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	12/06/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37147 Based on interview and record review, the facility failed to ensure an allegation of abuse and injury of unknown origin was reported for 1 of 3 residents reviewed for abuse (Resident F). Findings include: An anonymous complaint, reported to the Indiana Department of Health, dated 11/12/24, alleged Resident F had been hit by a visitor and was found with a black eye the following day. On 12/6/24 at 1:15 P.M., Resident F's record was reviewed. Diagnoses included vascular dementia with agitation, impulsiveness, delusional disorder, anxiety disorder, and major depressive disorder. She resided on the secured memory care unit. 1. A nurse progress note, dated 10/20/24 at 5:00 p.m., indicated a nurse manager notified the floor nurse Resident F had wandered into another resident's room and was hitting their visitor on the shoulder. In response, the visitor grabbed Resident F's shoulder to get her out of the room. The situation was reported to the Administrator and witness statements were obtained by the nurse manager. Witness statements indicated: -On 10/20/24 at unknown time, the Minimum Data Set (MDS) nurse was asked to go to the secured memory care unit after reports Resident F had been hit by another resident's visitor. The MDS nurse went to the peer's room and spoke with the visitor who confirmed the events. The visitor indicated they had stepped between the 2 residents when Resident F entered the room. Resident F hit the visitor on the shoulder. The visitor told Resident F not to hit and leave the room. Resident F hit the visitor on the other shoulder. The visitor then grabbed Resident F by the shoulders and removed her from the room. Resident F had no observed injuries at the time and continued to roam the halls without issues. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/20/24 at unknown time, a peer's visitor wrote he had been near the door of his loved one's room, when Resident F moved the STOP sign banner across the doorway and came into the room, directly in front of him. The visitor told the resident to leave as did the other resident. Resident F hit the visitor in the left chest/shoulder. The visitor told her Do not hit me-leave. Resident F hit him in the right chest/shoulder in response. The visitor grabbed Resident F's upper arms near her shoulders, moved her backwards towards the door and told her to leave. The resident left the room and went across the hall. There was no further documentation completed, no reporting the incident as required, nor further investigation of the incident. In an interview, on 12/6/24 at 1:51 P.M., the MDS nurse indicated on 10/20/24, he told the nurse who documented the incident in the resident's record and reported the incident to the Administrator. 2. On 10/21/24 at 7:00 a.m., a nurse progress note indicated Resident F had been observed with a 1 inch laceration above her right eye and a 2 inch skin tear on her right hand above her thumb. Both areas were cleansed but the resident was observed to get frustrated with first aid attempts. Resident F showed no signs of distress or discomfort but was unable to tell nurse how the injuries occurred and she'd had no recent falls. A Focused Head to Toe Observation, dated 10/21/24 at 12:09 p.m., indicated Resident F was involved in a possible altercation. During the assessment, the resident was anxious/nervous/restless. She had right eyelid bruising, a scrape in her eyebrow, and right wrist skin tear. There was no further documentation indicating the incident had been reported, the cause of the resident's injuries nor was the resident able to tell staff how the injuries had occurred. On 12/6/24 at 3:30 P.M., the Administrator indicated both incidents should have been reported to her immediately as well as the State agency, and investigations started. A current policy, titled Indiana Resident Abuse Policy, was provided by the Administrator on 12/6/24 at 11:00 A.M. which indicated the following: It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, and exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy .Abuse includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse includes .verbal abuse, physical abuse .and injuries of unknown origin .Injury of unknown source is when both the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident AND b. The injury is suspicious because of the extent of the injury, location of the injury .All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source .must be reported immediately to the Administrator, Director of Nursing and to the applicable State Agency .Protect the Resident .If a person not on staff is accused of Abuse .the facility will take action to protect the resident including, but not limited to, contacting the third party and addressing the issue directly with him/her, preventing access to resident during the investigation, and/or referring the matter to the appropriate authorities (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Citation relates to Complaint IN00447189. 3.1-28(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37147 Based on interview and record review, the facility failed to ensure a thorough investigation of allegation of abuse and injury of unknown source was completed for 2 of 3 residents reviewed for abuse (Resident F and Resident G). Findings include: An anonymous complaint, reported to the Indiana Department of Health, dated 11/12/24, alleged Resident F had been hit by a visitor and was found with a black eye the following day. On 12/6/24 at 1:15 P.M., Resident F's record was reviewed. Diagnoses included vascular dementia with agitation, impulsiveness, delusional disorder, anxiety disorder, and major depressive disorder. She resided on the secured memory care unit. An annual Minimum Data Set (MDS) assessment, dated 9/6/24, indicated Resident F had severely impaired cognition and rarely spoke. She had behaviors of inattention continually present and disorganized intermittant thinking behaviors which changed in severity. Staff assessment of her mood indicated she had little interest or pleasure in doing things, trouble concentrating, and trouble falling asleep almost daily. She had no wandering behaviors, no verbal or physical behaviors, and had not rejected care. She was independent with eating, walking and transfers, had no falls in the past 3 months, required maximal assistance with personal hygiene and bathing, and was dependent for toileting and dressing. Care plans, revised on 12/5/24 and 12/6/24, included: -Psychosocial well-being: Resident F resided on a secured unit due to dementia. She exhibited exit seeking tendencies, was an elopement risk, and had episodes of wandering in and out of others room at times, were difficult to redirect. Interventions included: attempt to redirect when wandering; encourage daily participation in activities and social events; and encourage family visits. -Behavioral symptoms: The resident was at risk for elopement and wandering. She wandered without purpose, wandered into other resident rooms, and disregarded STOP signs across other residents doorways. Interventions were to keep resident occupied; calmly redirect her; divert her attention; and relocate her to a different area. A nurse progress note, dated 10/20/24 at 5:00 p.m., indicated a nurse manager notified the nurse Resident F had wandered into another resident's room and hit their visitor in the shoulder. In response, the visitor grabbed Resident F's shoulder to get her out of the room. The situation was reported to the Administrator. Witness statements were obtained by the nurse manager from the visitor and staff present. Witness statements indicated: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/20/24 at unknown time, the MDS nurse was approached by Certified Nurse Aide 2 (CNA) and asked to go to the secured memory care unit. CNA 2 indicated Resident F had hit Resident G's visitor. Resident G's visitor removed Resident F from the room by grabbing her shoulders. CNA 2 went into Resident G's room to find out what happened when the visitor re-enacted the incident by grabbing CNA 2's shoulders. CNA 2 told the visitor not to touch her but he still grabbed her by the shoulders. The MDS nurse went to Resident G's room and spoke with the visitor who confirmed the events. The visitor indicated they had stepped between Resident G and Resident F when she entered the room. Resident F hit the visitor on the shoulder and was told not to hit and leave the room. Resident F hit the visitor on the other shoulder and then the visitor grabbed her by the shoulders and removed her from the room. Resident F had no observed injuries at the time and continued to roam the halls without issues. -On 10/20/24 at unknown time, Resident G's visitor wrote he had been near the door of Resident G's room, when Resident F moved the STOP sign banner across the doorway and came into the room, directly in front of him. The visitor told the resident to leave as did Resident G. Resident F hit the visitor in the left chest/shoulder. The visitor told her Do not hit me-leave then she hit him in the right chest/shoulder. The visitor grabbed Resident F's upper arms near her shoulders, moved her backwards towards the door and told her to leave. The resident left the room and went across the hall. There was no further documentation completed regarding further investigation of the incident including protection of Resident F or others who could wander into Resident G's room. Confidential interviews, conducted during the survey, indicated Resident G's visitor had grabbed the resident by the shoulders and moved her backwards towards the door. The visitor had not put Resident G's call light on nor summoned staff for help. After the incident, Resident G's visitor was not asked to leave the facility nor were his visits restricted. Visitors were not allowed to grab or push residents around when visiting the facility. Action of grabbing or pushing could be indicative of abuse. There was no documentation completed from 10/20/24 at 5:00 p.m. until 10/21/24 at 7:00 a.m. when a nurse note indicated Resident F had been observed with a 1 inch laceration above her right eye and a 2 inch skin tear on her right hand above her thumb. Both areas were cleansed but the resident was observed to get frustrated with first aid attempts. Resident F showed no signs of distress or discomfort but was unable to tell nurse how the injuries occurred and she'd had no recent falls. The Assistant Director of Nursing (ADON) and Medical Nurse Practitioner (NP) were notified. A Focused Head to Toe Observation, dated 10/21/24 at 12:09 p.m., indicated Resident F was involved in a possible altercation. During the assessment, the resident was anxious/nervous/restless. She had right eyelid bruising and scrape in her eyebrow, and right wrist skin tear. A nurse progress note, dated 10/21/24 at 3:31 p.m., indicated an order was given to apply steri-strips to the resident's skin tear on her right wrist. The scrape above her right eye was superficial and left open to air. A Wound Care NP progress note, dated 10/22/24 at 11:49 a.m., indicated the resident was seen following a fall and sustaining abrasions. She was pleasantly confused and wandered around the memory care unit. Her right eye was dark purple and blue around the rim with slight swelling noted. She had a right lateral skin tear with wound edges flat and attached. Assessment/Plan: Right hand skin tear-okay to leave open to air. Right orbital (eye) hematoma-staff to monitor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note, dated 10/22/24 at 5:23 p.m., indicated bruising to the resident's right eye remained purple in color and she denied pain/discomfort. A Psychiatric NP progress note, dated 10/22/24 at 7:19 p.m., indicated Resident F was seen for follow-up. She was observed wandering the unit and intruding into other resident's rooms. Despite multiple attempts by staff, she'd been difficult to redirect. The Assessment/Plan was Unspecified fall: The resident recently had an unwitnessed fall, likely due to her impulsivity and intrusive wandering. It was unclear exactly what happened during the incident. The Psychiatric NP progress note didn't indicate the resident had been involved in an altercation with a visitor prior to her injuries being observed or if the 2 incidents were related. A Interdisciplinary (IDT) note for skin integrity, dated 10/24/24 at 12:15 p.m., indicated Resident F had returned from a walk during mealtime with a laceration above her right eye and right hand. Steri-strips were applied to the right wrist skin tear. Her right forehead scrape was superficial and left open to air. Resident F had no signs of psychosocial distress; continued to walk, pace, and participate in activities of choice. The IDT note didn't include an investigation of the injury of unknown origin nor mention of the altercation between Resident F and the visitor on 10/20/24. There was no documentation to indicate Resident F had been assessed for injury following the incident and being grabbed on the shoulders by a visitor. On 12/6/24 at 2:30 P.M., the ADON was interviewed. She indicated the altercation between Resident F and Resident G's visitor had not been reported to her as documented in the record. She had been told of the injury to the resident's right eye and wrist and had called the night shift nurse on 10/21/24 at 1:30 p.m. to see if the nurse had seen any injuries to the resident or if she had fallen through the night. The night shift nurse indicated she hadn't seen any injuries or skin issues and staff hadn't reported any to her. Resident F had laid on a recliner chair in the dayroom for most of the night and had no known falls. She was unaware of any further investigation into either incident. On 12/6/24 at 2:50 P.M., Licensed Practical Nurse 3 (LPN) was interviewed. She indicated she served as the facility's in-house wound nurse. On Monday, 10/21/24, she had gone to the memory care unit to see if the nurse needed any assistance. She observed Resident F with a black eye which looked as if someone had hit the resident which had shocked her. The nurse, on duty, had indicated she saw it when she first arrived to the facility that morning, had immediately reported it to the Assistant Director of Nursing (ADON) and medical NP. LPN 3 indicated, late morning, she had been asked to perform a head to toe skin assessment which she had done with staff assistance. She indicated it had been very brief because of the resident's resistance to having her clothes removed. She observed Resident F with a black/purple right eye with a swollen eyelid. She had an abraised area in her right eyebrow which measured 0.2 centimeters (cm) by 0.1 centimeters. A skin tear to her right wrist, measured 2 cm by 0.2 cm, was cleansed, steri-strips applied followed by antibiotic ointment. She indicated she hadn't been told how the resident got the injuries nor been involved in investigating their cause. LPN 3 had not known about the altercation on 10/20/24 between the resident and Resident G's visitor, but hadn't seen any bruises on the resident's arms during her brief assessment. On 12/6/24 at 3:30 P.M., the Administrator indicated both incidents should have been investigated immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Indiana Resident Abuse Policy, was provided by the Administrator on 12/6/24 at 11:00 A.M. which indicated the following: It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, and exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy .Abuse includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse includes .verbal abuse, physical abuse .and injuries of unknown origin .Injury of unknown source is when both the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident AND b. The injury is suspicious because of the extent of the injury, location of the injury .All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source .must be reported immediately to the Administrator, Director of Nursing and to the applicable State Agency .Once the Administrator and DOH are notified, an investigation of the allegation or suspicion will be conducted .The person investigating the incident should generally take the following actions: Interview the resident, accused, and all witnesses .If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift. For Injuries of Unknown Source, the investigation will generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well. Obtain written statements from the resident, if possible, the accused, and each witness . Documentation: Evidence of the investigation should be documented This Citation relates to Complaint IN00447189. 3.1-28(c)