

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012288	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/10/2023
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NAME OF PROVIDER OR SUPPLIER GRAND MARQUIS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00412969 and IN00414442.</p> <p>Complaint IN00412969 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00414442 - No deficiencies related to the allegations are cited.</p> <p>Survey date: August 10, 2023.</p> <p>Facility number: 012288</p> <p>Residential Census: 97</p> <p>The Grand Marquis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00412969 and IN00414442.</p> <p>Quality review completed August 10, 2023</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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