

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 12/09/2025	
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 the Investigation of Intakes 465848, 466174, 466212 and 466280. Intake 465848 - No deficiencies related to the allegations are cited. Intake 466174 - No deficiencies related to the allegations are cited. Intake 466212 - No deficiencies related to the allegations are cited. Intake 466280 - No deficiencies related to the allegations are cited. Survey date: December 9, 2025 Facility number: 013463 Residential Census: 134	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

Georgetown Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes 465848, 466174, 466212 and 466280.

Quality review completed on December 9, 2025.

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
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