

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  852579	<b>(X3) Date Survey Completed</b>  08/01/2024
<b>Name of Provider or Supplier</b>  Home Dialysis Services Norcross, Llc	<b>Street Address, City, State</b>  3780 Holcomb Bridge Road, Suite E, Norcross, GA	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>E0000</b>	An unannounced Recertification survey was conducted at Home Dialysis Services Norcross, LLC from July 30, 2024 through August 1, 2024. The survey revealed that the facility was in substantial compliance with 42 CFR Part 494.62, Conditions for Coverage for Emergency Preparedness Plan for End Stage Renal Disease facilities. No deficiencies were cited.
<b>V0000</b>	{CORE} An unannounced Recertification survey was conducted at Home Dialysis Services Norcross, LLC from July 30, 2024, through August 1, 2024. The survey revealed that the facility was in substantial compliance with 42 CFR Part 494 Conditions for Coverage for End Stage Renal Disease Facilities. However, the following standard level deficiency was cited which resulted from the facility's noncompliance related to the survey:
<b>V0143</b>	IC-ASEPTIC TECHNIQUES FOR IV MEDS CFR(s): 494.30(b)(2)  [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and  This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility failed to ensure that one of one Licensed Practical Nurse [(LPN) AA], who prepared a medication that was not given immediately, labeled the medication with the patient's name, the name of medication, the dosage, and the date and time it was prepared along with LPN AA's initials. This deficient practice had the potential to negatively affect the health and safety of 25 Peritoneal Dialysis (PD) patients and three Home Hemodialysis (HHD) patients who were seen during monthly clinic visits and received support from the staff. Findings were: During observation of the medication

refrigerator on 7/30/24 at approximately 11:00 a.m., this surveyor found an unlabeled and undated 10 ml (milliliter) syringe filled with a dark brown colored liquid. During an interview on 7/30/24 at 11:03 a.m., LPN AA stated "I pulled up Venofer (iron medication given intravenously) this morning to give to a patient but he did not show up and I did not need it, so I put it in the refrigerator." During an exit interview with the Director of Operations and the Clinical Manager on 7/31/24 at approximately 2:00 p.m., both acknowledged the findings.