STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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: 02/25/2025-02/28/2025 Active Census: 126 At this Emergency Preparedness survey, East Evansville Dialysis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR on 03/12/2025 by A4	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal Recertification survey of an ESRD provider. Survey Dates: 02/25/2025-02/28/2025 Census by Service Type: In-Center Hemodialysis: 89 Home Hemodialysis: 5 Peritoneal Dialysis: 32 Isolation: Room Abbreviations: CVC- Central Venous Catheter FA- Facility Administrator RN- Registered Nurse	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Stepro	Facility Administrator	04/07/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
V 0111 Bldg. 00	PCT- Patient Care Technician 494.30 IC-SANITARY ENVIRONMENT Based on observation, record review, and interview, the facility failed to secure the lids to the bleach containers for 3 of 3 observation days and failed to ensure the staff used bleach wipes immediately after preparation for 2 of 3 observation days. Findings include: 1. A revised 10/2023 "Bleach Policy" policy indicated that staff are to cover the bleach solution containers with a lid. The policy stated the bleach solution would degrade over time and become less effective when open to air. 2. During a flash tour on 02/25/2025 at 9:13 AM, the surveyor found two 1:100 bleach containers and one 1:10 bleach container with the lid off sitting on the counter in a clean area. 3. During a flash tour on 02/25/2025 at 9:13 AM, the surveyor found four sharp containers (a container used to dispose of sharp objects like needles and syringes safely) with bleach wipes on top of each container. 4. During an observation on 02/26/2025 between 8:35 AM and 9:40 AM, the surveyor found one 1:10 and two 1:100 bleach containers with the lids not secured at pod B. During an interview on 02/26/2025 at 8:55 AM, PCT 3 stated she was unsure why the lids were not secure on the bleach containers. PCT 3 was able to fasten lids to the containers without	V 0111	The Facility Administrator or Clinical Coordinator will in-service 100% of teammates on Policy 1-05-08 “Bleach Policy”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Bleach solution needs to be covered with a secure lid and the solution should not be placed in the splash zone. NOTE: Without a secure lid, the bleach solution is open to air causing the solution to degrade over time and become less effective. The Facility Administrator or Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	difficulty. 5. During an observation on 02/26/2025 at 8:50 AM, the surveyor found two sharp containers with bleach wipes resting on top of each container. During an interview on 02/26/2025 at 8:55 AM, PCT 3 stated she prepared all the bleach wipes at the beginning of the shift and placed the bleach wipes on top of the red sharps containers in case of a blood spill. PCT 3 stated she did not know if the bleach wipes would degrade if not used immediately after preparation. 6. During a random interview on 02/26/2025 at 12:00 PM, PCT 1 stated she was unsure why staff did not secure the bleach container lid to the container. She said the bleach would evaporate if the lids were left off. 7. During an interview on 02/26/2025 at 2:47 PM, RN 1 stated she was unsure why the bleach container had no lid. She said the bleach would evaporate if the lid were left off. 8. During an observation on 02/27/2025 at 9:40 AM, the surveyor found a 1:100 bleach container in a designated dirty area at pod B with the lid off. During an interview on 02/27/2025 at 4:00 PM, the FA stated that staff are to secure the lids of the bleach containers when not in use.		Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the staff failed to ensure hand hygiene and/ or glove changes were performed before and	V 0113	The Facility Administrator or Clinical Coordinator will in-service 100% of teammates on Policy	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	after removing gloves, before collecting clean supplies, before caring for a patient, before preparing medication, and after touching dirty equipment affecting 5 of 8 staff members observed providing patient care (PCT 1, PCT 2, PCT 3, PCT 7, RN 2) Findings include: 1. A revised 10/2023 "Medication Policy" policy indicated that staff must use aseptic techniques when administering medications. The policy indicated that staff should prepare medications in an aseptic environment and perform proper hand hygiene. 2. A revised 04/2019 "Utilizing Vascular Access Clamps" policy indicates staff should perform hand hygiene and apply new gloves before patient contact and after touching the dialysis delivery system. 3. A revised 04/2023 "Infection Control for Dialysis Facilities" policy indicated all teammates would perform hand hygiene before gloving and immediately after removal of gloves, after coming in contact with infectious material, after patient and dialysis delivery system contact between patients, before touching clean (supplies, supply cart, and chairside keyboard/mouse). Gloves should be changed when going from a dirty area or task to a clean area or task, after touching one patient or their dialysis delivery system, and before arriving to care for another patient or touch another patient's dialysis delivery system. 4. During an AV fistula initiation observation on 02/25/2025 at 11:22 AM, PCT 2 removed one glove, went to a clean area to collect supplies, returned to station #7, placed the glove on the		1-06-01 “Medication Policy”, Policy 1-04-08A “Utilizing Vascular Access Clamps”, and Policy 1-05-01”Infection Control For Dialysis Facilities”. Verification of attendance will be evidenced by an inservice signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) An aseptic environment and aseptic technique is used when preparing medications. 2) Careful attention to proper hand washing is performed at this time. 3) Perform hand hygiene. 4) Disposable gloves will be worn when caring for the patient or touching the patient's equipment at the dialysis station…4) Gloves should be changed when: … After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient’s dialysis delivery system…5) All teammates… will perform hand hygiene: … prior to gloving and immediately after removal of gloves… after contamination with blood or other infectious material; after patient and dialysis delivery system contact… The Facility Administrator or Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	ungloved hand, and provided care to Patient #22. After completing care for Patient #22, PCT 2 retrieved the biohazard trash container with a gloved hand, brought the container to station #7, and then touched the dialysis machine. PCT 2 failed to remove gloves and hand hygiene before going to the clean area to collect supplies; she failed to remove one glove, hand hygiene, and don new gloves before providing patient care to Patient #22. PCT 2 failed to remove gloves and hand hygiene after touching the biohazard trash container and before providing patient care. 5. During an observation on 02/25/2025 at 11:50 AM, PCT 1 retrieved the biohazard trash container with a gloved hand, brought the container to station #6, and provided care to Patient #14. PCT 1 failed to remove gloves and hand hygiene after touching the biohazard trash container and before providing patient care. 6. During an observation on 02/25/2025 at 11:55 AM, PCT 2, with ungloved hands, gripped the top edge of the biohazard trash container to remove it from Station #6, then touched Station #10's computer keyboard. PCT 2 failed to glove before touching the biohazard container; she failed to hand hygiene after touching the biohazard container and before touching the computer keyboard. 7. During a CVC exit site care observation on 02/25/2025 at 11:30 AM, PCT 1 removed her gloves, collected new gloves from the glove box at a computer station, donned new gloves, and provided care to Patient #14. PCT 1 failed to hand hygiene between gloving. 8. During discontinuation of dialysis with a CVC observation on 02/25/2025 at 2:10 PM, PCT 7		policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	gloved, touched the computer keyboard, collected clean supplies, placed supplies on a chair side table at Station # 16, returned to the computer keyboard, then removed bloodlines from Patient #15. PCT 7 failed to change gloves and hand hygiene after touching the computer and before collecting clean supplies and placing them on the chair side table; failed to change gloves and hand hygiene after placing supplies on the chair side table and before touching the computer keyboard; failed to change gloves and hand hygiene after touching the computer and before removing Patient #15's bloodlines. 9. During discontinuation of dialysis with a CVC observation on 02/25/2025 at 2:50 PM, PCT 1 removed the first bloodline from Patient #16, attached it to the dialysis machine to start reinfusing blood, and then disinfected CVC connections on Patient #15. PCT 1, with gloved hands, discarded all used and unused supplies and then assessed the patient with personal items. PCT 1 failed to change gloves and hand hygiene after removing bloodlines and disinfecting the CVC connections; failed to change gloves after touching dirty supplies and assisting the patient with personal items. 10. During a Discontinuation of dialysis with an AV observation on 02/25/2025 at 10:40 AM, PCT 2 disconnected one bloodline, reinfused blood, removed gloves, and then touched the computer keyboard. PCT failed to perform hand hygiene after removing gloves. PCT 2 placed one glove on, went to the clean area, collected supplies with both hands for Patient # 19, returned to Station #8, removed gauze from Patient #19 AV site, and then placed clean gauze over the AV site. PCT 2 failed to remove gloves and hand hygiene before collecting clean supplies, after collecting supplies,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	and before providing AV site care. PCT 2, with ungloved hands, removed dirty supplies from Station # 8 and then touched the computer keyboard. PCT 2 failed to use hand hygiene and gloves before removing dirty supplies and touching the keyboard. 11. During a medication preparation and administration observation on 02/25/2025 at 12:17 PM, RN 2 failed to hand hygiene before preparing Patient #20 medication. 12. During a medication preparation and administration observation on 02/25/2025 at 12:20 PM, RN 2 failed to hand hygiene before preparing Patient #21's medication. 13. During an observation on 02/26/2025 at 8:55 AM, PCT 3 reached inside the biohazard container to pull it closer to station 15 using gloved hands. She removed the bloodlines from the machine and placed them in the biohazard container. The surveyor observed that the front part of PCT 3's gown and sleeves came directly in contact with the red bag liner. Afterward, she provided patient care to Patient #12. PCT 3 failed to change gloves, perform hand hygiene, and change into a new gown after touching the biohazard trash container. During an interview on 02/26/2025 at 8:55 AM, PCT 3 stated she should change gloves and perform hand hygiene after touching dirty items. 14. During an interview on 02/26/2025 at 11:50 AM, PCT 1 indicated staff should change their hand hygiene and gloves when going from dirty to clean, before and after working on the computer, touching biohazard containers, and before and after changing gloves. Staff are not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	allowed to have one glove on and leave the station to retrieve supplies from a clean area. Staff should remove gloves and hand hygiene before collecting supplies, then should hand hygiene and re-glove. 15. During an interview on 02/26/2025 at 2:45 PM, RN 1 emphasized the importance of hand hygiene in various situations, including during glove changes, transitioning from a dirty to a clean area, and after handling trash containers. She highlighted that staff must perform hand hygiene before preparing medication and that RN should clean the IV access port with alcohol before access. She stated that if staff use gloves to pull biohazard containers to the station, a glove change and hand hygiene are necessary before providing care. RN 1 staff are not to wear gloves while working on the computer.			
V 0119 Bldg. 00	494.30(a)(1)(i) IC-SUPPLY CART DISTANT/NO SUPPLIES IN POCKETS Based on observation, record review, and interview, the facility staff failed to store supplies in a designated clean area for 1 of 3 observation days. Findings include: A revised 04/2023 policy titled "Infection Control for Dialysis Facilities" indicated that staff are to disinfect non-disposable items after each patient use and before removal from the treatment station. During an observation on 02/26/2025 at 9:42 AM, the surveyor found one can of Cryodose (topical numbing spray for injections), with its lid off, sitting on the treatment chair tray next to Patient #23 during dialysis treatment.	V 0119	The Facility Administrator or Clinical Coordinator will in-service 100% of teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities". Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Non-disposable items are to be disinfected after each patient use, prior to removal from treatment area/ station…The Facility Administrator or Clinical Coordinator will conduct	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	During an interview on 02/26/2025 at 9:55 AM, PCT 4 stated that staff are to wipe the Cryodose with a bleach wipe after patient use, place the lid back on the Cryodose, and secure it in a locked drawer. During an interview on 02/26/2025 at 2:47 PM, RN 1 stated staff should place the Cryodose in a dirty area if they cannot disinfect the can after patient use. She stated staff should wipe the Cryodose can off with a bleach wipe, apply the lid, and place it in a locked drawer after use. She stated that staff should not leave the Cryodose to sit on the treatment chair tray during dialysis treatment.		observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction	
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 follow applicable infection control procedures when cleaning and disinfecting contaminated surfaces and equipment for 2 of 2 observations of cleaning and disinfecting the dialysis station. (Stations #16 & #17) Findings include:	V 0122	The Facility Administrator or Clinical Coordinator will in-service 100% of teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities". Verification of attendance will be evidenced by an inservice signature sheet. Teammates will be educated using surveyor observations as	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	1. A revised 04/2023 policy titled "Infection Control for Dialysis Facilities" indicated that staff should clean and disinfect all surfaces of the dialysis station, including TV, blood pressure cuffs, and countertops. Staff must disinfect non-disposable items after each patient's use before removal from the treatment/station area. 2. During cleaning and disinfection of the dialysis station observation on 02/25/2025 at 2:30 PM, PCT 7 failed to disinfect between the seat cushion and the right side of the chair; she failed to raise the chair side table and disinfect the chair under a chair side table while disinfecting Station 16. 3. During an observation on 02/27/2025 at 10:00 AM, PCT 6 removed the prime waste container from the dialysis machine at station 17 and emptied the contents into the sink. She returned to the station and placed the prime waste container onto the designated clean, snappy computer tray without disinfecting it. She walked to the bleach container to retrieve a wipe and clean the prime waste container. PCT 6 failed to disinfect the prime waste container before placing it in a designated clean area. During an interview on 02/27/2025 at 10:10 AM, PCT 6 stated she should disinfect the prime waste container before returning it to a clean area. PCT 6 stated that the snappy computer area was dirty. PCT 6 then changed her statement to say the area was considered clean.		examples with emphasis on, but not limited to the following: 1) Non-disposable items are to be disinfected after each patient use, prior to removal from treatment area/ station…2) At the end of each treatment, the dialysis station will be cleaned and disinfected. a. Surfaces to disinfect include but are not necessarily limited to: all surfaces in contact with the patient or their belongings (e.g., dialysis chair, tray tables, blood pressure cuffs) and frequently contacted by healthcare personnel (e.g., control panel; top, front and sides of dialysis machine; touchscreens; countertops). The Facility Administrator or Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
			effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS Based on observation, record review, and interview, the staff failed to use an aseptic technique when administering intravenous (IV) medication for 2 of 4 RN IV-administered medication observations. (Patient #20 & Patient #21) Findings included: 1. A revised 10/2023 "Medication Policy" policy indicated that staff must use aseptic techniques when administering medications. The policy indicated that staff should prepare medications in an aseptic environment and perform proper hand hygiene. 2. During a medication preparation and administration observation on 02/25/2025 at 12:17 PM, RN 2 failed to use antiseptic on top of the vial stopper before accessing the vial with a needle; RN 2 failed to clean the IV line port before accessing and administering Patient #20's medication. 3. During a medication preparation and administration observation on 02/25/2025 at 12:20 PM, RN 2 failed to use antiseptic on top of the vial stopper before accessing the vial with a needle;	V 0143	The Facility Administrator or Clinical Coordinator will in-service 100% of teammates on Policy 1-06-01 “Medication Policy”, Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) An aseptic environment and aseptic technique is used when preparing medications. 2) Careful attention to proper hand washing is performed at this time. The Facility Administrator or Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	RN 2 failed to clean the intravenous IV line port before accessing and administering Patient #21's medication. 4. During an interview on 02/26/2025 at 2:45 PM, RN 1 indicated before accessing the medication vial, the team members should clean the top with alcohol. Team members should use alcohol on the port before accessing IV lines.		meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0250 Bldg. 00	494.40(a) DIALYS PROPORT-MONITOR PH/CONDUCTIVITY Based on observation, record review, and interview, the staff failed to follow manufacturer instructions on the wait time to obtain accurate pH test results for 2 of 2 observations of staff preparing the Hemodialysis Machine. (Station #6 and Station #11). Findings include: 1. A document titled "E-Z Check 6.8 - 8.5 pH test Strips" indicates users should compare test results to the color scale on the bottle between 20 and 25 seconds after briskly shaking off excess solution. 2. During a random observation on 02/25/2025 at 11:40 AM, PCT 1 removed the pH test (a test to measure how acidic or basic a solution is) strip from the solution for station #6 and read the pH	V 0250	The Facility Administrator or Clinical Coordinator will in-service 100% of teammates on Policy 1-21-09 “Testing pH of Citric Acid Base Dialysate Using RPC E-Z CHEK K100-0117CT 6.8-8.5 Test Strips”. Verification of attendance will be evidenced by an inservice signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Remove the strip from the fluid and shake off excess dialysate. 2) Within 20 to 25 seconds, compare the color reaction on strip to the color chart on bottle to determine the closest match. The Facility Administrator	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	strip without looking at the clock or watch to allow for a 5-10 second test strip process time. PCT 1 failed to collect an accurate pH reading. 3. During a random observation on 02/25/2025 at 11:00 AM, PCT 1 removed the pH test strip from the solution for station #11 and read the pH strip without looking at the clock or watch to allow for a 5-10 second test strip process time. PCT 1 failed to collect an accurate pH reading. 4. During an interview on 02/26/2025 at 11:50 AM, PCT 1 indicated that staff should wait 15 seconds to read the results after dipping the pH strips. PCT 1 indicated during observation on 02/25/2025 that she did not wait 15 seconds to read the results. 5 During an interview on 02/26/2025 at 2:45 PM, RN 1 indicated staff should shake off excess fluid, wait 5 seconds and compare the results to the colors on the bottle.		or Clinical Coordinator will conduct observational audits of testing for pH of dialysate daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P Based on observation, record review, and staff interviews, the facility ' s medical director failed to ensure staff followed all policies and procedures, including the Medication Policy, Utilizing Vascular Access Clamps Policy, Pre-Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment Policy, and Initial Patient	V 0715	A Governing Body meeting will be conducted for review of the results of the survey conducted on 1/30/25. The Governing Body will review Policy COMP-DD-017 “Medical Director Qualifications and Responsibilities” with the	03/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	Assessment for New Patients Policy. (Patients #1, #4, #5, #6, #12, and #26 with the potential to affect all patients. Findings Include: Medication Policy A revised 11/2023 policy titled "Medication Policy" indicated, but was not limited to, "each vial is labeled with the initials of the person opening the vial and the expiration date." During an observation on 02/25/2025 at 9:45 AM, the surveyor found two opened multiple-dose vials in medication refrigerator 1: Parsabiv (hyperparathyroidism medication) 10mg/2mL and Parsabiv 5mg/1mL. There were no initials or expiration dates on the vials by the person opening the medication. During an interview on 02/25/2025 at 9:48 AM, RN 1 stated that staff must initial and date the two opened multiple-dose vials located in medication refrigerator 1 at the time of opening. Vascular Clamp Assessment Policy 1. A revised 04/2019 policy titled "Utilizing Vascular Access Clamps" indicated that if staff uses vascular clamps, they should assess the thrill (palpable vibration) and a bruit (audible whooshing sound heard through a stethoscope) during use. The policy indicated staff should not leave vascular clamps on a patient for longer than 20 minutes. 2. During an observation on 02/25/2025 between 10:55 and 11:15 AM, Patient #26 sat with one clamp in place on the first AV fistula needle site;		Medical Director to include: 1) Medical Director responsibilities include, but are not limited to, the following… Oversight of policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility….Verification of the Medical Director's attendance and understanding is evidence by his/her signature on the policy. The Facility Administrator or Clinical Coordinator will in-service 100% of the teammates on Policy 1-06-01 "Medication Policy", Policy 1-03-08 "Pre-Intra-Post Data Collection, Monitoring, and Nursing Assessment", Policy 1-04-08 "Utilizing Vascular Access Clamps" and Policy 1-03-07 "Initial Patient Assessment For New Patients". Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be instructed using surveyor observations as exampled with emphasis on, but not limited to the following: 1) Medications containing a preservative…Each vial is labeled with the initials of the person opening the vial and the expiration date. 2) Vascular access clamps…During use, the thrill and bruit of the access will be checked above and below the clamp. 3) …f a patient is unable to hold his/her own sites, it is recommended that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	the staff failed to evaluate the thrill and bruit of the access before or during clamping. At 11:20 AM, PCT 7 removed the first clamp and placed the second clamp over the second needle removal site. From 11:20 AM to 11:40 AM, a second clamp was in place on the AV fistula; the staff failed to evaluate the thrill and bruit of the access before or during clamp application. 3. During an interview on 02/26/2025 at 11:50 AM, PCT 1 indicated that clamps should be left for 5 to 10 minutes unless ordered by the physician. Patients should be checked for a thrill, both above and below the access site, every 5 minutes. 4. During an observation on 02/26/2025 at 8:55 AM, PCT 3 placed a vascular clamp on Patient #12 ' s left AV access site after disconnecting the bloodlines. PCT 3 left the station. Patient #12 ' s clamp stayed in place for 20 minutes. RN 1 came to the station to remove the clamp. The staff failed to assess the site for thrill and a bruit while using a vascular clamp. 5. During an interview on 02/26/2025 at 9:30 AM, RN 1 stated that staff could apply vascular clamps to access sites for 10 minutes. She stated Patient #12 has to leave the vascular clamp on longer to stop the bleeding. She stated staff should assess for thrill and bruit during clamp use. 6. During a random interview on 02/26/2025 at 12:00 PM, PCT 1 indicated that clamps should be left for 5 to 10 minutes unless ordered by the physician. Patients should be checked for a thrill, both above and below the access site, every 5 minutes. 7. During an interview on 02/26/2025 at 4:15 PM, the Manager of Clinical Services stated staff		only one (1) clamp is used at a time and should not be left on longer than 20 minutes. 4) Patient identity, prescription and machine settings…The prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation along with the nursing assessment or as allowable by state law. 5) The PCT or licensed nurse will obtain and document basic data on each patient post dialysis and compare to pre-dialysis findings. 6) If an abnormal finding(s) or concern is identified post treatment, this needs to be reported to the licensed nurse. The licensed nurse will assess the patient prior to discharge. 7) A registered nurse (RN) as required by federal regulation will perform an initial pretreatment evaluation of all patients prior to the initiation of their first treatment at the facility. The Facility Administrator or Clinical Coordinator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy for labeling multi-dose medication vials and the use of for access clamps. Ongoing compliance will be verified monthly. The Facility Administrator or Clinical Coordinator will audit twenty-five percent of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	should assess for a thrill and bruit every 5 to 10 minutes when clamps are in place. Pre-Intra-Post Treatment Data Collection Policy 1. A revised 04/2024 policy titled "Pre-Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment" indicated that licensed nurses should confirm patients' prescriptions and perform a nursing assessment on patients within one hour of treatment initiation. The policy indicated that a PCT or nurse would obtain and document a post-assessment for each patient. 2. A review of Patient #1 ' s record evidenced a Treatment Details Report dated 02/12/2025. The treatment record failed to evidence that the staff completed and documented a post-assessment. During an interview on 02/27/2025 at 2:50 PM, the Manager of Clinical Services indicated the nurse is required to do a post-assessment; she failed to provide evidence of a post-assessment in Patient #1 ' s record for 02/12/2025. 3. A review of Patient #4 ' s record evidenced a Treatment Details Report dated 01/24/2025. The treatment record failed to evidence that the staff completed and documented a post-assessment. During an interview on 02/26/2025 at 2:47 PM, RN 1 stated staff should complete a post-assessment before the patient leaves the treatment area. RN 1 wasn ' t sure why she did not complete a post-assessment on Patient #4. 4. A review of Patient #5 ' s record evidenced a Treatment Details Report dated 02/14/2025. The treatment record failed to evidence that the staff completed and documented a post-assessment.		facility policy for verification of the dialysis prescription, post dialysis assessments, and documentation of an initial nursing assessment prior to the first dialysis treatment. Instances of noncompliance will be addressed. The Facility Administrator will review results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Medical Director is responsible for compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	During an interview on 02/28/2025 at 9:00 AM, the Manager of Clinical Services reviewed Patient #5 ' s record. She stated the CWOW (electronic medical record) would not close out until a post-assessment was complete. She stated it must be a glitch in the CWOW system and that she would have to contact them. 5. During an interview on 02/28/2025 at 9:00 AM, the Manager of Clinical Services reviewed Patient #5 ' s record. She stated the CWOW (electronic medical record) would not close out until a post-assessment was complete. She stated it must be a glitch in the CWOW system and that she would have to contact them. 6. On 02/28/2025 at 8:35 AM, the Medical Director stated the nurse should complete a post-assessment on all patients. Initial Patient Assessment for New Patients Policy A revised 04/2024 policy titled "Initial Patient Nursing Assessment for New Patients" indicated the RN was required to perform an initial pre-assessment evaluation of all patients before initiating their first dialysis treatment at the facility. A review of Patient #6 ' s record evidenced an admission date of 01/14/2025, an Initial Patient Nursing Assessment date of 01/21/2025, and a Treatment Details Report dated 01/14/2025. The facility nurse failed to complete the initial assessment before initiating Patient #6 ' s first dialysis treatment. During an interview on 02/27/2025 at 4:00 PM, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152569	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714

(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
	FA stated the RN should have completed the initial assessment before initiating Patient #6 ' s first dialysis treatment. During an interview on 02/28/2025 at 9:15 AM, the Manager of Clinical Services stated the nurse who initiated the first treatment was a float nurse who was not currently at the facility. She said RN 1, who completed the initial assessment, did not know why the float nurse didn ' t complete the assessment timely.			