

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

PRINTED: 12/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>152580</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTRAL FORT WAYNE DIALYSIS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1940 BLUFTON RD FORT WAYNE, IN 46809</b>		
(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	
V 000	<p>INITIAL COMMENTS</p> <p>This was an "Other" survey.</p> <p>Date of survey: 7/22/13</p> <p>Facility #: 003241</p> <p>Medicaid #: 200827190A</p> <p>Surveyor: Susan E. Sparks, PHNS</p> <p>This surveyor arrived at the listed address at 11:00 AM. The parking lot was empty, the window's were covered with a silver film, and all facility identification had been removed from the windows. A phone book had obviously been laying outside the door in the elements for several months. This surveyor called the phone number listed for the facility and received a canned message about all circuits are busy. This surveyor went to the doors and tried to enter the facility. The doors were locked. This surveyor contacted her supervisor and it was determined this facility had closed and failed to notify the state office.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 23, 2013</p>	V 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.