STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152520	A. BUILDING _____ B. WING _____	R 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA	**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}	INITIAL COMMENTS	{V 000}		

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.

Survey date: 9/07/2023

Census by Service Type:

In-Center Hemodialysis: 84

Total Census: 84

Isolation Room/Waiver: yes

Fresenius Medical Care Mishawaka continues to be out of compliance with Conditions of Participation 42CFR 494.80 Patient Assessment.

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.

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
	152520	A. BUILDING _____ B. WING _____	R 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA	**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