

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

PRINTED: 08/15/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152612	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2023
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE NEPHROLOGY MISHAWAKA HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 250 DAY RD STE 300A 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	
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 Dates: August 2, 3, and 4, 2023 Facility Number: 006661 Provider/CCN Number: 152612 Census: 115 At this Emergency Preparedness survey, Fresenius Medical Care Nephrology Mishawaka Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 000			
V 000	INITIAL COMMENTS This visit was for a CORE Federal recertification survey of an ESRD. Survey dates: August 2, 3, and 4, 2023 Census by Service Type: Home Hemodialysis: 26 Home Peritoneal dialysis: 89 Total Census: 115 Fresenius Medical Care Nephrology Mishawaka Home was found to be in compliance with 42 CFR 494 in regard to an ESRD Recertification survey.	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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