CENTERS FO	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155809	B. WING	· · · · · · · · · · · · · · · · · · ·	01/25/2024	
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	l	
NAME OF	PROVIDER OR SUPPLIE	R		DUPONT OAKS BLVD		
GREY S	TONE HEALTH & F	REHABILITATION CENTER		WAYNE, IN 46845		
OI LI O	TONETIEAETTAT	TENADIENTATION CENTER	110111	WATNE, IN 40040		
(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)	DATE	
F 0000						
Bldg. 00						
		he Investigation of Complaints	F 0000	F684 Quality of Care		
	IN00425543, IN00	426560, and IN00426673.		1 What corrective action		
				will be accomplished by thos	se	
	_	5543 - Federal/state deficiencies		residents found to have beer	ı	
	related to the allega	ations are cited at F684.		affected by the deficient		
	Complaint IN0042	6560 - No deficiencies related to		practice?		
	the allegations are			Resident E was seen by the		
	the anegations are	citcu.				
	Complaint INIO042	6673 - No deficiencies related to		wound nurse practioner on 1/26/24. Orders were initiated	16	
	the allegations are				1 101	
	the anegations are	cited.		a wound culture as well as a		
	C 1-4 I	24 1 25 2024		change in treatment.		
	Survey dates: Janu	ary 24 and 25, 2024		Resident E was screened by	.	
	E 114 1 0	12025		therapy for positioning on 2/8/3		
	Facility number: 0			Resident E's wound preventio		
	Provider number: 1			interventions were reviewed for		
	AIM number: 2012	20/690		appropriateness by the Directo	or of	
	G D 1 m			Nursing on 2/8/24.		
	Census Bed Type:					
	SNF/NF: 79					
	SNF: 15			2 How other residents		
	Total: 94			having the potential to be		
				affected by the same deficien		
	Census Payor Type	2:		practice will be identified and		
	Medicare: 2			what corrective action will be	9	
	Medicaid: 64			taken?		
	Other: 28					
	Total: 94			Current residents and new		
				admissions who have arterial		
	-	lects State Findings cited in		ulcers have the opportunity to	be	
	accordance with 41	10 IAC 16.2-3.1.		affected. Utilizing the Skin		
				Alteration Audit tool the Direct	or of	
	Quality review con	npleted January 26, 2024		Nursing, Assistant Director of		
				Nursing or Staff Development		
				Coordinator will audit wound		
				orders and wound prevention		
				interventions for appropriatene	ess.	

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

TITLE

(X6) DATE

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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/25/2024	
	ROVIDER OR SUPPLIE	REHABILITATION CENTER	10445	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD WAYNE, IN 46845	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETION DATE
				This audit along with identified corrections will be completed or before 2/15/24.	
				3 What measures will be put into place and what systemic changes will be mato ensure that the deficient practice does not recur? To prevent this from reoccurrithe Director of Nursing, Assist 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 emphaton wound prevention interven and following physician orders This education will be completed on or before 9/22/23.	ng tant e sis tions s.
				4 How the corrective activial be monitored to ensure to deficient practice will not recur, what quality assurance program will be put into place. To monitor and maintain ongo compliance the Director of Nursin will complete weekly audits for weeks then monthly for 4 mor utilizing the Skin Alteration autool to ensure residents with arterial ulcers have appropriate wound orders and prevention.	the ee ce? sing rsing g r 8 aths dit

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING			COMPLETED	
		155809	B. WIN	NG		01/25/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		10445 E	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD VAYNE, IN 46845		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					interventions in place. The results of the audits will be forwarded to the facility QAPI committee for further review a recommendations. 5 By what date the systemic changes for each deficiency will be completed All audits, in servicing, and systemic changes will be in eff by 2/15/24.	nd ?	
					Re: Grey Stone Health and Rehabilitation Request for Informal Dispute Resolution Provider Number: 1556 Survey Date Ending: 1/25/24 Dear Reviewer: On behalf of Grey Stone Healt and Rehabilitation we respect request an Informal Dispute resolution with regard to the so and severity of F684, which we cited in the above referenced survey. Introduction:	309 th fully cope as	
					We respectfully request that the	ne l	

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	OF CORRECTION	IDENTIFICATION NUMBER 155809	A. BUILDING B. WING	00	COMPLETED 01/25/2024
	ROVIDER OR SUPPLIER	REHABILITATION 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 R 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
				scope and severity for citation F684 be decreased from a G I to a D level for the complaint survey ending on 1/25/24. Allegation: Based on review of clinical recand facility documentation, it will determined that the facility fail to prevent a non-pressure relawound from resting directly on floor. This resulted in Resider E's wound becoming infected requiring antibiotics. Dispute: Resident E admitted to the facton 6/28/22. Resident E had doppler studies completed on 8/23/23 (Exhibit 1) and subsequently received a diagrof PVD. Resident E and Daug declined a referral to a vascula specialist (Exhibit: #2). In add to PVD Resident E has a dx on diabetes type 2 with bilateral Lineuropathy, lymphedema, as as post-polio syndrome. Per the wound Nurse Practioner state Resident E. will often request be seated in her w/c and does routinely wish to elevate her let to help reduce edema. All of the co-morbidities have prevented wound from improving (Exhibit #3). Per the Wound Nurse Praction (Exhibit #3), Resident E was a again seen on 1/26/24-despiter recent antibiotics and Dakin's treatment, wound was still not	cords vas ed tted tted the ot sility nosis ghter er er lition fE well he ment to s not egs hese l her t:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/25/2024					
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	ALGOLATORI GI			to have an odor and wound cultures were obtained. The eschar cap was lifting quite a during this visit and was likely to the infectious process and exacerbated by her PVD and with neuropathy. She has bee started on additional antibiotic her infection to her heel wound Per the Wound Nurse Praction (Exhibit #3), despite appropria medical care, her wound was likely to decline due to her PV as well as her other co-morbic including a recent Covid 19 infection. Resident E's wound was not directly making contact with the floor as there was a multi-layed dressing (Dakin's moistened gauze, folded abdominal pad dressing, covering with layers kerlix) on her foot causing a between the wound and the float the time observations were made by the surveyor per the statement of deficiencies. (Exhibit: #4) Resident E's wound was note be stable from 10/30/23 through 12/18/23. (Exhibit: #5). Reside tested positive for Covid on 12/14/23 (Exhibit: #6) and on 1/3/24 shortly after having cover the resident was noted with a decline in the status of the wound (Exhibit: #7). Per the Wound	bit due DMII n s for d. ner tte D dities de r of arrier cor d to gh dent		

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Nurse Practioner (Exhibit #3),

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION (X3) DATE SUR	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETE	D	
155809 B. WING 01/25/202	01/25/2024	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 10445 DUPONT OAKS BLVD		
GREY STONE HEALTH & REHABILITATION CENTER FORT WAYNE, IN 46845		
GIVET STONE FIEAETH & IVEHABLEHATION CENTER TORY WATNE, IN 40043		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	MPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
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		
page #z) 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155809		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/25/2024			
	PROVIDER OR SUPPLIER		10445	ADDRESS, CITY, STATE, ZIP COD DUPONT OAKS BLVD	
GREY ST	FONE HEALTH & R	EHABILITATION CENTER	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				#16) and probiotic ordered.	
				Conclusion: Grey Stone Health and Rehabilitation takes the care services of our residents very seriously and continues to we diligently to ensure the safety our residents. Due to Reside E's comorbities, recent infect and refusal to consistently of R. Heel places this resident a high risk for wound decline a as delayed healing. Conside the wound was stable from 10/31/23 – 12/18/23 and dec shortly after having Covid on 12/14/24 it is not possible to determine that lack of offload the heel definitively resulted i worsening of the wound and causing actual harm to Resid E. We respectfully request your review of the documentation provided and consider amene F684 G severity to F684 D se as the observations during th survey do not support the fine of harm to this resident. We sincerely appreciate time and opportunity allowed.	ork ork of ent ions f load at s well ring lined ing n the ent ding everity e ding
F 0684 SS=G Bldg. 00	applies to all treat facility residents. I	a fundamental principle that ment and care provided to			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155809	B. Wl	NG	_	01/25/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF			10445 [DUPONT OAKS BLVD		
GREY S	TONE HEALTH & R	REHABILITATION CENTER		FORT \	WAYNE, IN 46845		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
		re that residents receive e in accordance with					
	•	dards of practice, the erson-centered care plan,					
	and the residents'						
		on, interview and record	F 06	501	F684 Quality of Care		02/16/2024
	review, the facility		1 00)0 4	1 What corrective action		02/10/2024
		d wound from resting directly			will be accomplished by thos		
	•	f 2 residents reviewed			residents found to have been		
		resulted in Resident E's wound			affected by the deficient	•	
	,	requiring antibiotics.			practice?		
	Findings include: On 1/24/24 at 11:01 A.M., Resident E was				Resident E was seen by the		
					wound nurse practioner on		
					1/26/24. Orders were initiated	for	
	observed seated in	a wheelchair next to her bed.			a wound culture as well as a		
	Her bare feet was in	n direct contact with the floor			change in treatment.		
	with no barrier. The	e right foot was wrapped with a			Resident E was screened by		
	gauze dressing fron	n the midfoot to above her			therapy for positioning on 2/8/	24.	
	ankle. Her right par	nt leg was pulled up and her			Resident E's wound preventio	n	
	calf was visible. Th	e exposed calf was red in color			interventions were reviewed for	or	
		ales of skin. The exposed			appropriateness by the Directo	or of	
		wollen, reddened with thick			Nursing on 2/8/24.		
		old non-skid strips beneath her					
		merous food and skin particles					
		d across the floor. The			2 How other residents		
		was stained and had no			having the potential to be		
	linens on it.				affected by the same deficien		
	0 1/04/04 + 1.00				practice will be identified and		
		P.M., the resident was observed			what corrective action will be	•	
		heelchair next to the bed. Black on and covered the forefoot			taken?		
	_	ght foot gauze dressing			Current residents and new		
	1	contact with the floor. Her bed			Current residents and new admissions who have arterial		
		edding. When questioned, the			ulcers have the opportunity to	he	
		he couldn't sit in the recliner			affected. Utilizing the Skin	ne	
		er feet because the path was			Alteration Audit tool the Direct	or of	
		her bed and window. She had			Nursing, Assistant Director of	01 01	
		the chair with her walker and			Nursing or Staff Development		
		vasn't safe for her to do this so			Coordinator will audit wound		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155809	B. W			01/25/	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		10445 [DUPONT OAKS BLVD		
GREY S	TONE HEALTH & R	REHABILITATION CENTER		FORT WAYNE, IN 46845			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		levate her legs. She indicated			orders and wound prevention		
	_	e of confusion "the other			interventions for appropriatene		
		she had been in another			This audit along with identified		
		ng antibiotics for her wound,			corrections will be completed	on	
		and indicated that could be			or before 2/16/24.		
	what was causing the						
	·	dent E was observed still					
		chair with feet in direct			3 What measures will be		
		and black socks pulled over			put into place and what	_	
		ppeared to be sleeping with			systemic changes will be ma	ide	
	her eyes closed.				to ensure that the deficient		
	On 1/25/24 at 0.57	A.M., Resident E was observed			practice does not recur?		
		chair with both feet flat on the			To manyout this facus as a commi		
		nt foot, she wore a sock over			To prevent this from reoccurri	-	
		he gauze dressing on her heel			the Director of Nursing, Assist Director of Nursing or Staff	anı	
		t contact with the floor. On her			Development Coordinator will		
		a blue slipper. She indicated			provide education to licensed		
		all night and felt confused at			nurses and nursing assistants		
		ned of having diarrhea again			utilizing Skin and Wound Care		
	_	as bare of linens. She indicated			Best Practices with an empha		
		vere going to get a stool			on wound prevention interven		
	_	infection due to the			and following physician orders		
	antibiotics she was				This education will be complete		
					on or before 2/16/24.		
	On 1/25/24 at 1:50	P.M., LPN 4 left the resident's					
	room carrying a sto	ol sample. She indicated staff					
		ident down after the resident			4 How the corrective acti	on	
	had a very large wa	tery stool and would return to			will be monitored to ensure t	the	
	the room to comple	te the resident's wound care.			deficient practice will not		
	-At 1:57 P.M., Resi	dent E was observed lying in			recur, what quality assuranc	е	
	bed with gray color	red skin. She indicated she			program will be put into place	e?	
	_	PN 4 and the LPN 5 (facility					
		assisted the resident to turn to			To monitor and maintain ongo	ing	
	_	up her leg pant. On the bed			compliance the Director of Nu	rsing	
	_	tht heel had sat, was red-brown			or Assistant Director of Nursin	-	
	_	e gauze dressing around the			will complete weekly audits fo		
	_	rated with red-brown drainage.			weeks then monthly for 4 mor		
		saturated dressing and a very			utilizing the Skin Alteration au	dit	
	large wound engulf	ing the entire swollen right			tool to ensure residents with		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED			ETED
		155809	B. W	ING		01/25/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			DUPONT OAKS BLVD		
GRFY S	TONE HEAI TH & F	REHABILITATION CENTER		FORT WAYNE, IN 46845			
	T		1		I		Γ
(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 APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		The wound was round and			arterial ulcers have appropriat	e	
		ches around. The wound bed			wound orders and prevention		
		n color and appeared very			interventions in place.		
		of the wound was an elevated			The results of the audits will b	е	
		ad skin tissue) cap, black in			forwarded to the facility QAPI		
		edge of the circular shaped			committee for further review a	nd	
		a of pale gray moist and soft			recommendations.		
		urrounding the entire wound					
	_	f thickened, dry and reddened			F Burning Co.		
		the resident toes. The wound had a strong foul odor. The			5 By what date the		
	_	•			systemic changes for each	•	
	_	eiven pain medication prior to			deficiency will be completed	7	
		e and denied pain during the			All and the improved a firm of the second		
	procedure.				All audits, in servicing, and	£1	
	0:- 1/24/24 -4 1:00	DM Desident Element			systemic changes will be in ef	Tect	
		P.M., Resident E's record was			by 2/16/24.		
	_	es included diabetes with					
		d peripheral vascular disease er to her right heel since 8/4/23.					
		one on 8/23/23, indicated the					
		l stenosis (blood vessels			Dear Reviewer:		
		d or blocked) to 3 arteries in her			On behalf of Grey Stone Heal	th	
	right leg.	of blocked) to 3 afteries in her			and Rehabilitation we respect		
	115111 105.				request an Informal Dispute	idily	
	There were no nurs	ing assessments of the wound	1		resolution with regard to the s	cone	
	available for review	_			and severity of F684, which w	•	
					cited in the above referenced	45	
	A quarterly MDS (Minimum Data Set)			survey.		
		1/29/23, indicated the resident					
		ted without cognitive	1		Introduction:		
		nd no behaviors or rejection of			We respectfully request that the	ne	
	_	nctional impairment to her			scope and severity for citation		
		remities but had impaired			F684 be decreased from a G		
		ess due to effects of childhood			to a D level for the complaint		
		very short distances using her			survey ending on 1/25/24.		
		air along with maximal	1		Allegation:		
		ff. She was dependent on staff			Based on review of clinical red	cords	
		aking off her footwear. She			and facility documentation, it v		
		r which was being treated.			determined that the facility fail		
					to prevent a non-pressure rela		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED				
		155809	B. W	WING		01/25/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			DUPONT OAKS BLVD		
GREV ST	TONE HEALTH & F	REHABILITATION CENTER			VAYNE, IN 46845		
	I SINE HEALING	C., GENTATION OF MILIT					
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG	ĭ	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Care plans were as	follows:			wound from resting directly on		
	40/4/00 5 11 11				floor. This resulted in Resider	nt	
		ad skin breakdown. The goal			E's wound becoming infected		
		her skin breakdown.			requiring antibiotics.		
		ded: turn and reposition as			Dispute:		
		reducing cushion to			Resident E admitted to the fac	cility	
	_	ssure reducing mattress; and			on 6/28/22. Resident E had		
	noat neets when in	bed as the resident allows.			doppler studies completed on		
	12/1/22 Dagidant	gith actual skin impairment, right			8/23/23 (Exhibit 1) and	nonio	
		vith actual skin impairment: right, surgical wound to top of			subsequently received a diagr of PVD. Resident E and Daug		
		associated skin disorder to			declined a referral to a vascula	•	
		was for areas to heal without			specialist (Exhibit: #2). In add		
	1	of infection. Interventions			to PVD Resident E has a dx o		
	, , ,	ed; complete skin checks and			diabetes type 2 with bilateral L	-	
		tocol; follow physician orders			neuropathy, lymphedema, as		
		idicated; refer to registered			as post-polio syndrome. Per th		
		ressure reducing devices as			wound Nurse Practioner state		
	indicated.				Resident E. will often request		
					be seated in her w/c and does		
	1/3/24-Resident wi	th infection to right heel ulcer:			routinely wish to elevate her le		
		e ulcer to heel. Interventions			to help reduce edema. All of the	_	
	included: assess for	pain every shift; encourage			co-morbidities have prevented		
	activity as tolerated	l; encourage to be out of bed			wound from improving (Exhibi		
		e medications and antibiotics			#3).		
	as ordered; monitor	the right heel ulcer; and notify					
	physician of change	es.			Per the Wound Nurse Praction	ner	
					(Exhibit #3), Resident E was c	nce	
		nt Detail Reports, dated			again seen on 1/26/24-despite	the	
		20, 11/27, 12/5, 12/11, and			recent antibiotics and Dakin's		
		the right heel wound had			treatment, wound was still not	ed	
		th daily treatment and dressing			to have an odor and wound		
		d remained approximately the			cultures were obtained. The		
	,	centimeters) by 6 cm with black			eschar cap was lifting quite a		
		age. The peri wound was			during this visit and was likely	due	
	consistently describ	ped as pink.			to the infectious process and		
					exacerbated by her PVD and		
	I -	nent Detail Report, dated			with neuropathy. She has bee		
	_	m., indicated the wound was			started on additional antibiotic		
	Letable but had light	serosanguineous (blood and	1		her infection to her heel wound	4	I

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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 00 B. WING 01/25/2024 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE serum) drainage with no odor. The resident was Per the Wound Nurse Practioner encouraged to elevate the right leg when able to. (Exhibit #3), despite appropriate medical care, her wound was A Wound Management Detail Report, dated likely to decline due to her PVD 1/2/24 at 7:56 p.m., indicated the wound had as well as her other co-morbidities purulent (pus) drainage, the peri wound was pink including a recent Covid 19 to red, with a mild odor. The medical NP was infection. notified and ordered lab work, an x-ray to be done of the right foot to check for a bone infection, and Resident E's wound was not a course of antibiotics. The resident was directly making contact with the encouraged to elevate the right leg when able to. floor as there was a multi-layer dressing (Dakin's moistened On 1/2/24 the medical NP ordered doxycycline (an gauze, folded abdominal pad antibiotic)100 mg po BID for 10 days. dressing, covering with layers of kerlix) on her foot causing a barrier A Wound Care note by the Wound NP (Nurse between the wound and the floor Practitioner), dated 1/3/24, indicated the resident at the time observations were had been seen for care of her chronic arterial made by the surveyor per the wound. The wound measured 6 cm by 6.5 cm and statement of deficiencies. was covered with an eschar cap that was starting (Exhibit: #4) to lift up with open edges to the wound. The wound had a small amount serosanguineous Resident E's wound was noted to drainage without odor and wound bed was 20% be stable from 10/30/23 through slough and 80% eschar. Assessment and Plan: 12/18/23. (Exhibit: #5). Resident x-ray of the foot was negative for osteomyelitis E tested positive for Covid on (bone infection) per LPN 5. Orders were given to 12/14/23 (Exhibit: #6) and on change the treatment and continue with the 1/3/24 shortly after having covid antibiotics as ordered by the house NP. The right the resident was noted with a heel was to be offloaded (pressure off of heel) at decline in the status of the wound all times. (Exhibit: #7). Per the Wound Nurse Practioner (Exhibit #3), Wound Management Detail Reports, dated 1/8/24 despite appropriate medical care, at 6:23 p.m. and 1/15/24 at 10:48 p.m., indicated the her wound was likely to decline right heel wound measured 6.5 cm by 7 cm with due to her PVD as well as her seropurulent drainage with mild odor. The other co-morbidities including a resident was encouraged to elevate the right leg recent Covid 19 infection. when able to. Resident E had an X-Ray to right A Wound Care note by the Wound NP, dated heel obtained on 1/2/24 (Exhibit

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1/19/24, indicated the resident's right heel wound

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#8). Wound NP visit on 1/19/24

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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 00 B. WING 01/25/2024 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 measured 6.5 cm by 7 cm and had a small amount incorrectly indicates X-Ray was of serosanguineous drainage with odor. The re-ordered by medical NP as well wound bed had 30% slough, 60% eschar and 10% as a venous ultrasound. Upon granulation tissue. Edges of the wound were open interview with wound NP (Exhibit and the eschar cap was lifting. Skin surrounding #3), Medical NP (Exhibit #11) and the wound was reddened and the wound was licensed nurse (Exhibit #10), worsening in size, increased drainage and wound wound NP verbally gave an order odor. Assessment and Plan: X-ray reordered by for an X-Ray and within an hour Medical NP as well as venous ultrasound. Medical NP clarified with wound Treatment to wound was changed and right leg NP that X-Ray was recently was to be offloaded at all times. obtained on 1/2/24 and there is no need to repeat. The licensed On 1/25/24 at 10:55 A.M., CNA 6 (Certified Nurse nurse entered a requisition in the Aid) was interviewed. They indicated the resident X-Ray software (Exhibit 9, page still walked with assistance to the bathroom but #1) and cancelled it (Exhibit 9, was very shaky and last week had almost fallen page #2) per follow up with the while being assisted. CNA 6 indicated the resident Medical NP. A physicians order wasn't able to sit in her recliner chair because she was never entered in Resident E's had to back up with the walker to get to the chair medical record. which was not safe. 1/20/24 - Macrobid ordered for UTI On 1/25/24 at 2:42 P.M., the Infection Control placing resident at higher risk for Nurse was interviewed. She indicated Resident E's further wound decline. (Exhibit: right heel wound and it's dressing should not be #12) sitting directly on the floor. 1/26/24 – Wound culture ordered. (Exhibit: #13) A current facility policy, titled "Skin and Wound 1/31/24 – Wound culture results Care Best Practices" was provided by the Director returned (Exhibit #14) and new of Nursing on 1/25/24 at 2:15 P.M., which stated: order received for Ceftriaxone x 7 "Skin Care and Pressure Injury Prevention: days (Exhibit #15) and Provide pressure reduction/redistribution for Levofloxacin for 7 days (Exhibit those at risk: offload/suspend heels for at risk #16) and probiotic ordered. residents...Pressure injuries and wounds will be treated with evidence-based interventions as Conclusion: ordered by the provider...All clinical staff will Grey Stone Health and receive education on pressure injury prevention Rehabilitation takes the care and and treatment...with focus on education staff in services of our residents very

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the importance of basic care such as skin care and

protection and pressure redistribution...."

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seriously and continues to work

diligently to ensure the safety of our residents. Due to Resident

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155809	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/25/2024		
NAME OF PROVIDER OR SUPPLIER GREY STONE HEALTH & REHABILITATION 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 LISC 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
	to heal, the goals ar and pressure and dr clean.	e to remove contact irritation essing should be kept dry and Complaint IN00425543.			E's comorbities, recent infection and refusal to consistently off R. Heel places this resident at high risk for wound decline as as delayed healing. Consider the wound was stable from 10/31/23 – 12/18/23 and decline shortly after having Covid on 12/14/24 it is not possible to determine that lack of offloading the heel definitively resulted in worsening of the wound and causing actual harm to Reside E. We respectfully request your review of the documentation provided and consider amending F684 G severity to F684 D seven as the observations during the survey do not support the finding of harm to this resident. We sincerely appreciate time and opportunity allowed.	well ing ned ng the ent	

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