STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155809	A. BUILDING -- B. WING	09/21/2023

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/21/23 Facility Number: 012935 Provider Number: 155809 AIM Number: 201207690 At this Emergency Preparedness survey, Grey Stone Health and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 100 and had a census of 85 at the time of this survey. Quality Review completed on 09/22/23 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000	To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567 in regards to the Recertification and Life Safety Survey. 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.	
E 0035 SS=F Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Hunter	Administrator	10/05/2023

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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	[(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Maintenance Supervisor (MS) on 09/21/23 between 09:20 a.m. and 12:30 p.m., the emergency preparedness communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview at the time of record review, the MS looked through the EPP and could not find a plan that discussed a method for sharing information from the emergency plan deemed appropriate with residents and their families or representatives. This finding was reviewed with the Administrator and MS at the exit conference.	E 0035	E035 Testing Requirements 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The emergency preparedness communication plan now includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected. By posting a sign in the receptionist desk where residents and families have access corrects this deficient practice.*** 3. What measures will be put into place and what systemic changes will be made to ensure	10/06/2023

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	3.1-19(b)		that the deficient practice does not recur? ***Education has been completed where all Maintenance Director has been educated on the location of the posted sign, and several locations of emergency preparedness communications.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Maintenance Director will ensure that the posting remains up as well as the locations of the emergency preparedness communications. He will confirm the whereabouts each week for the next six (6) months.*** 5. By what date the systemic changes for each deficiency will be completed? ***All education, exercises, and exercising planning will be completely in place by 10/6/23.*** All audits will be taken to the Monthly QAPI meeting for review and recommendations	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the	

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	Survey Date: 09/21/2023 Facility Number: 012935 Provider Number: 155809 AIM Number: 201207690 At this Life Safety Code survey, Grey Stone Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and in the resident sleeping rooms. The facility has a capacity of 100 and had a census of 85 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/22/23		2567 in regards to the Recertification and Life Safety Survey. 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.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated			

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	from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 5 hazardous rooms that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 10 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor on 09/21/22 at 1:05 p.m., in the laundry room which contained fuel fired dryers had one unsealed 1/2 inch hole in the door to the back of the fuel fired dyers. Based on interview at the time of the observation, the	K 0321	K321 Enclosure 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***The one unsealed 1/2 inch hole in the door to the back of the fuel fired dyers has now been sealed by the Maintenance Director using a fire resistant bolts and washers.*** 2. How other residents having the potential to be affected by the same deficient practice will be	10/06/2023

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	Maintenance Supervisor agreed there was an unsealed hole in the laundry room door which contained fuel fired equipment. The finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		identified and what corrective action will be taken? ***All residents in that smoke compartment area have the potential to be affected and the adjustment of the enclosure corrected that defective practice, and all other areas with the potential to have the same deficiency has been inspected. No other deficiencies have been identified in other areas.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The seal will permanently keep this practice in compliance as long as it remains intact. Education on Enclosures has been conducted with the Maintenance Director.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The maintenance director will review this area and like areas and inspect it for compliance weekly for the next six (6) months.*** 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 10/6/23.***	

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			All audits will be taken to the Monthly QAPI meeting for review and recommendations	