STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235369	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marwood Manor Nursing Home	1300 Beard Street Port Huron, MI 48060

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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely assess and implement interventions to prevent a right heel pressure ulcer for one (R54) of two residents reviewed for skin concerns resulting in the development of a stage three (full thickness tissue loss without visible bone, tendon or muscle) pressure ulcer. Findings include:Review of the facility record for R54 revealed admission into the facility on [DATE] with diagnoses including Status-Post Right Hip Fracture with Surgical Repair, Diabetes Mellitus, and Difficulty in Walking. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated R54 required Maximal Assistance (caregiver provides more than half the effort) for bed mobility and the Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. The record also indicated R54 currently had a facility-acquired pressure ulcer.Review of R54's hospital discharge documents revealed a Skin Assessment-Wound Documentation report dated 02/17/25 which indicated right hip surgical incision, left arm rash and no findings otherwise. Review of the facility Clinical admission Nursing assessment dated [DATE] revealed the skin notation Multiple areas of discoloration (rash-like) to right arm and bilateral thighs. Surgical dressing right hip. No notation pertaining to the right heel was identified. On the body part-specific checklist where a check mark indicates a problem area, the right foot and right heel boxes were not checked. Review of R54's Braden Scale of pressure ulcer risk dated 02/17/25 revealed a score of 18 with the resident categorized as At Risk.On 07/29/25 at 12:15 PM, R54 was interviewed in their room and asked about any pressure ulcers they may have developed since coming to the facility. R54 stated When I got here the bed I was in was too short. I'm 6'2 and the bed had a footboard at the end that my feet pushed up against. My feet only stayed off the footboard if I stayed perfectly flat and didn't move. It made it especially hard to move my right leg that the surgery was done on. R54 was asked if they discussed the bed with staff and they stated Yes, I know I talked to a maintenance guy about it, and they told me they couldn't take the footboard off. They eventually ended up getting me a different bed that was bigger and didn't have a footboard. R54 was not able to recall how long they were in the original bed.On 07/30/25 at 10:18 AM, R54 was interviewed in their room regarding the impact of the onset and ongoing treatment for the right heel wound. R54 became tearful and reported when they came to the facility they expected to do therapy for a few weeks after the right hip surgery then return home to their spouse. R54 reported they felt their progress with physical therapy was slowed due to weight bearing restrictions and use of an off-loading boot on the right foot due to the wound. They also indicated they have subsequently received intravenous (IV) antibiotic treatments for potential infection in the wound which they feel prolonged their stay. R54 reported feeling depressed and stated I've had at least four panic attacks now. I've had trouble when they talk about the wound not healing. I would get short of breath, and I thought I was having a heart attack. On 07/30/25 at 10:41 AM, Registered Nurse (RN) C was interviewed and reported they did recall R54 from the initial period of their admission. RN C reported they recalled R54 receiving a larger bed following their admission and stated, I think I may have ordered the bed but I'm not sure. RN C reported they could not recall having assessed or identified R54's right heel pressure ulcer prior to the bed being requested.On 07/30/25 at 12:20 AM, the facility Maintenance Director (MD) was interviewed and reported they could not recall having a conversation with R54 about their bed but agreed to check their work order record. The MD provided documentation of the work order being requested by RN C and completed on 02/24/25.On 07/30/25 at 01:50 PM, Licensed Practical Nurse (LPN) E reported they were the facility wound care nurse. LPN E reported they became aware of R54's right heel wound on 02/24/25 via the resident's floor nurse. They reported the concern about the resident's feet pushing up against the footboard was identified and they reported it to maintenance then wound prevention and care interventions were ordered and care planned. LPN E reported that the right heel wound was assessed to be a stage three pressure ulcer upon their initial assessment. LPN E acknowledged that there was no indication in the admission nursing assessment that any concerning right heel condition was present.Review of R54's care plan revealed preventive pressure ulcer interventions were initiated 02/25/25 and were not initiated upon admission or upon completion of the admission Braden pressure ulcer risk assessment. Review of R54's current wound care record verified the right heel wound has remained at a stage three with varying levels of improvement and decline regarding size measurements.On 07/30/25 at 02:05 PM, the facility Director of Nursing (DON) was interviewed and asked about why R54 was admitted on [DATE] with no skin concerns identified with the right heel and remained in bed in which their feet were up against the footboard

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure accurate Medication Regimen Review (MRR), accurate medication administration, and adequate medication monitoring was completed for one resident (R6) of three dialysis residents reviewed. Findings include: On 07/30/2025 at 8:11 AM, Licensed Practical Nurse (LPN) “A” was observed to administer Plavix (antiplatelet) 75 milligram (mg), Furosemide 20 mg (water pill), with Lokelma/Sodium Zirconium Cyclosilicate 10 grams (potassium binder). LPN “A” reported no concerns of giving the identified medications on a dialysis day. A review of the web page for the manufacturer's prescribing inserts for Lokelma (sodium zirconium cyclosilicate) documented: .Drug Interactions Section: In general, other oral medications should be administered at least 2 hours before or 2 hours after Lokelma Nine (9) of the 20 drugs that showed an in vitro interaction were subsequently tested in [NAME] with Lokelma 10 g (grams) in healthy volunteers . There was an increase in systemic exposure to weak acids such as furosemide and atorvastatin . Edema: Each 5 g dose of Lokelma contains approximately 400 mg (milligrams) of sodium, but the extent of absorption by the patient is unknown. In clinical trials of Lokelma in patients who were not on dialysis, edema was observed and was generally mild to moderate in severity. On 07/30/2025 at 10:53 AM, Pharmacist “C” was asked to review medications for R6 and reported Plavix should be administered two hours before the Lokelma or two hours after related to reduced effectiveness of Plavix. On 07/30/2025 at 11:37 AM, the identified concerns were reviewed with the Director of Nursing (DON). The DON reported monthly Medication Regimen Reviews (MRR) should be completed by the pharmacist. The Consultant Pharmacist Chart Review for January through July 2025 were reviewed and the “review notes” section did not identify any concerns. The DON reported they would have to review the Consultant Pharmacist Chart Reviews (MRRs). Review of the record for R6 revealed: R6 was admitted into the facility on [DATE]. Diagnoses included End Stage Kidney Disease, Stroke, and Diabetes. Review of the Medication Administration Records (MARs) for January 2025 through July 30, 2025, revealed three to four administrations weekly of Plavix with Lokelma. A review of the orders for Plavix and Lokelma revealed use since 11/22/2024. A review of the policy titled “Medication Administration” dated 06/09/2022, revealed, “Medications are administered by licensed nurses in accordance with professional standards of practice…administer mediation as ordered in accordance with manufacturer specifications…” A review of the facility policy titled, Medication Regimen Review and Reporting revised, 03/20/2013, revealed, .The consultant pharmacist reviews the medication regimen along with the medical record at least monthly . Identification of irregularities may occur by the consultant pharmacist utilizing a variety of resources . the consultant pharmacist incorporates federally mandated standards of care in addition to other applicable professional standards . A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to director of nursing, and the medical director and the care planning team .