STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152608	A. BUILDING _____ B. WING _____	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNELAND DIALYSIS KNOX	**1008 S EDGEWOOD DR KNOX, IN 46534**

(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 Department of Health in accordance with 42 CFR 494.62. Survey dates: 07/23/2025 to 07/25/2025 Census by Service Type: In-Center Hemodialysis: 17 During this Emergency Preparedness survey, Duneland Dialysis Knox, was found to be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers. QR: A1, 7/27/2025	E 000		
V 000	INITIAL COMMENTS This visit was for a CORE Federal Recertification survey of an ESRD provider. Survey dates: 07/23/2025, 07/24/2025, and 07/25/2025 Census by Service Type: In Center Hemodialysis: 17 Total Census: 17 Isolation: No room, area, nor a waiver. Isolation provided by an agreement with another Provider. Duneland Dialysis Knox 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 000	Continued From page 1 QR: A1, 7/27/2025	V 000		