STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/21/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake IN00471909. Intake IN00471909 - No deficiencies related to the allegations are cited. Survey dates: September 18 and 21, 2026 Facility number: 012263 Residential Census: 60 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 24, 2026.	R 0000		
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized	R 0120	**R120** 1. **What corrective**	11/02/2026

	inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor.		**action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. 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 same deficient practice and what corrective action will be taken:** 1. No residents had the potential to be affected by the alleged deficient practice.ED and/or designee will ensure that staff that have contact with residents will have a minimum of 6 hours of dementia training within 6 months of hire and 3 hours annually thereafter. 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:** 1. ED and/or designee will ensure that staff have sufficient dementia training	

	(D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to implement an effective annual in-service program to ensure all employees received the minimum required dementia-specific training for 3 of 5 employees reviewed. Findings include: On 9/21/26 at 1:00 p.m., five randomly selected employee in-service records were reviewed and included the following: Housekeeper 6 was hired on 6/10/26. Their employee in-service record lacked documentation of any dementia-specific training since her hire. Qualified Medication Aide 7 was hired on 10/1/24. Their employee in-service record lacked documentation of the minimally required three hours of dementia-specific annual training. Cook 8 was hired on 12/23/24. Their employee in-service		completed. Any staff member out of compliance with facility policies and protocols will receive progressive corrective action. The ED/designee will educate all newly hired staff on policies and protocols during employee 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:** 1. 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. 2. Results will be reviewed as part of the QA process to identify any anomalies or potential patterns. If indicated, an action plan will be implemented by QA team and reviewed as needed until resolved.	

	record lacked documentation of the minimally required three hours of dementia-specific annual training. During an interview, on 9/21/26 at 1:45 p.m., the Executive Director indicated she did not have additional records to provide for the employee files noted above. During an interview, on 9/21/26 at 2:41 p.m., the Executive Director indicated the facility did not have a policy which specifically addressed dementia-specific training, but the facility followed the Indiana Residential Regulations.		5. **By what date the systemic changes will be completed: 11/2/26**	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observations and interviews, the facility failed to ensure all refrigerators were at the appropriate temperature and dried goods were labeled and dated during 1 of 1 kitchen observations.	R 0273	**R273** 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. 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 same deficient practice and what corrective action**	11/02/2026

	Findings include: On 9/18/26 at 9:45 a.m., the kitchen was observed with the Dietary Manager. During that observation the following was observed. The refrigerator on the food line had a temperature log taped to the door which indicated the refrigerator was "Standing cooler #2." It did not have an internal thermometer, and the dietary manager indicated they used the external thermometer to check the temperature. The Dietary Manager indicated they typically open the line refrigerator more during meal services, so that makes the temperature in the evening go up. At the time of the observation, the external thermometer indicated it was 52 degrees Fahrenheit (F), and there was approximately a half inch of standing water at the bottom of the refrigerator. The Dietary Manager indicated they had a leak in the refrigerator that maintenance had just fixed, but she was planning to have them look at it again since it appeared to still be leaking. The dry storage area included an open box of cornbread mix, an open bag of an unlabeled white powder, and an open bag of cheese sauce mix with no opened date. The Dietary		**will be taken:** 1. No residents had the potential to be affected by the alleged deficient practice.Dietary Manager and/or designee will ensure that all refrigerators are at appropriate temperatures, and all dried goods are labeled and dated. 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:** 1. Dietary Manager and/or designee will ensure that all refrigerators are at appropriate temperatures, and all dried goods are labeled and dated. 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:** 1. This process will be reviewed by ED/designee on a weekly basis for 8 weeks, monthly for 4 months and as	

	Manager indicated the dry goods should have an opened date to ensure they were thrown away in a timely manner. On 9/21/26 at 2:00 p.m., a copy of the "Standing cooler #2" temperature log for the month of September was provided. That log indicated, "...Dietary staff is to take the temperature of the cooler(s)/freezer(s) twice per day and record temperature in appropriate column ... Minimum Cooler Temp = 41 degrees ... Any temperature problems, temperatures above the minimum, are to be reported to the Dietary Services Manager ...." The temperature log indicated 2 of 21 a.m. temperatures and 17 of 21 p.m. temperatures were above 41 degrees F. On 9/21/26 at 2:11 p.m., a copy of a current facility policy titled "Dry Food Storage," dated July 2025, was provided. That policy indicated " ...7. Unless its identity is unmistakable, bulk food such as cooking oil, syrup, salt, sugar, or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by its name ...."		needed thereafter as part of the QA process. 2. Results will be reviewed as part of the QA process 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: 11/2/26**	
R 0295	Pharmaceutical Services - Noncompliance	R 0295	**R295**	11/02/2026

	410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observations and interviews the facility failed to ensure residents who managed their own medications properly secured those medications from other residents for 1 of 1 residents (Resident 3) reviewed for medication storage in their room. Findings include: On 9/21/26 at 10:40 a.m., Resident 3 was observed as she was sitting in her motorized wheelchair in the living area of her apartment. Resident 3 indicated she managed her own medications, and typically just kept them out on her dining table so she could easily access them. After that observation, the resident left their apartment to go down to the dining room. Resident 3 did not lock her apartment door when she left, she indicated she did not usually lock her door when she was only going to be out for a short time. During an interview, on 9/21/26 at 2:30 p.m., the Director of Nursing (DON) indicated she		1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1. 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 same deficient practice and what corrective will be taken** 1. All residents that self-administer medications had the potential to be affected by the alleged deficient practice. The DON or designee will ensure all residents that self-administer medications, that include narcotics, are safely locked and stored. 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:** 1. The DON/designee will ensure all	

	knew that narcotic medications had to be in a locked container, but she was not sure about regular medications. She indicated they could not find a policy that spoke to whether or not residents who self-administered their medications needed to secure those medications. Article 16.2 of the Health Facilities; Licensing and Operational Standards manual indicated " ...410 IAC 16.2-5-6 Pharmaceutical services ... Sec. 6. (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents ...".		residents that self-administer medications, that include narcotics, are educated on the need for medications to be safely locked and stored. 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:** 1. The DON, Executive Director or designee will audit all residents that self-administer medications, that include narcotics, to ensure medications are properly locked and stored (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 executed. 5. **By what date will the systematic changes be completed: 11/2/26**	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S	TITLEExecutive Director	(X6) DATE10/02/2026

SIGNATURELily Price		