

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

PRINTED: 10/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/07/2023
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA			STREET ADDRESS, CITY, STATE, ZIP CODE 710 PARK PL MISHAWAKA, IN 46545		
(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 Survey was an Immediate Jeopardy revisit resulting from a CORE Federal recertification survey of an ESRD provider on 8/22/23, 8/23/23, 8/24/23, 8/25/23, 8/28/23, and 8/29/23.</p> <p>Survey date: 9/07/2023</p> <p>Census by Service Type:</p> <p>In-Center Hemodialysis: 84</p> <p>Total Census: 84</p> <p>Isolation Room/Waiver: yes</p> <p>Fresenius Medical Care Mishawaka continues to be out of compliance with Conditions of Participation 42CFR 494.80 Patient Assessment.</p> <p>Immediate Jeopardy related to 42 CFR 494.80, Patient Assessment, began on 6/19/2023, when the review of the patient records identified, the provider had failed to implement their policy when they failed to notify the physician of the patient beginning below his dry weight and having nausea and vomiting. The Facility Administrator was notified of the immediate jeopardy on 8/28/2023 at 4:40 PM. The immediate jeopardy was not removed prior to exit on 8/29/2023. The immediate jeopardy was removed on 9/7/2023 after the agency educated staff on policies and procedures related to patient assessment, plans of care and reporting. This was evidenced by staff interviews, review of the in-services completed by staff, the governing body meeting weekly to ensure the immediate corrections were in place and review of the treatment audits.</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.

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