

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grey Stone Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37147</p> <p>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).</p> <p>Findings include:</p> <p>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 missing 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.</p> <p>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.</p> <p>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 indicated both Mitagare and Nexium were from his home supply.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 because 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 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.</p> <p>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</p> <p>This Citation relates to Complaint IN00452515.</p> <p>3.1-28(c)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>37147</p> <p>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).</p> <p>Findings include:</p> <p>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 someone go to his home, retrieve the medications, 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.</p> <p>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.</p> <p>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.</p> <p>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 gout. The plan was to continue Allopurinol and Colchicine for gout and discontinue Nexium as he was also prescribed Pantoprazole which was duplicate therapy.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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).</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Neither Resident F's progress notes nor admission assessments indicated home medications had been brought to the facility.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Current facility pharmacy policies, provided by the Administrator on 2/25/25 at 10:45 A.M., indicated the following:</p> <p>-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</p> <p>-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 or loss of drugs to supervisor/manager or Director of Nursing for appropriate investigation and follow up; and 2. Investigating and reconciling discrepancies</p> <p>This Citation relates to Complaint IN00452515.</p> <p>3.1-25</p>		