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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grey Stone Health & Rehabilitation Center	10445 Dupont Oaks Blvd Fort Wayne, IN 46845

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37147 Based on interview and record review, the facility 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 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. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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., 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-37