STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195600	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matthews Memorial Health Care Center	5100 Jackson Street Ext. Alexandria, LA 71303

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31206 Based on interview and record review the facility failed to immediately consult with the physician, and notify the resident's representative when a resident experienced a fall for 1 Resident (#1) of 3 (Resident#1, Resident #2, Resident #3) sampled residents. Findings: Review of the Facility's Policy titled Change in Resident Medical Status with a revision date of 09/17 read in part: A change in medical status is defined as physical, psychological and/or medical deviation as compared to the resident's status as noted on the initial assessment. These changes may include: a fall and/or injury . A facility must immediately inform the resident; consult with the resident's physician; and or notify, consistent with his or her authority, the resident representative(s), when there is 1. An accident involving the resident which results in injury and has the potential for requiring physician intervention. Review of the facility's incident report dated 04/05/2024, revealed action taken: On 04/05/2024 at 9:15 p.m., Resident #1's physician was contacted. The report revealed the name of Resident #1's RP, with the time of contact was not documented. Review of the nurse's progress notes dated 04/05/2023, and documented at 10:12 p.m. by S3 LPN, revealed in part .on 04/05/2024 at approximately 9:12 p.m., Resident #1 slid out of bed, and onto the floor. Assessed with no injury noted and or c/o pain. Resident #1 was assisted back to bed, instructed to use the call light, and bed in low position. There was no documentation that the RP and/or the physician had been notified of Resident #1's fall. Review of the nurse's progress notes dated 04/05/2024, and documented at 9:19 p.m. by S12 LPN, revealed on 04/06/2024 at 9:19 p.m., while assisting Resident #1 to undress, the CNA noted swelling of the resident's right upper arm with greenish colored bruises. Resident #1 complained of right ribcage and back pain. The physician was notified with an order for stat x-ray of the right arm, ribcage and back. Resident #1's RP was notified. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the X-ray impression dated 04/06/2024 read in part .Acute fracture of the right 6th rib.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 31206 Based on interview and record review, the facility failed to ensure prompt efforts were made by the facility to resolve a grievance filed by a resident's Responsible Party, for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Review of the facility's policy/procedure titled, Grievances-Residents, last revised in 10/2023, revealed, in part . The facility shall make prompt efforts to resolve the grievances. The Administrator and his/her designees will conduct an impartial investigation of the allegations .will discuss the findings and recommendations within five (5) work days of receiving the complaint, with the complainant. Review of an electronic grievance complaint dated 04/08/2024, revealed an electronic complaint was registered by the DON. Resident #1's RP stated she was not notified of a fall that Resident #1 sustained on 04/05/2024. Findings of conclusion: Resident did in fact have a fall on 04/05/2024, and S3 LPN did not notify the RP of the fall. Corrective action taken: DON verbally counseled S3 LPN regarding policy to notify RP in the event of a fall. Telephone interview on 05/01/2024 at 12:25 p.m. with Resident #1's RP, revealed that it was not until 04/06/2024 at about 9:30 p.m. that S12 LPN notified her that Resident #1 had fallen the night of 04/05/2024. Interview on 05/01/2024 at 3:10 p.m. with S3 LPN revealed she had failed to notify Resident #1's RP on 04/05/2024 after the resident fell . Interview on 05/02/2924 at 5:05 p.m., S1Administrator revealed a grievance had been initiated by the DON on 04/08/2024 in regards to Resident #1's RP not being notified until 04/06/2024, that the resident had fallen on 04/05/2024. S1 Administrator confirmed that the complaint had not been completed, and should have been.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31206 Based on observations, interviews and record reviews, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 Resident (#3) of 3 sampled Residents (#1, #2, and #3). The facility failed to ensure that Resident #3 was safely secured in a shower chair prior to showering. This deficient practice resulted in an actual harm for Resident #3 on 04/19/2024 at approximately 7:30 p.m., when Resident #3 was placed in a shower chair that was not equipped with a safety belt. Resident #3 fell from the shower chair to the floor, after being showered by S5 CNA. Resident #3 was transferred to the emergency room and diagnosed with a Displaced Left Intertrochanteric Femur Fracture. Resident #3 required surgical intervention of an Intramedullary Nail placement, Left Intertrochanteric Femur Fracture, on 04/21/2024. Findings: Review of the facility's policy and procedure titled Bathing, with a revision date of 01/2024, read in part . Shower - Dependent Resident 2. When using the shower chair, always apply the safety belt. Review of Resident #3's EHR revealed an admitted [DATE], with admitting diagnoses that included: Endocarditis, End Stage Renal Disease, Acute Kidney Failure with Tubular Necrosis, Benign Prostatic Hyperplasia, and Thoracic Aortic Aneurysm. Review of Resident #3's Annual MDS with an ARD of 02/29/2024, revealed a BIMS score of 15 (intact cognition). The MDS revealed Resident #3 required substantial/maximal assistance x1 with shower/bathe, and partial/moderate assistance x1 with sit to standing, transfer from chair/bed-to-chair, toilet transfer, and tub/shower transfer. Resident #3 had impairment on one side to the upper/lower extremities, and used a motorized wheelchair for mobility. Review of Resident #3's Comprehensive Care Plan with a target date of 06/04/2024, revealed in part . 1. Resident required Restorative Nursing Program for transfers, with a problem onset of 10/04/2022. Resident needs staff assistance with ADLs and transfers. Approaches included in part .Assist with transfers 2. Resident has Hx. of falls with potential for fall impaired mobility, has unstable balance, has motorized wheelchair, and 04/19/2024 fall with injury. Approaches included in part .assist with ADLs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Post-Incident Actions notes dated 04/19/2024 at 7:30 p.m., read as follows in part . S6 CNA called S4 LPN to the shower room. Resident #3 was sitting on the wet floor on his buttocks - slid from the shower chair. Resident c/o severe pain to left leg and hip. Assisted Resident to wheelchair with lift, and placed in bed. Resident's pain = 10. Resident #3's physician was notified with orders given to transfer to ER for evaluation and treatment. Review of the Radiology Interpretation dated 04/19/2024 revealed in part . There is a Basicervical Left Proximal Femoral Fracture. Review of the hospital Discharge Summary read in part .Resident #3 was admitted to the hospital on 04/19/2024, with a diagnosis of Status Post Fall with Left-Sided Hip Fracture. The course of hospital treatment included: Surgical repair of the left hip with preoperative diagnosis of Displaced Left Intertrochanteric Femur Fracture, with PT and OT. Resident #3 was discharged back to the facility on [DATE]. Discharge instructions included: Continue PT and OT at the facility, and recommend to follow-up with primary care provider within 7 days. Interview on 04/30/2024 at 2:00 p.m. with S1 Administrator, revealed Resident #3 was transferred and admitted the hospital with a fractured left femoral, after sliding from the shower chair while in the shower on 04/19/2024. S1 Administrator stated Resident #3 required surgery in order to repair the left femoral fracture, and was scheduled to be discharged back to the facility this evening. Telephone interview on 05/01/2024 at 4:23 p.m. with S5 CNA, revealed she worked on 04/19/2024 from 3:00 p.m. - 11:00 p.m., and was assigned to Resident #3. S5 CNA stated on 04/19/2024, Resident #3 went into the shower room and transferred from the motorized wheelchair to the shower chair using his walker. S5 CNA stated there is a floor threshold before entering the shower stall, and while standing in front of Resident#3, she tried to pull the shower chair over the threshold, and Resident #3 fell forward. S5 CNA stated she tried to push the resident back onto the chair, but because he was heavier than her, the resident went down to the floor. S5 CNA stated on the day that Resident #3 fell out of the shower chair, there was no safety belt attached to the chair. S5 CNA stated the shower chair had been without a safety belt for a while (unable to recall how long). S5 CNA stated that she never reported the shower chair being without a safety belt, because she thought that the issue had already been reported by the day shift. S5 CNA stated this was not the first time she had used the shower chair without a safety belt, and never had any problems. Telephone interview on 05/02/2024 at 8:50 a.m. with S6 CNA, revealed S5 CNA called her cellphone, and asked that she come to the shower room, and get the nurse because Resident #3 had fallen. S6 CNA stated she went to get S4 LPN and reported to her that Resident #3 had fallen in the shower. S6 CNA stated when she entered the shower room, Resident #3 was sitting straight up on his buttocks, and S5 CNA was standing up holding the resident's back. S6 CNA stated she assisted with transferring Resident #3 from the shower floor into his motorized wheelchair using the lift, along with assistance from S4 LPN, S5 CNA, and S7 CNA. S6 CNA stated she didn't see a safety belt on the shower chair on the day that Resident #3 fell (04/19/2024), and she was aware that the shower chair should have had a safety belt attached to it. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/02/2024 at 9:40 a.m. with S8 CNA, revealed she was aware that the shower chairs were supposed to have safety belts, but they didn't always because the belts would break, and/or wouldn't snap close, and they would not be replaced. S8 CNA stated it was not usual for the shower chairs to be without safety belts. S8 CNA stated she was unable to recall the exact length of time that the shower chairs had been without safety belts, or if she had ever logged in the maintenance log book that the shower chairs needed safety belts. S8 CNA stated safety belts were attached to all shower chairs after Resident #3 fell on [DATE]. Interview on 05/02/2024 at 9:42 a.m. with S9 CNA, revealed she last used the shower chair in Shower Room B about 1 week before Resident #3 fell , and there was no safety belt on it at that time. S9 CNA stated she was aware at the time that she last used the shower chair, that it was supposed to have a safety belt on it. S9 CNA stated there were 2 shower chairs in Shower Room B, neither one had a safety belt on it, and that she used one of the shower chairs anyway. S9 CNA stated it was not until after Resident #3 fell last month that safety belts were attached to the shower chairs. Interview on 05/02/2024 at 10:00 a.m. with Resident #3, revealed he fell from the shower chair on 04/19/2024, as S5 CNA was trying to get him out of the shower stall. Resident #3 stated S5 CNA pulled him forward after she showered him, and while trying to get him out of the shower stall, he fell out of the shower chair. Resident #3 stated he was not strapped in the shower chair, and was not able to recall if the shower chair had a strap or not. Resident #3 stated his legs felt as if they had buckled underneath him and the chair came from under him as S5 CNA was pulling the shower chair forward. Resident #3 stated S4 LPN examined him, and his pain level at that time was a 10. Resident #3 stated he was transferred to the hospital, admitted on [DATE] with a fractured left hip, and had surgery on 04/21/2024. Telephone interview on 05/02/2024 at 11:30 a.m. with S4 LPN, revealed on 04/19/2024 Resident #3 fell out of a shower chair in the shower, and sustained a fractured left hip. S4 LPN stated when she arrived in shower room B, Resident #3 was seated on the shower floor in front of the threshold, and S5 CNA was bent over holding the resident up. S4 LPN stated S5 CNA told her that Resident #3 slipped out of the shower chair while she was trying to pull him over the threshold, and she was not able to stop his fall. S4 LPN stated she asked S5 CNA if she had used the safety belt to strap Resident #3 in, and S5 CNA answered, No ma'am, the shower chair had no safety belt on it. S4 LPN stated she checked the shower chair at that time, and there was no safety belt attached. Telephone interview on 05/02/2024 at 1:00 p.m. with S7 CNA revealed she assisted with transferring Resident #3 from off floor in the shower room using the lift, to his motorized wheelchair. S7 CNA stated when she entered the shower room, Resident #3 was sitting on the floor on his buttocks. S7 CNA stated there was no safety belt on the shower chair, and there should have been. Interview on 05/02/2024 at 2:10 p.m. with S11 Maintenance Supervisor revealed if there were problems with any of the shower chairs, whether it be a missing safety belt, brakes or anything, the staff would personally tell him, and/or write it in the maintenance log, at which time he would address it. S11 Maintenance Supervisor stated the logs are kept at each nurse's station, and he checked them daily. After checking each maintenance log with surveyor present, S11 Maintenance Supervisor confirmed there was nothing in the logs in regards to shower chairs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/02/2024 at 2:35 p.m. with S1 Administrator confirmed that the shower chair in use for Resident #3 when he fell on [DATE], did not have a safety belt, and stated that all shower chairs should have safety belts attached for residents' safety.