STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152605	A. BUILDING 00 B. WING	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BALL DIALYSIS AT FOREST RIDGE	101 EMERSON AVE NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: October 23rd, 25th. 28th, 29th, 30th of 2024 Active Census: 42 At this Emergency Preparedness survey, Ball Dialysis at Forest Ridge was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal Recertification survey of an ESRD provider. Survey Dates: October 23rd, 25th. 28th, 29th, 30th of 2024 Census by Service Type: In-Center Hemodialysis: 42 Total Active Census: 42 Isolation Room: 1 Abbreviations: RN: Registered Nurse PCT: Patient Care	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Mealman, RN, BSN	Director of Operations	11/14/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Technician FA: Facility Administrator CM: Clinical Manager QR Completed on 11/07/2024 by A4			
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL Based on observation, record review, and interview, the facility failed to ensure proper disinfection of the dialysis station preventing the spread of bloodborne pathogens in 1 of 2 Cleaning and Disinfection of the Dialysis Stations observations. (Station #7) Findings Include: 1. A policy titled, "General Cleanliness and Infection Control Guidelines" indicated but was not limited to, "All non-disposable containers, baskets, pails, etc., that are to be reused and have a reasonable likelihood of becoming contaminated, must be inspected, and disinfected on a regularly scheduled basis". 2. During an observation on 10/25/2024 at 10:35 AM, PCT 4 disinfected the dialysis station chair and hemodialysis machine using bleach except for the prime container. PCT 4 removed the prime container, emptied it in the dirty sink, then replaced it back on the dialysis machine without disinfecting it. PCT 4 proceeded to string the hemodialysis machine with new lines for the next patient. 3. During an interview on 10/25/2024 at 10:55 AM, PCT 4 indicated that the prime bucket should be	V 0122	**V 122** By 11/13/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: General Cleanliness and Infection Control Guidelines Cleaning and Disinfecting the Dialysis Station Emphasis was placed on: All non-disposable containers, baskets, pails, etc., that are to be reused and have a reasonable likelihood of becoming contaminated, must be inspected, and disinfected on a regularly scheduled basis. Such containers, etc. shall be cleaned and disinfected immediately, or as soon as feasible, upon visible contamination. The dialysis station could become contaminated with blood and other body fluids during treatment. After use, any non-disposable equipment and supplies brought into the dialysis	11/28/2024

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	emptied before starting disinfection of the dialysis station. PCT 4 further indicated that the prime bucket is to be disinfected along with the entire station, chair, machine, blood pressure cuffs, wall box) prior to prepping the station for the next patient.		station (ex. Stethoscope) must be disinfected with 1:100 bleach or EPA registered disinfectant before being removed from the dialysis station. Effective 11/18/24, Clinical Manager or Charge Nurse will conduct daily, 3 times per week, audits with focus on ensuing after use, any non-disposable containers brought into the dialysis station (i.e. Prime bucket) must be disinfected with 1:100 bleach after each use, utilizing specific plan of correction Audit Tool for 2 weeks, then weekly, 1 time per week for 2 weeks or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status	

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			of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 11/28/2024.	
V 0124 Bldg. 00	494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Based on record review and interview the agency failed to ensure Hepatitis B status was obtained prior to admission to the facility in 1 of 2 new admissions reviewed. (Patient #4)	V 0124	**V 124** On 11/13/2024, the Clinical Manager held a staff meeting and reinforced the expectations and	11/28/2024

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	Findings Include: 1. A policy titled, "Patient Hepatitis B Testing Requirements" indicated but was not limited to, "The CDC recommends the following tests: 1) Hepatitis B surface antigen (HBsAg) 2) Hepatitis B surface antibody (anti-HBs) 3) Hepatitis B core antibody "total" (anti-HBc) ... HBV status should be know prior to admission for all new patients. To be admitted to a facility, FKC requires a new patient have at a minimum a, Hepatitis B surface antigen (HBsAg) result within 30 days prior to the admission date. If Hepatitis B surface antibody (anti-HBs), and Hepatitis B core "total" (anti-HBc "total") are not available prior to admission, obtain a physician order to immediately draw blood specimens and submit for testing. Anti-HBs and anti-HBc "total" results must be available within 7 days of admission". 2. A document titled, "Plan of Care" indicated an admission date of 07/31/2024 for Patient #4, a new admit. 3. An untitled document for Patient #4 indicated the following Hepatitis B lab results: Antigen—non-reactive and Antibody--<3.5 on 07/23/2024. The facility failed to obtain a Hepatitis B core antibody "total" (anti-HBc) prior to admission the facility. 4. During an interview on 10/30/2024 the CM indicated that policy indicates that an antigen and antibody are required to be obtained prior to admission, not the core antibody "total" (anti-HBc). The CM further indicated having problems with laboratories/hospitals not drawing the core when requested.		responsibilities of the facility staff on policy: Patient Hepatitis B Testing Requirements Emphasis was placed on: HBV status should be known prior to admission for all new patients. To be admitted to a facility, FKC requires a new patient have at a minimum a, Hepatitis B surface antigen (HBsAg) result within 30 days prior to the admission date. If Hepatitis B surface antibody (anti-HBs), and Hepatitis B core antibody “total” (anti-HBc “total”) are not available prior to admission, obtain a physician order to immediately draw blood specimens and submit for testing. Anti-HBs and anti-HBc “total” results must be available within 7 days of admission. Effective 11/18/24, Clinical Manager or Charge Nurse will conduct daily audits with focus on ensuing all new admits have available, Hepatitis B surface antigen (HBsAg) result within 30 days prior to the admission date; If Hepatitis B surface antibody (anti-HBs), and Hepatitis B core antibody “total” (anti-HBc “total”) are not available prior to admission, obtain a physician order to immediately draw blood specimens and submit for testing. Anti-HBs and anti-HBc “total” results must be available within 7	

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			days of admission utilizing specific plan of correction audit tool for 4 weeks, or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly.	

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V 0142 Bldg. 00	494.30(b)(1) IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P Based on record review and interview the facility failed to ensure the second Tuberculosis skin test was completed upon hire for 1 of 3 employees reviewed. (PCT 1) Findings Include: 1. A policy titled, "Employee Tuberculosis Testing" indicated but was not limited to, "TB testing using the two-step tuberculin skin test (TST) method is required upon hire". 2. A document titled "Employee Tuberculosis Skin Test Administration Record" for PCT 1 indicated the initial test dose was administered on 04/08/2020 with a negative result confirmed on 04/10/2020. The facility failed to obtain the second TST. 3. A personnel document provided by the facility	V 0142	The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 11/28/2024. **V 142** On 11/13/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: Employee Tuberculosis Testing Emphasis was placed on: TB testing using the two-step tuberculin skin test (TST) method is required upon hire. If a new employee has a documented baseline TST result within the previous 12 months, a single TST can be administered as this additional TST represents the second stage of the two-step testing.	11/28/2024

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	indicated that PCT 1 was hired on 04/07/2020. 4. During an interview on 10/28/2024 at 2:39 PM, the Clinic Manager indicated that all new employees should receive a two-step tuberculosis screening and is unsure why PCT 1 did not.		Effective 11/18/24, Clinical Manager or Charge Nurse will conduct weekly audits with focus on ensuing TB testing using the two-step tuberculin skin test (TST) for all new employees is administered and documented utilizing employee personnel tracker audit tool for 3 months, or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible	

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			for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 11/28/2024.	
V 0507 Bldg. 00	494.80(a)(4) PA-ASSESS ANEMIA Based on record review and interview the agency failed to ensure the patient hematologic status were addressed to meet anemia needs in 1 of 5 anemia patients reviewed. (Patient #1) Findings Include: 1. A document titled, "Mircera Algorithm InCenter 4.0 Quick Reference Guide" indicated but was not limited to, "Spectra Hemoglobin to be drawn weekly ... Post-hospitalization: Draw first treatment back to facility and then follow weekly Hgb lab draw schedule".	V 0507	**V 507** On 11/13/2024, the Clinic Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: Mircera Algorithm InCenter 4.0 Quick Reference Guide Emphasis was placed on: Administer every 2 weeks or less frequently. Mircera will be administered to	11/28/2024

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	2. A policy titled, "Corportate MAB Recommended Anemia Algorithm Mircera IVP Administration (In Center Only) Version 4.0" indicated but was not limited to, "Post hospitalization patient: Draw Spectra Hgb [Hemoglobin] first treatment back to facility and then follow weekly Hgb lab draw schedule ... Hospitalization of any period of time or misses a Mircera dose for more than 7 days ... If a patient is hospitalized for any period of time or has an absence of more than 7 days ... Discontinue Mircera dose ... Following return from hospitalization or absence complete the Absence and Hospitalization Assessment ... Draw and obtain Spectra Hgb result ... Select the dose using the Maintenance Dose Chart and administer the dose following the Lab Draw/Dose Administration Schedule". 3. A document titled, "Lab Results/medication Administration Summary" indicated the following Hemoglobin labs: 09/16/2024 Hemoglobin of 13.1, 09/23/2024 Hemoglobin of 11.2, 09/30/2024 Hemoglobin of 10.1, 10/18/2024 Hemoglobin of 9.0, 10/21/2024 Hemoglobin of 9.1. 4. A document titled "Patient Transfer" indicated a physician order for Mircera (medication used to treat anemia) 75 milligrams Intravenous Push (IVP) during dialysis every 4 weeks. Start date was 10/04/2024. 5. During an interview on 10/30/2024 at 10:21 AM, the CM indicated that Patient #1 had been hospitalized from 10/04/2024-10/16/2024. A Hemoglobin was drawn on 10/18/2024 upon returning from the hospital. A 10/4/2024 order for Mircera 75 micrograms had not been administered to date. The CM was indicated waiting to obtain		all patients on the same dialysis day if the week, based on the facility weekly lab draw schedule. New Patient Mircera Dosing If 1st dose is to be administered </= 3 days before the facility Lab Draw/Dose Administration Schedule (LD/DAS) wait and administer the dose per LD/DAS. If the 1st dose is to be administered > 3 days before the LD/DAS, one dose of may be given on another day of the week. Administer subsequent per LD/DAS. Minimum Days Between ESA Doses At least 11 days must elapse since the patient's last dose of Mircera. At least 7 days must elapse since the patient's last dose of Aranesp. Spectra Hemoglobin to be drawn weekly. Hgb results used in calculating new Mircera dose must not greater than 7 days old. New Patient: Draw first treatment and then follow weekly Hgb lab draw schedule. Post-Hospitalization: Draw first treatment back at facility and then follow weekly Hgb lab draw schedule. Hgb available from hospital or other source: Use only facility-drawn and Spectra-resulted Hgb values. Do not use local lab Hgb values (from hospital or other source) in calculating Micera	

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	hospitalization records to see if any Erythropoietin Stimulating Agent (ESA) had been administered during his/her hospital stay. The CM acknowledged that 14 days has since passed since discharge and Patient #1's hemoglobin continues to rapidly fall with no intervention to date. The CM further explained having a very difficult time obtaining records from hospitals when requested, however she was able to pull up the Electronic Medical Record (EMR) for the hospital for Patient #1 to review with surveyor. No documentation was found in the discharge summary indicating Patient #1 received an ESA during his/her hospitalization. The Clinic Manager confirmed that the last dose of Mircera was administered on August 16th, 2024, in the facility. The Clinic Manager indicated that there had been a significant decline in Patient #1 ' s Hemoglobin over the past month as well as his/her overal health status. The CM indicated that since discharge from the hospital on 10/16/2024, Mircera has not been administered.		dose. Hgb results greater than 7 days old: Draw Spectra Hgb and consult Provider. Effective 11/18/24, Clinical Manager or Charge Nurse will conduct weekly audits with focus on ensuing all patient's hemoglobin status are addressed utilizing specific plan of correction audit tool for 3 months, or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.	

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			The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 11/28/2024.	
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Based on record review and interview the agency failed to ensure that the physician prescribed Blood Flow Rates (BFR) and Dialysate Flow Rates (DFR) were followed in 4 of 5 clinical records reviewed. (Patient #1, #2, #3, #4) Findings Include: 1. A policy titled, "Patient Assessment and Monitoring" indicated but was not limited to, "Check prescribed blood flow is being achieved or	V 0544	**V 544** By 11/13/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: Patient Assessment and Monitoring Emphasis was placed on: Check prescribed blood flow	11/28/2024

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	reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate setting is correct, and the prescribed flow is being delivered". 2. A 10/18/2024 document titled, "Treatment Sheet for Facility" for Patient #1 indicated a physician ordered BFR of 400. The treatment sheet evidenced a BFR of 350 without documentation of why the BFR order was not followed. The facility failed to follow the physician order. 3. A 10/18/2024 document titled, "Treatment Sheet for Facility" for Patient #2 indicated a physician ordered BFR of 400. The treatment sheet evidenced a BFR of 300 without documentation of why the BFR order was not followed. The facility failed to follow the physician order. 4. A 10/18/2024 document titled, "Treatment Sheet for Facility" for Patient #2 indicated a physician ordered BFR of 400. The treatment sheet evidenced a BFR of 275-350 without documentation of why the BFR order was not followed. The facility failed to follow the physician order. 5. A 10/16/2024 document titled, "Treatment Sheet for Facility" for Patient #3 indicated a physician ordered BFR of 400. The treatment sheet evidenced a BFR of 350 without documentation of why the BFR orders were not followed. The facility failed to follow the physician order. 6. A 10/11/2024 document titled, "Treatment Sheet for Facility" for Patient #4 indicated a physician ordered DFR of 800. The treatment sheet evidenced a DFR of 500, without documentation of why the DFR orders were not followed. The facility failed to follow the physician order.		is being achieved, or reason is documented in medical record if unable to meet prescribed blood flow Check dialysate flow rate setting is correct, and the prescribed flow is being delivered. Effective 11/18/24, the Clinical Manager or Charge Nurse will conduct daily audits, 3 times per week on 10 treatments sheets with a focus on ensuring the dialysate flow rate (DFR) and blood flow rate (BFR) are set according to physician order, or justification documented if unable to achieve for 4 weeks or until 100% compliance is achieved utilizing Treatment Sheet Audit Tool. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Tool per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status	

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	152605	A. BUILDING 00 B. WING	10/30/2024

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	7. A 10/14/2024 document titled, "Treatment Sheet for Facility" for Patient #4 indicated a physician ordered DFR of 800. The treatment sheet evidenced a DFR of 500, without documentation of why the DFR orders were not followed. The facility failed to follow the physician order. 8. A 10/18/2024 document titled, "Treatment Sheet for Facility" for Patient #4 indicated a physician ordered BFR of 400 and DFR of 800. The treatment sheet evidenced a BFR 350 and DFR of 500, without documentation of why the BFR and DFR orders were not followed. The facility failed to follow the physician order. 9. A 10/21/2024 document titled, "Treatment Sheet for Facility" for Patient #4 indicated a physician ordered DFR of 800. The treatment sheet evidenced a DFR of 500, without documentation of why the DFR orders were not followed. The facility failed to follow the physician order. 10. During an interview on 10/30/2024 at 10:21 AM the Clinic Manager indicated that staff should be following the prescribed BFR and DFR. If unable to obtain prescribed rate, staff should document the reason why in the clinical record. For Patient #1, the clinic manager indicated she was aware of the physician rounding on 10/18/2024 and may have advised staff to change the BFR but was unable to provide documentation that this happened. 11. During an interview on 10/30/2024 at 11:14 AM, the clinical manager indicated that for Patient #2, staff should be following the physician order for BFR. If unable to obtain, the expectation is to document the reason why and notify the nurse.		of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 11/28/2024.	

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	12. During an interview on 10/30/2024 at 12:28 PM, the clinical manager indicated that for Patient #3, the staff should be following the physician order for BFR and DFR. If unable to obtain, the expectation is to document the reason why and notify the nurse. 13. During an interview on 10/30/2024 at 12:04 PM, the clinical manager indicated that for Patient #4, the staff should be following the physician order for BFR and DFR. If unable to obtain, the expectation is to document the reason why and notify the nurse. 14. During an interview on 10/30/2024 at 12:53 PM, PCT 1 indicated the staff should be following the physician order for BFR and DFR. PCT 1 indicated if the BFR or DFR cannot be met, they document the rate and reason and notify the nurse. 15. During an interview on 10/30/2024 at 12:40 PM, RN 2 indicated the staff should be following the physician order for BFR and DFR. RN 2 indicated the physician ' s order should be entered and doubled checked on the machine before treatment begins.			
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P Based on record review and interview, the facility failed to follow policy by removing expired supplies from the treatment floor in 1 of 1 facility reviewed, failed to properly label medications set up in advance in 1 of 1 facility reviewed and failed to complete an initial nursing assessment on a new patient prior to starting treatment in 1 of 2 new admissions reviewed. (Patient #5)	V 0715	**V 715** By 11/13/2024, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policy: Storage of Supplies Medication Preparation and	11/28/2024

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	Findings Include: 1. A policy titled, "Storage of Supplies" indicated but was not limited to, "Proper storage conditions are necessary to provide a safe environment and to ensure supplies are not expired, contaminated or damaged ... Supplies must be rotated First-in First-out (FIFO) to ensure products maintain quality and do not expire. Appropriately dispose of items that have reached the expiration date". 2. A policy titled, "Medication Preparation and Administration" indicated but was not limited to, "All medications in syringes not being administered immediately shall be labeled appropriately with the name of the medication, route, dose, name of the patient, date, time and initials of the person who prepared the medication ... Oral medications not being administered immediately must also be labeled as indicated above". 3. A policy titled, "Comprehensive Interdisciplinary Assessment and Plan of Care" indicated but was not limited to, "A registered nurse must perform an assessment of patient NEW to dialysis BEFORE initiation of their first treatment to determine immediate needs". 4. During an observation of the isolation room on 10/23/2024 at 11:16 AM, a yellow container stored in a cabinet int the isolation room housed multiple supplies. Two mint green laboratory tubes expired on 12/31/2023 and one lavender tube expired on 05/31/2024. Two ChloraPrep Single Swab sticks (disinfectant used to clean dialysis catheter exit site), both had expired June of 2024 and July of 2024. 5. During an observation on 10/23/2024 at 10:24		Administration Comprehensive Interdisciplinary Assessment and Plan of Care Emphasis was placed on: Proper storage conditions are necessary to provide a safe environment and to ensure supplies are not expired, contaminated or damaged. All supplies must be stored in a clean, well lit, and climate-controlled environment. Storage of supplies outdoors is strictly prohibited. All supplies must be stored and handled in accordance with manufacturer's instructions for use and Safety Data Sheets. Review hazardous communication program for addition instruction. All clean or sterile supplies, except drums of concentrate, must be stored off the floor and a minimum of eighteen inches in a sprinklered facility from the ceiling. Sterile supplies must be stored above clean supplies. All liquid supplies must be stored separate from dry supplies to minimize damage from accidental breakage or spills. Supplies must be stored in a manner that does not present a safety hazard to staff such as slip and fall or trip hazard. Supplies must be rotated First in-First Out (FIFO) to ensure products maintain quality and do not expire. Appropriately dispose	

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	AM, two boxes of surgical tape with an expiration date of 07/13/2024 were found in a cabinet on the treatment floor. 6. During an observation on 10/23/2024 at 10:24 AM, one box of Povidone-iodine swabsticks (antiseptic used to cleanse or disinfect skin) with an expiration date of 03/2021 were found in the cabinet on the treatment floor. 7. During an observation on 10/23/2024 at 10:55 AM, three medications cups, each containing one oral pill each were found in the cabinet at the medication preparation area. Medication cup #1 was labeled 10/23/2024 Patient #6 Sensipar (medication used to lower calcium levels) 30 milligrams. Medication cup #2 was labeled 10/23/2024 Patient #7 Sensipar 30 milligrams. Medication cup #3 was labeled 10/23/2024 Patient #8 Calcitriol 0.25 micrograms. The medication labels affixed to the individual medicaiton cups failed to include the time the medications were set-up and the initials of the staff that prepared them. 8. During interview on 10/30/2024 at 12:04 PM, the FA indicated the admission date for Patient #5 was 10/21/2024, The initial nursing assessment was documented at 8:09 AM. The first, initial treatment data indicated that Patient #5 started treatment at 7:38 AM. The facility failed to ensure a nursing assessment was completed prior to starting treatment for a new patient admit. 9. During an interview on 10/23/2024 at 11:05 AM, RN 2 indicated that she had set-up the oral medications located in the medication cabinet for the day and indicated the expectation is include the time the medications were prepared along with her initials.		of items that have reached the expiration date. Store acid concentrates in accordance with the Acid Concentrate Storage and Handling policy. Bleach and vinegar should not be stored next to each other to minimize the potential for reaction leading to harmful vapors in the case of accidental breakage or spills. Bleach must be stored below other supplies to prevent contamination if leakage occurs Use proper body mechanics when handling, lifting, and moving supplies as outline in the Back-Injury Prevention Program. All medications in syringes not being administered immediately shall be labeled appropriately with the name of the medication, route, dose, name of patient, date, time and initials of the person who prepared the medication. If more than one syringe of the same medication is needed for a single patient, mark the label as “1 of 2, 2 of 2.” Reconstituted medication admixtures shall also include on the label the date and time the solution was prepared. Filled syringes do not have to be labeled if drawn up and administered immediately. These unlabeled, filled syringes must not be placed down at any time. Only	

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	10. During an interview on 10/23/2024 at 11:35 AM, RN 1 indicated that all staff members are responsible for ensuring supplies have not expired. If found to be expired, those supplies should be discarded and not used. 11. During an interview on 10/25/2024 at 10:45 AM, RN 2 indicated that the Betadine and plastic tape found during the flash tour on 10/23/2024 was indeed expired and should have been discarded. She indicated that it was a team effort to check for expired supplies, it was not designated to just one or two individuals. 12. During an interview on 10/30/2024 at 12:02 PM, the Clinic Manager indicated the expectation is for the RN to complete an assessment of each patient prior to starting the first treatment. 13. During an interview on 10/25/2024 at 9:49 AM, RN 1 indicated if a patient has an allergy to paper tape, the surgical tape may be substituted however this happens rarely. RN 1 indicated it is the FA ' s responsibility to maintain up to date stock. RN 1 also indicated the iodine swabs were used for a previous patient with an allergy to Chlorahexidine (disinfectant for skin). RN 1 indicated she would dispose of the expired supplies promptly.		one unlabeled, filled syringe can be drawn up and administered at one time. Oral medications not being administered immediately must also be labeled as indicated above. A registered nurse must perform an assessment on patients NEW to dialysis BEFORE initiation of their first treatment to determine immediate needs. The RN must document the assessment. The assessment may be documented on the CIA in eCC, evaluation cascade in Chairside or multidisciplinary notes and should include at a minimum: Neurologic: level of alertness/mental status, orientation, identification of sensory deficits Subjective Complaints Rest and comfort: pain status Activity: ambulation status, support needs, fall risk Access: assessment Respiratory: respirations description, lung sounds Cardiovascular: heart rate and rhythm; presence and location of edema Fluid gains, blood pressure and temperature pre-treatment Integumentary: skin color, temperature and as needed,	

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			type/location of wounds. Effective 11/18/24, Clinical Manager or Charge Nurse will conduct daily audits with focus on ensuing no expired supplies within the treatment area, and properly label medications prepared in advance, utilizing specific plan of correction audit tool for 4 weeks, or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. Effective 11/18/24, Clinical Manager or Charge Nurse will conduct weekly audits with focus on ensuing the initial nursing assessment conducted/ documented for new patients prior to treatment initiation utilizing medical record audit tool for 3 months, or until 100% compliance is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.	

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			The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic. Completion 11/28/2024.	