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	10/24/2025

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure residents were adequately assessed and provider lab orders followed up on timely after a resident change in condition. The deficit practice resulted in a resident's need for hospitalization for gastrointestinal bleed and blood transfusion for 1 of 3 residents reviewed (Resident L).Findings include:A report, dated 10/16/25, alleged Resident L had a change in condition for several weeks. His condition was not assessed and charted on daily, and he was not followed closely. He had been given several IV's (intravenous fluids) and eventually was sent to the hospital for evaluation. On 10/22/25 at 12:09 P.M., Resident L's record was reviewed. Diagnoses included atrial fibrillation, chronic obstructive pulmonary disease (COPD), and dementia. A quarterly Minimum Data Set (MDS) assessment, dated 9/2/25, indicated Resident L had moderately impaired cognition. He had no mood indicators or behaviors. He was non-ambulatory and required maximum assistance with his activities of daily living (ADL). He was not receiving supplemental oxygen therapy. A care plan, dated 8/7/25, indicated Resident L was at risk for bleeding due to use of blood-thinners (anticoagulant) to treat his atrial fibrillation. The goal was for the resident to be free from signs of abnormal bleeding or bruising. Interventions included: administer medications as ordered, monitor labs as ordered, report results to the physician, and monitor for bleeding or bruising. A current physician order, dated 4/21/23, was for Eliquis (anticoagulant) 2.5 milligram tablets; give 1 tablet by mouth 2 times per day for paroxysmal (intermittent) atrial fibrillation. Progress notes indicated:On 9/24/25 at 10:30 a.m., a contracted NP was notified of the residents' weakness and moist breath sounds. New orders were given to check his labs including a complete blood count (CBC) to be done STAT (immediately). At 4:44 p.m., the hospital lab results were reported, to the NP and the resident's hemoglobin (Hgb-carries oxygen from lungs to body tissues and muscle) level was 8.4 g/dL. (Normal Hgb blood levels are 14.0-18.0 g/dL). At 11:35 p.m., Resident L was found sitting on the floor in a large amount of black tarry stool. The on-call contracted NP was notified and orders given for a STAT CBC. There was no documentation the STAT CBC lab, ordered on 9/24/25 at 11:35 p.m., was completed nor were results of the lab in the record. On 9/26/25 at 12:35 p.m., the resident was seen by the contracted NP. Resident L continued with a moist cough, need for supplemental oxygen, and poor oral intake. He had been treated during the week for acute kidney failure. A chest x-ray showed moderate heart enlargement but no pneumonia. Treatment was started for COPD exacerbation with antibiotics and steroids. Staff reported poor oral intake. The plan was to give 2 liters of normal saline subcutaneous (under the skin) at 100 ml/hr., encourage fluid intake, and continue with as needed supplemental oxygen. The NP recommended repeating labs over the weekend (9-27 and 28) and giving more fluids as needed. Continue monitoring changes in breathing or wheezing. There was no order written to repeat labs over the weekend. There were no assessments or documentation of Resident L's condition completed on 9/27/25. On 9/28/25 at 9:38 p.m., Resident L's condition was improving. He was more alert, had good oral intake and his vital signs were stable. There were no assessments or documentation of Resident L's condition completed on 9/29/25. On 9/30/25 at 6:14 p.m., the on-call contracted NP was notified of Resident L's abnormal lab of a critical Hgb level of 5.8. Orders were given to call 911 and transfer the resident to the hospital for blood transfusion and evaluation. There was no assessment or documentation completed to indicate Resident L had a change/decline in condition on 9/30/25. A contracted on-call NP communication, dated 9/30/25 at 9:33 p.m., indicated Resident L was admitted to the hospital with a gastrointestinal bleed, anemia, and acute kidney failure. On 10/23/25 at 1:23 P.M., the Director of Nursing (DON) was interviewed. She indicated she wasn't sure why labs had been drawn on 9/30/25 and wasn't able to find orders for the lab draw. When questioned, she indicated she was unable to locate STAT lab results ordered 9/24/25 at 11:35 p.m. The facility contracted with a lab who were supposed to draw routine labs, run the labs, and report results to the facility. For STAT labs, the contracted lab was to draw the labs but take the blood to the hospital to be processed and reported. On 10/23/25 at 2:25 P.M., the contracted NP was interviewed. She indicated she had been monitoring Resident L's labs for some time, especially his WBC (white blood count) for infection due to his acute illness over the past month. Resident L's hemoglobin level chronically trended between 8-10; below the normal hemoglobin level of 14.0-18.0 g/dL. She indicated labs had been drawn during the day on 9/24/25 due to the residents' continued weakness and respiratory symptoms. She reviewed the lab results reported by the lab at 2:45 p.m. via secured hospital electronic medical records. She hadn't been made aware STAT labs had been re-ordered the evening of 9/24/25 following the resident's passage of black tarry stool and had

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a dependent resident at risk for pressure ulcers, was provided timely care and services to prevent development and worsening of a newly identified pressure ulcer for 1 of 3 residents reviewed. The resident was not provided care over an entire shift resulting in a deep tissue injury which progressed to an unstageable pressure ulcer to the left heel (Resident J).Findings include:A report, dated 10/20/25, indicated Resident J's family had been concerned, the resident's clothing had not been changed from one day to the next. The family alleged the resident hadn't received adequate care and developed a deep tissue injury to her left heel as a result.On 10/22/25 at 9:50 A. M., Resident J was observed lying diagonally across her bed with her head right next to the wall. Her husband was present, sitting at her bedside. Her husband indicated the morning of 10/18/25, he found Resident J lying in bed, in dirty clothes worn the day before, dirty linens with dried blood, and a sore on the bottom of her heel. He alleged she had been left up in her recliner chair all night on Friday, 10/17/25 until Saturday, 10/18/25. He was sitting in her recliner chair and put the footrest of the recliner chair up. The padding of the footrest was thin. He indicated the recliner had been in their home and used on the back porch. He pulled back Resident J's covers to expose her left foot. The foot was wrapped in gauze and resting on a pressure reducing mattress (not an air mattress). A heel protector was observed off the heel, turned all the way around and halfway up her calf. When asked, Resident J denied pain to her heel. Resident J's husband indicated to the dried blood on the bottom sheet beneath where the left heel had been resting. He indicated he wasn't sure where the dried blood originated, but it had been at there for 3 days without being changed.On 10/23/25 at 9:36 A.M., Facility Wound Nurse 9 and Registered Nurse (RN) 2 were observed to change the dressing to Resident J's heel. Resident J was lying straight in bed on a pressure-relieving mattress (not an air mattress) with her head elevated. Her heel protector was sitting on her left heel correctly when the blankets were pulled back. The old dressing was removed. The dressing contained serosanguinous (bloody) drainage and grey to green slough-type drainage. Neither the old dressing nor the wound had any odor. The observed wound was on the inner left side of the left heel, approximately 3 cm round. Inside the wound, was an area of soft eschar, grey/green in color, approximately 1.5 cm in length and 0.5 cm in width. The skin surrounding the eschar tissue was pale/white, soft appearing (boggy) with streaks of red and purple. Resident J denied pain during and after the dressing change.On 10/22/25 at 11:19 A.M., Resident J's record was reviewed. Diagnoses included dementia and need for assistance with personal care. An admission Assessment, dated 9/22/25 at 2:04 p.m., indicated Resident J was admitted following completion of therapy at another facility due to a fall with right hip fracture. She required assistance to transfer and walk with a walker or wheelchair. She'd recently had right hip surgery and could bear weight as tolerated. She had a healing surgical wound to the right hip which was left open to air and required no treatment. She had no other skin impairments observed.A Braden Scale Assessment, dated 9/22/25 at 2:04 p.m., indicated the resident had slightly limited sensory perception, occasionally moist skin, walked occasionally, made frequent though slight changes in position by herself, had adequate nutrition, and had a potential problem with friction and shearing. She was assessed as mild risk for developing pressure ulcers. A care plan was to be initiated to prevent pressure ulcers from occurring. The care plan was to include application of ointment/medication to areas other than her feet.Braden Scale Assessments, repeated on 9/30/25, 10/7/25, and 10/14/25 indicated Resident J was at mild risk for developing pressure ulcers.An admission Minimum Data Set (MDS) assessment, dated 10/1/25, indicated Resident J had severely impaired cognition. She had disorganized thinking and no behaviors. The resident required maximum assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. She used a wheelchair and walker for mobility. She was frequently incontinent of bladder and always incontinent of bowel. The MDS indicated she was not at risk for developing pressure ulcers nor did she currently have any pressure ulcers or injuries.Care plans indicated Resident J required assistance with activities of daily living (ADL) including bed mobility, dressing, toileting, and transfers. She was at risk for skin breakdown. Staff were to keep her clean and dry, provide incontinent care after each incontinent episode, keep linens clean, dry, and wrinkle free.A care plan, dated 10/8/25, indicated Resident J had a history of refusing care. Staff were to approach her in a calm, relaxed manner, observe and report behaviors.An Occupational Therapy (OT) Discharge summary, dated [DATE], indicated Resident J had received OT from 9/25/25 to 10/13/25. The summary indicated upon