompliance 1 What Corrective action(s) will be accomplished for the staff found to have been affected by the alleged deficient practice 2 How the facility will identify other staff having the potential to be affected by the same deficient practice and what corrective will be taken a An audit of all employee files will be completed by the Business Office Manager. The employee files found to be out of compliance during the audit will have 3 What measures will be put into place or what systemic	06/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 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 to ensure that the deficient practice does not recur: a .The Business Office Manager will conduct an audit of employee files weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of observation 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: b BOM and/ or ED to Results to be reviewed at monthly QI meetings and make further recommendations based off audit results. 5 By what date will the systematic changes be completed: 06/05/2025	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 1 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Cook 2) Finding includes:	R 0273	R273-Personnel- Noncompliance 1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice /p>	06/05/2025

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During the initial kitchen observation on 4/15/25 from 9:15 a.m. to 9:35 a.m., a sign was observed hanging on the kitchen's entry door. A review of the sign indicated, "Hair nets must be worn in the kitchen at all times." During a follow-up kitchen observation on 4/15/25 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 meal was being plated. Cook 2 was observed preparing the meat for the evening meal. Cook 2 was observed wearing a hair net that covered hair from the top of his ears to the top of his head. Cook 2's hair, approximately one-half inch in length, from below the hair net to the neckline was observed to not be covered. Cook 2 was observed 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 2 indicated all hair was to be covered while in the kitchen. On 4/15/25 at 1:30 p.m., the Executive Director provided a copy of the Culinary Dress Code and Requirements, dated July 2024, and indicated it was the current policy in use by the facility. A review of the document indicated, "...hair must be restrained...hairnets must be worn in the kitchen		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 dine from the kitchen had the potential to be affected by the alleged deficient practice. The Dietary Manager or designee will provide an in-service to all kitchen staff regarding the use of facial hair coverings 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 An in-service will be held by the Dietary Manager or designee to include all kitchen staff. Any staff member out of compliance with facility's policies and protocols relating to facial coverings will receive progressive corrective action. The Dietary Manager or designee will educate all newly hired clinical staff on policies and protocols relating to hair coverings 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 The Dietary Manager or	

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND VICTORIAN OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	while preparing food...beardnets 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 nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."		designee will audit the use of facial coverings daily for two (2) weeks, then two (2) times a week for two (2) weeks, and then weekly for three (3) weeks, then as needed to ensure that the proper procedure is properly executed. Results to be reviewed at monthly QI meetings and make further recommendations based on audit results. 5 By what date will the systematic changes be completed 06/05/2025	