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	145980	A. BUILDING _____ B. WING _____	C 06/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ST CHARLES	850 DUNHAM RD ST CHARLES, IL 60174

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F 425	Continued From page 12 dated 12/1/06 to 12/31/06, lists the medication Methotrexate 2.5 mg tablet 11/29/06 # 007264973 NDC# 00378001401. From interview conducted via telephone 6/7/07 at 11:45 a.m. with Z3 (RPh., Executive Director), Z3 states that the Pharmacy was notified of the incident on 12/19/06 and immediately began an investigation. Inservices were conducted with the facility on 12/20/06. It was determined that the medication order was entered by a technician incorrectly, and the Pharmacist failed to verify the order and medication. This resulted in the wrong medication being sent to the facility. There was no documented investigation into why the consulting pharmacist missed the medication on the facility's Monthly Medication Review (MMR). The error of the printed POS was not addressed. From interview with E1 and E2, the Pharmacy had not provided a summary or documentation of the outcome to their investigation or systems placed to prevent a re-occurrence of the incident.	F 425		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)1) 300.1620a) 300.1620c) 300.3240a)	F9999		

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F9999	Continued From page 13 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: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review	F9999		

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F9999	Continued From page 14 the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on record review and interview, the facility failed to ensure: 1. Residents remain free of significant medication errors and receive medication as ordered by the Physician. 2. Systems are in place to ensure physician's orders are transcribed accurately by Nursing and consulting Pharmacy . 3. Nursing staff check medication (Bingo) cards and Medication Administration Records (MAR) to ensure the correct medications are administered.	F9999		

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F9999	Continued From page 15 4. The consulting Pharmacy has systems in place to ensure Physician orders are transcribed accurately to prevent significant medication errors. 5. The consulting Pharmacy has systems in place to ensure the facility's Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. 6. The consulting Pharmacy conducts a thorough investigation of medication errors to ensure all aspect of their services are identified in the investigation and plan of action identified to facility. This if for 1 of 1 residents identified with a significant medication error (R1). The facility's system failures resulted in R1 receiving the wrong medication (Methotrexate) daily from 11/29/06 thru 12/18/06 for a total of 20 days. R1 was sent to the hospital on 12/18/06 with complaints of dizziness, weakness, lethargy, abdominal pain, thrombocytopenia, low blood hemoglobin, and low blood hematocrit as possible side effects of the medication Methotrexate per Z1. Example includes: R1 was admitted to the facility 11/28/06 with multiple diagnosis of including Anemia, Gastrointestinal Hemorrhage, Hyperthyroidism, and Chronic Renal Insufficiency.	F9999		

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On 12/19/06 the facility reported to the Department of Public Health a medication error was discovered through a hospital physician consultation conducted on 12/19/06.

The facility documented that the hospital discovered R1 was receiving the medication Methotrexate 2.5 mg (an anti-neoplastic agent) instead of the Physician's ordered medication Methimazole 2.5 mg (an anti-thyroid agent).

From the Lexi-Comp's Drug Reference Handbooks: Geriatric Dosage Handbook: Including Clinical Recommendations and Monitoring Guidelines: 12th Edition page 987:

"Medication Safety Issues:
Sound-alike/look-alike issues: Methotrexate may be confused with metolazone, mitoxantrone."

"High Alert Medication: The institute for safe medication practices (ISMP) includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error.
Errors have occurred (resulting in death) when oral methotrexate was administered as 'daily' dose instead of the recommended 'weekly' dose."

From record review of the Nurses notation dated 11/28/06 and interview of E3, R.N. (a contracted Agency Registered Nurse), conducted 6/7/07, E3 stated and documented she admitted R1 at 1:45 p.m. on 11/28/06 to the facility. E3 stated she reviewed the hospital transfer sheet which contained R1's medication orders. The medication orders were verified with R1's physician via telephone. E3 stated she transcribed the verified physician's orders to the

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F9999	Continued From page 17 facility's Physician Order Sheet (POS) and Medication Administration Record (MAR) sheet including the medication Methimazole. E3 stated she called the pharmacy and spoke to a pharmacy representative for R1's medicine delivery and faxed the hand written POS to the Pharmacy . E3 stated she worked two shifts on 11/28/06, days and evenings, and came back to work the next morning of 11/29/06 and delivered the morning medication pass for the Medicare wing. E3 stated she gave R1 her morning medications on 11/29/06 at 8:00 a.m. E3 stated she did not read the medication card entirely when she gave R1 the medication Methotrexate. E3 said she just saw the M-E-T-H 2.5 mg and did not read the whole medication (Bingo) card since she was the one who wrote the MAR and ordered the medication. The MAR documents the medication Methimazole was to be given. E3 stated she was not aware the pharmacy had dispensed the wrong medication. From the facility's investigation report, R1 continued to receive the medication Methotrexate daily from 11/29/06 through 12/18/06. On 12/18/06, R1 was examined by Z2, Nurse Practitioner. From interview conducted 6/7/07, Z2 stated that R1 was found to be complaining of weakness and not feeling well. Upon examination Z2 noted R1 with rebound tenderness in the abdomen. At that time, R1's physician was called, and R1 was sent to the hospital for evaluation. Per interview with Z1, R1's primary Physician via	F9999		

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telephone on 6/7/07 at 1:30 p.m., R1 on admission to the hospital had low blood platelet level and anemia.

Per review of the laboratory reports for R1 dated 12/15/06, R1's platelet count was documented as low 55 THO/mm3 (Lab reference levels are 150-400 Tho/mm3). The 12/15/06 lab records a low hemoglobin result of 8.4 gm/dl. (Lab reference 12.0-16.0 gm/dl). The hematocrit level was low at 24.7 % (Lab reference is 27.0 % - 47.0 %).

Z1 stated these were some of the side effects of the medication Methotrexate. Z1 verified that he did not order this medication.

The facility was unaware of the medication error with R1 until after R1 was admitted to the hospital, and the facility was informed of the possible Methotrexate medication error on 12/19/06 while the facility's Admission Coordinator was at the hospital.

The facility conducted an investigation 12/19/06. From record review and interview with E2 (Director of Nurses), the facility discovered two nurses mis-read the medication (Bingo) card and administered to R1 the medication Methotrexate on 11/29/06 and 11/30/06. The facility reported E5, R.N. (a part time nurse), also gave the incorrect medication. The MAR and POS document the medication Methimazole was to be given.

E2 stated on 11/30/06, E4, R.N. (an contracted Agency Nurse) reviewed the facility's Pharmacy computer generated POS for R1's end of the month physician orders carry over for December

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F9999	Continued From page 19 2006 with the handwritten POS of 11/28/2006. From the facility's investigation, E4 did not identify that the type written POS medication order of Methotrexate from the pharmacy was incorrect for R1. The pharmacy had written the medication Methotrexate instead of Methimazole. Interviews with E2, E1, and Z1 discussed that the facility currently did not have systems to ensure all staff are transcribing and verifying physician orders are accurately carried over for the end of the month orders. This failure resulted in Nurses giving the wrong medication to R1 from December 1, 2006, through December 18, 2006. Five Nurses (E3, E7, E8, E9, and E10) administered R1 the incorrect medication Methotrexate. R1 received 18 daily doses of the medication Methotrexate during this period. A review of R1's medical record documents a Consultant Pharmacist Drug Regimen Review was conducted on 12/1/06 which notes: "med 14, anemia, HTN, hypothyroid, h/o DVT/PE, h/o GI bleed / GERD, 0 labs yet, (11/26) INR 2.2 (hosp), 124/60, 81 female." There was no mention of the medication Methotrexate or it's daily dose. A review of the facility's printed Physician Orders Sheets (POS) and the printed Medication Administration Record (MAR), which were received from the Pharmacy dated 12/1/06 to 12/31/06, lists the medication Methotrexate 2.5 mg tablet 11/29/06 # 007264973 NDC#	F9999		

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F9999	Continued From page 20 00378001401. From interview conducted via telephone 6/7/07 at 11:45 a.m. with Z3 (RPh., Executive Director), Z3 stated that the Pharmacy was notified of the incident on 12/19/06 and immediately began an investigation. Inservices were conducted with the facility on 12/20/06. It was determined that the medication order was entered by a technician incorrectly, and the Pharmacist failed to verify the order and medication. This resulted in the wrong medication being sent to the facility. There was no documented investigation into why the consulting pharmacist missed the medication on the facility's Monthly Medication Review (MMR). The error of the printed POS was not addressed. From interview with E1 and E2, the Pharmacy had not provided a summary or documentation of the outcome of their investigation or systems placed to prevent a re-occurrence of the incident. (A)	F9999		