STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GEORGETOWN PLACE	1717 MAPLECREST ROAD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00453233. Complaint IN00453233 - Deficiencies related to the allegations are cited at R0243. Survey date: March 19, 2025. Facility number: 013463 Residential Census: 140 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed March 19, 2025.	R 0000		
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on interview and record review the facility failed to ensure residents were free from medication error for 1 of 3 residents reviewed (Resident B). Findings include: Resident B's record was reviewed on 3/19/25 at 10:38 AM. Diagnosis included hypertension, stage 3 chronic kidney disease and hyperlipidemia. A nursing note, dated 3/9/25 at 10:17 AM, indicated Resident B reported dizziness, lightheaded and her body hurt to Qualified Medication Aide (QMA) 2. Resident B indicated she received medication at 5 AM and 8:46 AM.	R 0243	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	04/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Renee Kreienbrink	Executive Director	04/03/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Resident B received her morning medications twice. The Medication Administration Record (MAR), dated 2/1/25 - 2/28/25, indicated Resident B received the following medications on 2/9/25 in the morning: - calcium chewable 500 mg, effective date 2/6/25, chew 1 tablet once daily - dronedarone (antiarrhythmic) HCl tablet 400 mg, effective date 2/6/25, take 1 tablet by mouth twice daily with breakfast and supper - eliquis (anticoagulant) tablet 2.5 mg, effective date 2/6/25, take 1 tablet by mouth twice a day - ezetimibe (cholesterol absorption inhibitor) tablet 10 mg, effective date 2/6/25, take 1 tablet by mouth once daily - gabapentin (anticonvulsant) capsule 100 mg, effective date 2/6/25, take 1 capsule twice a day - hydralazine (vasodilator) tablet 50 mg, effective date 2/6/25, take 1 tablet by mouth twice a day - losartan (antihypertensive) tablet 50 mg, effective date 2/6/25, take 1 tablet by mouth twice a day During an interview, on 3/19/25 at 10:51 AM, the Wellness Director indicated Resident B had received her morning medications twice on 2/9/25. The Wellness Director indicated Resident B requested her morning medications administered at 6 AM instead of 8 AM, effective 2/7/25. The Wellness Director indicated Licensed Practical Nurse (LPN) 3 administered Resident B's morning medications, included calcium, dronedarone, eliquis, ezetimibe, gabapentin, hydralazine and losartan at 6 AM, then QMA 2 administered the same medications at 8 AM. The Wellness Director indicated QMA 2 didn't notice the medication administration time had changed.		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. · 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 what date the systemic changes will be completed. R243 1 Resident B is receiving medication free from	

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	During an interview on 3/19/25 at 11:12 AM, QMA 2 indicated she had administered Resident B's morning medications, included calcium, dronedarone, eliquis, ezetimibe, gabapentin, hydralazine and losartan, at 8 AM on 2/9/25. QMA 2 indicated around 10 AM, Resident B reported dizziness, lightheaded and her body hurting. Resident B indicated she had received her morning medications twice on 2/9/25. QMA 2 indicated Resident B had requested her morning medications to be administered at 6 AM instead of 8 AM, but the MAR had not been updated. QMA 2 indicated, during morning report shift change, LPN 3 did not report Resident B's morning medications had been administrated on 2/9/25 at 6 AM nor medication administrated time change. QMA 2 indicated when a resident or doctor requested a medication administration time change, the Wellness Director would edit the MAR and notified the nurse/QMA. QMA 2 indicated during her medication admission pass, she only had access to the medications due during her shift. A policy, dated 5/3/2023, titled "Medication Administration," was provided by the Executive Director on 3/19/25 at 10:58 PM. The policy indicated residents received medications per physician orders. This State citation is related to Complaint IN00453233.		errors. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community reviewed all residents who receive medications and physicians' orders. In-service training was provided to all nursing staff on medication administration. 4 The Wellness Director or designee will conduct observations of random medication passes weekly x 4 weeks, then monthly thereafter. 5 Systematic changes were completed on 4/3/2025	