DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey Leted /2022
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		10445 [ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD WAYNE, IN 46845		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0039 SS=F Bldg	conducted by the Ir accordance with 42 Survey Date: 11/16 Facility Number: (1) Provider Number: 201 At this Emergency Stone Health and R not in compliance of Requirements for N Participating Provid 483.73. The facility census of 88 at the Quality Review conductive Condu	5/22 012935 155809	E 0	000	December 11, 2022 Department of Health and Huservices Centers for Medicare &	tion I the of our our ed and inue	
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATUR	E	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Eric Hunter Administrator 12/14/2022

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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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155809	B. WING		11/16/2022
NAME OF I	PROVIDER OR SUPPLIEI	R		ET ADDRESS, CITY, STATE, ZIP CO	DD .
GREY S	TONE HEALTH & F	REHABILITATION CENTER		I5 DUPONT OAKS BLVD T WAYNE, IN 46845	
	1				(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
TAG	, and the second	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE DATE
		1.12(d)(2), 494.62(d)(2)			
	EP Testing Requi				
		18.113(d)(2), §441.184(d)(2),			
	§460.84(d)(2), §482.15(d)(2), §483.73(d)(2),				
	. , , , .	484.102(d)(2), §485.68(d)(2),			
	§485.625(d)(2), §485.727(d)(2), §485.920(d)				
	(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at				
	§491.12, and ESF	RD Facilities at §494.62]:			
	(2) Testing. The [facility] must conduct exercises to test the emergency plan				
		cility] must do all of the			
	following:				
	(i) Participate in a	full-scale exercise that is			
		l every 2 years; or			
	1	nunity-based exercise is			
	1 ' '	onduct a facility-based			
	functional exercis	e every 2 years; or			
	(B) If the [fac	ility] experiences an actual			
		ade emergency that requires			
		mergency plan, the [facility]			
		ngaging in its next required			
	1	or individual, facility-based			
	actual event.	e following the onset of the			
		Iditional exercise at least			
	1 ' '	posite the year the full-scale			
		cise under paragraph (d)(2)			
		s conducted, that may			
		limited to the following:			
		scale exercise that is			
	community-based	l or individual, facility-based			
	functional exercis				
	(B) A mock disast				
	(C) A tabletop exe	ercise or workshop that is			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/16/2022		
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		10445 D	DDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD VAYNE, IN 46845	-	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	discussion using	and includes a group					
	_	emergency scenario, and a					
	set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.						
	*[For Hospices at	418.113(d):1					
	(2) Testing for hospices that provide care in the patient's home. The hospice must						
	conduct exercises to test the emergency						
	plan at least annu	ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
	1	every 2 years; or					
	1 ' '	nunity based exercise is not					
		ıct an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
	_	ency that requires activation					
		plan, the hospital is aging in its next required full					
		based exercise or individual					
	•	ctional exercise following the					
	onset of the emer						
		dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	(A) A second full-	-scale exercise that is					
	community-based	l or a facility based					
	functional exercis	e; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED
		155809	B. W	ING		11/16	/2022
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	•	
GREY ST	ΓONE HEALTH & F	REHABILITATION CENTER			WAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	discussion using						
	•	emergency scenario, and a					
		atements, directed					
	-	pared questions designed					
	to challenge an e	mergency pian.					
	(3) Testing for ho	spices that provide inpatient					
	care directly. The	e hospice must conduct					
		the emergency plan twice					
		spice must do the following:					
	* * * * * * * * * * * * * * * * * * * *	an annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not					
		uct an annual individual					
		ctional exercise; or					
		experiences a natural or					
		gency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event	dditional annual exercise					
	` '	but is not limited to the					
	following:	but is not innited to the					
	-	-scale exercise that is					
	, ,	d or a facility based					
	functional exercis	-					
	(B) A mock disas						
		tercise or workshop led by a					
		udes a group discussion					
	using a narrated,	• .					
	_	ario, and a set of problem					
		ted messages, or prepared					
		ed to challenge an					
	emergency plan.	-					
	(iii) Analyze the h	nospice's response to and					
	maintain docume	ntation of all drills, tabletop					
	exercises, and en	nergency events and revise					
	the hospice's eme	ergency plan, as needed.					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155809	B. W	ING		11/16/	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	ł.			DUPONT OAKS BLVD		
GRFY S1	TONE HEALTH & R	EHABILITATION CENTER			VAYNE, IN 46845		
						1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	*IEar DDETa at \$4	41.184(d), Hospitals at					
	§482.15(d), CAHs						
	- ' '	PRTF, Hospital, CAH] must					
		to test the emergency					
		r. The [PRTF, Hospital,					
	CAH] must do the						
	_	n annual full-scale exercise					
	that is community-						
		nunity-based exercise is not					
	l ` '	ct an annual individual,					
		tional exercise; or					
	1	Hospital, CAH] experiences					
		or man-made emergency					
		ation of the emergency					
	1	s exempt from engaging in					
		ıll-scale community based					
		ty-based functional exercise					
	following the onse	t of the emergency event.					
	(ii) Conduct a	an [additional] annual					
	exercise or and th	at may include, but is not					
	limited to the follow	wing:					
	(A) A second full-	scale exercise that is					
	community-based						
	facility-based func						
		ck disaster drill; or					
		exercise or workshop that					
	1	or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	1 ' ' '	ne [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	<u> </u>	cility's] emergency plan, as					
	needed.						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155809	B. WI	NG		11/16	/2022
NAME OF T	DDOWNER OF GURDINE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	C		10445 [DUPONT OAKS BLVD		
GREY S	TONE HEALTH & R	REHABILITATION CENTER		FORT V	VAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEPCIENCT)		DATE
	*[For PACE at §46	٥٥.٥५(۵):إ PACE organization must					
		to test the emergency					
	plan at least annually. The PACE organization must do the following:						
	_	an annual full-scale exercise					
	that is community						
	(A) When a community-based exercise is not						
	1 ' '	ict an annual individual,					
		ctional exercise; or					
		xperiences an actual natural					
	` '	ergency that requires					
		mergency plan, the PACE					
	is exempt from engaging in its next required						
	full-scale community based or individual,						
	facility-based fund	ctional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct a	ın additional exercise every					
	2 years opposite t	he year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	onducted that may include,					
	but is not limited t	-					
	` '	scale exercise that is					
	-	or individual, a facility					
	based functional e						
	(B) A mock disas						
	. ,	ercise or workshop that is					
		and includes a group					
	discussion, using						
	1	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	ule FACE'S emerg	gency plan, as needed.					
	*[For LTC Facilitie	es at \$483 73(d)·1					
	_	ity] must conduct exercises					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155809	B. W	ING		11/16	/2022
NAME OF I	PROVIDER OR SUPPLIER	R	-		ADDRESS, CITY, STATE, ZIP COD		
					DUPONT OAKS BLVD		
GREY S	ONE HEALTH & F	REHABILITATION CENTER		FORTV	VAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		ency plan at least twice per					
		announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or						
	(A) When a community-based exercise is not						
	accessible, conduct an annual individual,						
	facility-based functional exercise.						
	(B) If the [LTC facility] facility experiences an						
	actual natural or man-made emergency that requires activation of the emergency plan, the						
		mpt from engaging its next					
	· ·	ale community-based or					
	individual, facility-based functional exercise						
	I	et of the emergency event.					
	(ii) Conduct an ac	dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	(A) A second full-	-scale exercise that is					
	community-based	l or an individual, facility					
	based functional	exercise; or					
	(B) A mock disas						
	. , ,	ercise or workshop that is					
	led by a facilitator	— ·					
	discussion, using						
	I	emergency scenario, and a					
	· ·	tements, directed					
		pared questions designed					
	to challenge an e	• • •					
	. ,	LTC facility] facility's					
	1	maintain documentation of					
	1	exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
	-	CF/IID must conduct					
	` '	he emergency plan at least					
		ne ICF/IID must do the					

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155809	B. W	ING		11/16	/2022
NAME OF	DDOLUDED OF GUMPY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF 1	PROVIDER OR SUPPLIEI	<		10445 [DUPONT OAKS BLVD		
GREY S	TONE HEALTH & F	REHABILITATION CENTER		FORT V	VAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT		DATE
	following:	n annual full agala avaraiga					
		n annual full-scale exercise					
	that is community-based; or (A) When a community-based exercise is not						
	accessible, conduct an annual individual,						
	facility-based functional exercise; or.						
	-	experiences an actual					1
	natural or man-made emergency that requires						
	activation of the emergency plan, the ICF/IID						
	is exempt from engaging in its next required						
	full-scale community-based or individual,						
	facility-based functional exercise following the						
	onset of the emergency event.						
	(ii) Conduct an additional annual exercise						
	that may include,	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
		ercise or workshop that is					
	I -	and includes a group					
	discussion, using						
	-	emergency scenario, and a					
	· ·	nations designed					1
	to challenge an e	pared questions designed					
	1	CF/IID's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events, and revise					
	· ·	rgency plan, as needed.					
	*[For HHAs at §48	-					
		e HHA must conduct					
		he emergency plan at					1
	least annually. The HHA must do the						
	following:						
		full-scale exercise that is					
	community-based						
	(A) When a c	ommunity-based exercise					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155809	A. BUILDING B. WING		COMPLETED 11/16/2022	
		155609	B. WING	-	11/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD		
				DUPONT OAKS BLVD		
GREY S	IONE HEALTH & R	REHABILITATION CENTER	FORT	WAYNE, IN 46845		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X:	5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLE	ETION
TAG	i	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DAT	Е
		conduct an annual				
		based functional exercise				
	every 2 years; or.					
	(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,					
	onset of the emer	tional exercise following the				
		ditional exercise every 2				
	, ,	e year the full-scale or				
	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may					
		limited to the following:				
		full-scale exercise that is				
	community-based					
	facility-based fund					
		isaster drill; or				
	(C) A tableton	exercise or workshop that				
	is led by a facilitat	or and includes a group				
	discussion, using	a narrated,				
	clinically-relevant	emergency scenario, and a				
	set of problem sta	tements, directed				
		pared questions designed				
	to challenge an er					
		HA's response to and				
		ntation of all drills, tabletop				
		nergency events, and revise				
	the HHA's emerge	ency plan, as needed.				
	*[For OPOs at §48	26.2601				
		e OPO must conduct				
	. , . ,	he emergency plan. The				
	OPO must do the	5 .				
		er-based, tabletop exercise				
		ast annually. A tabletop				
	· ·	a facilitator and includes a				
		using a narrated, clinically				

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relevant emergency scenario, and a set of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	· /	JILDING		COMPI	
		155809	B. W.			11/16	
			<u> </u>		ADDRESS SITE OF THE STREET	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
GREV 91	LUNE HEVI TH & E	REHABILITATION CENTER			DUPONT OAKS BLVD WAYNE, IN 46845		
GNETS	I ONE HEALIH & P	LIADILIATION CENTER		IONIV	TVATINE, IIN 40040		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	its, directed messages, or					
		ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
	-	of the emergency plan, the					
	OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop						
		•					
		nergency events, and revise					
	<u> </u>	OPO's] emergency plan, as					
	needed.						1
	*	7401.					
	*[RNCHIs at §403	-					
		e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th	er-based, tabletop exercise					
		A tabletop exercise is a					
		led by a facilitator, using a					
		relevant emergency					
		et of problem statements,					
		s, or prepared questions					
		enge an emergency plan.					
	_	NHCI's response to and					
	. ,	ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		view and interview, the facility	E 0	039	E039 Testing Requirements		12/30/2022
		tercises to test the emergency			What corrective action	will	12.20,2022
	plan at least twice p				be accomplished by those		
		drills using the emergency			residents found to have been		
		C facility must do the			affected by the deficient pract		
	following:	-			The facility will conduct		
	_	annual full-scale exercise that			exercises to test the emerge	ency	
	is community-based; or			plan twice annually.	-		
		ity-based exercise is not			[
		an annual individual,			2. How other residents ha	ving	
	facility-based funct				the potential to be affected by	-	

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DEPARTMENT SENTERS FOR		RM APPROVED B NO. 0938-039					
STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA Q PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY ETED /2022
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		10445 [ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD WAYNE, IN 46845		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	: :IATE	(X5) COMPLETION DATE
IAG	b. If the LTC facility or man-made emergof the emergency prome engaging its many community-based of full-scale functional the onset of the activation of the onset of the	ty experiences an actual natural gency that requires activation lan, the LTC facility is exempt lext required full-scale in a per individual, facility-based lexercise for 1 year following lead event. It it in a continuous continuo		TAG	same deficient practice will be identified and what corrective action will be taken? All resinave the potential to be affected. The exercises to the emergency plan will conthis deficient practice. 3. What measures will be into place and what systemic changes will be made to ensithat the deficient practice door recur? The Administrator and the Maintenance Director with undergo education on semiannual Emergency Platexercises, with at least one being a full-scale exercise is community based, and at least one other full-scale exercise is community based, or and disaster drill, or a tabletop exercise. Will also analyze facility response, maintain analyze the drills, tabletops emergency events, and revithe facility emergency planneeded. The first exercise where the facility emergency planneeded. The first exercise where the completed by December 16th, 2022, and the second exercise will be completed December 30th, 2022. 4. How the corrective act will be monitored to ensure the deficient practice will not receive act will be put into place? The	e dents dest dest rect e put c ure es not nd vill nn ethat is east ee that nock the and s, ise as will r by ion he ur,	DATE
	not available fol le	, ic Dasca on mici view at the	I		will be har illo hiace; tile		I

time of records review, the Maintenance Director

stated both required exercises have not been

KVDP21

Administrator and the

Maintenance Director will

12/16/2022

DEPARTMENT CENTERS FOR	FORM APPROVED OMB NO. 0938-039							
	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/16/2022	
NAME OF PROVIDER OR SUPPLIER GREY STONE HEALTH & REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION conducted within the last 12 months. This finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit conference.			10445 I	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD WAYNE, IN 46845				
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	This finding was re the AIT, and Maint	eviewed with the Administrator,			discuss Emergency Plan exercises in each Life Safety meeting and will ensure exercises are planned no lor than 6 months apart from ea other, after the first two are completed. Each discussion be documented in the Life Safety minutes. 5. By what date the system changes for each deficiency w be completed? All education, exercises, and exercising planning will be completely in place by December 30th, 202 All audits will be taken to the Monthly QAPI meeting for revia	nger ch will nic vill		
K 0000								
Bldg. 01	Licensure Survey v	e Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0	000	December 11, 2022 Department of Health and Hur Services Centers for Medicare & Medic Services			

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID:

KVDP21

Facility ID: 012935

To whom it may concern,

Rehabilitation, CMS Certification Number 155809 has received the

Recertification and Life Safety

Survey. Enclosed is our Plan of

deficiencies we received during our

Grey Stone Health and

2567 in regards to the

Correction for all of the

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/16/2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	10445	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD WAYNE, IN 46845	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	National Fire Protect Life Safety Code (I. Health Care Occupate This one story facility on the corridors and the resident rooms. Protected by a Type The facility has a cacensus of 88 at the test access were sprinkle facility services were sprinkle facili	etion Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, areas open hard wired smoke detectors in The facility was partially as II EES 150 kW gas generator. Apacity of 100 and had a sime of this survey. The survey areas open that a survey area of the survey. The facility was partially as generator. And a sime of this survey. The survey area of the survey area of the survey. The survey area of the survey area of the survey area of the survey. The survey area of the survey area of the survey area of the survey area of the survey. The survey area of the survey	K 0345	Survey process. We ask that of Plan of Correction be reviewed accepted as we strive to contice operating in compliance with CMS. Thank you for your consideration this matter. Sincerely, Eric Hunter, Administrator Grey Stone Health and Rehabilitation eric.hunter@saberhealth.com 260-494-2740 K345 Fire Alarm System – Teand Maintenance 1. What corrective action we accomplished by those residents found to have been affected by the deficient practice.	our d and nue ion 12/30/2022 vill
	accordance with the	schedules in Table 14.3.1, or		The facility will test and	

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KVDP21 Facility ID: 012935

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
		155809	B. WING		11/16/2022		
		•	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹	10445	DUPONT OAKS BLVD			
GREY S	TONE HEALTH & F	REHABILITATION CENTER	FORT WAYNE, IN 46845				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	more often if required by the authority having			maintain the fire alarm syste	em		
	-	14.3.1 states that the following		twice annually. The first			
	_	spected semi-annually:		exercise was completed on			
	a. Control unit trou	_		February 8th, 2022, and the			
	b. Remote annuncia	s (e.g. duct detectors, manual		second will be completed by	'		
	_	eat detectors, smoke detectors,		December 16th, 2022.			
	etc.)	cat detectors, smoke detectors,		2. How other residents ha	vina		
	d. Notification appl	iances		the potential to be affected by	_		
	e. Magnetic hold-o			same deficient practice will be			
		ice affects all occupants in the		identified and what corrective			
	facility.			action will be taken? <i>All resig</i>	lents		
				have the potential to be			
Findings include:				affected. The testing and			
				maintenance of the fire aları	n		
	Based on record rev	view with the Administrator in		system twice annually will			
	Training (AIT) and	the Maintenance Director on		correct this deficient practic	e.		
	11/16/22 at 10:29 a	.m., no documentation was					
		a visual inspection of the fire		3. What measures will be	put		
	-	onths after the annual fire alarm		into place and what systemic			
	_	ed on 02/08/22. Based on		changes will be made to ensu			
		ne of records review, the		that the deficient practice doe			
		tor stated a visual inspection		recur? The Administrator an	-		
		stem six after the annual fire		the Maintenance Director wi			
	alarm inspection wa	as not conducted.		undergo education on fire a	larm		
	This finding was no	viarred with the Administrator		systems to ensure they will			
	_	viewed with the Administrator, enance Director during the exit		tested and maintained no fe than twice a year.	wer		
	conference.	enance Director during the exit		than twice a year.			
	conference.			4. How the corrective action	on l		
	3.1-19(b)			will be monitored to ensure th			
				deficient practice will not recu			
				what quality assurance progra			
				will be put into place? The			
				Administrator and the			
				Maintenance Director will			
				discuss Fire Alarm Testing a	and		
				Maintenance in each Life Sa	fety		
				meeting and will ensure the			
				practices are planned no lor	nger		

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155809	A. BUILDING B. WING	01	COMPLETED 11/16/2022	
		100000	<u> </u>		11/10/2022	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD		
GREY ST	TONE HEALTH & R	EHABILITATION CENTER		WAYNE, IN 46845		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE	
				than 6 months apart from ear other, beginning with the ne planned to be completed by December 16th, 2022. Each discussion will be documen in the Life Safety minutes. 5. By what date the syster changes for each deficiency who be completed? All education maintenance, and maintenance planning will be completely place by December 30th, 2021. All audits will be taken to the Monthly QAPI meeting for revand recommendations	xt ted nic vill nce in	
K 0346 SS=C Bldg. 01	services for more period, the authori be notified, and the evacuated or an aprovided for all pashutdown until the been returned to \$9.6.1.6 Based on record revialled to provide a conforthe protection of procedures to be fol alarm system has to four hours or more in the period.	e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall be building shall be pproved fire watch shall be rities left unprotected by the fire alarm system has service. The wand interview, the facility complete 1 of 1 written policy cresidents indicating lowed in the event the fire be placed out of service for in a twenty-four-hour period in C, Section 9.6.1.6. This	K 0346	K346 Fire Alarm System – Ou Service 1. What corrective action to be accomplished by those residents found to have been affected by the deficient pract The facility will provide the policy for action taken when fire alarm system is down for more than 4 hours. The policy	vill ice? the	

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Event ID:

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Facility ID: 012935

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/16/2022			
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	Director and the Ado on 11/16/22 at 10:3 Service" policy stat of Health" but the p contacting the India the IDOH Gateway https://gateway.isdr or by the secondary Gateway is nonoper Incident Reporting incidents@isdh.in.g the record review, t acknowledged the f provided stated to c Health" but not via the e-mail address l	n.in.gov as the primary method method when the IDOH rational by completing the form and e-mailing it to gov. Based on interview during the Maintenance Director fire watch documentation contact the "Department of the IDOH Gateway link or at		states that the Administrator designee will contact The Indiana Department of Healt via the IDOH Gateway link at https://gateway.isdh.in.gov. the gateway portal is nonoperational then the incident reporting form will completed by the Administra or designee and the form wie emailed to incidents@isdh.in.gov. This process will began immedia after the 4th hour of the fire alarm system being down. To policy will be provided by December 16th, 2022. 2. How other residents has the potential to be affected by same deficient practice will be identified and what corrective action will be taken? All resid have the potential to be affected. The policy, once provided, will correct this deficient practice. 3. What measures will be into place and what systemic changes will be made to ensut that the deficient practice doe recur? The policy on steps to in the even the fire system is down for more than four how will be copied and added to life safety manual, as well as each nurses station. 4. How the corrective actions.	h t If be ator II be tely the ving the s lents put re s not aken s urs the s at		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2022		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BITTE		
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar	<u>.</u>		will be monitored to ensure to deficient practice will not recomb what quality assurance progressive p	in nd for a audit ence blace, ced. emic will and n		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/16/2022			
		ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
PR	4) ID REFIX ΓAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	ΓAG	Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observation failed to ensure 10 or kitchen were not lost material in accordant 2011 edition, at 5.2 signs of leakage; she foreign materials, period shall be installed in up-right, pendent, of 5.2.1.1.2 any sprink the following shall Corrosion (3) Physisthe glass bulb heat a Loading (6) Painting sprinkler manufacture could affect staff are smoke compartment. Findings include: Based on observation Director on 11/16/2 heads in the kitcher grease. Based on in observation, the Mathe sprinkler heads with dirt and grease. The finding was revented.	RKS information on non-required or partial er system. , and NFPA 25 on and interview, the facility of 10 sprinkler heads in the aded and covered with foreign nee with LSC 9.7.5. NFPA 25, 1.1.1 sprinklers shall not show all be free of corrosion, aint, and physical damage; and the correct orientation (e.g., or sidewall). Furthermore, at aller that shows signs of any of the replaced: (1) Leakage (2) ical Damage (4) Loss of fluid in responsive element (5) g unless painted by the arer. This deficient practice and up to 25 residents in one it.	K 0		K353 Sprinkler System – Test and Maintenance 1. What corrective action to be accomplished by those residents found to have been affected by the deficient practic. The facility will test and maintain the automatic sprinkler systems will be do in accordance with NFPA 25 and will be completed by December 11th, 2022. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action will be taken? All resid have the potential to be affected. The testing and maintenance of the automatic sprinkler systems will be do in accordance with NFPA 25 correct this deficient practic. 3. What measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur? The Maintenance Dire will perform the inspection a cleaning on all sprinkler hea and will perform cleaning as necessary. A record will also kept stated the date the sprinkler system was last	will fice? ne wing the fents ic ne will e. put re s not re ctor and ds	12/30/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/16/2022		
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
				checked, who provided the and the water system supples source. 4. How the corrective act will be monitored to ensure the deficient practice will not rect what quality assurance prograwill be put into place? Maintenance Director/designal maintenance Director/designal maintenance will be performas necessary. All records of testing and maintenance will be performas necessary. All records of testing and maintenance will begin no late than December 11th, 2022. 5. By what date the system changes for each deficiency be completed? All maintenance maintenance maintenance maintenance will be completed and reporting will be completely in place by December 30th, 2022. All audits will be taken to the	ion ne ur, nam nee ce ty. med f ill be iter emic will nce		
I/ 0054	NEDA 404			Monthly QAPI meeting for reand recommendations	view		
K 0354 SS=C Bldg. 01	extent and duration been determined, are inspected and recommendations management or d	- Out of Service er system is impaired, the on of the impairment has areas or buildings involved I risks are determined,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/16/2022 155809 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10445 DUPONT OAKS BLVD **GREY STONE HEALTH & REHABILITATION CENTER** FORT WAYNE. IN 46845 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility K 0354 K354 Sprinkler System - Out of 12/30/2022 failed to provide 1 of 1 correct written policies in Service the event the automatic sprinkler system has to be 1. What corrective action will placed out-of-service for 10 hours or more in a be accomplished by those 24-hour period in accordance with LSC, Section residents found to have been 9.7.5. LSC 9.7.6 requires sprinkler impairment affected by the deficient practice? procedures comply with NFPA 25, 2011 Edition, The facility will provide the the Standard for the Inspection, Testing and policy for action taken when Maintenance of Water-Based Fire Protection Sprinkler System is down for Systems. NFPA 25, 15.5.2 requires nine more than 4 hours. The policy procedures that the impairment coordinator shall states that the Administrator or follow. A.15.5.2 (4) (b) states a fire watch should designee will contact The consist of trained personnel who continuously Indiana Department of Health patrol the affected area. Ready access to fire via the IDOH Gateway link at extinguishers and the ability to promptly notify https://gateway.isdh.in.gov. If the fire department are important items to the gateway portal is consider. During the patrol of the area, the person nonoperational then the should not only be looking for fire, but making incident reporting form will be sure that the other fire protection features of the completed by the Administrator building such as egress routes and alarm systems or designee and the form will be are available and functioning properly. This emailed to deficient practice could affect all occupants in the incidents@isdh.in.gov. This facility. process will began immediately after the 4th hour of the Findings include: Sprinkler system being down. The policy will be provided by Based on records review with the Maintenance December 16th, 2022. Director and the Administrator in Training (AIT) on 11/16/22 at 10:35 a.m., the "Sprinkler System How other residents having out of Service" policy stated to contact the the potential to be affected by the "Department of Health" but the plan failed to same deficient practice will be include contacting the Indiana Department of identified and what corrective

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			f '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 11/16/2022			COMPLETED
		155809	B. W			11/10/2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
CDEV 61	FONE HEALTH & D	EHABILITATION CENTER			DUPONT OAKS BLVD	
	IONE REALIR & R	ELIABILITÀ HON CENTER		FURIV	WAYNE, IN 46845	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	Health via the IDO	R LSC IDENTIFYING INFORMATION H. Gotevoov link at		TAG	action will be taken? All resid	DATE
		n.in.gov as the primary method			have the potential to be	ents
		method when the IDOH			affected. The policy, once	
		rational by completing the			provided, will correct this	
		form and e-mailing it to			deficient practice.	
	incidents@isdh.in.g	gov. Based on interview during				
		he Maintenance Director			3. What measures will be	put
	-	ire watch documentation			into place and what systemic	
	-	ontact the "Department of			changes will be made to ensu	
	the e-mail address l	the IDOH Gateway link or at			that the deficient practice does	
	me e-man address i	isica autve.			recur? The policy on steps to in the even the Sprinkler sys	
	The finding was reviewed with the AIT and				is down for more than four	, com
	-	for during the exit conference.			hours will be copied and add	ded
		C			to the life safety manual, as	
	3.1-19(b)				as at each nurses station.	
					4. How the corrective action	nn l
					will be monitored to ensure the	
					deficient practice will not recu	
					what quality assurance progra	
					will be put into place? <i>The</i>	
					Maintenance Director will	
					ensure the policies remain in	
					the designated locations and	
					will audit each area weekly f	
					duration of six months. All a will be logged. Any occurrer	
					where the policy is not in pla	
					it will be immediately replace	
					5. By what date the syster	mic
					changes for each deficiency w	
					be completed? All policies ar	nd
					audits will be completely in	20
					place by December 16th, 202	22.
					All audits will be taken to the	
					Monthly QAPI meeting for rev	iew
					and recommendations	

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i '		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155809	B. WING 11/16/20				
		10000	<i>D.</i>	_	ADDRESS CITY STATE TIP COD	11/10/	
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD		
GREY ST	ONE HEALTH & R	EHABILITATION CENTER	FORT WAYNE, IN 46845				
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEI IOLEKO I /		DATE
K 0754	NFPA 101						
SS=E	Soiled Linen and						
Bldg. 01	Soiled Linen and						
		sh collection receptacles 2 gallons in capacity. The					
		f container capacity in a					
	room or space shall not exceed 0.5 gallons/square feet. A total container						
capacity of 32 gallons shall not be exceeded							
	within any 64 square feet area. Mobile soiled						
	linen or trash colle	ection receptacles with					
	capacities greater	than 32 gallons shall be					
	located in a room	protected as a hazardous					
	area when not atte						
		olely for recycling are					
	•	cluded from the above					
	•	re each container is less					
	•	6 gallons unless attended, combustibles are labeled					
		ting FM Approval Standard					
	6921 or equivalen						
	18.7.5.7, 19.7.5.7	•					
		on and interview, the facility	K 0	754	K754 Soiled Linen and Trash		12/30/2022
	failed to ensure tras	h receptacles in 2 of 6			Containers		
	corridors were main	tained in accordance with			1. What corrective action v	will	
		ient practice could affect staff			be accomplished by those		
	and up to 40 resider	nts in the 200-hall and 400-hall.			residents found to have been		
	Findings include:				affected by the deficient practi		
	rindings include.				The facility will ensure soiled linen or trash receptacles sh		
	Based on observation	ons during a tour of the facility			not exceed 32 gallons in	uli	
		ce Director on 11/16/22 at 1:11			capacity.		
		n., there were two soiled					
	-	ide by side in front of the			2. How other residents hav	ving	
		otaling more than 32 gallons			the potential to be affected by	the	
		o, there was a 40-gallon barrel			same deficient practice will be	<u>;</u>	
		he soiled utility on the			identified and what corrective		
		interview at the time of			action will be taken? All resid	ents	
		intenance Director stated			have the potential to be		
	there were barrels o	f soiled linen/trash totaling			affected. Once the facility ha	I S	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X2)		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155809	B. WING 11/16/2022			2022	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					DUPONT OAKS BLVD		
GREY ST	FONE HEALTH & R	EHABILITATION CENTER	FORT WAYNE, IN 46845				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
more than 32 gallons in a 64 square foot area on				only 32 gallon or less sized			
the 200-hall and the 400-hall.				containers, the deficient			
	The finding was reviewed with the Administrator, the AIT, and Maintenance Director during the exit				practice will be corrected.		
					3. What measures will be	nut	
	conference.	chance Director during the exit			into place and what systemic	put	
	conference.				_	ro	
	2 1 10/b)				changes will be made to ensu		
	3.1-19(b)				that the deficient practice does		
					recur? Central Supply/design		
					has placed an order for 4 tra		
					collection receptacles which	ao	
					not exceed 32 gallons.		
					Receptacles will arrive no la		
					than December 16th, 2022. C		
					the receptacles arrive, all otl		
					receptacles will be disposed		
					All staff will be educated on	the	
					receptacle usage and the		
					storage of the receptacles.		
					How the corrective action	n	
					will be monitored to ensure the		
					deficient practice will not recu		
					what quality assurance progra		
					will be put into place? <i>The</i>	1	
					Maintenance Director/design	200	
					will monitor receptacles on t		
					-		
					(5) separate occasions each		
					week to ensure proper	and	
					receptacles are being used a		
					are not being packed beyond		
					capacity. Any occurrence of		
					noncompliance will be	_	
					immediately addressed. This		
					audit will begin no later than	1	
					December 16th and will		
					continue weekly for six (6)		
					months.		

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By what date the systemic

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01 COMPLETED			ETED
		155809	B. WING 11/16/2022			2022	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					changes for each deficiency w be completed? All orders, educations, and audits will b completely in place by December 30th, 2022.		
					All audits will be taken to the Monthly QAPI meeting for revi- and recommendations	ew	
K 0781 SS=E Bldg. 01	prohibited in all he except, unless use employee areas w do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on record revinterview; the facility space heater police does not exceed 212 space heaters use in practice could affect visitors in the vicinity. Findings include: Based on observation Training (AIT) and 11/16/22 at 11:39 a. in use in the Admin affixed label on the the heating element Based on records redocumentation was temperature of the second of the second in the second		K 0	781	K781 Portable Space Heaters 1. What corrective action who accomplished by those residents found to have been affected by the deficient practic. The facility will ensure portal Space Heaters are only used non-sleeping staff and emploareas where heating element do not exceed 212 degrees Fahrenheit. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action will be taken? All reside have the potential to be affected. All noncompliant Space Heaters have been	ce? ble by byee ss	12/30/2022

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/16/2022			
NAME OF PROVIDER OR SUPPLIER GREY STONE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE			
	Maintenance Direct of the portable the s the space heater pol	at the time of observation, the for stated the max temperature space heater was unknown and licy could not be found. Viewed with the Administrator, enance Director during the exit		removed as of December 2022, and the deficient prohas been corrected. 3. What measures will be into place and what system changes will be made to enthat the deficient practice descur? Portable Space Heavill be prohibited from us altogether. All staff will be educated on the prohibition portable space heaters. 4. How the corrective a will be monitored to ensure deficient practice will not rewhat quality assurance prowill be put into place? The Administrator will monitor area for Space Heater and deficient practices will be corrected immediately. 5. By what date the systemages for each deficience be completed? All educational removal of all space of will be completely in place will be completely in place will be completely in place. All audits will be taken to the Monthly QAPI meeting for mand recommendations	pe put iic iic issure oes not aters age on of ction the cur, gram r each f temic y will ons, heaters e by			
K 0923 SS=E Bldg. 01	Storag	Cylinder and Container Cylinder and Container						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
		155809	B. WING 11/16/2022			
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		DUPONT OAKS BLVD		
GRFY S	TONE HEALTH & F	REHABILITATION CENTER		WAYNE, IN 46845		
	T			T		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE	DATE	
		qual to 3,000 cubic feet				
	_	are designed, constructed,				
		accordance with 5.1.3.3.2				
	and 5.1.3.3.3. >300 but <3,000 o	public foot				
		are outdoors in an				
	_	n an enclosed interior				
		imited- combustible				
		door (or gates outdoors)				
		ed. Oxidizing gases are not				
		ables, and are separated				
		s by 20 feet (5 feet if				
		closed in a cabinet of				
		onstruction having a				
		ire protection rating.				
	Less than or equa	al to 300 cubic feet				
	In a single smoke	compartment, individual				
	cylinders available	e for immediate use in				
	patient care areas	s with an aggregate volume				
	of less than or eq	ual to 300 cubic feet are not				
	required to be sto	red in an enclosure.				
		e handled with precautions				
	as specified in 11					
		ign readable from 5 feet is				
	_	ate of a cylinder storage				
		sign includes the wording as				
		TION: OXIDIZING GAS(ES)				
	STORED WITHIN					
		d so cylinders are used in				
		ey are received from the				
	supplier. Empty cylinders are segregated from full cylinders. When facility employs					
	1					
	cylinders with integral pressure gauge, a					
	threshold pressure considered empty is established. Empty cylinders are marked to					
	avoid confusion. Cylinders stored in the open are protected from weather.					
		.3.3, 11.3.4, 11.6.5 (NFPA				
	99)					
		on and interview, the facility	K 0923	K923 Gas Equipment – Cylind	der 12/30/2022	
			1	1 , ,		

	C MEDICARE & MEDIC	· · · · · · · · · · · · · · · · · · ·	_		OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155809	B. WING		11/16/2022	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t		DUPONT OAKS BLVD		
GREY S	TONE HEALTH & R	REHABILITATION CENTER		WAYNE, IN 46845		
	T			1		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
		of 12 oxygen cylinders were		and Container Storage		
	-	ed to avoid confusion		What corrective action v	vill	
		empty cylinders. NFPA 99,		be accomplished by those		
		ites, if empty and full cylinders		residents found to have been		
		e same enclosure, empty		affected by the deficient practi		
	1 -	egregated from full cylinders.		The facility will ensure Oxyg	en	
		ites empty cylinders shall be		Cylinders will be properly		
		nfusion and delay if a full		stored by chains or a cart, a	nd	
	1 -	n a rapid manner. Also, the		will be segregated where full	!	
	•	sure 1 of 12 cylinders of		and empty Cylinders are clea	arly	
	nonflammable gase	s such as oxygen were		distinguished. This practice	was	
properly secured from falling. NFPA 99, Health			completed on December 9th	,		
Care Facilities Code, 2012 Edition, Section 11.3.2			2022.			
	states storage for no	onflammable gases greater				
than 8.5 cubic meters (300 cubic feet) but less than			2. How other residents have	/ing		
	85 cubic meters (3000 cubic feet) shall comply with			the potential to be affected by	the	
	11.3.2.1 through 11.3.2.3. NFPA 99, Section			same deficient practice will be		
	11.3.2.6 states cylinder or container restraints shall			identified and what corrective		
	comply with 11.6.2	.3. Section 11.6.2.3(11) states		action will be taken? All resid	ents	
		ers shall be properly chained		have the potential to be		
		oper cylinder stand or cart.		affected. With the Oxygen		
		ice could affect up to 20		Cylinders properly stored an	nd	
	residents in one smo	_		designated, the deficient		
		•		practice has been corrected.	,	
	Findings include:			1		
	_			3. What measures will be	put	
	#1) Based on obser	vations with Administrator in		into place and what systemic		
	· ·	the Maintenance Director on		changes will be made to ensu	re	
		.m., the oxygen storage room		that the deficient practice does	l l	
		nd empty oxygen cylinders, but		recur? Instructions will be		
	the cylinders were mixed together and not marked			placed at the storage area or	7	
	as full or empty. Based on interview at the time of			proper Cylinder storage and		
	observation, the Maintenance Director stated			labels designating full and		
	there are signs in the oxygen storeroom stating			'n		
	spots for full and empty cylinders but staff are not			empty Cylinders will be put i place. Education will be had		
	following the signs.			with nursing staff of instruct		
	Total ming the organi			and labeling. Central		
	#2) Based on obser	vations with Administrator in		Supply/designee will monito	r	
	· · ·			the Cylinder daily to ensure		
	Training (AIT) and the Maintenance Director on			Cylinder and Container stora	200	
11/16/22 at 12:19 a.m., one 'E' type oxygen cylinder			I	Store	iye	

KVDP21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		A. BU	A. BUILDING <u>01</u> C			3) DATE SURVEY COMPLETED 11/16/2022		
NAME OF PROVIDER OR SUPPLIER GREY STONE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	storage/trans-filling chained or supporte cart. Based on inter observation, the Ma acknowledged one oxygen storage/tran properly chained or stand or cart. The findings were respectively.	nintenance Director 'E' type oxygen cylinder in the as-filling room was not supported in a proper cylinder reviewed with the AIT, and Maintenance Director			4. How the corrective action will be monitored to ensure the deficient practice will not reculus what quality assurance prograwill be put into place? Central Supply/designee will monitor Cylinder storage on five (5) separate occasions each we to ensure proper Cylinder storage and labels designate full and empty Cylinders remain place. Any occurrence of noncompliance will be immediately addressed. This audit will begin no later than December 16th and will continue weekly for six (6) months. 5. By what date the system changes for each deficiency who be completed? All orders, educations, and audits will be completely in place by December 30th, 2022. All audits will be taken to the Monthly QAPI meeting for revand recommendations	e r, m r ek ing nain		
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Higl Oxygen Used for	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		COMPLETED		
		155809	B. WING 11/16/2022				
NAME OF PROVIDER OR SUPPLIER GREY STONE HEALTH & REHABILITATION CENTER				10445 [ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD NAYNE, IN 46845		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DROWINEDIS DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	PLETION
TAG				TAG	DEFICIENCY)		ATE
	prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation.		K 09	27	K927 Gas Equipment – Transferring Cylinders 1. What corrective action was be accomplished by those		30/2022
	NFPA 99 2012 edit oxygen transfilling ventilated. Section exhaust to maintain space continuously affect up to 20 resid compartment.	ion, 11.5.2.3.1 (2) requires rooms to be mechanically 9.3.7.5.3.1 requires mechanical a negative pressure in the This deficient practice could			residents found to have been affected by the deficient practi The facility will repair the air vent in the Cylinder storage room. This practice will completed on December 23r 2022.	d,	
	Training (AIT) and 11/16/22 at 12:19 a room contained larg was a vent to the or ventilated exhaust f from the vent. Base observation, the Mathe fan motor and s be replaced.	ons with Administrator in the Maintenance Director on .m., the oxygen storage/transfer ge liquid oxygen tanks. There attside with a mechanically can, but there was no pull of air d on interview at the time of aintenance Director looked at tated the belt is broke and will viewed with the Administrator, enance Director during the exit			2. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action will be taken? All resid have the potential to be affected. Once the Air Vent is repaired, the deficient praction has been corrected. 3. What measures will be into place and what systemic changes will be made to ensut that the deficient practice does recur? Once the air vent is repaired, Maintenance Director/designee will perfor Preventative Maintenance to ensure its continued working condition.	ents sce put re s not	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 11/16/2022				ETED		
NAME OF PROVIDER OR SUPPLIER GREY STONE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
					4. How the corrective action will be monitored to ensure the deficient practice will not recur what quality assurance prograwill be put into place? Maintenance Director /designation will monitor air vent operation on five (5) separate occasion each week to ensure its continued working condition Any occurrence of noncompliance will be immediately addressed. This audit will begin no later than December 30th and will continue weekly for six (6) months. 5. By what date the system changes for each deficiency who completed? All orders, educations, and audits will be completely in place by December 30th, 2022. All audits will be taken to the Monthly QAPI meeting for revi	nee on os oic vill		