

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

PRINTED: 11/23/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152585	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/12/2021
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE SHADELAND STATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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

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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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		