STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219

(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) COMPLETION DATE
V0000	This visit was an ESRD federal complaint investigation survey. Complaint number: IN00117416 - Substantiated: Federal deficiencies related to the allegation are cited. Survey date: November 13, 2012 Facility number: 005149 Medicaid vendor number: 100227200A Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor David Eric Moran, BSN, RN, Public Health Nurse Surveyor Quality Review: Joyce Elder, MSN, BSN, RN November 15, 2012	V0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219

(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) COMPLETION DATE
V0113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, staff interview, and policy and procedure review, the facility failed to ensure staff washed hands with soap and water when visibly soiled in 1 of 4 observations completed (#1) creating the potential for the transmission of disease causing organisms among staff and all of the facility's 130 current patients. The findings include: 1. On 11/13/12 at 10:50 AM, employee D, Patient Care Technician (PCT), was at machine #2 with patient #1. With gloves on, the PCT began to cleanse blood off of the patient's arm. The PCT then removed the clamp from the patient's arm and applied tape to needle site #1. The PCT then removed the 2nd needle. Visible blood was present on the gloves. The PCT then applied a clamp to the patient's arm. The PCT then walked to the sharps container to throw away the used needles and visible blood was seen on left arm sleeve of the PCT's gown. The PCT	V0113	The Clinical Manager is responsible to ensure that all staff members follow “Hand Hygiene and Personal Protective Equipment” policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies “Hand Hygiene” FMS-CS-IC-II-155-090A and “Personal Protective Equipment” FMS-CS-IC-II-155-080A with emphasis placed on appropriate glove usage, glove changes and hand hygiene using soap and water. Training will be completed on December 10 th 2012 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by December 10 th 2012 The Clinical Manager will hold a counseling session for Employee D by December 10 th 2012 to discuss policy violations on November 13, 2012 as noted in	12/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
	removed her gloves and applied gel. No hand cleanse with soap and water was completed and no gown change was performed. 2. On 11/13/12 at 4:20 PM, during the exit conference, employee A, clinical manager, indicated soap and water should be used instead of hand gel when hands are visibly soiled or come into contact with other potentially infectious material. 3. The facility's policy titled "Personal Protective Equipment" document number FMS-CS-IC-II-155-080A, effective date 1/4/2012, states, "Change gloves and practice hand hygiene between each patient and/or station to prevent cross-contamination. Remove gloves and wash hands after each patient contact, and after exposure to blood and body fluids. If hands are not visibly soiled, use of a waterless antiseptic hand rub is acceptable ... If gloves are visibly contaminated, change gloves. Wash hands before putting on new gloves, touching any surfaces and before performing other activities." 4. Facility policy titled "Hand Hygiene" document number FMS-CS-IC-II-155-090A, revision		the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219

(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) COMPLETION DATE
	date 1/04/2012, states, "Hands will be washed with antimicrobial soap and water when hands are visibly dirty or contaminated with proteinaceous material, blood, or other body fluids."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219

(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) COMPLETION DATE
V0115	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. Based on observation, staff interview, and policy and procedure review, the facility failed to ensure staff changed gowns when visibly soiled in 1 of 4 observations completed (#1) creating the potential for the transmission of disease causing organisms among staff and all of the facility's 130 current patients. The findings include: 1. On 11/13/12 at 10:50 AM, employee D, Patient Care Technician (PCT), was at machine #2 with patient #1. With gloves on, the PCT began to cleanse blood off of the patient's arm. The PCT then removed the clamp from the patient's arm and applied tape to needle site #1. The PCT then removed the 2nd needle. Visible blood was present on the gloves. The PCT then applied a	V0115	The Clinical Manager is responsible to ensure that all staff members follow “Hand Hygiene and Personal Protective Equipment” policies to ensure a safe treatment environment that prevents cross contamination of patients and equipment. The Clinical Manager met with the facility Education Coordinator to arrange and schedule staff in-services to re-educate all staff members on the following policies “Hand Hygiene” FMS-CS-IC-II-155-090A and “Personal Protective Equipment” FMS-CS-IC-II-155-080A with emphasis placed on appropriate glove usage, glove changes and hand hygiene using soap and water. Training will be completed on December 10 th 2012 and an in-service attendance sheet is available in the facility for review in addition an audit with skills checks will be completed by December 10 th 2012	12/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
	clamp to the patient's arm. The PCT then walked to the sharps container to throw away the used needles and visible blood was seen on left arm sleeve of the PCT's gown. The PCT removed her gloves and applied gel. No hand cleanse with soap and water was completed and no gown change was performed. 2. On 11/13/12 at 4:22 PM, during the exit conference, employee A, clinical manager, indicated gowns should be changed when they are visibly contaminated with blood or other infectious material. 3. The facility's policy titled "Personal Protective Equipment" document number FMS-CS-IC-II-155-080A, effective date 1/4/2012, states, "Personal protective fluid resistant gowns shall be changed whenever visibly soiled or worn."		The Clinical Manager will hold a counseling session for Employee D by December 10 th 2012 to discuss policy violations on November 13, 2012 as noted in the SOD. Expectations for improvement were discussed and documented. Emphasis and focus in this counseling session was on glove usage and proper hand hygiene. The Clinical Manager will ensure that infection control audits utilizing the QAI Infection Control audit tool are done monthly for 6 months and then as determined by the QAI calendar. Any deficiencies noted during the audits will be referred immediately to the Clinical Manager who is responsible to address the issue with each employee including corrective action as appropriate The Clinical Manager is responsible to report a summary of findings monthly in QAI and compliance will be monitored by the Governing Body.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
V0543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; Based on clinical record review, facility policy review, and interview with facility staff, the facility failed to ensure patients' blood pressures and safety checks were monitored as directed in the facility's policy in 4 of 4 clinical records reviewed. (#1, 2, 3, and 4) Findings: 1. Clinical record number 1 revealed the patient's blood pressure and safety checks were not monitored every 30 minutes in 12 of 12 hemodialysis treatment flow sheets reviewed. The hemodialysis flow sheets that failed to monitor blood pressure every 30 minutes were dated 10/16/12, 10/18/12, 10/20/12, 10/23/12, 10/25/12, 10/27/12, 10/30/12, 11/3/12, 11/6/12, 11/8/12, 11/10/12, and 11/13/12. 2. Clinical record number 2 revealed the patient's blood pressure and safety checks were not monitored	V0543	**V543** The Clinical Manager/Education Coordinator will educate and review with all staff “Patient Monitoring During Patient Treatment” FMC-CS-IC-I-110-133A and the requirements for receiving machine data electronically through the chairside system by December 10 th 2012 with emphasis and focus on monitoring the patient’s blood pressure every 30 minutes and verifying that machine data has been received in chairside. The Clinical Manager or designee will review treatment sheets daily for 2 weeks, weekly for 2 weeks, monthly times 2, then quarterly to ensure that all blood pressure checks are being done and documented. Any issues of noncompliance will be referred to the Clinical Manager immediately, the patient situation addressed, the Medical Director and/or attending physician notified as appropriate and corrective action taken as appropriate. The Clinical Manager is	12/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
	every 30 minutes in 12 of 13 hemodialysis treatment flow sheets reviewed. The hemodialysis flow sheets that failed to monitor blood pressure every 30 minutes were dated 10/13/12, 10/16/12, 10/18/12, 10/20/12, 10/23/12, 10/25/12, 10/27/12, 10/30/12, 11/1/12, 11/6/12, 11/8/12, and 11/10/12. 3. Clinical record number 3 revealed the patient's blood pressure and safety checks were not monitored every 30 minutes in 11 of 13 hemodialysis treatment flow sheets reviewed. The hemodialysis flow sheets that failed to monitor blood pressure every 30 minutes were dated 10/13/12, 10/16/12, 10/18/12, 10/20/12, 10/23/12, 10/25/12, 10/30/12, 11/1/12, 11/6/12, 11/8/12, and 11/10/12. 4. Clinical record number 4 revealed the patient's blood pressure and safety checks were not monitored every 30 minutes in 11 of 13 hemodialysis treatment flow sheets reviewed. The hemodialysis flow sheets that failed to monitor blood pressure every 30 minutes were dated 10/11/12, 10/16/12, 10/18/12, 10/23/12, 10/25/12, 10/27/12, 11/1/12, 11/3/12, 11/6/12, 11/8/12, and 11/10/12.		responsible to report a summary of findings monthly in QAI and compliance will be monitored by the QAI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
	5. On 11/13/12 at 12:05 PM, employee F, PCT, indicated safety checks and vital signs are supposed to be taken every 30 minutes. 6. On 11/13/12 at 4:15 PM, employee A, clinical manager, indicated their policy is to perform blood pressure and safety checks every 30 minutes. Employee A indicated they have had an issue with getting data to transfer from the dialysis machine and into the electronic record in a timely manner. Employee A indicated they have been experiencing delays with the dialysis machine transporting it to computer. Employee A indicated the safety checks and blood pressures are being taken every 30 minutes; however, it is not transferring to the electronic record in real time, and, therefore, it appears that it is not being done every 30 minutes. Employee A indicated she discussed this issue with her staff during a staff meeting yesterday and instructed them to call these issues into the helpdesk and document the blood pressure and safety checks in downtime charting. 7. A policy titled "Patient Monitoring During Patient Treatment" document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219

(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) COMPLETION DATE
	number FMS-CS-IC-I-110-133A, revision date 4/4/12, states, "Monitor the patient at the initiation of treatment and every 30 minutes, or more frequently as necessary ... Vital signs shall be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed ... Observe and document at the initiation of dialysis and at every safety check that all connections are secure and visible ... Check machine settings and measurements and document at the initiation of dialysis and at every safety check ... Documentation of monitoring will be completed on the treatment record."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
V0715	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on facility policy and procedure review, the medical director failed to ensure the facility had provided services in accordance with its own policies related to patient care and infection control with the potential to affect all the agency's patients. The findings include: 1. The medical director failed to ensure the facility policy titled "Hand Hygiene" document number FMS-CS-IC-II-155-090A, revision date 1/04/2012, was followed. (See V 113) 2. The medical director failed to ensure the facility policy titled "Personal Protective Equipment" document number FMS-CS-IC-II-155-080A, effective date 1/4/2012, was followed. (See V 113 an V 115) 3. The medical director failed to ensure the the facility policy titled	V0715	**V715** The Director of Operations will meet with the Medical Director before December 10 th 2012 to review his requirements as defined in the Condition for Coverage and Staff Bylaws to ensure that all policies and procedures relative to patient admission, patient care, infection control and patient safety are adhered to by all individual who treat patients in the facility emphasizing adherence to hand hygiene, PPE use and patient monitoring during treatment. The Director of Operations also reviewed the Plan of Correction to be instituted to correct this issue. The Medical Director approved and directed the implementation of the plan as noted below. The facility's patient care staff will be in-serviced on the following policies, "Hand Hygiene", "Personal Protective Equipment" and "Patient Monitoring During Patient Treatment" before December 10 th 2012 by	12/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE INDIANAPOLIS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219	

(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) COMPLETION DATE
	"Patient Monitoring During Patient Treatment" document number FMS-CS-IC-I-110-133A, revision date 4/4/12, was followed. (See V 543)		education with a record of training reviewed by the QAI committee. The Clinical Manager or designee will audit 100% of all treatment sheets daily for 2 weeks, weekly for 2 weeks, monthly times 2, then quarterly to ensure that VS are being monitored every 30 minutes. Any evidence of non-compliance will be addressed immediately including corrective action as appropriate. Frequency of ongoing audits will be determined by the QAI Committee upon review of the audit results and resolution of the issue. The Clinical Manager (CM) is responsible to present all data and monitoring/audit results as related to this Plan of Correction to the Medical Director at the QAI Meeting for oversight and review. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented to the Medical Director during the monthly QAI Committee Meeting. The Medical Director as Chairperson of the QAI Committee is responsible to analyze the results and direct a root cause analysis with the development of a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE INDIANAPOLIS EAST	6635 E 21ST ST STE 400 INDIANAPOLIS, IN 46219

(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) COMPLETION DATE
			committee	