STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MARQUIS, THE	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 the Investigation of Intakes 468871 and 469110. Intake 468871 - No deficiencies related to the allegations are cited. Intake 469110 - State deficiencies related to the allegations are cited at R0349. Survey date: April 29, 2026 Facility number: 012288 Residential Census: 94 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review April 30, 2026	R 0000		
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain	R 0349	1. -Resident B physician's order was clarified on 4/30/26 to allow	05/12/2026

	clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure medication administration records were complete and accurately documented for 1 of 3 residents reviewed for records (Resident B). Findings include: On 4/29/26 at 11:45 a.m., Resident B's record was reviewed. Diagnoses included chronic pain syndrome. A Service Plan, dated 8/3/25, indicated Resident B was unable to self-administer his medications and required assistance. Staff were to administer the resident's medications at preferred times or as ordered. Current Physician orders included: -Risperdal (anti-psychotic) 2		for medication staff to sign off on Resident B’s medication in the EMAR at the time of administration. 2. -A review of resident clinical records was completed by nursing personnel to identify any other residents who may have been affected. Any findings identified through the audit that were needing clarification were addressed at the time of the finding. 3. -Medication Administration Personnel were in-serviced 5/11/26 by the Administrator on the facility’s Medication Administration Policy & Procedure; specific to, ensuring resident clinical records are complete and accurate, and ensuring medications are being signed out by the nursing personnel administering the medication. -Resident clinical records will be reviewed on a weekly basis by the DON, or designee, to ensure resident clinical records are complete and accurate, and that medications are being signed out by the nursing personnel administering the medication. 4.	

	milligram (mg) tablets: give 2 mg tablet by mouth, 2 times per day and, -Oxycodone (for pain) 10 mg tablets: give 1 tablet by mouth, 3 times per day for pain. Medication Administration Records (MAR), dated March 2026 and April 2026, indicated Risperdal was scheduled to be given at 8:00 a.m. on day shift and 4:00 p.m. on evening shift. Oxycodone was scheduled to be given at 6:00 a.m. and 2:00 p.m. on day shift, and 10:00 p.m. on evening shift each day. A MAR, dated March 2026, indicated Risperdal was given by 3rd shift Qualified Medication Aids (QMA) on 3/1, 3/14, 3/15, 3/24, 3/25, 3/26, 3/27, 3/29, 3/30, and 3/31/26. Day shift QMA's initialed the MAR and indicated in the record, 3rd shift QMA's gave the medication. The MAR had not indicated which 3rd shift QMA had administered the Risperdal or the time it was given.		The DON, with oversight from the Administrator, will conduct monthly audits to ensure resident clinical records are complete and accurate; to include, ensuring resident medications are being signed out by the nursing personnel administering the medication. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	

The MAR, dated March 2026, indicated Oxycodone, scheduled to be given at 6:00 a.m. by day shift, was given by 3rd shift QMA's on 3/1, 3/25, and 3/27/26. The MAR had not indicated which 3rd shift QMA had administered the Oxycodone or the time it was given.

A MAR, dated April 2026, indicated Risperdal was given by 3rd shift QMA's on 4/1, 4/8 through 4/15, 4/18, 4/19, 4/22 through 4/26, 4/28, and 4/29/26. Day shift QMA's initialed the MAR and indicated in the record, 3rd shift QMA's had given the medication. The MAR had not indicated which 3rd shift QMA had administered the Risperdal or the time it was given.

The MAR, dated April 2026, indicated Oxycodone, scheduled to be given at 6:00 a.m. by day shift QMA's , was given by 3rd shift QMA's on 4/15, 4/19, and 4/25/26. The MAR had not indicated which 3rd shift QMA had administered the Oxycodone or the time it was given.

The Indiana Qualified Medication Aid curriculum, retrieved on 4/29/26 at 1:00 P.M., indicated part of the 6 rights of medication administration included the Right Documentation. QMA's

were to document in the MAR or resident's chart, all medications provided to the resident. They were to document only those medications personally administered and were not to document medications administered by someone else. It was important that documentation be entered accurately and immediately after the administration of any medication. A QMA's signature or initials on an entry indicated the QMA assumed responsibility for the entry and had administered the medication.

On 4/29/26 at 1:44 P.M., QMA 2 was interviewed and asked about signing her initials in the MAR for 3rd shift QMA's. QMA 2 hadn't recalled doing that but believed administration staff had directed them to do so.

-At 1:48 P.M., QMA 3 was interviewed and asked about signing her initials in the MAR for 3rd shift QMA's. She indicated having been directed to this but had not believed it was the correct thing to do. If she hadn't given a medication herself, she wouldn't sign one had been given because she couldn't be sure the 3rd shift QMA had really given the medication.

-At 1:56 P.M., QMA 4 was interviewed and asked about signing her initials in the MAR

for other QMA's. She indicated she had never done that because it wasn't allowed.

-At 2:55 P.M., QMA 5 was interviewed. She indicated she had signed her initials in the MAR for 3rd shift QMA's when they indicated they had given Resident B his medications early and had been instructed to do so by management.

On 4/29/26 at 4:00 P.M., the Administrator was interviewed. She indicated the MAR was part of the resident's record and they were to be complete and accurately documented on. She had not been aware of 1st shift QMA's initialing medications given by 3rd shift staff. The Administrator indicated QMA's should only initial medications on the MAR which they, themselves, had administered.

A current pharmacy policy, titled "Medication Administration" was provided by the Administrator on 4/29/26 at 4:00 P.M., which indicated assistance with medication administration was to be documented on the MAR immediately after giving the resident the medication.

This citation is related to Intake 469110.

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJina Babani	TITLEAdministrator	(X6) DATE05/11/2026