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	02/11/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 2 (Resident #1 and Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents received services and treatments necessary to promote wound healing.Review of facility policy titled Prevention and Treatment of Skin Issues, revised 09/2025, revealed in part. Policy: It is the policy to properly identify and assess residents whose clinical conditions increase risk for impaired skin integrity and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care.Resident #1Review of Resident #1's clinical record revealed an admission date of 03/07/2024, with diagnoses that included, in part,. Squamous Cell Carcinoma of Skin, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Benign Neoplasm of the Brain, history of Pulmonary Embolism, Atherosclerosis of Native Arteries of Extremities with Intermittent Claudication to Bilateral Legs.Review of Resident #1's Quarterly MDS with an ARD of 12/24/2025 revealed Resident #1 had a BIMS score of 99, indicating the resident was unable to complete the interview. Resident #1 was dependent on putting on/taking off footwear and Rolling left to right. Resident #1 was at risk for pressure ulcer/injury.Review of Resident #1's wound assessment dated [DATE], revealed the resident had a Stage 2 pressure ulcer to her right heel.Review of Resident #1's care plan with an initiation date of 08/30/2024 and next review date of 02/24/2026 revealed, in part, that Resident #1 had a care plan focus: Current Safety Devices and Special Equipment. Goal: Maintain optimal level of functioning. Intervention included in part.: heel protectors.On 02/09/2026 at 10:00 a.m., observation revealed Resident #1 was lying in her bed with her eyes closed. The resident was positioned on her back, without any positioning supports in place. Observation further revealed signage posted on the wall that read, Resident is to wear heel protectors. Two heel protectors were observed on top of Resident #1's clothes closet next to the bed and not on the resident's heels.On 02/09/2026 at 2:00 p.m., observation revealed Resident #1 sitting up in specialized wheelchair in her room with a family member. Two heel protectors were observed on top of Resident #1's clothes closet next to the bed and not on the resident's heels. A family member revealed that she has never observed heel protectors placed on Resident #1.On 02/10/2026 at 9:26 a.m., observation revealed Resident #1 lying in bed with her eyes closed. Resident #1 was positioned on her back. Resident #1's heels were positioned on the mattress without any positioning supports in place. Two heel protectors were observed on top of Resident #1's clothes closet next to the bed and not on the resident's heels.On 02/10/2026 at 11:04 p.m., S5TreatmentNurse revealed Resident #1 had a Stage 2 pressure ulcer to the right heel that was previously a deep tissue injury (DTI). Interventions in place to promote wound healing for Resident #1's right heel, in part, included pressure reduction.On 02/10/2026 at 11:33 a.m., observation revealed Resident #1 sitting up in a specialized wheelchair in the dining room with a family member. Resident #1 was not wearing heel protectors.On 02/11/2026 at 07:44 a.m., observation revealed Resident #1 lying in bed with eyes closed. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was positioned on her back. Two heel protectors were observed on top of Resident #1's clothes closet next to the bed and not on the resident's heels.On 02/11/2026 at 07:58 a.m. S3LPN was present at Resident #1's bedside. S3LPN confirmed Resident #1 had a wound to her right heel. S3LPN revealed that interventions to aid in Resident #1's wound healing included routine turning and repositioning and heel protectors. S3LPN confirmed Resident #1's heel protectors were located on top of the clothes closet not on Resident #1's heels, but should have been.Resident #3Review of Resident #3's clinical record revealed an admission date of 11/31/2021 with diagnoses that included Paraplegia, Neuromuscular Dysfunction of the Bladder, acquired absence of left leg above the knee, acquired absence of right leg above the knee, Pressure Ulcer of Right Buttock Stage 4, and Pressure Ulcer of Left Buttock Stage 4.Review of Resident #3's Quarterly MDS with an ARD of 11/20/2025 revealed a BIMS score of 15, indicating intact cognition. Resident #3 was dependent for personal hygiene, rolling left to right, and all transfers.Review of Resident #3's care plan, initiated on 08/29/2024, with next review on 02/18/2026, revealed that Resident #3 was dependent for bed mobility and was care planned for the facility's Turn and Repositioning Program.Review of Resident #3's clinical record skin evaluation dated 02/05/2026 revealed Resident #3 had two skin issues: Stage 4 Pressure Ulcer to the right gluteus with measurements: Length (cm): 1.23, Width (cm): 1.61, Depth (cm): 0 Area (cm2): 2.32. Resident #3 had a Stage 4 Pressure Ulcer to the left gluteus with measurements: Length (cm): 1.22, Width (cm): 2.96, Depth (cm): 0, Area (cm2): 2.79.On 02/09/2026 at 12:25 p.m., observation revealed Resident #3 sitting up in bed with the head of the bed elevated. Resident #3 was positioned on his back. In an interview at this time, Resident #3 revealed he had a bilateral above-the-knee amputation (AKA) and required full assistance with turning and repositioning. The resident revealed that staff do not turn and reposition him or offer to do so every 2 hours. The resident stated he does not refuse to be turned.On 02/09/2026 at 12:25 p.m., observation of the turn schedule located on Resident #3's wall at this time revealed the resident's turn schedule was as follows: 12 o'clock- right, 2 o'clock- left, 4 o'clock- right, 6 o'clock- left, 8 o'clock- right, 10 o'clock- left.On 02/10/2026 at 08:37 a.m., observation revealed Resident #3 sitting up in bed with the head of the bed elevated. Resident #3 was positioned on his back without any supportive equipment in place. On 02/10/2026 at 10:20 a.m. observation/interview with Resident #3 at this time revealed the resident sitting up in bed with the head of the bed elevated. The resident was positioned on his back without any supportive equipment in place. According to his turn schedule, the resident should have been positioned on his left side. The resident stated he would like to be turned and had not been repositioned in several hours. Resident #3 stated he had two wedges for his repositioning and pointed to the corner of his room, where two wedges were observed in a box.On 02/10/2026 at 11:37 a.m., observation of Resident #3 revealed the resident sitting up in bed with the head of the bed elevated. Resident #3 was positioned on his back without any supportive equipment in place. Two position wedges were observed in a box in the corner of Resident #3's room.On 02/10/2026 at 12:45 p.m., observation of Resident #3 revealed the resident sitting up in bed with the head of the bed elevated. Resident #3 was positioned on his back without any supportive equipment in place. Two position wedges were observed in a box in the corner of Resident #3's room.On 02/10/2026 at 12:47 p.m., an interview with Resident #3 revealed no staff member had offered to turn or reposition him at any point that day.On 02/10/2026 at 1:05 p.m., an interview with S4CNA revealed she was assigned to Resident #3 that day and was familiar with the care he required. S4CNA revealed that Resident #3 required total care and was unable to reposition himself in the bed. S4CNA stated that Resident #3 was not on a turn schedule and that she had not turned or repositioned him that day. S4CNA revealed she had not offered to turn or reposition Resident #3 at (continued on next page)

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