STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155809	A. BUILDING 00 B. WING	10/15/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00444452. Complaint IN00444452 - Federal/state deficiencies related to the allegations are cited at F684 . Survey dates: October 15, 2024 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 13 Medicaid: 65 Other: 10 Total: 88 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 17, 2024	F 0000	October 24, 2024 Indiana State Department of Health Department of Health and Human Services Centers for Medicare & Medicaid Services To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567. 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	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility	F 0684	**F684**	10/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria Diaz		10/24/2024

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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	failed to ensure monitoring and assessment related to recurrent urinary retention for 1 of 1 residents reviewed (Resident E). Findings include: On 10/15/24 at 2:15 P.M., Resident E's record was reviewed. Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), and anxiety disorder. An annual Minimum Data Set (MDS) assessment, dated 6/3/24, indicated Resident E had severely impaired cognition, was always incontinent of bladder and bowel and was dependent on staff for transfers on and off the toilet and toileting hygiene. A urinary care area assessment (CAA), dated 6/4/24, indicated the resident was incontinent of bladder and bowel and a care plan had been initiated to prevent/minimize complications. A care plan, revised on 7/24/24, indicated the resident was incontinent of bowel and bladder. The goal was for Resident E to receive assistance with toileting, be comfortable, clean, dry and free from skin breakdown. Interventions, dated 12/19/23, were: administer medications per physician order; assess resident's pattern of episodes of incontinence; monitor for redness, irritation, skin excoriation and breakdown; and provide incontinence care as needed. A nurse progress note, dated 8/2/24 at 9:52 a.m., indicated the resident was constantly yelling out for help but was unable to tell staff what he needed help with. The Nurse Practitioner (NP) was notified and order given for one time dose of anti-anxiety medication. -At 1:09 p.m., Resident E was observed perspiring		**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident E was discharged from the facility on 8/28/24. **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?** Current resident and new admits with a decline in urinary status will have an audit along with identified corrections completed by the Director of Nursing or designee to ensure the decline is assessed, the provider is notified and follow up is completed as appropriate. This audit will be documented on the Urinary Status audit tool. **3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Nursing or	

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	and having anxiety. His oxygen saturation levels were low at 82% (Normal is >90%). He was given oxygen and began to calm down. His daughter was informed and indicated he could become hypoxic (low oxygen) and had orders for oxygen when his happened because it created anxiety for him. The NP ordered a STAT chest x-ray and supplemental oxygen to be on continuously until the chest x-ray results were in. -At 4:01 p.m., the NP and resident's daughter were notified of the normal chest x-ray results. He became anxious again, as his daughter was leaving the facility and began yelling out for staff to help him. The NP ordered Ativan (anti-anxiety) by mouth every 8 hours as needed (PRN) for 14 days in addition to his routine dose of Ativan given daily at 5:00 p.m. An NP progress note, dated 8/5/24 at 3:23 p.m., indicated Resident E had been seen for follow up of worsening anxiety from 8/2/24. A urinalysis was ordered on 8/2/24, then successfully collected on 8/5/24 to rule out an infection worsening his anxiety. A nurse progress note, dated 8/6/25 at 6:00 a.m., indicated the resident was straight cathed for not having any urine output with a distended abdomen. 1000 milliliters of urine was removed. The NP was notified of his urinary retention and an order given to administer 1 dose of antibiotic intramuscularly for urinary retention. The order included a urine for culture (obtained and taken to hospital on 8/5/24) and to obtain labwork. The resident displayed anxiety. He had a low oxygen level of 84%. Oxygen was applied and his oxygen level increased and he was given PRN Ativan for the anxiety. An NP progress note, dated 8/9/24 at 6:08 p.m.,		designee will have an in-service/education with Licensed nurses on Resident Change in Condition Policy. **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 Nursing or designee will be complete random audits of residents noted with a decline in urinary status utilizing the Urinary Status audit tool. This audit will be completed Weekly for 4 weeks, then monthly for 5 months. **5.By what date the systemic changes for each deficiency will be completed?** All audits, in-servicing, and systemic Changes will be in effect by October 16, 2024.	

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	indicated the resident was seen for follow up of anxiety. The note indicated his x-rays, lab work and urinalysis were all unremarkable. There was no documentation or follow up of the resident's urinary retention. There was no abdominal assessment or documentation of urine output monitoring. There was no documentation in the nurse notes, NP progress notes or care plan addressing the urinary retention observed on 8/6/24. NP progress notes and nurse progress notes, from 8/8/24 at 6:00 a.m. until 8/28/24, indicated Resident E had intermittent episodes of anxiety, a "fast heart rate" and low oxygen levels. The resident was not monitored or assessed for cause of the urinary retention or reoccurrence of the condition. Vital signs obtained 8/28/24 indicated Resident E had a low grade temperature of 98.8. Hospital records, dated 8/28-8/30/24, indicated the resident had been seen in the emergency room due to lethargy, shortness of breath, low oxygen blood levels, and not eating or drinking well. On arrival to the hospital, on 8/28/24, his heart rate was elevated, respirations were fast and hard, oxygen level low, temperature elevated at 101 degrees, and he had abnormal lab results with a high white blood count (indicated infection). A CAT scan x-ray was done of his pelvis which showed marked distention of the urinary bladder with mild enlargement of both kidneys due to back up of urine from the bladder. A urinalysis showed pus and bacteria in his urine and blood cultures were positive with E. Coli bacteria. Resident E was diagnosed with sepsis due to E. Coli bacteremia from a urinary tract infection and urinary retention.			

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	A copy of Resident E's documentation of bladder incontinence, dated August 2024, indicated there was no output documented for 1 to 2 shifts on 9 of the 22 days between 8/6 and 8/28/24. On 10/15/24 at 3:38 P.M., Resident E's daughter was interviewed. She indicated the resident had been admitted to hospice following his hospitalization. When asked, she indicated the resident had no history of urinary retention. She alleged chronic issues with her father's toileting and personal hygiene and her belief these issues contributed to his infection and death. On 10/15/24 at 3:00 P.M., the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) were interviewed. They indicated there was no facility policy for assessing and monitoring residents for urinary retention. The DON indicated the Certified Nurse Aids (CNA) documented, each shift, resident's urinary output by charting continent or incontinent. This Citation relates to Complaint IN00444452. 3.1-37			