

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/13/2023	
NAME OF PROVIDER OR SUPPLIER GEORGETOWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 MAPLECREST ROAD, FORT WAYNE, , 46815					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: April 12, and 13, 2023 Facility number: 013463 Residential Census: 147 Georgetown Place with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed April 14, 2023	R 0000					
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE			(X6) DATE	