

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	<p>This was an ESRD federal recertification survey.</p> <p>Survey dates: June 18, 19, 20, 21, and 22, 2012.</p> <p>Provider #: 152520</p> <p>Medicaid #: 20032320A</p> <p>Surveyor: Susan E. Sparks, RN, PHNS</p> <p>154 Incenter hemodialysis patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 26, 2012</p>	V0000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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:  152520		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545			
(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			
V0408	<p>494.60(d) PE-EMERGENCY PREPAREDNESS-PROCEDURES The dialysis facility must implement processes and procedures to manage medical and non medical emergencies that are likely to threaten the health or safety of the patients, the staff, or the public. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on observation and interview, the facility failed to maintain the emergency evacuation cart in 1 of 1 carts observed with the potential to affect all 156 patients.</p> <p>Findings:</p> <p>On June 21, 2012 at Noon the Emergency Evacuation cart was observed with inadequate supplies to evacuate 26 patients simultaneously. Registered Nurse, Employee B, indicated there were not enough supplies in the cart to safely evacuate 26 patients simultaneously.</p>	V0408	<p>V408-The Director of Operations will meet with the facility's staff on <b>7/5/2012</b> to review their requirements detailed in Fresenius policy "Emergency Equipment/Supplies" to ensure that emergency supplies are maintained at the dialysis facility.</p> <p>The Clinical Manager under the guidance of the Medical Director will obtain the medications and equipment that is to be kept at the facility.</p> <p>The Clinical Manager will create a checklist by <b>7/9/2012</b> containing all medications and supplies that are kept in the emergency evacuation cart. The supplies and equipment will be checked monthly for expiration dates, quantities and the medications and supplies are covered and locked.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of</p>	07/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
			<p>the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly to the QAI. The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545			
(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			
V0409	<p>494.60(d)(1) PE-ER PREP STAFF-INITIAL/ANNUAL/INFORM PTS The dialysis facility must provide appropriate training and orientation in emergency preparedness to the staff. Staff training must be provided and evaluated at least annually and include the following: (i) Ensuring that staff can demonstrate a knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs.</p> <p>Based on agency document and policy review and interview, the agency failed to ensure it followed its own policy of quarterly fire alarms in 1 of 1 facilities with the potential to effect all 154 patients.</p> <p>Findings:</p> <p>1. Agency document "Fire / Emergency Drill Observation", dated 1/20/2011, failed to evidence a fire drill after</p>	V0409	V409- Clinic Manager met with the staff to review the requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Fire Drill Policy" FMS-132-060-000 and "Evacuation Procedure" 132-020-000 to ensure that staff will be oriented and educated on emergency preparedness including the procedure of disconnecting patients from the dialysis machine if an emergency occurs with instructions of how to exit as well as where to assemble	07/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
	<p>9/29/11.</p> <p>2. On June 21, 2012, the Clinical Manager, Employee A, indicated a fire drill had not been conducted since 9/29/11.</p> <p>3. A policy titled "Fire Drill", FMS-132-060-000, Effective Date 16-Mar-2011, states, "Quarterly, all FMC facilities shall perform a fire drill for each shift of patients and staff including Home Therapies patients present in the facility and Nocturnal shifts."</p>		<p>afterwards.</p> <p>A fire drill was performed on <b>6/29/12</b> for all 3 shifts and on <b>7/3/12</b> for all 3 patient and staff shifts. The Clinical Manager will complete 100% review of all staff Participation in Fire and Disaster Drill Form on <b>7/9/12</b> to ensure that all staff was given the opportunity to participate in the facility's Fire Drill, as evidenced by having each staff sign the participation form after each Fire Drill. Any staff lacking a signature will have the emergency preparedness information reviewed and form signed by his/her next day scheduled for work.</p> <p>Before the scheduled quarterly fire drills, each patient will be provided a handout with the contact information if an emergency were to occur on an "off dialysis day". This contact information will include an alternate emergency phone number for the facility in case the facility is unable to receive phone calls due to an emergency situation.</p> <p>Quarterly, the facility will perform a fire drill with participation documented on the "Staff Participation in Fire and Disaster Drill Form", this form will also be used to document review of the information if a staff was absent on the day of the facility's fire drill</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
			<p>and a review of the procedures will then occur.</p> <p>The Clinical Manager will utilize the QAI tool for Fire Drill Observation tracking quarterly to ensure that all patients and staff participated in the facility's fire drill as evidenced by their participation form and timely signature.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to the QAI.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p> <p>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.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545			
(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			
V0412	<p>494.60(d)(2) PE-ER PREP-PTS ORIENTED/TRAINED The facility must provide appropriate orientation and training to patients, including the areas specified in paragraphs (d)(1)(i) of this section.</p> <p>Based on 5 of 5 interviews with patients regarding emergency planning, the facility failed to provide emergency training for evacuation of the facility as to the patient taking themselves off the machine, exiting, and where to assemble afterwards. (#4, 7, 8, 10, and 17)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On June 20, 2012, at 10:30 AM, Patient # 7 was interviewed and indicated no knowledge of how to evacuate the facility in the case of an emergency. The patient indicated the patient was handed a manual to read and hadn't read it yet. The patient indicated the patient would wait for the technician to come and disconnect the machine and then follow the technician to safety.</li> <li>On June 20, 2012, at 1:00 PM, Patient # 8 was interviewed and indicated how to clamp off and disconnect but did not know where to meet after exiting. The patient indicated it would just be common sense to find the nearest door.</li> <li>On June 20, 2012, at 1:40 PM, Patient</li> </ol>	V0412	<p>V412-Clinic Manager met with the staff to review the requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Fire Drill Policy" FMS-132-060-000 and "Evacuation Procedure" 132-020-000 to ensure that every patient will be oriented and educated on emergency preparedness including the procedure of disconnecting from the dialysis machine if an emergency occurs with instructions of how to exit as well as where to assemble afterwards. Any patient's with special needs will be identified and specific instructions developed to ensure safe evacuation.</p> <p>A fire drill was performed on <b>6/29/12</b> for all 3 shifts and on <b>7/3/12</b> for all 3 patient and staff shifts. The Clinical Manager will complete 100% review of all patients' participation in Fire and Disaster Drill Form on <b>7/9/12</b> to ensure that all patients were given the opportunity to participate in the facility's quarterly Fire Drill, as evidenced by having each patient sign the participation form after each Fire Drill. Any patient without a form</p>	07/13/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
	<p># 10, was interviewed and indicated how to clamp off and disconnect but did not know where to meet after exiting. The door the patient indicated to leave was on the opposite side of the clinic with one door directly behind the patient's chair.</p> <p>4. On June 20, 2012, at 8:10 PM, Patients 4 and 7 were interviewed and indicated they had to be clamped off but wasn't sure how. Patient 4 indicated the patient is legally blind and would have to be patient. Neither patient knew where to meet afterwards but would go out the nearest door.</p> <p>5. On June 18, 2012, at 2 PM, observation identified the layout behind the facility is that of a small retaining pond. The patients from area A would need to exit the building and navigate a small area between the building and the pond to meet in the ambulance parking lot or ambulate around the end of the building and the entire length of the front of the building to meet in the ambulance parking lot.</p> <p>6. On June 21, 2012, at 5 PM, the Clinical Manager, Employee A, indicated the evacuation process was not where it should be.</p> <p>7. A policy titled "Evacuation</p>		<p>or lacking a signature will have the emergency preparedness information reviewed and form signed by 7/13/12.</p> <p>As part of the admission process, each new patient will also be given this education.</p> <p>Quarterly, each patient will be invited to participate in the facility's fire drill with participation documented on the "Patient Participation in Fire and Disaster Drill Form", this form will also be used to document review of the information if a patient was absent on the day of the facility's fire drill, which will be available within the patient's chart.</p> <p>The Clinical Manager will utilize the QAI tool for Fire Drill Observation tracking of all patients quarterly to ensure that all patients participated in the facility's fire drill as evidenced by their participation form and timely signature. New patients will be tracked utilizing the medical record audit form for all new patients monthly to ensure that they have been educated and trained on emergency preparedness.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tool as noted above to the QAI. Any patient without</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
	Procedure", 132-020-000, 7/19/06, states, "8. Everyone should proceed calmly to the nearest exit per command of the person in charge. ... 10. All staff and patients, once outside should proceed to the predetermined point for a head count."		evidence of review and/or participation in the facility's fire drill will be scheduled for completion the following month and corrective action will be taken as appropriate.  The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a 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.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545			
(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			
V0506	<p>494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following:</p> <p>Immunization history, and medication history. Based on clinical record review and interview, the facility failed to ensure allergies were correctly noted in 2 of 15 clinical records. (# 5 and 7)</p> <p>Findings:</p> <p>1. Clinical record 5, with an admit date of 11/19/08, failed to indicate any allergies in the allergy section of the clinical record binder and on the monthly physician notes. The "Comprehensive Interdisciplinary Assessment" signed 11/2/11 by the Interdisciplinary team indicates on page 1 under allergies in a handwritten note "allergic to heparin-anaphylactic reaction, Benzocaine-anaphylactic." The clinical record failed to indicate the patient had ever been given heparin.</p> <p>On June 19, 2012, at 5:40 PM, the Clinical Manager, Employee A, indicated the patient's allergies were not noted on the binder. Allergies are gotten from the physician notes and they are not on the physician notes. The patient has a</p>	V0506	<p>V506-The Director of Operations met with the facility's Interdisciplinary Team on <b>6/20/12</b> to review their requirements as stated in the Conditions for Coverage and detailed in Fresenius policy "Comprehensive Interdisciplinary Assessment and Plan of Care" FMS-CS-I-110-125A, to ensure that every patient will have a timely, complete and current Comprehensive Assessment and Plan of Care completed and available within their medical record that meets all criteria including medication with known allergies clearly noted.</p> <p>The Clinical Manager or designee will complete 100% review of all patients' Comprehensive Assessments by <b>7/20/12</b> to ensure that all Assessments include a medication, allergy and immunization review that are complete and current. Any patient's Assessment found to be out of compliance will be presented to the IDT for completion by <b>7/31/12</b>.</p> <p>The Clinical Manager or designee will utilize the QAI tool for</p>	07/31/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
	<p>religious preference to not using a pork preference.</p> <p>On June 21, 2012, at 5:00 PM, the Operation Manager, Employee D, indicated the patient had refused the testing for the heparin allergy.</p> <p>2. Clinical record 7, with an admit date of 5/1/12, failed to indicate any allergies in the allergy section of the clinical record binder and on the monthly physician notes.</p> <p>A outside physician note dated 12/2/10 stated, "Uloric caused break outs."</p> <p>On June 21, 2012, at 3 PM, the Operations Manager, Employee D, indicated the allergies should be noted on the jacket of the clinical record and did not note the Uloric.</p>		<p>Assessment and Care-Plan tracking of all patients monthly to ensure that timely completion of all patients' medication, allergy and immunization review as part of their Comprehensive Assessment.</p> <p>The Clinic Manager will also ensure that the QAI tool for Medical Records Audit is utilized and that the appropriate notation to known allergies is present on the jacket of the clinical record.</p> <p>The Clinical Manager is responsible to report a summary of findings monthly utilizing the tracking tools as noted above to include the number of Assessments due, completed and missed to the QAI Committee. Any patient missing any component of the Assessment will be scheduled for completion the following month and corrective action will be taken as appropriate. The Medical Record Audit tool is reported on monthly in QAI with identified plans of correction noted and timelines established.</p> <p>The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as appropriate with the subsequent development of action plans.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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	
			The QAI Committee is responsible to analyze the results and determine a root cause analysis and new Plan of Action if resolution is not occurring. Ongoing compliance will be monitored by the QAI committee and Governing Body.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545			
(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			
V0520	<p>494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted-</p> <p>At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.</p> <p>Based on clinical record and policy review and interview the facility failed to ensure the interdisciplinary team completed a comprehensive reassessment on a patient after an extended hospitalization for 1 of 1 unstable patients with the potential to effect all 154 patients.</p> <p>Findings:</p> <p>1. Clinical record 11, with a plan of care (POC) dated 1/17/12, evidenced the patient as being unstable due to frequent hospitalizations. The clinical record failed to evidence the interdisciplinary team developed and implemented a written and individualized comprehensive plan of care on a monthly basis after the</p>	V0520	<p>V520-On <b>6/21/12</b>, the Director of Operations reviewed the "Comprehensive Interdisciplinary Assessment and Plan of Care" policy with all members of the IDT in reference to patients who should be considered unstable with emphasis on those patients with frequent hospitalizations. The Clinical Manager or designee will complete 100% review of all patients' Comprehensive Assessments by <b>7/20/12</b> to ensure that any patient, who meets the criteria for being unstable, has been identified and monthly Assessments and Plans of Care are occurring. Any patient identified as unstable, who has not been seen on a monthly basis, will be scheduled for initiation of monthly reviews by <b>7/31/12</b>. On <b>6/21/12</b>, all members</p>	07/31/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2012	
NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA				STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545			
(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			
	<p>patient was discharged from a 18 day hospital stay.</p> <p>2. On June 20, 2012 at 4 PM, the Registered Dietitian, Employee C, indicated there was a six week gap between the patient's hospital discharge and the next comprehensive assessment and plan of care, and, when reviewed, the comprehensive assessment did not show the patient as unstable.</p> <p>3. On June 20, 2012, at 4 PM, the Clinical Manager, Employee A, indicated there is not a tracking system for 15 or more consecutive hospital days.</p> <p>4. A policy titled "Comprehensive Interdisciplinary Assessment and Plan of Care", FMS-138-020-091, Revised 01-Feb-2011, states, "Unstable patients must be reassessed by the IDT and a new comprehensive assessment and Plan of Care completed monthly until the patient is determined by the IDT to be stable. The following are unstable criteria: Extended or Frequent hospitalizations: Hospitalization of more than 15 days with discharge occurring within the last 30 days, or ... "</p>		<p>of the IDT met to reassess and update the Plan of Care for patient # 11 as reflected within that patient's medical record. Ongoing, all members of the IDT will review patient status monthly to identify any patient who is not meeting their patient specific goal. Any patient deemed unstable will then be reassessed and a new Plan of Care developed for the purpose of making an adjustment to the Plan of Care. The Clinical Manager with the assistance of the facility secretary will utilize the QAI tool for hospitalizations, in addition to all members of the IDT reviewing all patients to identify any patient who meet s the unstable criteria for Assessment and Care-Plan tracking of all patients monthly to ensure the timely monthly completion of any unstable patient's Comprehensive Re-Assessment. The Clinical Manager is responsible to report a summary of findings monthly utilizing the audit to include the number of unstable Assessments due, completed and missed to the QAI. Any unstable patient that was missed will be scheduled for completion the following month and corrective action will be taken as appropriate. The Director of Operations is responsible to ensure all documentation required as part of the QAI process; is presented, current, analyzed, trended and a root cause analysis completed as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA	STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545
---	---

(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
			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	