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	03/20/2025

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 a State Residential Licensure 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 completed March 21, 2025	R 0000		
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review the facility failed to ensure a current, signed service plan was completed for 1 of 9 residents reviewed. (Resident 8) Findings include: Resident 8's record was reviewed on 3/20/25 at 1:16PM. Diagnoses included dementia, arthritis, and gastrointestinal disorder. Resident 8's current Individualized Service Plan (ISP) documents, dated 11/3/24 and 5/3/24, were signed by Resident 8. Resident 8 had Power of Attorney (POA) paperwork, dated 6/15/2015, appointing someone else to make all healthcare decisions. A consent for treatment for the facility was signed on 10/19/23 by her POA. The consent for treatment was not signed by Resident 8.	R 0217	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	05/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Renee Kreienbrink	Executive Director	04/07/2025

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	In an interview with the Assistant Wellness Director on 3/20/25 at 2:06PM she indicated when a person had a POA they were to make medical decisions and sign all paperwork rather than the resident. The Assistant Wellness Director explained the POA should have signed the ISP and not the resident in this situation. No policy and procedure was provided by time of exit.		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	

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			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. R 217 1. Resident 8 service plan is current and signed. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. An immediate audit was initiated by the Wellness Director of all resident individual service plans within resident charts and 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 service plan is reviewed, the Wellness	

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			Director will be responsible for verifying the listed diagnoses ensuring the appropriate party has signed the service plan. Additionally, all residents diagnosed with dementia will have a designated power of attorney or healthcare representative sign on their behalf. 4. The Executive Director or designee will audit the service plans of all new admits monthly x 4 months to ensure compliance. 5. Date of completion: 5/1/2025	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance 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 at 12:00 PM. Diagnoses, hospital preference, name and phone number of physician. Allergies were	R 0356	R 356 1 The emergency files for Residents 1, 2, 3, 5, 6, and 7 have been filled out completely. 2 The Community reviewed each resident's record to	05/01/2025

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	not present on the facesheet. 2. Resident 2's record was reviewed on 03/20/2025 at 12:15 PM. Diagnoses included depressive disorder, hypertension, and actinic keratosis (damaged skin from sun exposure). Hospital preference was not present on facesheet. 3, Resident 3's record was reviewed on 03/20/2025 at 12:24 PM. Diagnoses included cystoid macular degeneration (fluid filled cysts on retina), hypertension, and mixed hyperlipidemia. Hospital preference was not present on facesheet. 4. Resident 5's record was reviewed on 03/20/2025 at 12:30 PM. Diagnoses and hospital preference were not present on the facesheet. 5. Resident 6's record was reviewed on 03/20/2025 at 12:35 PM. Diagnoses included hypertension. Date of birth and age were not present on facesheet. 6. Resident 7's record was reviewed on 03/20/2025 at 12:45 PM. Diagnoses included anxiety disorder, depression, and type two diabetes. Hospital preferences were not present on the facesheet. 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.		determine which residents, if any, could be affected by the alleged deficient practice. 3 The nursing staff and or administrative team will review the resident's charts to ensure compliance with regulation 410 IAC 16.2-5-8(1)(1-8)(i). Going forward the Wellness Director or designee will be responsible for reviewing the emergency information file with the residents, family, or representative and will update it as needed. 4 The Executive Director or designee will conduct a random audit of the emergency information file, monthly x 4 months. 5 Date of completion: 5/1/2025	