

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

PRINTED: 06/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152545	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2020
NAME OF PROVIDER OR SUPPLIER BLUE RIVER VALLEY RENAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST STE 106 SHELBYVILLE, IN 46176		
(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 State Department of Health in accordance with 42 CFR 494.62. Survey date: 6/22/2020 Facility number: 10000 Provider number: 152545 Census: 16 At this Emergency Preparedness survey, Blue River Valley Renal Center was found in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62 in regards to the COVID-19 pandemic.	E 000			
V 000	INITIAL COMMENTS This visit was for an Infection Control Focused Survey. Survey date: 6/22/2020 Facility number: 010000 Provider number: 152545 Census: 16 Home dialysis: None Blue River Valley Renal Care was found to be in compliance with 42 CFR 494.30 Conditions of Participation Infection Control in regards to COVID-19 pandemic. Quality Review: 06/23/2020 by Area 3	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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