PRINTED: 10/29/2024
FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	•				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPLETED 10/07/2024	
		155809	B. WI	NG			
				CEDEEE	ADDRESS CHEW STATE THE SOR		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ODEVO	TONE HEALTH OF	DELLA DIL ITATIONI OENTED			DUPONT OAKS BLVD		
GREYS	TONE HEALTH & F	REHABILITATION CENTER		FORT	WAYNE, IN 46845		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
E 0000							
Bldg							
	An Emergency Pre	paredness Survey was	E 00	000	October 17, 2024		
		ndiana Department of Health in		,,,,	Emergency Preparedness		
	accordance with 42	-			conducted by Indiana State		
		. 6111 1051751			Department of Health		
	Survey Date: 10/07	1/24			Department of Flediti		
	Survey Bute. 10/0/	721			To whom it may concern,		
	Facility Number: 0	12935			Grey Stone Health and		
	Provider Number:				Rehabilitation, CMS Certificati	ion	
	AIM Number: 2012				Number <b>155809</b> has received		
	Alivi Number. 201.	207090				uie	
	At this Emanagement	Duamanadu ass sumuer. Cuer			2567 in regards to the		
	1	Preparedness survey, Grey			Emergency Preparedness Sur	vey.	
		Lehabilitation Center was found			Enclosed is our Plan of		
	-	with Emergency Preparedness			Correction for all of the		
	1 -	Medicare and Medicaid			deficiencies we received durin		
		ders and Suppliers, 42 CFR			Survey process. We ask that		
	-	has a capacity of 100 and had a			Plan of Correction be reviewe		
	census of 91 at the	time of this survey.			accepted as we strive to conti	nue	
					operating in compliance with		
	Quality Review con	mpleted on 10/08/24			CMS. We are also requesting		
					desk review approval to place		
					back into compliance as quick	ily	
					as possible.		
					Thank you for your considerat	ion	
					in this matter.		
					Sincerely,		
					Maria Diaz, Administrator		
					Grey Stone Health and		
					Rehabilitation		
					maria.diaz1@saberhealth.com	n	
					260-471-4770		
E 0041	482.15(e), 483.73	8(e), 485.542(e), 485.62					
SS=F	Hospital CAH and	LTC Emergency Power					
Bldg							
	Based on record re	view and interview, the facility	E 00	)41	E041		10/15/2024
	failed to ensure tha	t the emergency generator had			1.What corrective action(s) v	vill	
					l `´		
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	3	TITLE		(X6) DATE
Maria				HFA			10/28/2024
ivialia				1 II 🗥			10/20/2024

Maria HFA 10/28

Any defiency statement 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.

## 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			JILDING	ONSTRUCTION	(X3) DATE SI COMPLE 10/07/2	TED		
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	requirements of NF 19.5.1.1, 9.1, 9.1.3. 5.1. LSC Section 9 generators shall be maintained in according Systems, 2010 Edit following energy so used for the emerge (1) Liquid petroleur pressure (2) Liquefied petroleur pressure (2) Liquefied petroleur pressure (3) Natural or synthese Exception: For Lev where the probability fuel supplies is high alternate energy so output of the EPSS specified shall be reautomatic transfer to the alternate energy.	fuel in accordance with the PA 101 - 2012 edition, Section 1 and NFPA 110, 2010 Edition, 0.1.3.1 states emergency installed, tested and rdance with NFPA 110, gency and Standby Power ion. Section 5.1.1 states the burces shall be permitted to be ency power supply (EPS): m products at atmospheric leum gas (liquid or vapor letic gas rel 1 installations in locations ity of interruption of off-site h, on-site storage of an larce sufficient to allow full to be delivered for the class equired, with the provision for from the primary energy source rgy source. This deficient et all residents, staff and			be accomplished for those residents found to have been affected the deficient practice?  No residents were affected by alleged deficient practice.  2. How other residents having the potential to be affected by the same deficient practice will 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	/ the  ng  ne be /e		
	Maintenance Direction 10/07/24, the fact had a natural gas for provided a letter of 2013 from NIPSCO natural gas; however of the required info authored by a technical knowledge.	view and interview with the tor from 9:16 a.m. to 10:54 a.m. cility's emergency generator lel source. The facility reliability dated August 14, 0, the utility providing the letter did not include all rmation. The letter was not lical person who had the ge to make those statements.			recur?  Director of Maintenance react out to facility's gas provider to acquire a letter of reliability from NIPSCO. Letter was obtained 10/15/24. Administrateducated Maintenance Direct E041.  4.How the corrective action(will be monitored to ensure the deficient practice will not recur, i.e.,	ator or on		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG <u></u>	COMPLETED			
		155809	B. WING		10/07/2024			
GREY ST	NAME OF PROVIDER OR SUPPLIER  GREY STONE HEALTH & REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTIO				
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROP				
TAG		R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)	DATE			
	there was no explar responsibilities to c technical knowledg statements. Based of Director stated he w requirements of the This finding was re	who was not an engineer and nation of the author's job confirm that they had the e to make the required on interview the Maintenance was not aware of the Letter of Reliability.  Viewed with the Director of a content of the content		what quality assurance program be put into place?  The Director of Maintenance re-assure for the next 6 monthat the letter of reliability still be effective from our program of the theorem of the tester of reliability. Audit will weekly for 4 weeks, then monthated at QAPI monthly meeting for review and recommendated.  5.By what date the system changes for each deficiency will be completed?  Letter of Reliablity letter was received on October 15, 2024.	e will inths  povider ivider iv be ponthly be ations.			
K 0000								
Bldg. 01								
	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/07. Facility Number: 0	12935	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 Certific	ation			
	Provider Number: 1	.55809		Number <b>155809</b> has receive	ed the			

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AIM Number: 201207690

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2567 in regards to the

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155809	B. WING 10/07/2024				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
GREY ST	TONE HEALTH & R	EHABILITATION CENTER	10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTIO!			(X5)
PREFIX	(EACH DEFICIENCY 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
	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.			Emergency Preparedness Sur Enclosed is our Plan of Correction for all of the deficiencies we received durin Survey process. We ask that of Plan of Correction be reviewed accepted as we strive to continuoperating in compliance with CMS. We are also requesting desk review approval to place back into compliance as quick as possible.  Thank you for your considerate in this matter.  Sincerely, Maria Diaz, Administrator Grey Stone Health and Rehabilitation maria.diaz1@saberhealth.com 260-471-4770		g our our d and nue us ly	
	Quality Review completed on 10/08/24						
K 0324 SS=E Bldg. 01	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  K 324  1. What corrective action be accomplished for the residents found to have been affect the deficient practice?		1.What corrective action(s) we be accomplished for those	⁄ill	10/08/2024		
					found to have been affected the deficient practice?		
	requiring protection or rearranged witho	1.2.2* Cooking appliances shall not be moved, modified, ut prior re-evaluation of the			No residents were affected by alleged deficient practice.		
	fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by				2.How other residents having the	j	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155809	B. W	ING		10/07/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			DUPONT OAKS BLVD		
GRFY S	TONE HEAI TH & R	REHABILITATION CENTER			WAYNE, IN 46845		
	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 APPROPR DEFICIENCY)	AIL	PLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	+	TAG			OATE
	_	re extinguishing system.			potential to be affected by t		
		e fire-extinguishing system			same deficient practice will		
	_	evaluation where the cooking			identified and what correcti	ve	
		ed for the purposes of			action(s) will be taken?		
		eaning, provided the					
		ned to approved design			None of residents were affect	ted	
		oking operations, and any			by the alleged deficient.		
		xtinguishing 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				3.What measure will be put		
					into		
					place and what systemic		
					changes	_	
					will be made to ensure that	the	
		cient practice could affect			deficient practice does not		
	kitchen staff only.				recur?		
	Tri (* 1' ' 1 1				B		
	The findings includ	e:			Director of Maintenance appl	ied	
	D 1 1	1			secured bright paint to the		
		on and interview with the			floor where the appliances m	ust	
		tor from 10:58 a.m. to 1:09 p.m.			be		
		ng appliances including a gas			placed back under the appro		
		ren with a flat-top grill was			design location. Administrato		
		ood in the kitchen was not			educated Maintenance Direc	tor	
		oproved method that would			on K324.		
		iance was returned to an			4.1141	(a)	
		cation after it had been moved			4.How the corrective action	(8)	
		d cleaning. Based on interview			will		
		ff and the Maintenance			be monitored to ensure the		
	· ·	y was not aware of a method			deficient		
	_	that the appliance was			practice will not recur, i.e.,		
		oved design location after			what		
	maintenance or clea	ınıng.			quality assurance program	WIII	
	This finding was ==	viewed with the Director of			be		
	_				put into place?		
	_	nintenance Director at the exit			The Director of Maintenance	النمد	
	conference.				The Director of Maintenance		
	2.1.10(b)				audit that the paint remains in		
	3.1-19(b)				required location weekly for 4		
					weeks, will be then monthly f		
					months. All audits will be take	en	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	l ′	PLE CONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDI B. WING	NG <u>01</u>	COMPLETED		
155809		B. WING 10/07/2024					
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	ORRECTION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE		SHOULD BE COMPLETION APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY)	DATE		
K 0511 SS=F	NFPA 101 Utilities - Gas and	Flectric		to QAPI monthly mee review and recommendation  5.By what date the schanges for each deficiency scompleted?  Completion of secure was on October 8, 20	s.  ystemic  will be  paint		
Bldg. 01	Based on record reversal failed to ensure that a reliable source of requirements of NF. 19.5.1.1, 9.1, 9.1.3. 5.1. LSC Section 9 generators shall be in maintained in accord Standard for Emerg Systems, 2010 Editifollowing energy sourced for the emerge (1) Liquid petroleur pressure (2) Liquefied petrol withdrawal) (3) Natural or synth Exception: For Lew where the probabilitituel supplies is high alternate energy sourced to the EPSS.	riew and interview, the facility the emergency generator had fuel in accordance with the PA 101 - 2012 edition, Section I and NFPA 110, 2010 Edition, 1.3.1 states emergency installed, tested and dance with NFPA 110, ency and Standby Power ion. Section 5.1.1 states the furces shall be permitted to be incy power supply (EPS): in products at atmospheric  eum gas (liquid or vapor	K 0511	1. What corrective ace be accomplished for residents found to have been at the deficient practice?  No residents were affected alleged deficient practice.  2. How other resident the potential to be affect same deficient practice identified and what conduction action will be taken to be alleged deficients.  None of residents we by the alleged deficients.	r those  affected by  fected by the stice.  hts having  ted by the stice will be corrective en?  are affected ent.		
	-	rom the primary energy source		place and what syste	emic		

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## 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 C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  10/07/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	10445	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD WAYNE, IN 46845	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF to the alternate ener	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION rgy source. This deficient at all residents, staff and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  changes will be made to ensure that the	DATE
	practice could affect visitors.  Findings include:  Based on record rev Maintenance Direct on 10/07/24, the fact had a natural gas fur provided a letter of 2013 from NIPSCO natural gas; however of the required informauthored by a technical knowledg. The letter was authored by a technical knowledg. The letter was authored was no explain responsibilities to ce technical knowledg statements. Based of Director stated he was requirements of the This finding was responsibilities.	view and interview with the for from 9:16 a.m. to 10:54 a.m. cility's emergency generator el source. The facility reliability dated August 14, 0, the utility providing the er, the letter did not include all rmation. The letter was not ical person who had the e to make those statements. Or the Manager, Major who was not an engineer and nation of the author's job onfirm that they had the e to make the required on interview the Maintenance		will be made to ensure that to deficient practice does not recur?  Director of Maintenance react out to facility's gas provider to acquire a letter of reliability from NIPSCO. Letter was obtained 10/15/24. Administrateducated Maintenance Direct on K511.  4.How the corrective action(will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program whose put into place?  The Director of Maintenance was re-assure for the next 6 month that the letter of reliability still be effective from our proviand that any changes in provia	ned ator or s)  will will ns ider der e thly s
				5.By what date the systemic changes for each deficiency will be completed?	

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

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STATEMEN	IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP.			JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01			COMPLETED	
		155809	B. WING			10/07/2024		
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	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL				re l	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE	
					Letter of Reliablity letter was received on October 15, 2024.			

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