PRINTED: 04/10/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			ľ í	B) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER				COMPLETED	
		B. WI	B. WING 03/20/			2025	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
GEORGETOWN PLACE					APLECREST ROAD VAYNE, IN 46815		
GEORGETOWN PLACE				VATNE, IN 40013			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION DATE
R 0000	REGGERTORT OR	CESC IDENTIFIED IN GRAMMITON		1710			DATE
Bldg. 00							
		State Residential Licensure	R 0	000			
	Survey.						
	Survey date: March 20, 2025 Facility number: 013463						
	Residential Census:	. 141					
	These State Residential Findings are cited in accordance with 410 IAC 16.2-5.						
	Quality reiew comp	eleted March 21, 2025					
R 0217	410 IAC 16.2-5-2(e)(1-5)					
Distr. 00	Evaluation - Defici	iency					
Bldg. 00	Rased on interview	and record review the facility	R 02	017	This Plan of Correction is		05/01/2025
	Based on interview and record review the facility failed to ensure a current, signed service plan was		I K U.	21/	submitted as required under State		03/01/2023
		9 residents reviewed. (Resident			law. The submission of this Plan		
	8)				of Correction does not constitute		
					an admission on the part of		
	Findings include:				Georgetowne Place as to the	lingo	
	Resident 8's record	was reviewed on 3/20/25 at			accuracy of the surveyors' find or the conclusions drawn	iligs	
		included dementia, arthritis,			therefrom. The submission of	this	
	and gastrointestinal				Plan of Correction does not		
	Dagidant Ola annuand	Individualized Service Plan			constitute an admission that the		
		ated 11/3/24 and 5/3/24, were			findings constitute a deficiency that the scope and severity	, OI	
		8. Resident 8 had Power of			regarding the deficiency cited	are	
		perwork, dated 6/15/2015,			correctly applied. Any changes		
		e else to make all healthcare			the Community's policies and		
	decisions. A consen	nt for treatment for the facility			procedures should be conside		
	was signed on 10/19/23 by her POA. The consent for treatment was not signed by Resident 8.				subsequent remedial measure		
					as that concept is employed in		
					Rule 407 of the Federal Rules	OĪ	
			-				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Renee Kreienbrink Executive Director 04/07/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any defiency statement 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 disclodays 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	B. WING 03/20/2025				
NAME OF PROVIDER OR SUPPLIER GEORGETOWN PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 1717 MAPLECREST ROAD FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	Director on 3/20/25 a person had a POA decisions and sign a resident. The Assis explained the POA and not the resident	at 2:06PM she indicated when they were to make medical ll paperwork rather than the tant Wellness Director should have signed the ISP in this situation. Edure was provided by time of		Evidence and any correspond state rules of civil procedure a should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this of Correction with the intention that it be inadmissible by any party in any civil or criminal adagainst the Community or any employee, agent, officer, direct attorney, or shareholder of the Community or affiliated companies. What corrective action(s) be accomplished for those residents found to have been affected by the deficient pract. How the facility will ident other residents having the potential to be affected by the same deficient practice and we corrective action will be taken. What measures will be printo place or what systemic changes the facility will make ensure that the deficient practices not recur;	e Plan n third ction / ctor, e will lice.		
				How the corrective action will be monitored to ensure the	` '		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2025	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD MAPLECREST ROAD	
GEORGE	ETOWN PLACE		FORT	WAYNE, IN 46815	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(X5) COMPLETION DATE	
				deficient practice will not recur i.e., what quality assurance program will be put into place;	
				By what date the systemi changes will be completed.	С
				R 217	
				Resident 8 service plan is current and signed.	
				2. The Community reviewed expression resident's record to determine which residents, if any, could be affected by the alleged deficient practice.	pe e
				3. An immediate audit was initiated by the Wellness Direct of all resident individual service plans within resident charts an MARs, including the involvement of POAs and healthcare representatives. This audit ensures that service plans are signed by the resident or appropriate resident designee. Going forward, whenever a seplan is reviewed, the Wellness	e d ent rvice

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2025	
NAME OF PROVIDER OR SUPPLIER GEORGETOWN PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG CONTROL OF THE APPROPRIATE DEFICIENCY)		
				Director will be responsible for verifying the listed diagnoses ensuring the appropriate party signed the service plan. Additionally, all residents diagnosed with dementia will a designated power of attorned healthcare representative significant their behalf. 4. The Executive Director or designee will audit the service plans of all new admits month 4 months to ensure compliance. 5. Date of completion: 5/1/202	y has have ey or n on e ally x ce.	
R 0356 Bldg. 00	410 IAC 16.2-5-8 Clinical Records					
3	Based on interview and record review the facility failed to ensure emergency files were filled out completely for 6 of 8 residents reviewed. (Resident 1, Resident 2, Resident 3, Resident 5, Resident 6 & Resident 7) Findings include: 1. Resident 1's record was reviewed on 03/20/2025		R 0356	R 356 1 The emergency files for Residents 1, 2, 3, 5, 6, and 7 been filled out completely.		
	at 12:00 PM. Diag	noses, hospital preference, name of physician. Allergies were		The Community reviews each resident's record to	ed	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WING		03/20/2025		
			CTDE	ET ADDRESS CITY STATE 7ID COD			
NAME OF PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COD			
GEORGETOWN PLACE				7 MAPLECREST ROAD RT WAYNE, IN 46815			
GEORGE	ETOWN PLACE		FOR	AT WATNE, IN 40015			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	not present on the fa	acesheet.		determine which residents, if	any,		
				could be affected by the alleg	ed		
		ord was reviewed on 03/20/2025		deficient practice.			
	-	noses included depressive					
		ion, and actinic keratosis					
		n sun exposure). Hospital					
	preference was not	present on facesheet.		3 The nursing staff and or			
				administrative team will revie	w the		
		ord was reviewed on 03/20/2025		resident's charts to ensure			
	_	noses included cystoid macular		compliance with regulation 41			
	-	filled cysts on retina),		IAC 16.2-5-8(1)(1-8)(i). Going			
	hypertension, and mixed hyperlipidemia. Hospital			forward the Wellness Director or			
	preference was not present on facesheet.			designee will be responsible for			
				reviewing the emergency information file with the residents,			
	4. Resident 5's record was reviewed on 03/20/2025			· I			
	at 12:30 PM. Diagnoses and hospital preference			family, or representative and	WIII		
	were not present on the facesheet.			update it as needed.			
	5. Resident 6's reco	ord was reviewed on 03/20/2025					
	at 12:35 PM. Diagn	noses included hypertension.					
	Date of birth and ag	ge were not present on					
	facesheet.			4 The Executive Director of	or		
				designee will conduct a random			
	6. Resident 7's record was reviewed on 03/20/2025			audit of the emergency inform	nation		
	at 12:45 PM. Diagnoses included anxiety disorder,			file, monthly x 4 months.			
	depression, and type two diabetes. Hospital						
	preferences were not present on the facesheet.			5 Date of completion:			
				5/1/2025			
	In an interview, on 03/20/2025 at 2:40 PM, the						
	Assistant Wellness Director indicated the						
	emergency files book should have included the						
	residents' name, hospital preference, allergies, and						
	emergency contact information.						
	No policy regarding emergency files was						
	presented upon exit	t.					
	l		1	1	i		

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