

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/03/2026
NAME OF PROVIDER OR SUPPLIER GRAND MARQUIS, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD, FORT WAYNE, , 46802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for an investigation of Intake IN00471001. Complaint IN00471001 No deficiencies related to the allegations are cited. Survey Date: August 3, 2026 Facility number: 012288 Census Bed Type: Residential: 97 Total: 97 Census Payor Type: Medicare: 62 Other: 35 Total: 97 The Grand Marquis was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

Investigation of Complaint Intake 471001.			
Quality review completed August 3, 2026			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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