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	12/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00437649, IN00448201, and IN00449376. Complaint IN00437649 - No deficiencies related to the allegations are cited. Complaint IN00448201 - No deficiencies related to the allegations are cited. Complaint IN00449376 - State deficiencies related to the allegations are cited at R0053 Survey date: December 23, 2024 Facility number: 012288 Residential Census: 99 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed December 23, 2024	R 0000		
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency Based on interview and record review the facility failed to ensure residents were free of verbal abuse for 1 of 6 residents reviewed (Resident B). Findings include: A facility reported incident, dated 12/15/24, was provided by the Administrator on 12/23/24 at 11:27 AM. The report indicated Resident B had reported he had requested medications from Qualified Medication Aide (QMA) 2 on 12/15/24	R 0053	1. QMA 2 was separated from employment 12/19/24. 2. An Audit was completed by the Case Manager on 1/9/2025 through independent resident interviews to assess the treatment of residents by facility staff. Any concerns identified through the	01/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jina Babani	Administrator	01/09/2025

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	at 5:40 PM. The report indicated Resident B's interaction with QMA 2 led to cursing, profanity and throwing the resident's medication pack towards Resident B. Resident B's grievance form, dated 12/15/24 was provided by the Administrator on 12/23/24 at 11:27 AM. The form indicated Resident B went to get his medication from QMA 2 around 5:40 PM on 12/15/24. The request led to arguing and cursing by QMA 2. Resident B indicated QMA 2 called him a "punk b**** and other names." Resident B's record review was completed on 12/23/24 at 10:49 AM. Diagnosis included bipolar disorder, post traumatic stress disorder, and major depressive disorder. A nursing note, dated 12/15/24, indicated Resident B reported to the nursing station for his medication and the resident was upset at QMA 2. The note also indicated words were exchanged between QMA 2 and Resident B. During an interview, on 12/23/24 at 11:16 AM, Resident B indicated on 12/15/24 he went to the nurse's station for his medication. Resident B indicated QMA 2 had requested his weight 3 or 4 times and Resident B refused. Resident B also indicated QMA 2 indicated "I don't f****ing care" and "you're a f****ing punk b****." During an interview on 12/23/24 at 10 AM, the Administrator indicated Resident B was interviewable. The Administrator indicated Resident B reported on 12/15/24 that QMA 2 had cursed at him. A video with audio, time stamped 12/15/24 at 4:55 PM, was provided by the Administrator on		audit that was completed were addressed at that time. 3. -All Staff were in-serviced by the Administrator on 1/9/2025 on the facility's Abuse Policy, specific to, Resident Rights. -All Staff were in-serviced by the DON on 1/10/2025 on common mental health conditions and de-escalation of behavior techniques. 4.The DON and Case Manager, with oversight from the Administrator, will conduct monthly audits through independent Resident interviews to ensure Residents Rights are upheld, to include, Residents are being treated with Respect and Dignity. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	

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	12/23/24 at 11:52 AM. The video showed Resident B went to the nurse's station and requested his medication from QMA 2. The video showed Resident B indicated he was upset with QMA 2 for not providing his medication the previous few nights. The video showed QMA 2 hand Resident B his medication and Resident B indicated "don't throw my medication at me." The video showed Resident B walked away from the nurse's station and QMA 2 followed, cursing at the resident. The video showed QMA 2 indicated Resident B was a "f***ing idiot" and "punk b****." The video then showed while Resident B walked towards the stairs; QMA 2 indicated "I don't give a f****, b****, a** go downstairs." A current policy, last reviewed 3/1/2020, titled "Abuse, Neglect and Exploitation," was provided by the Administrator on 12/23/24 at 12:13 PM. The policy indicated verbal abuse was the use of oral, written or gestured language that willfully included disparaged and derogatory terms to residents..regardless of their age, ability to comprehend or disability. This citation is related to complaint IN00449376.			