

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 07/15/2026	
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 Intake 470144. Intake 470144 - Deficiencies related to the allegations are cited at R0240. Survey date: July 15, 2026 Facility number: 013463 Residential Census: 148 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed July 16, 2026	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Georgetowne Place as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the				

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intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?; and
- By the date the systemic

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			changes will be completed.	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed (Resident B). Findings include: In an interview, on 7/15/26 at 10:07 AM, Resident B's family indicated Resident B missed 7 days of her metformin (diabetic management) medication. The family indicated they were not notified until day 7 of the missed medication. Resident B's record was reviewed on 7/15/26 at 11:46 AM. Diagnoses included diabetes, dementia and Alzheimer's disease. A current physician's order, dated 4/22/26, indicated to give Resident B metformin 2- 500 mg (1000 mg) tablets twice a day. The Medication Administration Record (MAR), dated 5/1/26 - 6/30/26, was reviewed. The	R 0240	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Georgetowne Place as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	07/17/2026

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MAR indicated Resident B did not receive metformin on the following days and times:

5/25/26 AM

5/25/26 PM

5/26/26 AM

5/26/26 PM

5/27/26 AM

5/27/26 PM

5/28/26 AM

5/28/26 PM

5/29/26 AM

5/29/26 PM

5/30/26 AM

5/30/26 PM

5/31/26 AM

5/31/26 PM

6/1/26 AM

The daily MAR notes indicated metformin was reordered and awaiting delivery from the pharmacy.

Nursing notes, dated 5/15/26 through 6/1/26, did not indicate staff checked with the pharmacy regarding the status of Resident B's metformin medication nor

R 240

1. Resident B physician orders are being followed, and the resident is receiving his/her medication.
2. Upon identification of the deficient practice, all residents with physician-ordered medications were reviewed to determine whether any medication doses were missed, delayed, or not administered as prescribed. Any identified discrepancies were immediately addressed with notification to the physician and responsible party. Going forward, medications that are unavailable will be obtained immediately through the pharmacy, emergency medication supply, or an alternate approved source.
3. On 7/21/2026 the Wellness Director initiated education to all LPN's and Med techs on proper procedures to be followed to ensure medications are requested in a timely manner and that unavailable medications are promptly

was the physician notified.

A nursing note, dated 6/3/26, indicated it had been identified that Resident B had not received her prescribed twice a day metformin from 5/25/26 - 6/1/26, a total of 7 days.

In an interview, on 7/15/26 at 11:18 AM, Qualified Medication Aide (QMA) 2 indicated when a resident's medication was out and not received from the pharmacy, the Director of Nursing (DON), family, physician and pharmacy were notified.

In an interview, on 7/15/26 at 11:59 AM, the DON indicated Resident B's missed metformin medication was notified by the nurse on cart after 7 days. The DON indicated Resident B's order was sent to pharmacy for a refill. The DON indicated staff should have checked on the status of the medication refill daily until the medication was received. The DON indicated staff should have notified the physician and family after 3 days of no medication refill. The DON indicated no staff followed up on the medication refill or notified Resident B's family and physician until day 7 of the missed doses.

A current policy, undated, titled Procedures for General Community Team Members

communicated to the provider, pharmacy and appropriate parties, how to implement appropriate interim measures when medications are unavailable. These measures ensure physician orders are carried out timely, medication availability is proactively monitored, communication is maintained across shifts, and residents receive medications as prescribed without unnecessary delay. Any licensed staff who administer medication and have not completed education by 7/30/2026 will not be allowed to work until training has been completed. This education will also be added to the new hire clinical orientation checklist. A medication availability audit will be completed daily through EMAR to identify medications that require reordering before supplies are depleted. A medication reorder tracking log has been implemented to ensure timely follow-up on all medication orders. Pharmacy communication logs and medication reorder documentation will be reviewed to ensure staff are following the established reorder processes.

4. Medication Administration

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Training, was provided by the DON on 7/15/26 at 2:36 PM. The policy indicated physician orders were followed and when medication was unavailable the physician was notified. The policy also indicated staff checked medication status with the pharmacy.

This finding relates to Intake 470144.

performance audits will begin 7/30/2026 and will be monitored by the Wellness Director or designee weekly for four weeks, then monthly for four months. Any identified concerns will be addressed through immediate coaching and corrective action. Ongoing monitoring will continue thereafter to ensure sustained compliance.

5. Corrective action date:
August 15, 2026.

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
SIGNATURERenee Kreienbrink

TITLEExecutive Director

(X6) DATE07/27/2026