STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152564	A. BUILDING _____ B. WING _____	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CHICAGO DIALYSIS CENTER	4016 E MAIN STREET EAST CHICAGO, IN 46312

(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
E 000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: 11-16, 11-17, 11-18, and 11-19-2021 Facility #: 002414 CCN: 152564 Census: 82 In-center hemodialysis patients, no home program At this Emergency Preparedness survey, East Chicago Dialysis Center, was found to have been in compliance with the Emergency Preparedness Requirements for Medicare participating Providers and suppliers, 42 CFR 494.62. Quality Review Completed on 11/23/2021 by Area 3	E 000		
V 000	INITIAL COMMENTS This visit was for a Recertification survey of an End Stage Renal Disease supplier. Survey Dates: 11-16, 11-17, 11-18, and 11-19-2021 Facility #: 002414 CCN: 152564 Medicaid #: 200259750 A	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152564	A. BUILDING _____ B. WING _____	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CHICAGO DIALYSIS CENTER	4016 E MAIN STREET EAST CHICAGO, IN 46312

(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	Continued From page 1 Census: 82 In-center hemodialysis patients, no home program Census: 82 In-patient hemodialysis patients 1 isolation room No home program Stations: 24 and 1 isolation room = 25 stations Clinical Record Review: 7 Patients' clinical records were reviewed At this Recertification and Complaint survey, East Chicago Dialysis Center was found to have been in compliance with the requirements of 42 CFR 494.20, et seq., for End Stage Renal Suppliers. Quality Review Completed on 11/23/2021 by Area 3	V 000		