

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013463	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/01/2023
NAME OF PROVIDER OR SUPPLIER GEORGETOWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 MAPLECREST ROAD FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00398541.</p> <p>Complaint IN00398541 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: February 1, 2023</p> <p>Facility number: 013463</p> <p>Residential Census: 160</p> <p>Georgetown Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00398541.</p> <p>Quality review completed February 2, 2023</p>	R 000		

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

TITLE

(X6) DATE