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 _____	C 05/22/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00458861, IN00459193 and IN00459432. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00458344 completed on April 30, 2025. Complaint IN00458861 - No deficiencies related to the allegations are cited. Complaint IN00459193 - No deficiencies related to the allegations are cited. Complaint IN00459432 - No deficiencies related to the allegations are cited. Survey dates: May 21 and 22, 2025 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 74 SNF: 13 Total: 87 Census Payor Type: Medicare: 13 Medicaid: 62 Other: 12 Total: 87 Grey Stone Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00458861,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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
	155809	A. BUILDING _____ B. WING _____	C 05/22/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	Continued From page 1 IN00459193 and IN00459432. Quality review completed May 23, 2025	F 000		