Jina Babani

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-039

05/10/2024

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/24/2024	
NAME OF PROVIDER OR SUPPLIER GRAND MARQUIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 E WASHINGTON BLVD FORT WAYNE, IN 46802					
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg. 00	Survey. Survey dates: April Facility number: 01 Residential Census: These State Resider accordance with 416	100 Itial Findings are cited in O IAC 16.2-5.	R 0	000				
R 0036 Bldg. 00	Quality review completed April 29, 2024 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 0	036	1. Resident 7 date of death, Res Representative and Medical Provider notification was recor 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.	rded	05/20/2024	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE	

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 1 of 9

Administrator

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>00</u>		COMPLETED		
			B. W.	ING		04/24/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	₹					
CDAND	MADOUIC THE				VASHINGTON BLVD		
GRAND	MARQUIS, THE			FURI	WAYNE, IN 46802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CO]	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	following:				2.		
	On 7/25/23 at 1:29	PM indicated there were 3			An Audit was completed by the	e	
	attempts to notify the	he family, but there were no			administrator on 5/10/24 of		
	specific times or na	mes of femily documented.			residents who had been		
	There was no docur	mentation of notification to the			discharged to identify any		
	physician.				systemic issues or trends. An	y	
					resident records identified thro		
	On 7/26/23 at 11:27	7AM indicated the resident			the audit to not have complete	~	
	refused medication	3 times. There was no			documentation were addresse	d at	
	documentation of n	otification to another staff on			the time of the finding.		
	duty to attempt to h	nave someone try a different					
	approach. There wa	as no documentation of			3.		
	notification to fami	ly or physician.			-The facility's policy on Reside	nt	
				Rights; Notifying Appropriate			
	On 7/28/23 at 1:37	PM indicated there were 3			Parties and Medical Provider of a		
	attempts to give me	edication. There was no			resident's change of condition,		
		otification to another staff on			was reviewed and revised by the		
	duty to have someo	one try a different approach.			Administrator on 5/10/24.		
	There was no docur	mentation of notification to			-Nursing staff and Management		
	family or physician	ı .			staff were in-serviced by the		
					Administrator on 5/13/24 on th	e	
	On 7/29/23 at 9:10	PM and 9:12 PM the resident			facility's Resident Rights Policy;		
	was deceased. Ther	e was no documentation of			Notifying Appropriate Parties and		
	notification to fami	ly or physician.			Medical Provider of a resident		
					change of condition.		
	From 7/25/23 to 7/2	29/23 there was no			-Resident records will be revie	wed	
	documentation Res	ident 7 had been seen by NP,			on a weekly basis by the DON	, or	
	and no documentati	ion of notification to the NP.		designee, to ensure resident			
				representative and medical			
	Resident 7's MAR	(Medication Administration			provider have been notified of	a	
	Record) dated July	2023 indicated the resident		resident's change of condition.			
	took her medication	ns routinely, other than bedtime			_		
	insulin, until 7/24/2	23. There was no documentation			4.The DON, with oversight from	m	
	of increased refusa	lls or change in behavior			the Administrator, will conduct		
	notification of fami	ly or the NP.		monthly audits to ensure Resident			
					Representatives and Medical		
	In an interview on	4/24/24 at 10:16AM the DON			Providers are notified of a		
	(Director of Nursin	g) and QMA 3; QMA 3			Residents change of condition	at	
		aught after 3 days of refusing			the time of the resident's chan		
	I	were to contact the NP. QMA 3	1		of condition. The findings fron	-	

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 2 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>00</u>			COMPLETED		
			B. W	B. WING			04/24/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				VASHINGTON BLVD			
CDAND	MADOLIIS THE				VASHINGTON BLVD VAYNE, IN 46802			
GRANDI	MARQUIS, THE			FURIV	WATNE, IN 40002			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
	indicated after 2 atte	empts staff were to ask			audits will be reviewed during	the		
	someone else to atte	empt and document.The DON			facility's quarterly QAPI meetir	ng		
	indicated staff were	not wait 3 days for			until there is 100% compliance) .		
	medications refusal	s such as insulin. The DON						
	indicated after 24 he	ours of refusal of insulin a call						
	to the NP was expec	cted. QMA 3 indicated						
	management contac	ted 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)							
R 0216	410 IAC 16.2-5-2(c)(1-4)(d)						
	Evaluation - Nonc	,, ,,,						
Bldg. 00	(c) The scope and	content of the evaluation						
	shall be delineated	d in the facility policy						
	manual, but at a n	ninimum the needs						
	assessment shall	include an evaluation of the						
	following:							
	(1) The resident 's	s physical, cognitive, and						
	mental status.							
	(2) The resident 's	s independence in the						
	activities of daily li	ving.						
	(3) The resident 's	s weight taken on						
	admission and ser	miannually thereafter.						
	(4) If applicable, th	ne resident ' s ability to						
	self-administer me	edications.						
	(d) The evaluation	shall be documented in						
	writing and kept in	the facility.						
	Based on interview	and record review the facility	R 0	216	1.		05/20/2024	
	failed to ensure a resident was weighed upon admission for 1 of 4 residents reviewed (Resident				Resident 4 weight was recorde	ed		
					on 10/5/23 in the resident's			
	4).				clinical record. Res 4 weight h			
					been recorded on a monthly b			
	Findings include:				as of 12/20/23 and documente	ed		
					each month in the resident's			
		was reviewed on 4/22/24 at			clinical record.			
	_	s included anxiety, insomnia,						
nicotine dependence and vitamin D deficiency.					2.			

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 3 of 9

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON				3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED		
		B. WING 04/24/2024			/2024			
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	R			WASHINGTON BLVD			
GRAND	MARQUIS, THE				WAYNE, IN 46802			
	· I				T		ī	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE)		DATE	
	D 11 / 41 34	' D. 1' 1' 4 13			-An audit of residents weights			
		in Record indicated the			completed by Nurse Managen			
		ted on 8/13/24. No wieght was			on 5/9/24. Any residents foun			
	documented in the	admission date.			not having a weight recorded			
	D '1 44 337 ' 1	1377.1.6			resident's clinical record that v	vas		
		its and Vitals Summary			found through the audit was			
		ent weighed 168 pounds on			completed and recorded in the			
	10/5/23.				resident's clinical record at tha	π		
	D 11 44				time.			
		t service plan dated 9/19/23 for						
		icated the resident's nutritional			3.			
		t. The target goal date was to			- The facility's policy on Weigh			
		thout significant changes by			was reviewed and revised by	the		
		ns included encouragement to			Administrator on 5/10/24.			
		om, monitor and record weights			-Nursing staff were in-serviced	-		
		nal status could be impacted by			the Administrator on 5/10/24 of	n		
		ication that stimulates appetite)			the facility's weight policy;			
	and a regular diet.				Resident weights are to be			
	T	A/0.4/0.4 + 0.00 A.M. (1. D.)			completed upon admission, ar	nd		
		4/24/24 at 9:22 AM the Director			no less than every 6 months.			
		indicated Resident 4 was			-A monthly wellness clinic is			
		ility on 8/13/24. The DON			conducted each month by nur	-		
		4 was weighed for the first time ON indicated Resident 4 should			personnel, where the resident			
					weights are taken and recorde	ea in		
		within 2 weeks of admission			the resident's clinical record.			
	to the facility.							
	A current undeted t	facility policy provided by the			4.	n the		
		/23/24 at 10:45 AM indicated			The ADON, with oversight from			
		resident would be monitored.			DON, will conduct monthly au			
		ed weight changes would be			to ensure resident weights are taken and recorded in the	;		
		0 0						
	counseled appropriately by the nurse or a Registered Dietitian.				residents charts on a monthly basis. For those residents that	ot o		
	Registered Dictilial	и.						
					monthly weight is not able to be obtained, the reason will be) C		
					documented in the residents			
						om		
					clinical record. The findings fr			
					the audits will be reviewed du	ıııg		
					the facility's quarterly QAPI			
			- 1		meeting until there is 100%		I	

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 4 of 9

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

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 00 B. WING		COMPLETED 04/24/2024		
NAME OF PROVIDER OR SUPPLIER GRAND MARQUIS, THE			STREET ADDRESS, CITY, STATE, ZIP COD 300 E WASHINGTON BLVD FORT WAYNE, IN 46802				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	410 IAC 16.2-5-8. Clinical Records - (a) The facility muston each resident. maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on interview failed to ensure 1 of complete, accurate, (Resident 7). Findings include: Resident 7's record 10:46AM. The only insipidus. Diabetes insipidus von MAR (Medicatic face sheet, order sur diagnosis tab. A Nurse Practitione	1(a)(1-4) Noncompliance st maintain clinical records These records must be the supervision of an icility designated with that records must be as umented. sible. organized. and record review, the facility 8 residents reviewed had and easily compiled records was reviewed on 4/22/24 at diagnosis listed was diabetes vas the only diagnosis listed on Administration Record) on mmary sheet, and under	R 03	TAG	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 by the nursing personnel that won duty the day of the resident death. 2An Audit was completed by the administrator on 5/10/24 of residents who had been discharged to identify any systemic issues or trends. Any	6/24 was 7's	
	of diabetes, gastropa pain, neuropathy, re hypothyroidism, ins schizophrenia. A progress note date				resident records identified thro the audit to not have complete documentation were addresse the time of the findingAn Audit was completed by no management on 5/9/24 of residents diagnoses to identify any systemic issues or trends.	d at urse	

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 5 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING	COMPLETED	
			B. WING 04/24/2024		
			CTREET	CADDREGG GITY GTATE ZIR GOD	
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	
CDAND	MADOLIIC THE			WASHINGTON BLVD	
GRAND	MARQUIS, THE		FORT	WAYNE, IN 46802	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWINED'S DI AN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	cardiologist. There	was no documentation of the		Any resident records identified	d
	reason for the appor			through the audit to not have	
				complete list of diagnoses we	
	A NP note dated 6/2	20/23 did not indicate need or		addressed at the time of the	
	reason to see cardio			finding.	
				l mang.	
	In an interview on 4	4/23/23 at 10:16AM with the		3.	
	DON (Director of N	Nursing) indicated a complete		-The facility's policy on Clinica	al
	and accurate list of	all diagnosis were to be listed		Documentation was reviewed	
	on face sheet, diagr	nosis tab, order summary		revised by the Administrator of	n
	sheet, and on the M	AR.		5/10/24.	
				-Nursing staff and Manageme	nt
	Resident 7 was four	nd in her apartment not		staff were in-serviced by the	
	breathing early in the	he morning on 7/29/23. No time		Administrator on 5/13/24 on the	ne
	was listed in the rec	cord. There was no		facility's Clinical Documentation	on
	documentation in h	er chart regarding the		policy; ensuring resident reco	rds
	circumstances surro	ounding the resident death.		are complete and accurate wi	th
				the full list of medical diagnos	is;
	In an interview on 4	4/23/23 at 3:05 PM CNA 2,		complete and accurate record	of
	whom was the first	to start CPR, indicated she was		resident's discharge, to include	e,
	unsure why the resi	dent was added to the nightly		date/time of resident death,	
	rounds list. She ind	icated CNA's only chart in		disposition of resident, dispos	ition
	tasks and are unable	e to document in progress		of medication, release of	
	notes.			resident's personal items, and	ı
				family and medical provider	
	No policy was prov	rided prior to exit.		notification.	
				-Resident records will be revie	ewed
				on a weekly basis by the DON	
				designee, to ensure resident	
				representative and medical	
				provider have been notified of	a
				resident's change of condition	
				4.The DON, with oversight fro	m
				the Administrator, will conduc	
				monthly audits to ensure resid	
				records are complete and	
				accurate to reflect the residen	_{t's}
				service plans; to include the	
				current list of medical diagnos	es
			1	J Surrous list of modical diagnos	

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 6 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/24/2024	
	ROVIDER OR SUPPLIER		300 E \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON BLVD WAYNE, IN 46802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				and discharge summary at tim discharge. The findings from t audits will be reviewed during facility's quarterly QAPI meeti until there is 100% compliance	the the ng
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		R 0357	1. Resident 7 date of death, Res Representative and Medical Provider notification, and Fun- home notification was recorde 7/29/23 in the resident's clinic record on 5/6/24 by the nursin personnel that was on duty th day of the resident 7's death. Resident 7 medications were disposed of by nursing persor	eral ed as al ng e
	following: A note dated 7/29/2 resident was deceas documentation to in surrounding the dea	3 at 9:12 PM indicated the ed. There was no diate the circumstances th, the condition of the d, assessments completed,		2. An Audit was completed by th administrator on 5/10/24 of residents who had been discharged to identify any systemic issues or trends. An resident records identified throthe audit to not have complete	ny Dugh

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 7 of 9

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

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPLETED	
		B. W	B. WING 04/24/2024				
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			VASHINGTON BLVD		
CRAND	MARQUIS, THE				WAYNE, IN 46802		
GIVAIND	WININGUIO, ITIE			IOKIV			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		en upon finding the resident			documentation were addresse	ed at	
	deceased.				the time of the finding.		
		ss notes did not indicate when			3.		
		een released to the funeral			-The facility's policy on Clinica		
	home.				Documentation was reviewed		
	D 11 . 7	. 111			revised by the Administrator o	n	
		ess notes did not indicate the			5/10/24.		
	family was notified	1.			-Nursing staff and Manageme	nt	
	D 11 471	4 111 41 11 4 16			staff were in-serviced by the		
		ess notes did not indicate if or			Administrator on 5/13/24 on the		
	when personal item	ns had been released.			facility's Clinical Documentation		
	Dasidant 7la musana	as motos did not indicate their			policy; ensuring resident reco	ras	
		ess notes did not indicate their lisposed or returned to the		are complete and accurately documented in the resident's			
		insposed or returned to the			clinical record to include:		
	pharmacy.					ooio	
	A notification of de	eath, burial transit permit, dated			complete list of medical diagn complete and accurate record		
		, indicated the Resident 7 was			resident's discharge, resident		
		ere was no cause of death on			representative and medical		
		nt did not indicate the time			provider notification, disposition	on of	
		ns had been released to the			medication, and release of		
	funeral home.				resident's personal items.		
					-Resident records will be revie	ewed	
	In an interview on	4/23/23 at 1:26 PM, the			on a weekly basis by the DON		
		cated there should have been			designee, to ensure resident	,	
		on regarding resident death.					
		indicated documentation			records are complete and accurate.		
		ompleted by the nurse on duty					
		eath and should have been			4.The DON, with oversight fro	m	
	ongoing until the re	esident's remains and			the Administrator, will conduct		
	1	operly documented. The			monthly audits to ensure resid		
					records are complete and		
	In an interview on	4/23/23 at 3:05 PM, CNA 2			accurate to reflect the residen	t's	
	indicated CNA's or	nly chart in the tasks section of			service plans; to include the		
		unable to document in progress			complete list of medical		
	notes.				diagnoses, discharge summai	ry,	
					resident representative and	-	
	An undated policy	titled, Resident Found Dead in			medical provider notification,		
		nded Death) provided on			disposition of medication and		

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 8 of 9

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

PRINTED: 05/15/2024 FORM APPROVED OMB NO. 0938-039

	ì ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	JILDING ING	00	COMPL 04/24		
			D. WI			04/24/	2024	
NAME OF PROVIDER OR SUPPLIER GRAND MARQUIS, THE				STREET ADDRESS, CITY, STATE, ZIP COD 300 E WASHINGTON BLVD FORT WAYNE, IN 46802				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION					DATE	
		I by the BOM (Business Office			release of personal belonging			
		dicate documentation	The findings from the audits wi		vill be			
		y indicated "1. Call the DON			reviewed during the facility's			
		g) and she will notify the family			quarterly QAPI meeting until t	here		
		istrator. 4. Have the following			is 100% compliance.			
		le a. name b. address c. time if						
	known or time rang	e 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 resider							
		-						

State Form Event ID: 00X011 Facility ID: 012288 If continuation sheet Page 9 of 9