STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING _____ B. WING _____	04/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210 b)1) Section 300.1210 General Requirements for Nursing & Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous, and imtramuscular shall be properly administered. This regulation is not met based on observation, interview and record review the facility failed to provide R17 her morning medications instead giving R17 R41's medications on 2/18/06. R17 received 16 medications that were prescribed to R41, including Glipizide 2.5mg. This resulted in R17 being transported to a local emergency room for treatment and admitted to the intensive care unit with low blood sugar levels and altered mental status. The findings include: The incident report dated 2/18/06 for R17 showed, "R17 given incorrect medications. I (E16 - Registered Nurse/RN) was getting ready to pass medications. I started getting R41's medications ready...therapy came and said, "Could you give R41 her pain medication.... Therapist walked into room 501 and I followed and gave R17 the incorrect medications." The order on R17's physician order sheet (POS) dated 2/18/06 showed, "Send to the emergency room to evaluate and treat."	F9999		

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F9999	Continued From page 21	F9999		

The emergency room physicians dictation dated 2/18/06 for R17 showed, "Chief Complaint: Aberrant mental status. This is an 85 year old female with a past history of Hypertension, Depression, Anemia, Hypothyroidism, previous unstable Cervical Fracture, Hyperlipidemia, Atrial Flutter, Coronary Artery Disease, and Gastroesophageal Reflux Disease. She presents from a local nursing home as the patient was aberrant and somewhat obtunded this morning. It was noted, on arrival, that the patient was given another patient's medications at the local nursing home. Physical examination: The patient was lethargic, though, with a blood sugar of 59. She was given an ampule of dextrose 50. She became more alert, though still somewhat aberrant as to her mental status as compared to usual according to family. Patients care was continued...blood sugars fluctuated...at approximately 1:50pm, the blood sugar was back down to the 60's. Likely all these problems that the patient is experiencing today were related to the Glipizide amongst the other medications given in error this morning causing the mental status aberrations. In view of the fluctuating neurological status, hypoglycemia and relative risk for this occurring rather rapidly, the patient will be admitted to the intensive care unit."

The hospital history and physical dated 2/19/06 for R17 showed, "This 85 year old female patient is admitted with a history of receiving the wrong medication this morning. The patient (R17) is a resident at a nursing home. She was given the medications that belong to another patient. The medications were Glipizide 2.5mg, Aspirin 81mg, Reglan 10mg, Os-cal 500mg, Zoloft 100mg, Zinc

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F9999	Continued From page 22 Gluconate 50mg, Maxzide 25mg, multivitamin 1 tablet, Lipitor 10mg, Diovan 160mg, Colace 100 mg, Synthroid 200mcg and Darvocet N100 (2 tablets). The patient was transferred to the emergency room by ambulance. She is lethargic. She is admitted to the intensive care unit for observation." On 3/27/06 at 3:00pm R17 was observed sitting in a wheelchair in her room eating a snack. An interview was conducted at that time. R17 was asked if she remembered an incident in which she received the wrong medication and was admitted to the hospital? R17 stated that she remembered the incident. R17 stated, "I got so dizzy and it wouldn't stop. I felt awful. I don't know what the medications were but I stayed in the hospital several days." The Minimum Data Set (MDS) dated 6/22/05 and 1/18/06 for R17 showed no impairment of long term memory, short term memory or cognition. The monthly care report dated 3/1/06 for R17 showed, "Alert and oriented to person, place and time." On 3/28/06 at 12:15pm, E1 (Administrator) stated, "We know a mistake was made. It is all in the report (incident report)." (A)	F9999		