

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

PRINTED: 07/25/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>152681</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/13/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>FORT WAYNE NORTH DIALYSIS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 E DUPOND RD</b> <b>FORT WAYNE, IN 46825</b>		
(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 visit was for a Federal complaint survey of an ESRD provider.</p> <p>Complaint: IN00382575 Unsubstantiated. No Federal deficiencies were cited.</p> <p>Survey Date: 7/13/2022</p> <p>Census: 34</p> <p>Isolation Room: 1</p> <p>Fort Wayne North Dialysis was found to be in compliance with 42 CFR 494.90 and 42 CFR 494.150 as related to this complaint.</p> <p>QA: A2 7/19/22</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.