STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152585	A. BUILDING _____ B. WING _____	C 11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE SHADELAND STATION	**7155 SHADELAND STATION STE 130 INDIANAPOLIS, IN 46256**

(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: 11-4, 11-5, 11-9, 11-10, and 11-12-2021 Facility #: 003483 CCN: 152585 Census: 94 In-center hemodialysis patients, no home program At this Emergency Preparedness survey, FMC Shadeland Station was found to have been in compliance with Emergency Preparedness Requirements for Medicare participating Providers and suppliers, 42 CFR 494.62.	E 000		
V 000	Quality Review Completed on 11/23/21 by Area 3 INITIAL COMMENTS This visit was for a CORE Recertification survey of an End Stage Renal Disease supplier. A complaint survey was conducted in conjunction with this survey. Complaint #: IN 00306366; Substantiated; no deficiencies were cited. Survey Dates: 11-4, 11-5, 11-9, 11-10, and 11-12-2021 Facility #: 003483	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152585	A. BUILDING _____ B. WING _____	C 11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE SHADELAND STATION	**7155 SHADELAND STATION STE 130 INDIANAPOLIS, IN 46256**

(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 CCN: 152585 Census: 94 In-patient hemodialysis patients No isolation room (exempt; opened prior to 2-9-2009) No home program Stations: 24 Clinical Record Review: 7 Patients' clinical records were reviewed At this Recertification and Complaint survey, FMC Shadeland Station 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 11/23/21 by Area 3	V 000		