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	10/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/07/24 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 91 at the time of this survey. Quality Review completed on 10/08/24	E 0000	October 17, 2024 Emergency Preparedness conducted by Indiana State Department of Health To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567 in regards to the Emergency Preparedness 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. 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	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to ensure that the emergency generator had	E 0041	**E041** **1.What corrective action(s) will**	10/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria	HFA	10/28/2024

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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	a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:16 a.m. to 10:54 a.m. on 10/07/24, the facility's emergency generator had a natural gas fuel source. The facility provided a letter of reliability dated August 14, 2013 from NIPSCO, the utility providing the natural gas; however, the letter did not include all of the required information. The letter was not authored by a technical person who had the technical knowledge to make those statements. The letter was authored by the Manager, Major		**be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **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?** None of residents were affected by the alleged deficient. **3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Maintenance reached out to facility's gas provider to acquire a letter of reliability from NIPSCO. Letter was obtained 10/15/24. Administrator educated Maintenance Director on E041. **4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.,**	

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	Accounts Support who was not an engineer and there was no explanation of the author's job responsibilities to confirm that they had the technical knowledge to make the required statements. Based on interview the Maintenance Director stated he was not aware of the requirements of the Letter of Reliability. This finding was reviewed with the Director of Nursing and the Maintenance Director at the exit conference.		**what quality assurance program will be put into place?** The Director of Maintenance will re-assure for the next 6 months that the letter of reliability still be effective from our provider and that any changes in provider will be addressed with a new letter of reliability. Audit will be weekly for 4 weeks, then monthly for 5 months. All audits will be presented at QAPI monthly meeting for review and recommendations. **5.By what date the systemic changes for each deficiency will be completed?** Letter of Reliablity letter was received on October 15, 2024.	
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). Survey Date: 10/07/2024 Facility Number: 012935 Provider Number: 155809 AIM Number: 201207690	K 0000	October 17, 2024 Emergency Preparedness conducted by Indiana State Department of Health To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567 in regards to the	

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	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 V(111) 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 91 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 10/08/24		Emergency Preparedness 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. 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	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by	K 0324	**K324** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **2.How other residents having the**	10/08/2024

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	the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. The findings include: Based on observation and interview with the Maintenance Director from 10:58 a.m. to 1:09 p.m. on 10/07/24, cooking appliances including a gas burner stove and oven with a flat-top grill was located under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the kitchen staff and the Maintenance Director, the facility was not aware of a method provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was reviewed with the Director of Nursing and the Maintenance Director at the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** None of residents were affected by the alleged deficient. **3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Director of Maintenance applied secured bright paint to the floor where the appliances must be placed back under the approved design location. Administrator educated Maintenance Director on K324. **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?** The Director of Maintenance will audit that the paint remains in its required location weekly for 4 weeks, will be then monthly for 5 months. All audits will be taken	

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			to QAPI monthly meeting for review and recommendations. **5.By what date the systemic changes for each deficiency will be completed?** Completion of secure paint was on October 8, 2024.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source	K 0511	**K511** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **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?** None of residents were affected by the alleged deficient. **3.What measure will be put into place and what systemic**	10/15/2024

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	to the alternate energy source. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:16 a.m. to 10:54 a.m. on 10/07/24, the facility's emergency generator had a natural gas fuel source. The facility provided a letter of reliability dated August 14, 2013 from NIPSCO, the utility providing the natural gas; however, the letter did not include all of the required information. The letter was not authored by a technical person who had the technical knowledge to make those statements. The letter was authored by the Manager, Major Accounts Support who was not an engineer and there was no explanation of the author's job responsibilities to confirm that they had the technical knowledge to make the required statements. Based on interview the Maintenance Director stated he was not aware of the requirements of the Letter of Reliability. This finding was reviewed with the Director of Nursing and the Maintenance Director at the exit conference.		**changes will be made to ensure that the deficient practice does not recur?** Director of Maintenance reached out to facility's gas provider to acquire a letter of reliability from NIPSCO. Letter was obtained 10/15/24. Administrator educated Maintenance Director on K511. **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?** The Director of Maintenance will re-assure for the next 6 months that the letter of reliability still be effective from our provider and that any changes in provider will be addressed with a new letter of reliability. Audit will be weekly for 4 weeks, then monthly for 5 months. All audits will be presented at QAPI monthly meeting for review and recommendations. **5.By what date the systemic changes for each deficiency will be completed?**	

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			Letter of Reliablity letter was received on October 15, 2024.	