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	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grey Stone Health and 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self-administration of medication assessment was done prior to allowing a resident to self-administer medications for 1 of 1 residents reviewed. (Resident 5) Findings include: During an observation, on 8/19/25 at 12:27pm, on Resident 5's bedside table an albuterol inhaler labeled with Resident 5's name was observed. In an interview, on 8/19/25 at 12:31pm, LPN 6 indicated the Nurse Practioner indicated Resident 5 was allowed to have both the albuterol inhaler and flonase nasal spray at bedside for self-administration. LPN 6 indicated there was no order for Resident 5 to self-administer the medications. Resident 5's record was reviewed on 8/19/25 at 2:10pm. Resident 5's diagnoses included muscle weakness and paraplegia. Resident 5's quarterly Minimal Data Set assessment, dated 7/21/25, indicated her Brief Interview of Mental Status score was a 13. A score of 13 indicated a minimal decline in mental status. Resident 5's self administration assessment, dated 8/13/25, indicated Resident 5 did not want to self administer medications. The remainder of the self-administration of medication assessment was left blank. In an interview, on 08/20/2025 at 10:52 AM, the Director of Nursing (DON) indicated the facility should have done a specific self-administration of medication for Resident 5. The DON indicated Resident 5 should not have had the medications in her room without an order to indicate she could self-administer the medication and an assessment to indicate she was able to administer them herself. A policy titled, Self-Administration of Medications dated 12/1/07 and last revision date of 6/1/24. The policy indicated.2. Facility, in conjunction with the Interdisciplinary care team, should assess and determine, with respect to each resident, whether the self-administration of medications is safe and clinically appropriate based on the resident's functionality and health condition. 3. To ensure safe and appropriate self-administration, facility should educate residents to ensure that a resident is able to: 3.1 state the name, dose, strength, frequency, and purpose for use of their medications. 3.2 Understand the possible medication side effects and that they should notify facility staff if they experience any such side effects. 3.3 Correctly administer, inject, or apply all prescribed medications. 3.4 Correctly store their medications in a locked compartment.5. Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer. 3.1-11

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 24 resident reviewed. (Resident 75)A review of Resident 75's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated the resident did not have chronic skin abnormalities.During an observation, on 8/18/2025 at 11:25 AM, Resident 75 had an area of skin below the right knee, red in color, approximately 1 inch by 3/4 inch with satellite red areas above and below the larger area. The resident indicated this area had been going on for a month or more.A review of physician orders, dated 6/25/25, indicated that staff would monitor for signs and symptoms of abnormal bleeding or abnormal bruising. A review of physician orders, dated 06/15/2025, indicated Resident 75 was to take Eliquis 5 mg, orally, twice a day. The order was discontinued on 07/08/2025.A record review began on 8/14/2025 at 10:32 PM, indicated a physician plan for staff to monitor for skin color changes or dryness, consider lotion daily, if changes are noted consider an ultrasound to rule out clot.A record review, on 8/19/25, included skin assessments, progress notes, care plans, and a daily skin assessment for August indicated an absence of documentation for abnormal skin coloration for the resident's right lower leg.In an interview, on 08/19/2025 at 12:30 PM, RN 5 indicated the Medication Administration Record had a task to assess skin. No information about the area was communicated in nursing report. The right lower leg reddened area would be categorized as abnormal. The resident 75 has not had any recent falls or known cause of the abnormal reddened area.In an interview, on 08/19/2025 at 12:32 PM, CNA 4 indicated Resident 75 did not have any recent falls. In an interview, on 08/19/2025 at 12:49 PM, the Director of Nursing indicated she assessed the reddened area and was unsure if there was a diagnosis for the area.Progress notes, dated 8/19/25 at 1:35 PM, indicated scattered redness area on the resident's right lower leg measuring 15 cm by 2.3 cm. The resident stated she had this redness for years, it comes and goes. The resident was taking aspirin and the nurse practitioner was notified with new orders to monitor the area, keep skin moisturized, and collect a blood sample tomorrow morning. Resident 75 was made aware and agreed with the plan of care. A physician note, dated 8/19/25, identified the reddened area on the right lower leg as hemosiderin staining and for staff to monitor for pain or temperature changes.In an interview, on 08/21/2025 at 10:40 PM, the Director of Nursing indicated shower sheets for resident 75 were not available for review.A current policy, dated 9/9/25, provided by the Director of Nursing, indicated nursing assistants will look at all areas of the resident's skin and indicate abnormalities or changes and document on a shower sheet or verbally notify the charge nurse. Reportable skin conditions include reddened areas. The nurse will address any findings in the clinical record and appropriate interventions will be initiated. If shower sheets are used for documentation, the documentation will be submitted to the DON or designee. 3.1-35(a)

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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. Based on interview and record review the facility failed to ensure physician orders were followed for 1 of 1 resident receiving dialysis reviewed. (Resident 2) Findings include:Resident 2's record review began on 8/21/25 at 1:30 PM, diagnoses included chronic kidney disease and outpatient hemodialysis treatment.A review of Resident 2's current quarterly MDS dated indicated their BIMS (Basic Interview for Mental Status) score was 14 (cognitively intact). The MDS indicated the resident receives hemodialysis treatment 3 days a week. Resident 2's Dialysis Communication Binder included a medication list, dated 7/10/25. The medication list did not include sevelamer carbonate, ordered on 7/25/25 at 2:17 PM. A review of physician orders, dated 7/25/25 at 2:17 PM, indicated sevelamer carbonate 800mg, was to be given three times a day with meals.A review of the dialysis company medication list dated 8/21/25 indicated sevelamer carbonate 800 mg, was to be given with meals and one tablet with snacks. A review of the August 2025 Medication Administration Record (MAR) on 8/21/25 at 1:00 PM indicated 15 of 61 scheduled doses of sevelamer were not given or missing documentation. Scheduled times for medication were 8:00 AM, 12:00 PM, and 5:00 PM. The scheduled times did not include a snack dose as ordered by the dialysis company. A list of reasons the medication was not given included on hold, resident unavailable, at dialysis, or drug/item unavailable.A review of food intake measurements, dated 8/1/25 through 8/21/25 at 1:57 PM, indicated Resident 2 had received breakfast, lunch, dinner, and bedtimes snacks on the days she remained at the facility. Lunch was not offered during dialysis appointments. Resident 2 had refused breakfast on 8/4/25, 8/6/25, and 8/15/25.In an interview, on 8/21/25 at 1:25 PM, the Director of Nursing (DON) indicated staff should notify the physician when a resident missed a dose of medication. In the past, staff have sent medication with a resident to dialysis or staff have called the provider to ask for a time change for scheduled medications to ensure medications are given as ordered.Review of progress notes, dated 7/25/25 - 8/14/25, indicated there was no documentation of communication to the provider about missed doses, clarification to change the medication time, nor notes of sending sevelamer carbonate 800 mg to dialysis. A review of Resident 2's Dialysis Communication Binder dated 7/25/25 through 8/21/25 indicated the resident's dialysis company had not given the resident sevelamer carbonate during their care.A review of Resident 2 Dialysis Communication Binder Cover directed the staff to fill out communication log with any medication changes.A current policy dated 7/2/25 provided by the DON, indicated the pre-dialysis process is to administer medications as ordered by the provider. Communicate any concerns to the dialysis provider. Document in the Dialysis Communication Tool of medications administered before treatment, any additional alerts or information. The post-dialysis process indicates communication of any medications administered during or after treatment.3.1-37