STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING ______ B. WING ______	C 10/21/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEVY CHASE N & REHAB CENTER	**3400 SOUTH INDIANA CHICAGO, IL 60616**

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F 309	Continued From page 10 2. All schedule appointments are made by the Assist. Director of Nursing for dialysis residents 3. Transportation for outside appointments are made by the Assist. Director of Nursing for all dialysis residents. 4. Clerks making outside appointments must report to the Assist. Director of Nursing with any concerns. 5. The Director of Nursing and the Assistance Director of Nursing will review all dialysis residents charts 6. Quality assurance will continue to develop and monitor compliance with the treatment and care of all dialysis residents.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 11 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1810 Resident Record Requirements a) Each facility shall have a medical record system that retrieves information regarding individual residents. 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by : Based on observations, records reviews, and	F9999		

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F9999	Continued From page 12	F9999		

interviews, the facility :
1) Failed to provide 1 of 18 residents in the facility, (R1), with her scheduled hemodialysis.
2) Failed to monitor R1 after missed dialysis, and neglected to assess R1 for signs and symptoms of confusion, lethargy, and irregular heart beat for 3- shifts, (24 hours) that caused R1 to be admitted to an acute care hospital with the transient ischemic attack, hypertension and end stage renal failure.

Findings Include:

Observations made on 10-6-05 noted R1 was sitting on her bed in her room. R1 told surveyor on 9-20-05 she returned from her eye surgery at 11:00AM. R1 told surveyor she went to the basement where the dialysis unit is located and tried to receive her scheduled dialysis for the day . R1 further went on to tell surveyor there was no chair available and she was told to come back by the staff. R1 also told surveyor no one told her when to come back and she assumed someone would call for her as usual for dialysis treatment when they were ready. R1 told surveyor no one called her right away and she fell asleep in bed because she was tired from surgery. R1 went on to say the next thing she knew she was being transported to the hospital and was not doing very well the next day. R1 denied refusing her treatment.

Review of R1's clinical records shows R1 is a 65 year old female admitted to the facility on 3-27-03 with a diagnosis that included polyneuropathy, chronic renal failure and hemodialysis need. On 9-20-05 R1 had an appointment for eye surgery at 5:00AM. R1 returned to the facility at 11:00AM

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F9999	Continued From page 13 . R1 had physician's orders to have hemodialysis three times a week, every Tuesday, Thursday and Saturday. According to R1's minimum data set (MDS), with no date shown, R1's cognitive level is assessed at a level 1, meaning modified independent, but has some difficulty in new situations. Review of R1's hemodialysis treatment flow records shows no dialysis records on 9-20-05, Tuesday, R1's scheduled day. Interview was done with E5,(staff nurse/dialysis) on 10-6-05. E5 confirmed that R1 did not get hemodialysis on 9-20-05. E5 also told surveyor the dialysis unit probably did not know that R1 had returned from the eye clinic later in the day. "This is probably why she did not get dialysis on 9-20-05." Nursing note dated 9-21-05 at 10:30AM, indicates R1 was assessed to have significant mental status changes, lethargy and slurred speech..... R1's transfer form shows R1 needs dialysis today in big bold letters on both sides of the transfer form. This was written by E6(staff nurse). Phone interview was done with E6 on 10-14-05 at 12:05PM. E6 confirmed R1 was restless, anxious, had mental status changes, crying and an increase in blood pressure. E6 told surveyor he knew R1 needed dialysis and he obtained physician's orders to transport to the hospital. E6 also told surveyor the facility had a plan to re-schedule R1's dialysis for the following day. E6 did not obtain any physician's orders to re-schedule R1's hemodialysis or had the physician been notified of the missed dialysis. E6 also confirmed that no one in the facility documented	F9999		

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F9999	Continued From page 14 that R1 did not receive her dialysis and gave no reason as to why it was not done or offered. There are no nursing notes or any other documentation in the clinical records monitoring R1 over the 3-8 hours shifts for any change or decline in physical condition. R1 had the stress of eye surgery and missed hemodialysis and there was no obserbvation or monitoring of her medical status. Not until 9-21-05 at 10:30AM did any documented assessments of R1 's condition appear in the clinical records, and by then R1 was being transferred to an acute care hospital. Review of R1's hospital records shows R1 was admitted to the hospital on 9-21-05. The intensive care consultation report reveals R1 was admitted to the hospital through the emergency room because of missed dialysis with symptoms of lethargy, confusion, peaked T waves (irregular heart beat), and increased potassium of 7.5 (norm 3.5 to 5.3). Review of R1's consultation report dated 9-24-05 from Z4, (consulting nephrology), reveals R1 problems list included altered mental status, transient ischemic attack, and end stage renal disease on hemodialysis. Review of the emergency room records dated 9-21-05 reveals R1 missed hemodialysis and presented with symptoms of increased blood pressure, confusion, lethargy and irregular T waves, (irregular heart beat). Interview was done with Z3 (nurse consultant) on 10-6-05. Z3 told surveyor R1 refused dialysis. Z 3 had no comment as to why the physicians were	F9999		

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F9999	Continued From page 15 not notified, nor as to why R1 refused her hemodialysis which should have been charted and noted to physician. Interview was done with E12 (dialysis tech) on 10-6-05 at 5:30PM. E12 told surveyor a nurse called to the dialysis lab and told her R1 had refused dialysis for the day. E12 did not know who she spoke to when she spoke to the nurse, and why R1 was refusing dialysis. E12 said nothing about notifying a physician . E12 also had no documentation stating in the clinical records nor in the dialysis chart that R1 had refused dialysis on 9-20-05. Phone interview was done with Z1 (attending physician) on 10-6-05. Z1 told surveyor R1 was put into the hospital with congestive heart failure, increased potassium of 7.5 (norm 3.5 to 5.3), and then suffered TIA's because she missed her scheduled dialysis. Z1 further went on to say he would never allow a resident to stop or delay dialysis. Z1 also told surveyor no one from the facility called him to tell him that R1 did not receive her dialysis. Phone interview was done with Z2 (nephrologist) on 10-6-05. Z2 told surveyor, she did not give any orders to delay or stop hemodialysis. Z2 also told surveyor she did not even know that R1 had surgery earlier that day.	F9999		