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 08/09/2012

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 PERCEDED 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: IN00113217 - Substantiated: Federal deficiencies related to the allegation are cited. Survey date: August 9, 2012 Facility number: 005149 Medicaid vendor number: 100227200A Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor Quality Review: Joyce Elder, MSN, BSN, RN August 14, 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.

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V0765	494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services. The grievance process must include- (1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance. Based on patient interview, staff interview, facility document review, and policies and procedures review, the facility failed to ensure the facility's internal grievance process included follow-up with the patient or legal guardian in 5 of 15 Patient Complaint/Grievance Logs reviewed creating the potential for no follow up when a patient complaint is made with all of the facility's 130 current in-center patients. The findings include: 1. On 8/9/12 at 5:30 PM, patient #3 was at machine #6. Patient #3 indicated that some of the staff do not change their gloves or wash their hands like they should. The patient indicated they placed a complaint with	V0765	**V 765** On **August 24 th 2012** the Governing Body will meet to review the statement of deficiencies and to make certain that all identified deficiencies are being addressed both immediately and with long term resolution. On **September 10 th 2012** the Director of Operations will meet with all facility staff to discuss the identified deficiencies and to provide a mandatory staff in-service to re-educate the patient care staff, emphasizing the patient's right to voice a complaint and the facility's requirement to ensure the patient complaints have been investigated, documented and individual patients informed of the outcome. Further emphasis was	09/10/2012

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	the management regarding their infection control concerns and no follow-up was done. 2. On 8/9/12 at 10:00 PM, employee G, clinical nurse manager, indicated they spoke with patient #3 regarding the infection control concerns and apologized. Employee G indicated it must have been an oversight that the follow-up was not noted on the grievance / complaint log. 3. Facility document titled "Patient Complaint/Grievance Log" for "Indianapolis East, Facility #4339, Reporting Year: 2012" failed to evidence completion of the section titled "Follow up with Patient/Legal Guardian" for 5 of 15 complaints or grievances received. A. A complaint or grievance received on 2/10/12 by patient #5 failed to evidence any follow up with the patient or legal guardian was completed. B. A complaint or grievance received on 3/20/12 by patient #6 failed to evidence any follow up with the patient or legal guardian was completed. C. A complaint or grievance received		placed on ensuring that patients' complaints are followed up and documented appropriately. Effective immediately, all patient complaints will be entered into the QAI complaint/grievance tracking tool by Clinical Manager. PCT's are to report any complaint or grievance to the Clinical Manager who will investigate the complaint, the Clinical Manager will bring it to QAI for discussion and will then follow up with the patient. The Clinical Manager will assure that the cited deficiency does not reoccur by reviewing all patient complaints/grievances weekly using the QAI complaint/grievance tracking tool. The complaints will be analyzed, a plan of action determined and resolution addressed. All appropriate individuals will be contacted so as to resolve the complaints timely. The respective patient will be notified of the resolution and if not satisfactory, the complaint will remain open until resolved. The Clinical Manager will report a summary of all complaints, actions taken monthly in QAI and compliance will be monitored by the Governing Body. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a	

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	on 4/2/12 by patient #7 failed to evidence any follow up with the patient or legal guardian was completed. D. A complaint or grievance received on 4/7/12 by patient #8 failed to evidence any follow up with the patient or legal guardian was completed. E. A complaint or grievance received on 6/5/12 by patient #3 failed to evidence any follow up with the patient or legal guardian was completed. 4. Facility policy titled "FMS Clinical Services Patient Complaints and Grievances" document number FMS-CS-IC-I-103-006A, effective date 4/4/12 states, "Patients will be informed about the facility's process for addressing and resolving complaints and the grievance process available to patients if needed. Patients will be encouraged to express concerns freely. All patient complaints shall be taken seriously by facility staff and brought immediately to the attention of the Team/Charge Nurse or Clinical Manager. Patient complaints may be easily resolved if		root cause analysis completed as appropriate with the subsequent development of action plans. The QAI Committee is responsible to analyze the results and determine a root cause analysis then develop a new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee	

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	responded to promptly and with the goal of working with the patient to solve the problem. The Clinical Manager will meet with the patient to discuss the concerns and make a plan to resolve them."			