

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FRESENIUS MEDICAL CARE FRANKLIN B. WING _____		(X3) DATE SURVEY COMPLETED R 09/17/2014
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1159 W JEFFERSON STREET, SUITE 201 FRANKLIN, IN 46131		
(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	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Certification Survey on 07/23/14 for the relocation of an End Stage Renal Disease (ESRD) facility was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.60(d).</p> <p>Survey Date: 09/17/14</p> <p>Facility Number: 006646 Provider Number: 152621 AIM Number: 200897490</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At Life Safety Code survey, Fresenius Medical Care Franklin was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 494.60(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>This facility located on the second story of a three story facility was determined to be of Type II (111) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all treatment areas.</p> <p>The facility has elected to utilize a Categorical Waiver pertaining to electric motor driven fire pump assemblies.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/17/14.</p>	{K 000}			
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.

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