

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 01/20/2026	
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 the Investigation of Intakes 466604, 467010, and 467184. Intake 466604 - No deficiencies related to the allegations are cited. Intake 467010 - No deficiencies related to the allegations are cited. Intake 467184 - No deficiencies related to the allegations are cited. Survey date: January 20, 2026 Facility number: 012288 Residential Census: 100 The Grand Marquis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes 466604, 467010, and 467184. Quality review completed on January 21, 2026.	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

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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