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	155809	A. BUILDING 00 B. WING	01/25/2024

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 Complaints IN00425543, IN00426560, and IN00426673. Complaint IN00425543 - Federal/state deficiencies related to the allegations are cited at F684 . Complaint IN00426560 - No deficiencies related to the allegations are cited. Complaint IN00426673 - No deficiencies related to the allegations are cited. Survey dates: January 24 and 25, 2024 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 79 SNF: 15 Total: 94 Census Payor Type: Medicare: 2 Medicaid: 64 Other: 28 Total: 94 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 26, 2024	F 0000	**F684 Quality of Care** **1 What corrective action will be accomplished by those residents found to have been affected by the deficient practice?** Resident E was seen by the wound nurse practioner on 1/26/24. Orders were initiated for a wound culture as well as a change in treatment. Resident E was screened by therapy for positioning on 2/8/24. Resident E's wound prevention interventions were reviewed for appropriateness by the Director of Nursing on 2/8/24. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Current residents and new admissions who have arterial ulcers have the opportunity to be affected. Utilizing the Skin Alteration Audit tool the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will audit wound orders and wound prevention interventions for appropriateness.	

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

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			This audit along with identified corrections will be completed on or before 2/15/24. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** To prevent this from reoccurring the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will provide education to licensed nurses and nursing assistants utilizing Skin and Wound Care Best Practices with an emphasis on wound prevention interventions and following physician orders. This education will be completed on or before 9/22/23. **4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** To monitor and maintain ongoing compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 8 weeks then monthly for 4 months utilizing the Skin Alteration audit tool to ensure residents with arterial ulcers have appropriate wound orders and prevention	

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			interventions in place. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. **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 2/15/24. Re: Grey Stone Health and Rehabilitation Request for Informal Dispute Resolution Provider Number: 155809 Survey Date Ending: 1/25/24 Dear Reviewer: On behalf of Grey Stone Health and Rehabilitation we respectfully request an Informal Dispute resolution with regard to the scope and severity of F684, which was cited in the above referenced survey. **Introduction:** We respectfully request that the	

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			scope and severity for citation F684 be decreased from a G level to a D level for the complaint survey ending on 1/25/24. **Allegation:** Based on review of clinical records and facility documentation, it was determined that the facility failed to prevent a non-pressure related wound from resting directly on the floor. This resulted in Resident E's wound becoming infected requiring antibiotics. **Dispute:** Resident E admitted to the facility on 6/28/22. Resident E had doppler studies completed on 8/23/23 (Exhibit 1) and subsequently received a diagnosis of PVD. Resident E and Daughter declined a referral to a vascular specialist (Exhibit: #2). In addition to PVD Resident E has a dx of diabetes type 2 with bilateral LE neuropathy, lymphedema, as well as post-polio syndrome. Per the wound Nurse Practioner statement Resident E. will often request to be seated in her w/c and does not routinely wish to elevate her legs to help reduce edema. All of these co-morbidities have prevented her wound from improving (Exhibit: #3). Per the Wound Nurse Practioner (Exhibit #3), Resident E was once again seen on 1/26/24-despite the recent antibiotics and Dakin's treatment, wound was still noted	

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			to have an odor and wound cultures were obtained. The eschar cap was lifting quite a bit during this visit and was likely due to the infectious process and exacerbated by her PVD and DMII with neuropathy. She has been started on additional antibiotics for her infection to her heel wound. Per the Wound Nurse Practioner (Exhibit #3), despite appropriate medical care, her wound was likely to decline due to her PVD as well as her other co-morbidities including a recent Covid 19 infection. Resident E's wound was not directly making contact with the floor as there was a multi-layer dressing (Dakin's moistened gauze, folded abdominal pad dressing, covering with layers of kerlix) on her foot causing a barrier between the wound and the floor at the time observations were made by the surveyor per the statement of deficiencies. (Exhibit: #4) Resident E's wound was noted to be stable from 10/30/23 through 12/18/23. (Exhibit: #5). Resident E tested positive for Covid on 12/14/23 (Exhibit: #6) and on 1/3/24 shortly after having covid the resident was noted with a decline in the status of the wound (Exhibit: #7). Per the Wound Nurse Practioner (Exhibit #3),	

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			despite appropriate medical care, her wound was likely to decline due to her PVD as well as her other co-morbidities including a recent Covid 19 infection. Resident E had an X-Ray to right heel obtained on 1/2/24 (Exhibit #8). Wound NP visit on 1/19/24 incorrectly indicates X-Ray was re-ordered by medical NP as well as a venous ultrasound. Upon interview with wound NP (Exhibit #3), Medical NP (Exhibit #11) and licensed nurse (Exhibit #10), wound NP verbally gave an order for an X-Ray and within an hour Medical NP clarified with wound NP that X-Ray was recently obtained on 1/2/24 and there is no need to repeat. The licensed nurse entered a requisition in the X-Ray software (Exhibit 9, page #1) and cancelled it (Exhibit 9, page #2) per follow up with the Medical NP. A physicians order was never entered in Resident E's medical record. 1/20/24 – Macrobid ordered for UTI placing resident at higher risk for further wound decline. (Exhibit: #12) 1/26/24 – Wound culture ordered. (Exhibit: #13) 1/31/24 – Wound culture results returned (Exhibit #14) and new order received for Ceftriaxone x 7 days (Exhibit #15) and Levofloxacin for 7 days (Exhibit	

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			#16) and probiotic ordered. **Conclusion:** Grey Stone Health and Rehabilitation takes the care and services of our residents very seriously and continues to work diligently to ensure the safety of our residents. Due to Resident E's comorbities, recent infections and refusal to consistently off load R. Heel places this resident at high risk for wound decline as well as delayed healing. Considering the wound was stable from 10/31/23 – 12/18/23 and declined shortly after having Covid on 12/14/24 it is not possible to determine that lack of offloading the heel definitively resulted in the worsening of the wound and causing actual harm to Resident E. We respectfully request your review of the documentation provided and consider amending F684 G severity to F684 D severity as the observations during the survey do not support the finding of harm to this resident. We sincerely appreciate time and opportunity allowed.	
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to prevent a non-pressure related wound from resting directly on the floor for 1 of 2 residents reviewed (Resident E). This resulted in Resident E's wound becoming infected requiring antibiotics. Findings include: On 1/24/24 at 11:01 A.M., Resident E was observed seated in a wheelchair next to her bed. Her bare feet was in direct contact with the floor with no barrier. The right foot was wrapped with a gauze dressing from the midfoot to above her ankle. Her right pant leg was pulled up and her calf was visible. The exposed calf was red in color with thick white scales of skin. The exposed forefoot skin was swollen, reddened with thick scales. There were old non-skid strips beneath her feet. There were numerous food and skin particles beneath her feet and across the floor. The mattress on her bed was stained and had no linens on it. On 1/24/24 at 1:20 P.M., the resident was observed still seated in her wheelchair next to the bed. Black socks had been put on and covered the forefoot of both feet. The right foot gauze dressing remained in direct contact with the floor. Her bed remained without bedding. When questioned, the resident indicated she couldn't sit in the recliner chair and elevate her feet because the path was too narrow between her bed and window. She had to back herself into the chair with her walker and staff assistance. It wasn't safe for her to do this so	F 0684	**F684 Quality of Care** **1 What corrective action will be accomplished by those residents found to have been affected by the deficient practice?** Resident E was seen by the wound nurse practioner on 1/26/24. Orders were initiated for a wound culture as well as a change in treatment. Resident E was screened by therapy for positioning on 2/8/24. Resident E's wound prevention interventions were reviewed for appropriateness by the Director of Nursing on 2/8/24. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Current residents and new admissions who have arterial ulcers have the opportunity to be affected. Utilizing the Skin Alteration Audit tool the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will audit wound	02/16/2024

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	she was unable to elevate her legs. She indicated she'd had an episode of confusion "the other night" and thought she had been in another home. She was taking antibiotics for her wound, had some diarrhea and indicated that could be what was causing the confusion. -At 3:05 P.M., Resident E was observed still seated in her wheelchair with feet in direct contact on the floor and black socks pulled over both forefeet. She appeared to be sleeping with her eyes closed. On 1/25/24 at 9:57 A.M., Resident E was observed seated in her wheelchair with both feet flat on the ground. On her right foot, she wore a sock over the forefoot while the gauze dressing on her heel wound was in direct contact with the floor. On her left foot, she wore a blue slipper. She indicated she hadn't felt well all night and felt confused at times. She complained of having diarrhea again and her mattress was bare of linens. She indicated staff told her they were going to get a stool culture to check for infection due to the antibiotics she was taking. On 1/25/24 at 1:50 P.M., LPN 4 left the resident's room carrying a stool sample. She indicated staff had just laid the resident down after the resident had a very large watery stool and would return to the room to complete the resident's wound care. -At 1:57 P.M., Resident E was observed lying in bed with gray colored skin. She indicated she hadn't felt good. LPN 4 and the LPN 5 (facility wound care nurse) assisted the resident to turn to her side and pulled up her leg pant. On the bed sheet, where the right heel had sat, was red-brown wet drainage and the gauze dressing around the right heel was saturated with red-brown drainage. LPN 4 removed the saturated dressing and a very large wound engulfing the entire swollen right		orders and wound prevention interventions for appropriateness. This audit along with identified corrections will be completed on or before 2/16/24. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** To prevent this from reoccurring the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will provide education to licensed nurses and nursing assistants utilizing Skin and Wound Care Best Practices with an emphasis on wound prevention interventions and following physician orders. This education will be completed on or before 2/16/24. **4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** To monitor and maintain ongoing compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 8 weeks then monthly for 4 months utilizing the Skin Alteration audit tool to ensure residents with	

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	heel was observed. The wound was round and approximately 5 inches around. The wound bed was gray to green in color and appeared very moist. In the center of the wound was an elevated eschar (necrotic-dead skin tissue) cap, black in color. On the outer edge of the circular shaped wound, was an area of pale gray moist and soft appearing tissue. Surrounding the entire wound were deep scales of thickened, dry and reddened skin extended onto the resident toes. The wound itself and drainage had a strong foul odor. The resident had been given pain medication prior to the dressing change and denied pain during the procedure. On 1/24/24 at 1:00 P.M., Resident E's record was reviewed. Diagnoses included diabetes with polyneuropathy and peripheral vascular disease with an arterial ulcer to her right heel since 8/4/23. A Doppler study, done on 8/23/23, indicated the resident had arterial stenosis (blood vessels which are narrowed or blocked) to 3 arteries in her right leg. There were no nursing assessments of the wound available for review. A quarterly MDS (Minimum Data Set) assessment, dated 11/29/23, indicated the resident was alert and oriented without cognitive impairment. She had no behaviors or rejection of care. She had no functional impairment to her upper or lower extremities but had impaired balance and weakness due to effects of childhood illness. She walked very short distances using her walker or wheelchair along with maximal assistance from staff. She was dependent on staff for putting on and taking off her footwear. She had an arterial ulcer which was being treated.		arterial ulcers have appropriate wound orders and prevention interventions in place. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. **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 2/16/24. Dear Reviewer: On behalf of Grey Stone Health and Rehabilitation we respectfully request an Informal Dispute resolution with regard to the scope and severity of F684, which was cited in the above referenced survey. **Introduction:** We respectfully request that the scope and severity for citation F684 be decreased from a G level to a D level for the complaint survey ending on 1/25/24. **Allegation:** Based on review of clinical records and facility documentation, it was determined that the facility failed to prevent a non-pressure related	

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	Care plans were as follows: 12/1/23-Resident had skin breakdown. The goal was to have no further skin breakdown. Interventions included: turn and reposition as indicated; pressure reducing cushion to wheelchair and pressure reducing mattress; and float heels when in bed as the resident allows. 12/1/23-Resident with actual skin impairment: right heel arterial wound, surgical wound to top of head, and moisture associated skin disorder to buttocks. The goal was for areas to heal without signs or symptoms of infection. Interventions were: diet as ordered; complete skin checks and assessment per protocol; follow physician orders and treatments as indicated; refer to registered dietician; and use pressure reducing devices as indicated. 1/3/24-Resident with infection to right heel ulcer: the goal was for the ulcer to heel. Interventions included: assess for pain every shift; encourage activity as tolerated; encourage to be out of bed as tolerated; provide medications and antibiotics as ordered; monitor the right heel ulcer; and notify physician of changes. Wound Management Detail Reports, dated 11/6/23, 11/13, 11/20, 11/27, 12/5, 12/11, and 12/18/23, indicated the right heel wound had remained stable with daily treatment and dressing changes. The wound remained approximately the same size of 6 cm (centimeters) by 6 cm with black eschar and no drainage. The peri wound was consistently described as pink. A Wound Management Detail Report, dated 12/26/23 at 6:48 p.m., indicated the wound was stable but had light serosanguineous (blood and		wound from resting directly on the floor. This resulted in Resident E's wound becoming infected requiring antibiotics. **Dispute:** Resident E admitted to the facility on 6/28/22. Resident E had doppler studies completed on 8/23/23 (Exhibit 1) and subsequently received a diagnosis of PVD. Resident E and Daughter declined a referral to a vascular specialist (Exhibit: #2). In addition to PVD Resident E has a dx of diabetes type 2 with bilateral LE neuropathy, lymphedema, as well as post-polio syndrome. Per the wound Nurse Practioner statement Resident E. will often request to be seated in her w/c and does not routinely wish to elevate her legs to help reduce edema. All of these co-morbidities have prevented her wound from improving (Exhibit: #3). Per the Wound Nurse Practioner (Exhibit #3), Resident E was once again seen on 1/26/24-despite the recent antibiotics and Dakin's treatment, wound was still noted to have an odor and wound cultures were obtained. The eschar cap was lifting quite a bit during this visit and was likely due to the infectious process and exacerbated by her PVD and DMII with neuropathy. She has been started on additional antibiotics for her infection to her heel wound.	

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	serum) drainage with no odor. The resident was encouraged to elevate the right leg when able to. A Wound Management Detail Report, dated 1/2/24 at 7:56 p.m., indicated the wound had purulent (pus) drainage, the peri wound was pink to red, with a mild odor. The medical NP was notified and ordered lab work, an x-ray to be done of the right foot to check for a bone infection, and a course of antibiotics. The resident was encouraged to elevate the right leg when able to. On 1/2/24 the medical NP ordered doxycycline (an antibiotic)100 mg po BID for 10 days. A Wound Care note by the Wound NP (Nurse Practitioner), dated 1/3/24, indicated the resident had been seen for care of her chronic arterial wound. The wound measured 6 cm by 6.5 cm and was covered with an eschar cap that was starting to lift up with open edges to the wound. The wound had a small amount serosanguineous drainage without odor and wound bed was 20% slough and 80% eschar. Assessment and Plan: x-ray of the foot was negative for osteomyelitis (bone infection) per LPN 5. Orders were given to change the treatment and continue with the antibiotics as ordered by the house NP. The right heel was to be offloaded (pressure off of heel) at all times. Wound Management Detail Reports, dated 1/8/24 at 6:23 p.m. and 1/15/24 at 10:48 p.m., indicated the right heel wound measured 6.5 cm by 7 cm with seropurulent drainage with mild odor. The resident was encouraged to elevate the right leg when able to. A Wound Care note by the Wound NP, dated 1/19/24, indicated the resident's right heel wound		Per the Wound Nurse Practioner (Exhibit #3), despite appropriate medical care, her wound was likely to decline due to her PVD as well as her other co-morbidities including a recent Covid 19 infection. Resident E's wound was not directly making contact with the floor as there was a multi-layer dressing (Dakin's moistened gauze, folded abdominal pad dressing, covering with layers of kerlix) on her foot causing a barrier between the wound and the floor at the time observations were made by the surveyor per the statement of deficiencies. (Exhibit: #4) Resident E's wound was noted to be stable from 10/30/23 through 12/18/23. (Exhibit: #5). Resident E tested positive for Covid on 12/14/23 (Exhibit: #6) and on 1/3/24 shortly after having covid the resident was noted with a decline in the status of the wound (Exhibit: #7). Per the Wound Nurse Practioner (Exhibit #3), despite appropriate medical care, her wound was likely to decline due to her PVD as well as her other co-morbidities including a recent Covid 19 infection. Resident E had an X-Ray to right heel obtained on 1/2/24 (Exhibit #8). Wound NP visit on 1/19/24	

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(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
	measured 6.5 cm by 7 cm and had a small amount of serosanguineous drainage with odor. The wound bed had 30% slough, 60% eschar and 10% granulation tissue. Edges of the wound were open and the eschar cap was lifting. Skin surrounding the wound was reddened and the wound was worsening in size, increased drainage and wound odor. Assessment and Plan: X-ray reordered by Medical NP as well as venous ultrasound. Treatment to wound was changed and right leg was to be offloaded at all times. On 1/25/24 at 10:55 A.M., CNA 6 (Certified Nurse Aid) was interviewed. They indicated the resident still walked with assistance to the bathroom but was very shaky and last week had almost fallen while being assisted. CNA 6 indicated the resident wasn't able to sit in her recliner chair because she had to back up with the walker to get to the chair which was not safe. On 1/25/24 at 2:42 P.M., the Infection Control Nurse was interviewed. She indicated Resident E's right heel wound and it's dressing should not be sitting directly on the floor. A current facility policy, titled "Skin and Wound Care Best Practices" was provided by the Director of Nursing on 1/25/24 at 2:15 P.M., which stated: "Skin Care and Pressure Injury Prevention: Provide pressure reduction/redistribution for those at risk: offload/suspend heels for at risk residents...Pressure injuries and wounds will be treated with evidence-based interventions as ordered by the provider...All clinical staff will receive education on pressure injury prevention and treatment...with focus on education staff in the importance of basic care such as skin care and protection and pressure redistribution...."		incorrectly indicates X-Ray was re-ordered by medical NP as well as a venous ultrasound. Upon interview with wound NP (Exhibit #3), Medical NP (Exhibit #11) and licensed nurse (Exhibit #10), wound NP verbally gave an order for an X-Ray and within an hour Medical NP clarified with wound NP that X-Ray was recently obtained on 1/2/24 and there is no need to repeat. The licensed nurse entered a requisition in the X-Ray software (Exhibit 9, page #1) and cancelled it (Exhibit 9, page #2) per follow up with the Medical NP. A physicians order was never entered in Resident E's medical record. 1/20/24 – Macrobid ordered for UTI placing resident at higher risk for further wound decline. (Exhibit: #12) 1/26/24 – Wound culture ordered. (Exhibit: #13) 1/31/24 – Wound culture results returned (Exhibit #14) and new order received for Ceftriaxone x 7 days (Exhibit #15) and Levofloxacin for 7 days (Exhibit #16) and probiotic ordered. **Conclusion:** Grey Stone Health and Rehabilitation takes the care and services of our residents very seriously and continues to work diligently to ensure the safety of our residents. Due to Resident	

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	01/25/2024

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	WebMD.com indicated aterial wounds are slow to heal, the goals are to remove contact irritation and pressure and dressing should be kept dry and clean. This tag relates to Complaint IN00425543. 3.1-37		E's comorbities, recent infections and refusal to consistently off load R. Heel places this resident at high risk for wound decline as well as delayed healing. Considering the wound was stable from 10/31/23 – 12/18/23 and declined shortly after having Covid on 12/14/24 it is not possible to determine that lack of offloading the heel definitively resulted in the worsening of the wound and causing actual harm to Resident E. We respectfully request your review of the documentation provided and consider amending F684 G severity to F684 D severity as the observations during the survey do not support the finding of harm to this resident. We sincerely appreciate time and opportunity allowed.	