

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 09/15/2023
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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 IN00416836.</p> <p>Complaint IN00416836 - No deficiencies related to the allegations are cited.</p> <p>Survey date: September 15, 2023.</p> <p>Facility number: 012288</p> <p>Residential Census: 102</p> <p>The Grand Marquis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00416836.</p> <p>Quality review completed September 15, 2023</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____