

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2025
NAME OF PROVIDER OR SUPPLIER Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE 220 South Hughston Street McBain, MI 49657	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0711</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician reviewed medication orders for accuracy for one Resident (#3) of three residents reviewed for physician visits. This deficient practice resulted in Resident #3 experiencing a significant medication error and subsequent severe adverse effects. Findings include:</p> <p>This citation pertains to intake numbers: MI00153136 and MI00153196.</p> <p>Resident #3 (R3)</p> <p>Review of R3's face sheet revealed admission to the facility on [DATE], with diagnoses including, cirrhosis (chronic liver damage), diabetes mellitus, hypertension (elevated blood pressure), hypothyroidism (not producing enough thyroid hormone), and Parkinson's disease (central nervous system disorder affecting movement).</p> <p>Review of complaint intake number MI00153136 submitted to the State Agency (SA), dated [DATE] revealed, R3 was admitted to (skilled nursing facility name) on [DATE] and discharged on [DATE]. Upon discharge from an acute care hospital, R3 was ordered to receive Carbidopa/Levodopa five times per day and Levothyroxine once a day. Upon admission to [Nursing Home Facility], the medication frequencies were transposed which resulted in R3 receiving the incorrect dosage of both Carbidopa/Levodopa and Levothyroxine. When R3 arrived at the nursing home they were ambulatory, able to function, able to make themselves lunch and care for self. When R3 was discharged, R3 was unable to ambulate, appeared confused, and could not have a conversation.</p> <p>Review of complaint intake number MI00153196 to the SA, dated [DATE], revealed R3 was admitted to (skilled nursing facility name) on [DATE]. On [DATE], the facility reversed the order for thyroid medicine and Carbidopa/Levodopa medications which resulted in R3 receiving five times the dose of the Levothyroxine for five consecutive days ([DATE] through [DATE]). Further review of the intake indicated R3 expired at home the next day days after discharge from the facility.</p> <p>Review of R3's progress note, dated [DATE] at 1:00 PM, read in part, Resident admitted .for 5-day respite care by wife in personal vehicle. A & O x 3 (alert and oriented to person, place and situation) ambulated to room with walker. Lungs CTA (clear to auscultation) .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0711</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's progress note generated by the electronic medical record, dated [DATE] at 3:14 PM, read in part, This order is outside the recommended dose or frequency. (Levothyroxine) oral tablet 200 mcg, give 2 tablets by mouth on time a day for thyroid and give 2 tablets by mouth one time a day for Parkinson's and give 1 tablet by mouth one time a day for Parkinson's .exceeds the usual dosing regimen .daily .exceeds the usual frequency of daily .</p> <p>Review of R3's progress note created by Physician Assistant (PA) P, dated [DATE] at 6:39 PM, read in part, Patient is a new admission to the facility. Patient medications were reviewed/verified against discharge summary which nursing had supplied. Pending confirmation of Levothyroxine, Carbidopa-Levodopa and Trazodone dosing .</p> <p>On [DATE] at 9:35 AM, an interview was conducted with Family Member (FM) J' who was asked about R3 respite stay at the facility and replied, On [DATE], I received a phone call from the NP (Nurse Practitioner) at the facility and was told (R3's) condition had changed and developed a fever, increased heart rate, receiving fluids, was on oxygen, and had taken a turn for the worst. The facility told me that (R3) had gotten a couple extra doses of Levothyroxine. Several extra doses of Levothyroxine. When I asked why (R3) got extra doses the facility would not answer me. The facility said that (R3) could not go home as scheduled and that they were keeping (R3) for an extra night, maybe two. Then finally the facility told me what happened that they switched the scheduling of the Levothyroxine with the Carbidopa/Levodopa and put (R3) in a thyroid storm. More than one nurse gave (R3) the incorrect medication scheduling. (R3's) condition change was related to the medication errors. The nurse transcribed the medications wrong, and the doctor signed off and sent a note to nursing and then nursing never changed the orders. (R3) walked into the facility and when I went to go get (R3) they had to be taken out of the facility via wheelchair and two-person assistance. (R3) was so mentally out of it he could not walk. (R3) was rambling on from the time I picked him up and continued all through the remainder of the day until (R3) finally fell asleep. (R3) was hallucinating and talking to our dog like it was (R3's) sister-in-law calling the dog by her name. (R3) was disoriented totally. (R3) was mentally and physically not normal and could not stand on his own. (R3) fell in the middle of the night, Hospice had to come out, he was incontinent, and the Hospice doctor recommended comfort care. (R3) passed away around 5:30 AM the next day on [DATE]. After (R3) passed the Hospice nurse and the medical examiner came out. (R3's) body was sent down state to a hospital for an autopsy and then was sent back to a local funeral home for cremation.</p> <p>On [DATE] at 10:40 AM, an interview was conducted with Medical Examiner (ME) G who was asked if they recalled R3's respite care at the facility and replied, I didn't know about (R3) until I was called to his house after he passed. I know that his wife took him in on [DATE] for respite care to the facility. (R3's) wife told me that 2 to 3 days into the stay that (R3) was acting strange and not making much sense. After 4 or 5 days (R3's) wife was like, 'What's going on with (R3)?' and apparently the facility nurse transcribed the wrong medications. The facility switched the scheduling of the Levothyroxine with the Carbidopa/Levodopa and put (R3) in a thyroid storm. (R3) was incoherent and talked to the dog as if it was his sister-in-law. (R3) received a God-awful amount of Levothyroxine in a short amount of time. (R3) had elevated temperature and was shaky. The facility admitted to wrongdoing.</p> <p>Review of R3's Hospice plan of care and admission medication list, dated [DATE], revealed the following orders:</p> <p>1.)</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R3 received two extra doses of Levothyroxine on [DATE], four extra doses on [DATE], four extra doses on [DATE], and four extra doses on [DATE], equating a total of 2800 mcg within a 96-hour time period.</p> <p>Review of R3's originally transcribed medication orders for Levothyroxine and Carbidopa /Levodopa, dated [DATE] at 3:14 PM, revealed orders to be transcribed/created by RN / Unit Manager B and confirmed by RN B.</p> <p>On [DATE] at 10:40 AM, an interview was conducted with the Medical Director (MD) E who was asked what the normal dose was for Levothyroxine and replied, Dose varies with lab work. If the dose is more than 200 mcg then I normally refer the patient to an endocrinologist. However, 200 mcg is the cut off. MD E was asked what the signs and symptoms are of a thyroid storm and replied, Tachycardia (increased heart rate), muscle aches, elevated temperature, difficulty sleeping, feeling hot, palpitations and weight loss. MD E was asked about the transcription error for R3 and their Levothyroxine and Carbidopa /Levodopa and replied, The physician assistant should have discontinued the order and made a new order to reflect the correct instructions and not left it as pending. The pharmacist should have caught the errors. I would expect nursing to know better because you only give Levothyroxine once a day in the morning before breakfast. It is basic nursing 101.</p> <p>On [DATE] at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who was asked about the progress note in R3's medical record dated [DATE] created by Physician Assistant (PA) P stating pending confirmation of Levothyroxine, Carbidopa-Levodopa and Trazodone dosing and who was responsible for how the confirmation was made and replied, PA P should have discontinued or changed the medication orders with verification of R3 medication list.</p> <p>Thyroid storm is a rare life-threatening condition of the thyroid gland. It develops in cases of untreated hyperthyroidism, or overactive thyroid (thyrotoxicosis) [or overdosing of a synthetic medication designed to act to supplement the decreased activity of the thyroid gland in the case of synthroid/levothyroxine use]. Retrieved from: https://medlineplus.gov/ency/article/000400.htm</p> <p>Review of Levothyroxine, retrieved from website: http://www.synthroid.com/starting/taking-synthroid-the-right-way?cid=ppc_ppd_MSFT_Synthroid_Branded_when_is_best_time_of_day_to_take_synthroid_Phrase_USS_YNT210334&gclid=9df9ab0c7de2146322dec3334cfd7502, date retrieved [DATE], read in part, Taking [Levothyroxine] the right way: In order for Synthroid to be effective, it should always be taken the same way every day. This is important because the amount of medicine you need is very precise. And even the way you take Synthroid can affect how much medicine your body is getting. It's important to always take your medication exactly as your doctor prescribed. The right way, every day. Take [Levothyroxine] once a day, every day at the same time before breakfast. Take [Levothyroxine] with only water and on an empty stomach. Wait 30 minutes to 1 hour before eating or drinking anything other than water .Use and Important Safety Information .Taking too much levothyroxine may affect your heart, especially if you are elderly or have heart disease. Tell your doctor immediately if you have any signs of increased heart rate, chest pain, or an irregular heartbeat .Tell your doctor if you start experiencing any of the following symptoms: rapid or abnormal heartbeat, chest pain, difficulty catching your breath, leg cramps, headache, nervousness, irritability, sleeplessness, shaking, change in appetite, weight gain or loss, vomiting, diarrhea, increased sweating, difficulty tolerating heat, fever, changes in menstrual periods, swollen red bumps on the skin (hives) or skin rash, or any other unusual medical event .Use SYNTHROID only as ordered by your doctor. Take SYNTHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast .</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify harmful dosing parameters and recognize the resulting side effects for an incorrectly prescribed thyroid medication for one Resident (#3) of 3 residents reviewed for .three residents reviewed for new admissions. Findings include:</p> <p>This citation pertains to intake numbers: MI00153136 and MI00153196.</p> <p>Resident #3 (R3)</p> <p>Review of R3's face sheet revealed admission to the facility on [DATE], with diagnoses including, cirrhosis (chronic liver damage), diabetes mellitus, hypertension (elevated blood pressure), hypothyroidism (not producing enough thyroid hormone), and Parkinson's disease (central nervous system disorder affecting movement).</p> <p>Review of complaint intake number MI00153136 submitted to the State Agency (SA), dated [DATE] revealed, R3 was admitted to (skilled nursing facility name) on [DATE] and discharged on [DATE]. Upon discharge from an acute care hospital, R3 was ordered to receive Carbidopa/Levodopa five times per day and Levothyroxine once a day. Upon admission to [Nursing Home Facility], the medication frequencies were transposed which resulted in R3 receiving the incorrect dosage of both Carbidopa/Levodopa and Levothyroxine When R3 arrived at the nursing home they were ambulatory, able to function, able to make themselves lunch and care for self. When R3 was discharged , R3 was unable to ambulate, appeared confused, and could not have a conversation</p> <p>Review of complaint intake number MI00153196 to the SA, dated [DATE], revealed R3 was admitted to (skilled nursing facility name) on [DATE]. On [DATE], the facility reversed the order for thyroid medicine and Carbidopa/Levodopa medications which resulted in R3 receiving five times the dose of the Levothyroxine for five consecutive days ([DATE] through [DATE]). Further review of the indicated R3 expired at home the next day after discharge from the facility.</p> <p>Review of R3's vital signs, dated [DATE] at 12:53 PM, revealed the following: Blood pressure 127/71, pulse 91, respiratory rate 16, temperature 98.6, and oxygen saturation 93%. Weight 228.6 pounds obtained on [DATE] at 4:05 PM.</p> <p>Review of R3's progress note, dated [DATE] at 1:00 PM, read in part, Resident admitted .for 5-day respite care by wife in personal vehicle. A & O x 3 (alert and oriented to person, place and situation) ambulated to room with walker. Lungs CTA (clear to auscultation) .</p> <p>Review of R3's progress note, dated [DATE] at 3:14 PM, read in part, This order is outside the recommended dose or frequency. (Levothyroxine) oral tablet 200 mcg, give 2 tablets by mouth on time a day for thyroid and give 2 tablets by mouth one time a day for Parkinson's and give 1 tablet by mouth one time a day for Parkinson's .exceeds the usual dosing regimen .daily .exceeds the usual frequency of daily .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's progress note, dated [DATE] at 6:39 PM, read in part, Patient is a new admission to the facility. Patient medications were reviewed/verified against discharge summary which nursing had supplied. Pending confirmation of Levothyroxine, Carbidopa-Levodopa and Trazodone dosing .</p> <p>Review of R3's progress note, dated [DATE] at 5:50 AM, read in part, At 0510 (5:10 AM) CNA (Certified Nurse Aide) reported resident to be confused and shaking. VSS (vital signs) were taken and BP (blood pressure) 180/84 T (temperature) 101.6 P (pulse) 116 R (respirations) 22 BS (blood sugar) 165 O2 (oxygen) 93%-86% (acetaminophen) administered at 0524 (5:24 AM) (lorazepam) at 0516 (5:16 AM). Cold wash cloths applied to neck and O2 applied at 2L (liters) nc (nasal cannula) .</p> <p>Review of R3's progress note, dated [DATE] at 1:04 PM, read in part, Resident noted to have increased confusion, abnormal vitals (sic) signs. N.O (new order) from .NP (nurse practitioner) for NS (normal saline) IV at 125 ml/hr (milliliters/hour) for 24 hours, vitals (sic) signs every 4 hours for 24 hrs (hours), Labs ordered .</p> <p>Review of R3's progress note, dated [DATE] at 3:34 PM, read in part, Patient being seen today as he is febrile, tachycardic, and increase confusion .overnight he became febrile, tachycardic and lethargic with need for oxygen .It was also noted he was receiving more than double of dose of his levothyroxine as well . Due to the unsureness of cause of symptoms will order labs as well as give a liter of IV Normal Saline and continue to monitor vitals .not been drinking very much the last couple days .patient was supposed to be discharged home today .would like to keep him overnight to be monitored and possibly discharge home tomorrow .</p> <p>On [DATE] at 9:10 AM, an interview was conducted with Licensed Practical Nurse (LPN) L who was asked what the process was for adding new admission orders in for medications and replied, The unit managers normally add them in and then they are checked by a second manager. If it is the weekend or the managers are gone then the floor nurses must do it but there should always be a second check.</p> <p>Review of R3's Hospice plan of care and admission medication list, dated [DATE], revealed the following orders:</p> <p>1.)</p> <p>Carbidopa 25 mg (milligram) /Levodopa 100 mg, disintegrating tablet, oral, one tablet three times daily, morning one pill, at noon two pills, and one pill in the evening,</p> <p>2.)</p> <p>Levothyroxine 200 mcg, one tablet one time daily.</p> <p>Review of facility physician orders, dated [DATE], revealed the following:</p> <p>1.)</p> <p>Carbidopa /Levodopa 25 mg/100 mg, disintegrating tablet, give 1 tablet by mouth one time a day for Parkinson's,</p> <p>2.)</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy titled, Medication Administration, dated [DATE], read in part, Resident medication are administered in an accurate, safe, timely, and sanitary manner .Procedure .2. Verify the medication label against the medication administration record for resident name, time, drug, dose, and route. a. The nurse is responsible to read and follow precautionary instructions on prescription labels. b. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. c. Report any discrepancies to the pharmacy. Do not administer the medication until the discrepancy is resolved .</p> <p>Review of Levothyroxine, retrieved from website: http://www.synthroid.com/starting/taking-synthroid-the-right-way?cid=ppc_ppd_MSFT_Synthroid_Branded_when_is_best_time_of_day_to_take_synthroid_Phrase_USS_YNT210334&gclid=9df9ab0c7de2146322dec3334cfd7502, date retrieved [DATE], read in part, Taking [Levothyroxine] the right way: In order for Synthroid [Levothyroxine's brand name] to be effective, it should always be taken the same way every day. This is important because the amount of medicine you need is very precise. And even the way you take Synthroid can affect how much medicine your body is getting. It's important to always take your medication exactly as your doctor prescribed. The right way, every day. Take [Levothyroxine] once a day, every day at the same time before breakfast. Take [Levothyroxine] with only water and on an empty stomach. Wait 30 minutes to 1 hour before eating or drinking anything other than water .Use and Important Safety Information .Taking too much levothyroxine may affect your heart, especially if you are elderly or have heart disease. Tell your doctor immediately if you have any signs of increased heart rate, chest pain, or an irregular heartbeat .Tell your doctor if you start experiencing any of the following symptoms: rapid or abnormal heartbeat, chest pain, difficulty catching your breath, leg cramps, headache, nervousness, irritability, sleeplessness, shaking, change in appetite, weight gain or loss, vomiting, diarrhea, increased sweating, difficulty tolerating heat, fever, changes in menstrual periods, swollen red bumps on the skin (hives) or skin rash, or any other unusual medical event .Use SYNTHROID only as ordered by your doctor. Take SYNTHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast .</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately transcribe and double check admission medications per standards of practice for one Resident (#3) of three residents reviewed for new admissions. This deficient practice resulted in Resident #3 experiencing a significant medication error and subsequent severe adverse effects. Findings include:</p> <p>This citation pertains to intake numbers: MI00153136 and MI00153196.</p> <p>Resident #3 (R3)</p> <p>Review of complaint intake number MI00153136 submitted to the State Agency (SA), dated [DATE] revealed, R3 was admitted to (skilled nursing facility name) on [DATE] and discharged on [DATE]. Upon discharge from an acute care hospital, R3 was ordered to receive Carbidopa/Levodopa five times per day and Levothyroxine once a day. Upon admission to [Nursing Home Facility], the medication frequencies were transposed which resulted in R3 receiving the incorrect dosage of both Carbidopa/Levodopa and Levothyroxine. R3 was supposed to receive Carbidopa/Levodopa five times a day, and Levothyroxine once a day 200 mcg (micrograms). The nursing home flipped R3's medications. R3 was provided Levothyroxine five times a day, and Carbidopa/Levodopa once a day. When R3 arrived at the nursing home they were ambulatory, able to function, able to make themselves lunch and care for self. When R3 was discharged , R3 was unable to ambulate, appeared confused, and could not have a conversation</p> <p>Review of complaint intake number MI00153196 to the SA, dated [DATE], revealed R3 was admitted to (skilled nursing facility name) on [DATE]. On [DATE], the facility reversed the order for thyroid medicine and Carbidopa/Levodopa medications which resulted in R3 receiving five times the dose of the Levothyroxine for five consecutive days ([DATE] through [DATE]). Further review of the indicated R3 expired at home the next day after discharge from the facility.</p> <p>Review of R3's face sheet revealed admission to the facility on [DATE], with diagnoses including, cirrhosis (chronic liver damage), diabetes mellitus, hypertension (elevated blood pressure), hypothyroidism (not producing enough thyroid hormone), and Parkinson's disease (central nervous system disorder affecting movement).</p> <p>Review of R3's progress note, dated [DATE] at 1:00 PM, read in part, Resident admitted .for 5-day respite care by wife in personal vehicle. A & O x 3 (alert and oriented to person, place and situation) ambulated to room with walker. Lungs CTA (clear to auscultation) .</p> <p>Review of R3's progress note, dated [DATE] at 3:14 PM, read in part, This order is outside the recommended dose or frequency. (Levothyroxine) oral tablet 200 mcg, give 2 tablets by mouth on time a day for thyroid and give 2 tablets by mouth one time a day for Parkinson's and give 1 tablet by mouth one time a day for Parkinson's .exceeds the usual dosing regimen .daily .exceeds the usual frequency of daily .</p> <p>Review of R3's progress note, dated [DATE] at 6:39 PM, read in part, Patient is a new admission to the facility. Patient medications were reviewed/verified against discharge summary which nursing had supplied. Pending confirmation of Levothyroxine, Carbidopa-Levodopa and Trazodone dosing .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's Hospice visit note, dated [DATE], read in part, Vital signs: Blood pressure 160/84, pulse 78, respiratory rate 24, temperature 98.2, pain 3/10, and oxygen saturation 95%. Patient (R3) arrived at the facility 1:15 PM. (R3) is in his room, resting on his bed. He stated the transport went well. Patient said he is good with his room .Went over meds (medications) with nurse .</p> <p>On [DATE] at 9:00 AM, an interview was conducted with the Hospice Licensed Practical Nurse (LPN) O who was asked to verify their visit note when R3 was admitted on [DATE]. LPN O replied, Yes, I went over the medication list with the unit manager (Registered Nurse [RN] B), but I was not with them when the medication orders were transcribed. LPN O was asked if R3 at the time of admission was at their baseline and replied, Yes, (R3) walked into the facility with their walker and no assistance. (R3) was fine then. (R3's) lungs were clear and showed no signs or symptoms of a urinary tract infection of any other infection. The facility screwed up their medications and instead gave them one Carbidopa/Levodopa once a day and Levothyroxine three times a day with a total of five tabs. I was surprised the facility had released (R3). I thought the facility would have kept (R3) until returning to their baseline. I feel like (R3) was discharged too soon. I would have done things differently and made the medication error right. LPN O was asked if they were present at the time R3 was discharged and replied, Not at the facility, but I did go to see (R3) at home later. (R3) was not quite up to their normal self. I was surprised and sad to hear that (R3) had passed away. I did not expect that. LPN O was asked if they recalled how R3 was when they came to visit R3 on [DATE] and replied, (R3) had increased fever, and their vital signs were all messed up. (R3) was not normal. (R3's) temperature changed because they were getting too much Levothyroxine.</p> <p>Review of R3's vital signs, dated [DATE] at 12:53 PM, revealed the following: Blood pressure 127/71, pulse 91, respiratory rate 16, temperature 98.6, and oxygen saturation 93%. Weight 228.6 pounds obtained on [DATE] at 4:05 PM.</p> <p>Review of R3's progress note, dated [DATE] at 5:50 AM, read in part, At 0510 (5:10 AM) CNA (Certified Nurse Aide) reported resident to be confused and shaking. VSS (vital signs) were taken and BP (blood pressure) 180/84 T (temperature) 101.6 P (pulse) 116 R (respirations) 22 BS (blood sugar) 165 O2 (oxygen) 93%-86% (acetaminophen) administered at 0524 (5:24 AM) (lorazepam) at 0516 (5:16 AM). Cold wash cloths applied to neck and O2 applied at 2 L (liters) nc (nasal cannula) .</p> <p>Review of R3's progress note, dated [DATE] at 1:04 PM, read in part, Resident noted to have increased confusion, abnormal vitals (sic) signs. N.O. (new order) from .NP (nurse practitioner) for NS (normal saline) IV at 125 ml/hr (milliliters/hour) for 24 hours, vitals (sic) signs every 4 hours for 24 hrs (hours), Labs ordered .</p> <p>Review of R3's progress note, dated [DATE] at 3:34 PM, read in part, Patient being seen today as he is febrile, tachycardic, and increase confusion .overnight he became febrile, tachycardic and lethargic with need for oxygen .It was also noted he was receiving more than double of dose of his levothyroxine as well . Due to the unsureness of cause of symptoms will order labs as well as give a liter of IV Normal Saline and continue to monitor vitals .not been drinking very much the last couple days .patient was supposed to be discharged home today .would like to keep him overnight to be monitored and possibly discharge home tomorrow .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 9:20 AM, an interview was conducted with Hospice RN I who was asked if she recalled R3 being at the facility for respite care and replied, Yes. I found out on [DATE] of the medication errors. (R3) was getting Levothyroxine the same as they would with their Carbidopa/Levodopa. So (R3) was getting one Carbidopa/Levodopa once a day and Levothyroxine three times a day with a total of five tabs (two in the morning, one in the afternoon and two in the evening).</p> <p>On [DATE] at 9:27 AM, an interview was conducted with Hospice Case Manager K who was asked if they recalled R3 being at the facility for respite care and replied, Yes. (R3) was supposed to be at the facility for respite care including five nights and six days, but (R3) was discharged on [DATE] on the seventh day. The facility notified her (Case Manager K) of the medication error and R3 needing to stay an extra day because of requiring IV fluids. The medication error was between two medications that were transcribed incorrectly by the facility staff. R3 was getting one Carbidopa/Levodopa once a day and Levothyroxine three times a day with a total of five tabs (two in the morning, one in the afternoon and two in the evening). The facility Nurse Practitioner (NP) assessed and ordered the normal saline fluids, monitoring, and labs to be drawn. Labs ordered were a comprehensive metabolic (CMP), thyroid stimulating hormone (TSH), triiodothyronine (T3), and a thyroxine (T4). The facility has the results. I notified my supervisor regarding the medication errors and interventions.</p> <p>On [DATE] at 9:35 AM, an interview was conducted with Family Member (FM) J' who was asked about R3 respite stay at the facility and replied, On [DATE], I received a phone call from the NP (Nurse Practitioner) at the facility and was told (R3's) condition had changed and developed a fever, increased heart rate, receiving fluids, was on oxygen, and had taken a turn for the worst. The facility told me that (R3) had gotten a couple extra doses of Levothyroxine. Several extra doses of Levothyroxine. When I asked why (R3) got extra doses the facility would not answer me. The facility said that (R3) could not go home as scheduled and that they were keeping (R3) for an extra night, maybe two. Then finally the facility told me what happened that the switched the scheduling of the Levothyroxine with the Carbidopa/Levodopa and put (R3) in a thyroid storm. More than one nurse gave (R3) the incorrect medication scheduling. (R3's) condition change was related to the medication errors. The nurse transcribed the medications wrong, and the doctor signed off and sent a note to nursing and then nursing never changed the orders. (R3) walked into the facility and when I went to go get (R3) they had to be taken out of the facility via wheelchair and two-person assistance. (R3) was so mentally out of it he could not walk. (R3) was rambling on from the time I picked him up and continued all through the remainder of the day until (R3) finally fell asleep. (R3) was hallucinating and talking to our dog like it was (R3's) sister-in-law calling the dog by her name. (R3) was disoriented totally. (R3) was mentally and physically not normal and could not stand on his own. (R3) fell in the middle of the night, Hospice had to come out, he was incontinent, and the Hospice doctor recommended comfort care. (R3) passed away around 5:30 AM the next day on [DATE]. After (R3) passed the Hospice nurse and the medical examiner came out. (R3's) body was sent down state to a hospital for an autopsy and then was sent back to a local funeral home for cremation.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:40 AM, an interview was conducted with Medical Examiner (ME) G who was asked if they recalled R3's respite care at the facility and replied, I didn't know about (R3) until I was called to his house after he passed. I know that his wife took him in on [DATE] for respite care to the facility. (R3's) wife told me that 2 to 3 days into the stay that (R3) was acting strange and not making much sense. After 4 or 5 days (R3's) wife was like, 'What's going on with (R3)?' and apparently the facility nurse transcribed the wrong medications. The facility switched the scheduling of the Levothyroxine with the Carbidopa/Levodopa and put (R3) in a thyroid storm. (R3) was incoherent and talked to the dog as if it was his sister-in-law. (R3) received a God-awful amount of Levothyroxine in a short amount of time. (R3) had elevated temperature and was shaky. The facility admitted to wrongdoing.</p> <p>On [DATE] at 9:10 AM, an interview was conducted with LPN L who was asked what the process was for adding new admission orders in for medications and replied, The unit managers normally add them in and then they are checked by a second manager. If it is the weekend or the managers are gone then the floor nurses must do it but there should always be a second check.</p> <p>Review of R3's Hospice plan of care and admission medication list, dated [DATE], revealed the following orders:</p> <p>1.)</p> <p>Carbidopa 25 mg (milligram) /Levodopa 100 mg, disintegrating tablet, oral, one tablet three times daily, morning one pill, at noon two pills, and one pill in the evening,</p> <p>2.)</p> <p>Levothyroxine 200 mcg, one tablet one time daily.</p> <p>Review of facility physician orders, dated [DATE], revealed the following:</p> <p>1.)</p> <p>Carbidopa /Levodopa 25 mg/100 mg, disintegrating tablet, give 1 tablet by mouth one time a day for Parkinson's,</p> <p>2.)</p> <p>Levothyroxine 200 mcg, give 1 tablet by mouth at dinner for Parkinson's,</p> <p>3.)</p> <p>Levothyroxine 200 mcg, give 2 tablets by mouth at lunch for Parkinson's,</p> <p>4.)</p> <p>Levothyroxine 200 mcg, give 2 tablets by mouth upon rising for Parkinson's.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's medication administration record (MAR), dated [DATE] through [DATE], revealed the following:</p> <ol style="list-style-type: none"> 1.) Carbidopa /Levodopa 25 mg/100 mg, disintegrating tablet, give 1 tablet by mouth one time a day for Parkinson's, 2.) Levothyroxine 200 mcg, give 1 tablet by mouth at dinner for Parkinson's, 3.) Levothyroxine 200 mcg, give 2 tablets by mouth at lunch for Parkinson's, 4.) Levothyroxine 200 mcg, give 2 tablets by mouth upon rising for Parkinson's. <p>R3 received two extra doses of Levothyroxine on [DATE], four extra doses on [DATE], four extra doses on [DATE], and four extra doses on [DATE], equating a total of 2800 mcg within a 96-hour time period.</p> <p>Review of R3's originally transcribed medication orders for Levothyroxine and Carbidopa /Levodopa, dated [DATE] at 3:14 PM, revealed orders to be transcribed/created by RN / Unit Manager B and confirmed by RN B.</p> <p>On [DATE] at 10:40 AM, an interview was conducted with the Medical Director (MD) E who was asked what the normal dose was for Levothyroxine and replied, Dose varies with lab work. If the dose is more than 200 mcg then I normally refer the patient to an endocrinologist. However, 200 mcg is the cut off. MD E was asked what the signs and symptoms are of a thyroid storm and replied, Tachycardia (increased heart rate), muscle aches, elevated temperature, difficulty sleeping, feeling hot, palpitations and weight loss. MD E was asked about the transcription error for R3 and their Levothyroxine and Carbidopa /Levodopa and replied, The physician assistant should have discontinued the order and made a new order to reflect the correct instructions and not left it as pending. The pharmacist should have caught the errors. I would expect nursing to know better because you only give Levothyroxine once a day in the morning before breakfast. It is basic nursing 101.</p> <p>On [DATE] at 11:45 AM, an interview was conducted with RN M who was asked what the normal time and frequency was for Levothyroxine and replied, It is given in the morning and once a day. RN M was asked if they recalled R3 and their Levothyroxine dose, time, and frequency and replied, I didn't think it was strange to give it three times a day because (R3) was on Hospice. RN M was asked why they never checked the electronic medical record for the admission paperwork to double check the Levothyroxine frequency and dosing and replied, I don't know. I just assumed the order was put in correctly.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:05 PM, an interview was conducted with Pharmacist F who was asked what their process is for medication regimen reviews for new admissions and replied, I have to run a report for verification of orders on new admissions in the electronic medical records system. I try to get in there Monday through Friday everyday to see who a new admission is or if someone was transferred out. Or pull the report and look to see if they have documentation to verify the orders. Pharmacist F was asked if they were the pharmacist that did the medication regimen review for R3 on [DATE] and replied, Yes. Pharmacist F was asked why they did not address the pending confirmation for R3's Levothyroxine, Carbidopa-Levodopa and Trazodone dosing and replied, I think the orders may have been pending confirmation, so it was not official yet, so it did not show up on the order profile.</p> <p>On [DATE] at 12:45 PM, an interview was conducted with RN C who was asked what pending confirmation meant from a physician who signed off on a medication review for a new admit and replied, The physician should have compared the admit instructions with the transcribed orders and made a change if a change needed to be made. RN C was asked why the nurse practitioner had ordered normal saline for R3 and replied, For fluid resuscitation related to dehydration potential and medication errors. RN C was asked for what medication error for R3 and replied, The Levothyroxine error I think. RN C was asked what the process was for new admission medications and replied, Orders are transcribed by the unit managers and double checked with the original admission paperwork to the orders transcribed by another unit manager or nurse if one is not available. Then after the second check the on-call or house physician verifies the orders. RN C verified that the created by and the confirmed by should be two different nurse signatures.</p> <p>On [DATE] at 1:00 PM, an interview was conducted with RN B who was asked about the process for new admissions and transcribing medication orders and replied, The unit manager normally puts them in if they are at the facility and then the orders are double checked by a second nurse usually another unit manager. RN B was asked if she put the orders in for R3 and replied, Yes. RN B was asked who did the second check on R3's medication orders and replied, RN 'C'.</p> <p>On [DATE] at 1:10 PM, and interview was conducted with RN C who was asked if they recalled double checking the medication orders transcribed by RN B for R3 and replied, I can't recall double checking (R3's) medication orders. There needs to be a better process. RN C was asked if there was a check off list that must be completed for new admissions that certain things were completed and initialed off by staff and replied, No, there is not a check off list. We just use the medication list provided by the receiving hospital or where the resident comes from. RN C confirmed that there was no progress note for R3 that medications transcribed were double checked.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 1:20 PM, an interview was conducted with Nurse Practitioner (NP) D who was asked if they recalled R3 and replied, Yes. (R3) was admitted to the facility for respite care. (R3) became tachycardic, febrile, and lethargic. When it was discovered that (R3) was receiving more Levothyroxine I ordered normal saline and (R3) perked up. I wish nursing would have asked about and questioned the frequency of (R3's) Levothyroxine and they never did. I put a hold on the Levothyroxine for five days. I ordered a TSH, T3, T4, and CMP. NP D was asked if they got all the results back of the lab work for R3 and replied, The TSH result was 0.02, which is low, and I did order a T4, but we never got results. NP D was asked where in the human body Levothyroxine was metabolized and replied, I'm not sure. NP D was asked if poison control was notified of the medication error for direction and replied, No. NP D stated, There should have been better communication with pending confirmation and reviewed the admitting medications and made changes on order entry failures. NP D was asked if R3 had a medical diagnosis of end stage liver failure and replied, Yes, decreased liver function and would not have excreted the Levothyroxine as fast as a normal healthy liver. The medication would have had more of a build up in (R3's) system. My first presentation I did think (R3) was possibly in a thyroid storm because (R3) had increased heart rate, increased fever, lethargy, and confusion.</p> <p>Review of R3's medication audit report, dated [DATE] at 1:54 PM, revealed that RN B queued the Levothyroxine 200 mcg, give 2 tablets by mouth upon rising, give 2 tablets by mouth at lunch, and give 1 tablet by mouth at dinner for Parkinson's order for R3 on [DATE] at 11:23 AM and then created and confirmed the same order on [DATE] at 3:14 PM.</p> <p>On [DATE] at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who was asked about the process for new admissions and transcribing medication orders and replied, We receive a referral and get the discharge summary with a list of medications currently being taken and confirm if the person is coming. The unit manager who receives the referral enters the medication orders in the electronic medical record and a second unit manager double checks the orders entered. The DON was asked if there was anyway to know who did the second check on R3's medication order entry and replied, No, there is no way to know who did the second check in the electronic medical record. The DON was asked about the progress note in R3's medical record dated [DATE] created by Physician Assistant (PA) P stating pending confirmation of Levothyroxine, Carbidopa-Levodopa and Trazodone dosing and who was responsible for how the confirmation was made and replied, PA P should have discontinued or changed the medication orders with verification of R3 medication list. The DON was asked if there is a policy for transcribing medication orders and replied, No policy just a process. I am not sure how the provider or the pharmacist did not catch the errors either.</p> <p>On [DATE] at 2:52 PM, an interview was conducted with LPN N who was asked what the normal time and frequency was for Levothyroxine and replied, It is given in the morning and once a day. LPN N was asked if they recalled R3 and their Levothyroxine dose, time, and frequency and replied, I assumed because (R3) was on Hospice that it was correct. LPN N was asked if they ever checked the electronic medical record for the admission paperwork to double check the Levothyroxine frequency and dosing and replied, I don't think of that. I just assumed the order was put in correctly.</p> <p>Review of R3's laboratory requisition from the facility, dated [DATE] at 10:20 AM, revealed R3's labs were to be drawn for a CMP, CBC (complete blood count), T3, T4, and TSH. Check boxes on the laboratory requisition were marked with a black X.</p> <p>Review of R3's laboratory results dated , [DATE] at 10:20 AM, revealed the lack of a T4 result.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 3:15 PM, a request was sent to the local laboratory for R3's original laboratory blood draw requisition.</p> <p>On [DATE] at 3:25 PM, R3's original laboratory requisition was obtained and revealed the lab for the T4 was never marked by the facility staff to be tested.</p> <p>On [DATE] at 3:45 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked why the laboratory requisition that the facility had on file was different from the original one that the local laboratory had on file and replied, I don't know. That is a good question. I will go ask the DON.</p> <p>On [DATE] at 3:55 PM, an interview was conducted with the DON who was asked why the discrepancy between the local laboratory requisition and the facility requisition and replied, I called the nurse who filled out the laboratory requisition for R3's blood to be drawn and they stated that after the original laboratory requisition was filled out and blood was drawn they noted the error and then later marked it after the laboratory requisition was sent. The DON was asked if the local laboratory was called to add the lab test for the T4 and replied, It was an oversight on the nurse and no malice was intended.</p> <p>Review of facility document titled, Medication Incident Report, dated [DATE] at 12:10 PM, revealed the following:</p> <ol style="list-style-type: none"> 1.) Two medication transcription errors with Levothyroxine and Carbidopa-Levodopa. 2.) Incorrect dose times were entered incorrectly in eMAR (electronic medication administration record) upon admission. 3.) As noted by PA P and dosage times for Levothyroxine entered for Carbidopa-Levodopa and vice versa. 4.) Physician notified on [DATE] at 9:40 AM. 5.) Order changes: Lab draw. 6.) Corrective action taken: Nurse educated to ensure new admission orders are entered correctly. Follow up with physician verifying orders for any resident corrections. <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 4:00 PM, an interview was conducted with the DON who was asked if any other nurses were educated or written up and replied, No, just the one who transcribed the orders incorrectly.</p> <p>Thyroid storm is a rare life-threatening condition of the thyroid gland. It develops in cases of untreated hyperthyroidism, or overactive thyroid (thyrotoxicosis) [or overdosing of a synthetic medication designed to act to supplement the decreased activity of the thyroid gland in the case of synthroid/levothyroxine use]. Retrieved from: https://medlineplus.gov/ency/article/000400.htm</p> <p>Review of policy titled, Medication Administration, dated [DATE], read in part, Resident medication are administered in an accurate, safe, timely, and sanitary manner .Procedure .2. Verify the medication label against the medication administration record for resident name, time, drug, dose, and route. a. The nurse is responsible to read and follow precautionary instructions on prescription labels. b. If the label and medication sheet are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. c. Report any discrepancies to the pharmacy. Do not administer the medication until the discrepancy is resolved .</p> <p>Review of Levothyroxine, retrieved from website: http://www.synthroid.com/starting/taking-synthroid-the-right-way?cid=ppc_ppd_MSFT_Synthroid_Branded_when_is_best_time_of_day_to_take_synthroid_Phrase_USS_YNT210334&gclid=9df9ab0c7de2146322dec3334cfd7502, date retrieved [DATE], read in part, Taking [Levothyroxine] the right way: In order for Synthroid [Levothyroxine's brand name] to be effective, it should always be taken the same way every day. This is important because the amount of medicine you need is very precise. And even the way you take Synthroid can affect how much medicine your body is getting. It's important to always take your medication exactly as your doctor prescribed. The right way, every day. Take [Levothyroxine] once a day, every day at the same time before breakfast. Take [Levothyroxine] with only water and on an empty stomach. Wait 30 minutes to 1 hour before eating or drinking anything other than water .Use and Important Safety Information .Taking too much levothyroxine may affect your heart, especially if you are elderly or have heart disease. Tell your doctor immediately if you have any signs of increased heart rate, chest pain, or an irregular heartbeat .Tell your doctor if you start experiencing any of the following symptoms: rapid or abnormal heartbeat, chest pain, difficulty catching your breath, leg cramps, headache, nervousness, irritability, sleeplessness, shaking, change in appetite, weight gain or loss, vomiting, diarrhea, increased sweating, difficulty tolerating heat, fever, changes in menstrual periods, swollen red bumps on the skin (hives) or skin rash, or any other unusual medical event .Use SYNTHROID only as ordered by your doctor. Take SYNTHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast .</p> <p>Review of Thyroid Storm: Causes, Symptoms, Diagnosis & Treatment, retrieved from website: https://my.clevelandclinic.org/health/diseases/23203-thyroid-storm, date retrieved [DATE], read in part, .Diagnosis and tests. How is thyroid storm diagnosed? A healthcare provider diagnoses thyroid storm if the person has severe and life-threatening symptoms, such as extreme fever and heart issues, and high levels of thyroid hormone and low levels of thyroid-stimulating hormone (TSH) in their blood .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2025
NAME OF PROVIDER OR SUPPLIER Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE 220 South Hughston Street McBain, MI 49657	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Thyroxine Poisoning, retrieved from website: http://www.ncbi.nih.gov/books/NBK279036/, dated retrieved [DATE], read in part, Clinical recognition . Ingested thyroxine, which is itself probably of modest physiologic significance, is rapidly partially converted to triiodothyronine (T3), the active form of thyroid hormone .Both thyroxine and triiodothyronine levels in serum rise within 1-2 hours of ingestion. Rarely, the overdose is discovered immediately, and the patient is brought to the hospital 6-12 hours after the ingestion. At this time, the common clinical signs and symptoms include nervousness, insomnia, mild tremor of hands, tachycardia, mild elevation of body temperature, blood pressure elevation, and loose stools . Cardiac effects aside from tachycardia are seldom seen in young adults but may occur in middle age and older adults, with reported arrhythmias and acute myocardial infarction . One-time ingestion of up to 3 mg thyroxine .As already mentioned serious complications are not common, but they can appear days after ingestion, and therefore the patients should be closely monitored .Diagnosis and differential: Elevated levels of total and free T4 and T3 have been described with suppressed serum TSH levels and otherwise typically a normal biochemical profile. The half-life of serum T4 may be shortened. In one study the half-life of LT4 was 5.7 days which is slightly shorter than the usual half-life of L-thyroxine . n many cases, there is a progressive rise in both serum total T4 and total T3 levels in the first 24 hours following the overdose, caused by continued absorption of the ingested LT4 .Follow-up: Patients should be monitored for several days to be sure that serum T4 and T3 levels are falling .</p> <p>Review of A Study of Thyroid Dysfunction in Cirrhosis of Liver and Correlation with Severity of Liver Disease, retrieved from website: http://pmc.ncbi.nlm.gov/articles/PMC6166553/, date retrieved [DATE], read in part, Introduction: Liver plays an important role in the metabolism of thyroid hormones . Moreover, the liver is involved in thyroid hormone conjugation and excretion .End-stage liver disease can significantly impact the metabolism of levothyroxine, a synthetic thyroid hormone .</p>		