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	03/31/2025

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 1 of 3 residents reviewed were assessed and findings reported to the physician related to a change in condition. (Resident C). Findings include: On 3/31/25 at 10:23 A.M., Resident C's record was reviewed. Diagnoses included colostomy status, recurrent small bowel obstructions and congestive heart failure (CHF). A hospital note, dated 9/17/24, indicated the resident had been sent to the hospital with symptoms of abdominal pain, distention, and nausea developed the morning of 9/6/24. The resident denied vomiting but had indicated output in her colostomy bag had abruptly stopped. A CT scan indicated the resident had a small bowel obstruction in the right lower abdomen. She was admitted to the hospital for treatment of the obstruction. Medical records indicated she had a left hemicolectomy (removal of left side bowel) with a colostomy due to a perforated bowel (years prior) and had been treated for a small bowel obstruction on 3/17/23 and 5/24/24. A hospital Emergency Department (ER) Provider Note, dated 3/24/25 at 6:32 a.m., indicated Resident C, had a history of CHF requiring continued oxygen use at 2 liters per minute by nasal cannula, colostomy with multiple abdominal surgeries and recurrent small bowel obstructions. Resident C came to the ER for nausea, vomiting and shortness of breath. The resident had complained of increased fatigue and decreased oral intake. Physical exam indicated Resident C was ill-appearing, was positive for confusion, had dry mucous membranes, fast heart and respiratory rates, decreased blood pressure, abdominal distention, and tenderness over the right side of her abdomen. CT x-rays of her chest, abdomen, and pelvis indicated the resident had right sided pneumonia and small bowel obstruction. Resident C was admitted to the medical intensive care unit (ICU) with acute illness that posed a threat to her life and bodily functions. A hospital Discharge Summary, dated 3/25/25 at 1:17 p.m., indicated the residents' condition worsened with respiratory and circulatory failure and she passed away. The final discharge diagnosis and cause of Resident C's death was small bowel obstruction. An annual Minimum Data Set (MDS) assessment, dated 1/3/25, indicated Resident C had no cognitive impairment and no behaviors of rejecting care. She had a colostomy with no constipation. Care plans indicated: (continued on next page)

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

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	03/31/2025

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	-Revised 2/15/25: the resident was at risk for impaired skin integrity as she required a colostomy related to history of colon resection due to cancer. The goal was to maintain the skin integrity around the stoma and have no signs or symptoms of complications related to the colostomy. Interventions included: monitor skin for irritation around the stoma; empty and cleanse the ostomy pouch on a routine basis; and change the colostomy bag as ordered. The care plan did not indicate specific signs and symptoms for staff to monitor related to identification of small bowel obstructions such as nausea, vomiting, abdominal pain, or lack of output in her colostomy pouch. Physician orders for routine medications to maintain bowel function and prevent constipation/lack of stool in the colostomy pouch were: -Miralax powder 17 grams by mouth 3 times per day. -Linzess 72 micrograms by mouth 1 time per day. -Senna laxative 8.6 milligram tablet by mouth 2 times per day. A Medication Administration Record (MAR), dated March 2025, indicated Resident C's colostomy bag was to be changed 1 time every 3 days and skin barrier appliance changed 1 time every 7 days. Documentation indicated the bag and skin barrier changes were completed as ordered. A Nurse Practitioner (NP) progress note, dated 3/7/25 at 6:27 a.m., indicated Resident C was seen for chronic illness management. The resident indicated stool output in her colostomy was normal without any issues. An NP progress note, dated 3/17/25 at 8:36 a.m., indicated Resident C was seen for pain management and follow up of routine labs. The resident had chronic pain in her back, legs and abdomen relieved with her routine prescribed medications. The resident had a colostomy and denied any changes with stool output due to narcotic medication use. Prescriptions for Lyrica-used to manage neuropathic pain and Tramadol-used on as needed basis for pain, were given and refilled. There were no further NP progress notes or nurse progress notes from 3/18/25 through 3/23/25. Bowel movement records, dated 3/20/25 at 11:32 a.m. indicated Resident C had a medium amount of stool in her colostomy bag. On 3/21, 3/22, 3/23, and 3/24/25, the records indicated there was no stool in her colostomy bag. A nurse progress note, dated 3/24/25 at 3:49 a.m., indicated at 2:15 a.m., Resident C had been having nausea and vomiting for the past 24 hours. She had been administered Zofran (anti-nausea/vomiting medication) per as-needed orders, but it had not been effective. The resident was weak, skin pale and cool to touch, and she had no stool in her colostomy bag since 3/23/25. Her blood pressure was low at 99/56, pulse 99, respirations 24, and her oxygen saturation was 85% (normal oxygen saturation is >90%) with oxygen on at 3 liters per minute per nasal cannula. The resident requested to go to the hospital. The on-call NP was notified and orders given to transport to the hospital. The EMS arrived at 2:45 a.m. and the resident transported to the hospital. (continued on next page)

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	03/31/2025

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	On 3/31/25 at 12:45 P.M., Qualified Medication Aide (QMA) 2 was interviewed. She indicated she had worked on 3/22/25 and 3/23/35, 10:00 p.m. to 6:00 a.m. During those 2 nights, she cared for Resident C who had been ill with nausea and vomiting. QMA 2 indicated she had been told the resident had been vomiting since Friday 3/21/25 but hadn't wanted to go to the hospital. Resident C had a large emesis on the morning of 3/23/25. It was reported to her, when she returned to work, the resident had continued with vomiting all day on 3/23/25. She reported the vomiting to the nurse in charge. On 3/31/25 at 1:00 P.M., QMA 4 was interviewed. She indicated she had worked 3/21, 3/22, and 3/23/25. On 3/21/25, she worked 10:00 to 6:00 a.m. and was told in report, Resident C had begun vomiting earlier in the day. During her shift on 3/21/25, Resident C had a small emesis colored like spit or sputum. On 3/22/25, she began her shift at 6:00 p.m. and worked until 6:00 a.m. 3/23/25. In report at the beginning of her shift, the off-going QMA 2 reported the resident was still vomiting and had been given Zofran by Licensed Practical Nurse (LPN) 7 earlier in the day 3/22/25. QMA 4 indicated she'd intended to give the resident more Zofran for the nausea but hadn't found an order for the medication. QMA 4 returned on 3/23/25 for night shift but had not worked with Resident C as she was scheduled on another wing. On 3/31/25 at 2:00 P.M., LPN 7 was interviewed. She indicated she worked on 3/22/25 and 3/23/25, from 6:00 a.m. until 6:00 p.m. When she received report on 3/22/25, she had not been informed Resident C had been vomiting or had been sick. On 3/22/25, at approximately 3:00 p.m., Resident C reported to LPN 7, she wasn't feeling good and wanted to lie down. On 3/23/25, she was told in report the resident had vomited 1 time during the night. During her shift (6:00 a.m. to 6:00 p.m.) on 3/23/25, Resident C had 2 more episodes of vomiting. LPN 7 indicated she had not contacted the on-call NP but had put a note in the NP's folder to be seen on Monday. When questioned, LPN 7 indicated she had not been aware the resident had a history of small bowel obstructions as she was new to the facility. She indicated she had not administered Zofran to the resident becasue the resident had no orders for the medication. On 3/31/25 at 2:07 P.M., LPN 9 was interviewed. She indicated she worked 3/22/25 and 3/23/25, on the night shift (6P-6A). She was scheduled to work on the memory care unit but was responsible for covering the QMA's scheduled on the other hall. She indicated QMA 2 reported to her Resident C had been vomiting over the past 2 days and was ill. LPN 9 assessed the resident and obtained her vital signs. Resident C was very ill and when asked, agreed to go to the hospital. LPN 9 indicated, she reported the information to the on-call NP and hospital staff the resident had been sick with nausea and vomiting the past 24 hours; she had no stool in her colostomy bag; and had been given as needed Zofran as ordered, which had not been effective in relieving the resident's symptoms. On 3/31/25 at 3:53 P.M., the Assistant Director of Nursing (ADON) was interviewed. She indicated she had not been made aware of Resident C being ill with nausea and vomiting, only that she had been sent to the hospital. When questioned, the ADON indicated the NP/Physician should have been notified immediately of the resident's symptoms due to her previous small bowel obstructions resulting in hospitalization s. A current facility policy, titled Resident Change in Condition was provided, on 3/31/25 at 4:00 P.M., by the ADON which indicated the following: (continued on next page)

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	03/31/2025

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	Resident Change in Condition: The nurse will recognize and intervene in the event of a change in resident condition. The physician and family will be notified as soon as the nurse had identified the change in condition and the resident is stable. A Significant change of condition is a decline or improvement in the resident's status that 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention; and/or one that 2. Impacts more than one area of the resident's health status This Citation relates to Complaint IN00456458. 3.1-37