STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRAND MARQUIS, THE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 22, 23 and 24, 2024 Facility number: 012288 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 29, 2024	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review the facility failed to enusre family and physician notification of a change in resident condition for 1 of 8 residents reviewed. (Resident 7) Findings include: Resident 7's record was reviewed on 4/22/24 at 10:46 AM. Diagnosis included diabetes insipidus. Resident 7's progress noted indicated the	R 0036	1. Resident 7 date of death, Resident Representative and Medical Provider notification was recorded as 7/29/23 in the resident's clinical record on 5/6/24 by the nursing personnel that was on duty the day of the resident 7's death.	05/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jina Babani	Administrator	05/10/2024

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	following: On 7/25/23 at 1:29 PM indicated there were 3 attempts to notify the family, but there were no specific times or names of femily documented. There was no documentation of notification to the physician. On 7/26/23 at 11:27AM indicated the resident refused medication 3 times. There was no documentation of notification to another staff on duty to attempt to have someone try a different approach. There was no documentation of notification to family or physician. On 7/28/23 at 1:37 PM indicated there were 3 attempts to give medication. There was no documentation of notification to another staff on duty to have someone try a different approach. There was no documentation of notification to family or physician. On 7/29/23 at 9:10 PM and 9:12 PM the resident was deceased. There was no documentation of notification to family or physician. From 7/25/23 to 7/29/23 there was no documentation Resident 7 had been seen by NP, and no documentation of notification to the NP. Resident 7's MAR (Medication Administration Record) dated July 2023 indicated the resident took her medications routinely, other than bedtime insulin, until 7/24/23. There was no documentation of increased refusals or change in behavior notification of family or the NP. In an interview on 4/24/24 at 10:16AM the DON (Director of Nursing) and QMA 3; QMA 3 indicated she was taught after 3 days of refusing medications, staff were to contact the NP. QMA 3		2. An Audit was completed by the administrator on 5/10/24 of residents who had been discharged to identify any systemic issues or trends. Any resident records identified through the audit to not have complete documentation were addressed at the time of the finding. 3. -The facility's policy on Resident Rights; Notifying Appropriate Parties and Medical Provider of a resident's change of condition, was reviewed and revised by the Administrator on 5/10/24. -Nursing staff and Management staff were in-serviced by the Administrator on 5/13/24 on the facility's Resident Rights Policy; Notifying Appropriate Parties and Medical Provider of a resident's change of condition. -Resident records will be reviewed on a weekly basis by the DON, or designee, to ensure resident representative and medical provider have been notified of a resident's change of condition. 4.The DON, with oversight from the Administrator, will conduct monthly audits to ensure Resident Representatives and Medical Providers are notified of a Residents change of condition at the time of the resident's change of condition. The findings from the	

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	indicated after 2 attempts staff were to ask someone else to attempt and document.The DON indicated staff were not wait 3 days for medications refusals such as insulin. The DON indicated after 24 hours of refusal of insulin a call to the NP was expected. QMA 3 indicated management contacted family and nurses would contact the NP and/or the physicians. There was no policy provided at time of exit. 16.2-5-1.2 (k)(1-2)		audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review the facility failed to ensure a resident was weighed upon admission for 1 of 4 residents reviewed (Resident 4). Findings include: Resident 4's record was reviewed on 4/22/24 at 9:45 AM. Diagnoses included anxiety, insomnia, nicotine dependence and vitamin D deficiency.	R 0216	1. Resident 4 weight was recorded on 10/5/23 in the resident's clinical record. Res 4 weight has been recorded on a monthly basis as of 12/20/23 and documented each month in the resident's clinical record. 2.	05/20/2024

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	Resident 4's Move in Record indicated the resident was admitted on 8/13/24. No wieght was documented in the admission date. Resident 4's Weights and Vitals Summary indicated the resident weighed 168 pounds on 10/5/23. Resident 4's current service plan dated 9/19/23 for nutrition status indicated the resident's nutritional needs would be met. The target goal date was to maintain weight without significant changes by 4/5/24. Interventions included encouragement to eat in the dining room, monitor and record weights as needed, nutritional status could be impacted by mirtazapine (a medication that stimulates appetite) and a regular diet. In an interview on 4/24/24 at 9:22 AM the Director of Nursing (DON) indicated Resident 4 was admitted to the facility on 8/13/24. The DON indicated Resident 4 was weighed for the first time on 10/5/23. The DON indicated Resident 4 should have been weighed within 2 weeks of admission to the facility. A current undated facility policy provided by the Administrator on 4/23/24 at 10:45 AM indicated the weight of each resident would be monitored. The policy indicated weight changes would be counseled appropriately by the nurse or a Registered Dietitian.		-An audit of residents weights was completed by Nurse Management on 5/9/24. Any residents found not having a weight recorded in the resident's clinical record that was found through the audit was completed and recorded in the resident's clinical record at that time. 3. - The facility's policy on Weights was reviewed and revised by the Administrator on 5/10/24. -Nursing staff were in-serviced by the Administrator on 5/10/24 on the facility's weight policy; Resident weights are to be completed upon admission, and no less than every 6 months. -A monthly wellness clinic is conducted each month by nursing personnel, where the residents weights are taken and recorded in the resident's clinical record. 4. The ADON, with oversight from the DON, will conduct monthly audits to ensure resident weights are taken and recorded in the residents charts on a monthly basis. For those residents that a monthly weight is not able to be obtained, the reason will be documented in the residents clinical record. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100%	

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			compliance.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain 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 1 of 8 residents reviewed had complete, accurate, and easily compiled records (Resident 7). Findings include: Resident 7's record was reviewed on 4/22/24 at 10:46AM. The only diagnosis listed was diabetes insipidus. Diabetes insipidus was the only diagnosis listed on MAR (Medication Administration Record) on face sheet, order summary sheet, and under diagnosis tab. A Nurse Practitioner (NP) visit note dated 7/2/23 indicated past medical history included diagnoses of diabetes, gastroparesis, depression, chronic pain, neuropathy, retinal neuropathy, hypothyroidism, insomnia, bipolar, and schizophrenia. A progress note dated 6/30/23 at 3:38PM indicated an appointment was scheduled with	R 0349	1. Resident 7 diagnoses were documented on 5/10/23 in the resident's clinical record. Resident 7 date of death was recorded as 7/29/23 in the resident's clinical record on 5/6/24 by the nursing personnel that was on duty the day of the resident 7's death. 2. -An Audit was completed by the administrator on 5/10/24 of residents who had been discharged to identify any systemic issues or trends. Any resident records identified through the audit to not have complete documentation were addressed at the time of the finding. -An Audit was completed by nurse management on 5/9/24 of residents diagnoses to identify any systemic issues or trends.	05/20/2024

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	cardiologist. There was no documentation of the reason for the appointment. A NP note dated 6/20/23 did not indicate need or reason to see cardiology. In an interview on 4/23/23 at 10:16AM with the DON (Director of Nursing) indicated a complete and accurate list of all diagnosis were to be listed on face sheet, diagnosis tab, order summary sheet, and on the MAR. Resident 7 was found in her apartment not breathing early in the morning on 7/29/23. No time was listed in the record. There was no documentation in her chart regarding the circumstances surrounding the resident death. In an interview on 4/23/23 at 3:05 PM CNA 2, whom was the first to start CPR, indicated she was unsure why the resident was added to the nightly rounds list. She indicated CNA's only chart in tasks and are unable to document in progress notes. No policy was provided prior to exit.		Any resident records identified through the audit to not have a complete list of diagnoses were addressed at the time of the finding. 3. -The facility's policy on Clinical Documentation was reviewed and revised by the Administrator on 5/10/24. -Nursing staff and Management staff were in-serviced by the Administrator on 5/13/24 on the facility's Clinical Documentation policy; ensuring resident records are complete and accurate with the full list of medical diagnosis; complete and accurate record of resident's discharge, to include, date/time of resident death, disposition of resident, disposition of medication, release of resident's personal items, and family and medical provider notification. -Resident records will be reviewed on a weekly basis by the DON, or designee, to ensure resident representative and medical provider have been notified of a resident's change of condition. 4.The DON, with oversight from the Administrator, will conduct monthly audits to ensure resident records are complete and accurate to reflect the resident's service plans; to include the current list of medical diagnoses	

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			and discharge summary at time of discharge. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure documentation was complete in the resident chart concerning the resident's death for 1 of 2 residents reviewed (Resident 7). Findings include: Resident 7's record was reviewed on 4/22/24 at 10:46AM. The only diagnosis listed in the medical record was diabetes insipidus. Resident 7 was a full code and was not on hospice. Death was not expected or imminent. Resident 7's progress notes indicated the following: A note dated 7/29/23 at 9:12 PM indicated the resident was deceased. There was no documentation to indiate the circumstances surrounding the death, the condition of the resident when found, assessments completed,	R 0357	1. Resident 7 date of death, Resident Representative and Medical Provider notification, and Funeral home notification was recorded as 7/29/23 in the resident's clinical record on 5/6/24 by the nursing personnel that was on duty the day of the resident 7's death. Resident 7 medications were disposed of by nursing personnel. 2. An Audit was completed by the administrator on 5/10/24 of residents who had been discharged to identify any systemic issues or trends. Any resident records identified through the audit to not have complete	05/20/2024

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	and/ or actions taken upon finding the resident deceased. Resident 7's progress notes did not indicate when their remains had been released to the funeral home. Resident 7's progress notes did not indicate the family was notified. Resident 7's progress notes did not indicate if or when personal items had been released. Resident 7's progress notes did not indicate their medications were disposed or returned to the pharmacy. A notification of death, burial transit permit, dated 7/29/23 at 1:58AM, indicated the Resident 7 was 58 years of age. There was no cause of death on form. The document did not indicate the time Resident 7's remains had been released to the funeral home. In an interview on 4/23/23 at 1:26 PM, the Administrator indicated there should have been more documentation regarding resident death. The Administrator indicated documentation should have been completed by the nurse on duty at the time of the death and should have been ongoing until the resident's remains and belongings were properly documented. The In an interview on 4/23/23 at 3:05 PM, CNA 2 indicated CNA's only chart in the tasks section of the record and are unable to document in progress notes. An undated policy titled, Resident Found Dead in Apartment (Unattended Death) provided on		documentation were addressed at the time of the finding. 3. -The facility's policy on Clinical Documentation was reviewed and revised by the Administrator on 5/10/24. -Nursing staff and Management staff were in-serviced by the Administrator on 5/13/24 on the facility's Clinical Documentation policy; ensuring resident records are complete and accurately documented in the resident's clinical record to include: complete list of medical diagnosis, complete and accurate record of resident's discharge, resident representative and medical provider notification, disposition of medication, and release of resident's personal items. -Resident records will be reviewed on a weekly basis by the DON, or designee, to ensure resident records are complete and accurate. 4.The DON, with oversight from the Administrator, will conduct monthly audits to ensure resident records are complete and accurate to reflect the resident's service plans; to include the complete list of medical diagnoses, discharge summary, resident representative and medical provider notification, disposition of medication and	

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	4/23/23 at 11:26AM by the BOM (Business Office Manager) did not indicate documentation required. The policy indicated "1. Call the DON (Director of Nursing) and she will notify the family ... 3. Call the administrator. 4. Have the following information available a. name b. address c. time if known or time range d. location where the resident's body was found (in bed, on the bedroom floor, etc.) e. date of admission f. funeral home to be used g. names, addresses, phone numbers of significant others h. circumstances under which resident expired		release of personal belongings. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	