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	02/25/2025

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 IN00452515. Complaint IN00452515 - Federal/state deficiencies related to the allegations are cited at F609 and F755. Survey date: February 25, 2025 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 78 SNF: 7 Total: 85 Census Payor Type: Medicare: 7 Medicaid: 65 Other: 13 Total: 85 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 26, 2025	F 0000	March 10, 2025 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 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to ensure an allegation of missing medication was reported for 1 of 3 residents reviewed (Resident B).	F 0609	**F609** **1.What corrective action(s) will be accomplished for those residents found to have been**	03/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria Diaz	HFA	03/10/2025

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	Findings include: A complaint, submitted to the Indiana Department of Health on 1/31/25, alleged Resident B had brought medications to the facility during his stay. The allegations included the medications were not returned to him upon discharge. While at the facility, he alleged he told nursing staff what medications he needed but they refused to give him any medication unless he brought in his home medications. He had someone go to his home and return with the medication. The home medication was given to a staff member to administer. The resident was then discharged home. After returning home, Resident B alleged he had been unable to find the 2 medications he had brought to the facility from home. Resident B notified the facility of the missing medications. The facility was unable to find the 2 missing medications brought from home. Resident B then contacted the sheriff's department and reported the 2 missing medications. The missiong medications were Nexium (for acid reflux) and Mitagare (brand name for Colchicine used to treat gout). Resident B indicated both medications (90 pills each) had been filled in December 2024. On 2/25/25 at 10:50 A.M., Resident B's record was reviewed. Diagnoses included fall with fractured right femur requiring surgical repair, gastro-esophageal reflux disease (GERD), and gout. The resident was admitted from the hospital for short-term rehabilitation services. A Medication Administration Record (MAR) dated January 2025, indicated the resident was administered Mitagare 0.6 mg-1 tablet by mouth daily on 1/23 and 1/24/25 for gout and the brand name Nexium daily on 1/23 and 1/24/25. The MAR		**affected by the deficient practice?** Resident B had an SRI submitted on 3/6/2025 related to the alleged missing medications. **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?** Residents who discharged from the facility will be interviewed by the Social Services Director utilizing the PCP Transitional Form to ensure they received the appropriate medications at time of discharge. This audit along with identified corrections will be completed on or before 3/10/25. **3. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Administrator and Director of Nursing were educated on the Indiana Resident Abuse Policy with an emphasis on reporting and conducting a through investigating by the Regional Director of Clinical Services. This education will be completed on or before 3/7/2025. **4. How the corrective action(s)**	

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	indicated both Mitagare and Nexium were from his home supply. On 2/25/25 at 11:05 A.M., Licensed Practical Nurse 5 (LPN) was interviewed. She indicated she had discharged the resident from the facility on 1/24/25. The resident had 2 bottles of medication, supplied from home, stored in the upper drawer of the secured nurses medication cart. 1 bottle was Mitagare 0.6 mg tablets and 1 bottle of Nexium 40 mg delayed release capsules. She removed the medications from the medication cart and placed them in a facility blue bag on the day of discharge. She indicated the resident had 2 of the facility blue bags filled with medications to take home with him. LPN 5 indicated she had gone over discharge instructions, including his medications, and told him when he was ready to leave, he could pick up the medication in the 2 blue bags sitting on the nurses desk at the nurses station. She was not at the nurse's desk when Resident B left the facility and did not see who had picked up the bags of medications. On 2/25/25 at 12:05 P.M., the Administrator was interviewed. She and the Director of Nursing (DON) had been made aware Resident B's 2 missing medications. On 1/28/25, the DON offered to replace his 2 missing medications becasue the facility had not found the Nexium or the Mitagare. Resident B did not accept the offer and did not return phone calls to the facility. The Administrator indicated staff hadn't known what happened to the 2 bottles of missing medications and she hadn't been aware medications had been left unsecured on the nurse's station desk when the medications had gone missing. She was notified by the manager on duty, on 2/1/25, a police report had been filed regarding the 2 missing medications and a police officer was in		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Utilizing the PCP Transitional Form, the Social Services Director will interview residents who discharged from the facility to ensure they received the appropriate medications at time of discharge. This audit will be completed weekly for 4 weeks then monthly for 5 months. The QAPI Committee will validate the actions are effective in resolving the cited issue and will continue to validate through the date of compliance and randomly thereafter to maintain compliance. **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 3/10/25.	

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	the building to follow up on the report. The Administrator indicated she had not reported the incident but should have according to the facility policy. A current facility policy, titled "Indiana Resident Abuse Policy", was provided by the Administrator on 2/25/25 at 10:45 A.M., and stated: "The facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone...Allegations of misappropriation of resident property must be reported immediately...The facility will contact the police for any allegation of misappropriation of resident property...Complete reporting per state specific procedure...." This Citation relates to Complaint IN00452515. 3.1-28(c)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure medications brought from home were reconciled and securely stored for 2 of 3 residents reviewed (Resident B and Resident F). Findings include: A complaint, submitted to the Indiana Department of Health on 1/31/25, alleged Resident B had brought medications to the facility, but the medications were not returned to him upon discharge. While at the facility, he alleged he told nursing staff what medications he needed but they refused to give him the medication unless he brought in his home medications. He had	F 0755	**F755** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B discharged from the facility on 1/24/2025. Resident F discharged from the facility on 2/4/2025. **2. How other residents having the potential to be affected by the same deficient practice will**	03/10/2025

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	someone go to his home, retrieve the medicaitons, return, and give the medications, Nexium (for acid reflux) and Mitagare (brand name for Colchicine used to treat gout) to a staff member. The resident was then discharged with his medications except for 2 he had brought from home. After returning home, Resident B alleged he had been unable to find the 2 medications and had erroneously been given a bag containing 22 bottles of another resident's medication (Resident F). The resident notified facility staff who went to his home to collect the bag of medications belonging to the other resident but were unable to find his 2 missing medications. Resident B then contacted the sheriff's department and reported the 2 missing medications. 1. On 2/25/25 at 10:50 A.M., Resident B's record was reviewed. Diagnoses included fall with fractured right femur requiring surgical repair, gastro-esophageal reflux disease (GERD), and gout. The resident was admitted from the hospital, following right hip replacement, for short-term rehabilitation services. Hospital discharge medication orders, dated 1/14/25, included Colchicine (Mitagare 0.6 mg oral capsule)-take 1 capsule by mouth daily for gout, Esomeprazole (Nexium 40 mg oral delayed release capsule, 1 capsule by mouth daily, brand name only) for GERD, and Pantoprazole 40 mg 1 tablet by mouth daily. A Nurse Practitioner (NP) note, dated 1/16/25 at 6:55 a.m., indicated the resident was seen for a post-hospital visit. The resident had gout and was prescribed Allopurinol and Colchicine daily, however, he indicated these 2 medications hadn't worked well and he needed the brand name of Colchicine, which was Mitagare, to manage his		**be identified and what corrective action(s) will be taken?** Residents who provide medications from home will have an audit completed by the DON or Designee utilizing the Medication Provided by Resident/Family Audit Tool. This audit along with identified corrections will be completed by the Director of Nursing or Nursing Manager on or before 3/10/25. **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 Designee will provide education to Licensed Nurses on the Medication brought into the facility policy as well as Delivery and Storage of medications and supplies policy. This education will be completed on or before 3/10/25. **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?** Utilizing the Medication Provided by Resident/Family Audit Tool the	

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	gout. The plan was to continue Allopurinol and Colchicine for gout and discontinue Nexium as he was also prescribed Pantoprazole which was duplicate therapy. An NP note, dated 1/20/25 at 7:15 a.m., indicated the resident was seen for a 2nd post-hospital visit. Resident B complained about not having Mitagare to treat his gout and his left lower extremity was beginning to hurt. He indicated if he went 7 days without that medication, he would want to cut his leg off because of the pain. The resident took Allopurinol and Colchicine daily but had indicated the Colchicine was ineffective. The change from Mitagare to the generic Colchicine was due to a pharmacy interchange but if he had Mitagare at home, he could bring it to the facility and staff would administer. Additional concerns he had was about the Nexium he was taking for GERD. He indicated he was getting Omeprazole 1 tablet but required 2 to equal the strength of Nexium (he was prescribed pantoprazole and nexium at the facility). Nexium was to be discontinued and the Pantoprazole continued. The plan indicated if the resident was able to provide Mitagare, the order could be changed from Colchicine (generic) to Mitagare (brand name). A nurse note, dated 1/20/25 at 9:30 a.m., indicated Resident B had been refusing Colchicine because it wasn't "the correct medication". He refused the generic form of Nexium and indicated he needed the brand name of these medications. A Medication Administration Record (MAR) dated January 2025, indicated the resident had been prescribed and had taken Colchicine and generic Nexium daily on 1/15, 1/16, 1/17, 1/18, 1/19, 1/21 and 1/22/25 and had refused on 1/20/25 after stating they were not the correct medications. He		Director of Nursing or designee will audit residents who provide medication from home to ensure they were reconciled and are stored appropriately. This audit will be completed weekly for 4 weeks then monthly for 5 months. The QAPI Committee will validate the actions are effective in resolving the cited issue and will continue to validate through the date of compliance and randomly thereafter to maintain compliance. **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 3/10/25.	

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	was administered Mitagare 0.6 mg-1 tablet by mouth daily on 1/23 and 1/24/25 and the brand name Nexium daily on 1/23 and 1/24/25. The MAR indicated both Mitagare and Nexium were from his home supply. Resident B's medical record did not indicate when his home supply of Mitagare and name brand Nexium had been brought into the facility nor amount of medication he supplied from home. On 2/25/25 at 11:05 A.M., Licensed Practical Nurse 5 (LPN) was interviewed. She indicated she had discharged the resident from the facility on 1/24/25. The resident had 2 bottles of medication stored in the upper drawer of the secured nurses medication cart. 1 bottle was Mitagare 0.6 mg tablets and 1 bottle was Nexium 40 mg delayed release capsules. She removed the medications from the medication cart and placed them in a facility blue bag on the day of discharge. She indicated the resident had 2 of the facility blue bags filled with medications to take home with him. She didn't know when the bottles of medication had been brought in or how much medication had been in the bottles. LPN 5 indicated she had gone over discharge instructions, including his medications, and told him when he was ready to leave, he could pick up the medication in the 2 blue bags sitting on the nurses desk at the nurses station. She did not indicate what time she had gone over the discharge instructions or when the blue bags containing medications had been placed on the nurses desk. LPN 5 indicated next to Resident B's 2 blue bags, was a Walmart bag filled with an unknown number of bottles of Resident F's medications, brought from Resident F's home. The bag of medications was being picked up by Resident F's family member. LPN5 indicated she			

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	was not at the nurse's desk when Resident B left the facility and did not see who had picked up the bags of medications. She indicated all 3 bags were removed. A progress note, dated 1/24/25 at 6:28 p.m., indicated Resident B had discharged with a friend, all his belongings and medications sent home with him. Refer to F609. 2. On 2/25/25 at 3:12 P.M., Resident F's record was reviewed. Diagnoses included chronic pain syndrome and weakness. Prior to admission, she'd been hospitalized for acute respiratory issues and was receiving rehabilitation services with plans to go back home. Neither Resident F's progress notes nor admission assessments indicated home medications had been brought to the facility. An MAR, dated January 2025, listed medications prescribed and administered by staff. The MAR did not indicate any medications were from Resident F's home supply. Progress notes, dated 1/17/25 through 2/4/25, did not indicate home supplied medications had been returned to the resident. Resident F's record did not indicate Resident F's home medications had been erroneously given to another resident discharged home. A discharge assessment, dated 2/4/25, did not indicate home supplied medications had been returned to the resident. Resident F's record did not indicate her home medications had been erroneously given to another resident discharged home.			

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	On 2/25/25 at 12:05 P.M., the Administrator and Assistant Directors of Nursing (ADON 8 and ADON 9) were interviewed. The Administrator indicated staff didn't know what happened to Resident B's 2 bottles of missing medications and she wasn't aware 3 bags of medications had been left unsecured on the nurse's station desk. Both ADON's indicated neither Resident B's nor Resident F's medications should've been left unsecured at the nurses station. Medications brought in from home by residents were to be documented in the resident record when received, when returned to the resident, and kept securely stored. ADON 8 indicated there had been no documentation in the record of the number of medications placed in a bag to be returned to Resident F's family. The Administrator indicated she had been notified of the missing medications reported to the sheriff's office. Prior to being notified of the police report, she indicated, on 1/28/25, the Director of Nursing (DON) had picked up Resident F's medications from Resident B's home and the facility offered to pay for the missing medications but had received no response from the resident. Current facility pharmacy policies, provided by the Administrator on 2/25/25 at 10:45 A.M., indicated the following: -"Medication Brought into the Facility" policy stated: "Procedure: Facility staff should not administer medications...brought to facility by a resident...without physician/prescriber's order...Facility staff should return any unused medications brought into the facility by the resident...to the resident's family...A facility nurse should store unused non-controlled substance medications securely...."			

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	-"Loss or Theft of Medications" policy stated: "Where facility staff suspect theft or loss of medications, staff should take such actions as required by applicable law and facility policy. Appropriate actions may include, without limitation: 1. Immediately reporting suspected theft of loss of drugs to supervisor/manager or Director of Nursing for appropriate investigation and follow up; and 2. Investigating and reconciling discrepancies...." This Citation relates to Complaint IN00452515. 3.1-25			