STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155809	A. BUILDING 00 B. WING	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREY STONE HEALTH & REHABILITATION CENTER	10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00458344. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00458344 - Deficiencies related to the allegations are cited at F684. Survey dates: April 29 and 30, 2025. Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 73 SNF: 10 Total: 83 Census Payor Type: Medicare: 10 Medicaid: 58 Other: 15 Total: 83 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 1, 2025	F 0000	May 13, 2025 Indiana State Department of Health Department of Health and Human Services Centers for Medicare & Medicaid Services To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567. Enclosed is our Plan of Correction for all of the deficiencies we received during our Survey process. We ask that our Plan of Correction be reviewed and accepted as we strive to continue operating in compliance with CMS. We are also requesting desk review approval to place us back into compliance as quickly as possible. Thank you for your consideration in this matter. Sincerely, Maria Diaz, Administrator Grey Stone Health and Rehabilitation maria.diaz1@saberhealth.com 260-471-4770	
F 0684 SS=J Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility	F 0684	**F684**	05/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria Diaz	HFA	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.

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	failed to ensure residents were adequately assessed and provider orders were followed after a change in condition post-surgery for 1 of 4 residents reviewed. The facility failed to ensure the resident was assessed and a doppler study completed timely as ordered when Resident B's leg showed a change in condition. This deficient practice resulted in hospitalization and death. (Resident B). The Immediate Jeopardy began on 3/20/25 when the facility failed to assess Resident B's change of condition. The Assistant Director of Nursing (ADON) and Minimum Data Assessment (MDS) Nurse were notified of the Immediate Jeopardy on April 29, 2025 at 3:51 P.M. The immediate jeopardy was removed on 4/30/25 but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: In an interview on 4/29/25, Resident B's family indicated Resident B fell on 3/10/25. The family indicated the fall resulted in a left hip fracture with surgical intervention on 3/11/25. The family indicated Resident B returned to the facility on 3/14/25. On 3/20/25, the family received a call from the facility regarding a change of condition. The family indicated the nurse indicated Resident B's leg was red and swollen and a doppler ultrasound was ordered to rule out a blood clot. The family indicated she received no updates 3/21, 3/22 or 3/23. The family indicated on 3/24/25, Resident B was admitted to the hospital due to significant bruising and mottling without a pulse to her left leg. The family indicated the hospital indicated Resident B was not a surgical candidate and decided to elect inpatient hospice. The resident		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B discharged from the facility on 3/24/2025. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** To identify other residents that have the potential to be affected, on 4/29/25 the Director of Nursing (DON)/designee completed on an audit for the last 30 days of progress notes for all residents in the facility to identify change in condition and to ensure physician orders have been followed. The audit along with identified corrections were completed on 4/29/25. **3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** To prevent this from recurring, immediate in-servicing by the Director of Nursing and Assistant Director of Nursing began on 4/29/2025, for Nurses, Qualified Medication Assistants, and Certified Nursing Assistants on change of condition. Education included an increased focus on Nurses assessing and monitoring	

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	passed away on 4/8/25. Resident B's record was reviewed on 4/29/25 at 11:07 AM. Diagnosis included fracture of the left femur, type 2 diabetes mellitus and dementia. A nursing note, dated 3/10/25, indicated Resident B had a fall on 3/10/25, with resultant left hip fracture. The note indicated Resident B was sent to the hospital. A care plan, dated 3/14/25, indicated surgical hip precautions to be taken after hip surgery included encourage mobility, but did not include specific interventions to prevent blood clots. A nursing note, dated 3/14/25, indicated Resident B had surgery on 3/11/25 and returned to the facility 3/14/25. The note indicated Resident B's doctor ordered heparin three times a day (TID) for 2 weeks for deep vein thrombus prevention and initiated skilled therapy. A nurse practitioner (NP) note, dated 3/20/25, indicated Resident B was seen for left hip fracture follow up. The note indicated Resident B attempted to pull out her staples and an antibiotic was ordered. The NP noted Resident B's left leg was swollen and ordered a doppler ultrasound to rule out a blood clot. There was no doppler ultrasound order in Resident B's physician orders, on the Treatment Administration Record (TAR) or referenced in the progress notes including therapy notes between 3/20/25 and 3/ 24/25 to indicate a new order for doppler study had been received. A nursing note, dated 3/24/25 at 8:30 AM, indicated Qualified Medication Aide (QMA) 6		after change of condition and timely implementation of physicians/NPs orders. In-service completed on 4/30/25. Staff who were unable to attend education have been removed from the schedule until education is completed. **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?** To monitor and maintain ongoing compliance, Utilizing the Change in Condition Audit Tool residents identified to have a change of condition documented in their progress notes will be audited by the Director of Nursing or Designee. This Audit will be completed every shift for a week, then once a day for two months, then three times a week for two months, then once a week for two months. Negative findings will be addressed, and Ad Hoc education will be completed as necessary. Results of the audits will be submitted to the facility QAPI committee for further review and recommendation. **5. By what date the systemic changes For each deficiency will be completed?** All audits, in-servicing, and systemic changes will be in effect by May 4, 2025.	

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	observed a deep purple discoloration of Resident B's posterior left thigh all the way to her ankle. The left leg was cold to touch, and the staff were unable to palpate a pedal (foot) pulse. A nursing note, dated 3/24/25 at 9:10 AM, indicated the Assistant Director of Nursing (ADON) and the NP assessed Resident B's leg on 3/24/25. Edema was noted from the left hip extending to the left foot with dark purple discoloration/mottling to the back, medial, lateral thigh and left foot up to the ankle. The note indicated Resident B complained of pain to left lower extremity and was unable to move her foot and toes. The note indicated the ADON was unable to locate a pedal pule per palpation. The note indicated Resident B was sent to the hospital. An NP note, dated 3/24/25 at 9:22 AM, indicated she assessed Resident B due to changes in her left leg. The NP observed swelling, significant bruising, mottling to left leg, extended to back of thigh and wrapped around the sides with some bruising noted to foot and toes. The NP indicated she was not able to feel a pedal pulse and capillary refill was greater than 3 seconds. The note indicated doppler ultrasound was ordered but not completed and indicated Resident B was sent to the hospital. Hospital records, dated 3/24/25 - 4/8/24 were reviewed on 4/29/25 at 2:50 PM. An Emergency Department (ED) note, dated 3/24/25, indicated Resident B was brought to the hospital via ambulance for a cold, pulseless left leg and foot. The medics indicated the staff at the facility were unable to answer questions because the staff was not familiar with Resident B. The facility staff indicated the last time Resident B's left leg was			

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	seen normal was Thursday, 3/20/25. The ED note indicated a physical exam showed Resident B's left leg was swollen, mottled and cold. No pulses were present in the thigh, behind the knee or behind the ankle on palpitation or with doppler. The ED note indicated Resident B was consulted by 3 cardiology doctors. The doctors indicated Resident B was not a candidate for surgical intervention as the left leg was extremely ischemic and beyond effective surgical intervention. The note indicated the family was updated and indicated they would like admission to inpatient hospice. The hospital admission diagnosis included heparin - induced thrombocytopenia, other acute pulmonary embolism without acute cor pulmonale (heart involvement) and arterial embolism and thrombosis of lower extremity. An ultrasound, dated 3/24/25 at 6:17 PM, indicated Resident B had an occlusive thrombus (blood clot) extending greater than 5 cm in length and less than 3 cm away from the bend in the knee with edema present in the left leg. The report indicated extensive left lower deep vein thrombus. A CAT (CT) Scan, dated 3/24/25, indicated Resident B had a pulmonary embolism involving the left mainstem bronchus (big airway in the lung) as well multiple blood clots of the left upper lobe, left lower lobe and right middle lobe. An inpatient hospice note, dated 3/25/25 - 4/8/25, indicated Resident B was admitted with a diagnosis of critical limb ischemia of left lower extremity and closed displaced fracture of greater trochanter of left femur. The note indicated Resident B passed away on 4/8/25.			

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	In an interview, on 4/29/25 at 10:45 AM, Registered Nurse (RN) 2 indicated she observed Resident B's left leg on 3/20/24. The leg was red, swollen, warm to touch. RN 2 indicated she notified the NP. RN 2 indicated on 3/22 and 3/23, Resident B expressed pain with little to no difference appearance from 3/20. The leg remained swollen, redness, warm to touch, with no discoloration. RN 2 indicated on 3/22/25 she checked the order status for the doppler ultrasound through the mobile ultrasound company website. RN 2 indicated the order was still pending, so she submitted the STAT order request. RN 2 indicated the doppler ultrasound was not completed on 3/22 nor 3/23. RN 2 indicated she did not communicate with the NP regarding Resident B's status or lack of doppler ultrasound. RN 2 indicated when a STAT request is sent through the website, the company was onsite within 24-48 hours. RN 2 indicated she was unsure if the mobile company was open on the weekends. RN 2 indicated the nurse who took the order from the NP was responsible for entering the order in the resident's health record and submitting a request on the website. Progress notes dated 3/20/25 through 3/24/25 did not include any assessment of Resident B's left lower extremity, any vital signs, or any documentation of redness, pain, swelling, or to address pedal pulses. In an interview, on 4/29/25 at 11:10 AM, the ADON indicated the NP ordered a doppler ultrasound for Resident B on 3/20/25. The ADON indicated the nurse was responsible for entering the order into Resident B's chart as well as a request on the mobile doppler website. The ADON indicated the order was not entered into Resident B's chart on 3/20/25. The ADON also			

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	indicated the order through the website was not entered until 3/22/25 and was not completed. The ADON indicated the mobile doppler company was not open on the weekends so the ultrasound would have been completed on the following Monday. The ADON indicated the nurse should have reached out to the NP when the ultrasound was not available, or the resident had a change of condition. The ADON indicated on 3/21/24 Resident B's leg was still red but less swollen than 3/20/25. The ADON indicated during assessment on 3/24/25, Resident B was noted to have a swollen left leg, discoloration and absent pedal pulse. The ADON indicated Resident B was sent to the hospital, went to inpatient hospice and passed away. The ADON indicated staff should document on resident condition, physician orders to follow, and staff actions to prevent blood clots, but there was no documentation. In an interview, on 4/29/25 at 10:31 AM, RN 5 indicated when a change of condition was observed, she reached out to the NP for next steps. RN 5 indicated signs/symptoms of a blood clot would include redness, swollen, warm to touch, increased pain and absent or weak pedal pulses. In an interview, on 4/29/25 at 10:42 AM, Licensed Practical Nurse (LPN) 3 indicated signs/symptoms of a blood clot included redness, swelling and pain. LPN 3 indicated when a resident had a change of condition, she reached out to the NP for direction. In an interview, on 4/29/25 at 12 PM, RN 4 indicated she worked on 3/20/25. RN 4 indicated the NP ordered a doppler ultrasound but was unsure if the request was submitted into the mobile doppler website. RN 4 indicated STAT			

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	requests are completed within 48-72 hours. RN 4 indicated she was unsure if the mobile doppler company was open on the weekends. A current policy, last revised 5/27/2024, titled "Resident Change in Condition" was provided by the ADON on 3/24/25 at 4/29/25. The policy indicated a significant change of condition is a decline or improvement in a resident's status that would not normally resolve without intervention. The policy indicated the physician/provider were updated of resident's change of conditions, including a need to alter the medical treatment/orders. The policy also indicated a change of condition was documented in the resident's health record. The Immediate Jeopardy that began on 3/20/25 was removed and the deficient practice corrected on 4/30/25 when the facility re-educated all licensed nurses on facility policies for change of condition identification, assessments, documentation and following physician orders but will remain at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This tag relates to Complaint IN00458344. 3.1-37			