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	06/03/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide care and services that met professional standards of quality by failing to ensure physician orders for blood glucose monitoring were implemented for 2 (Resident #1 and Resident #2) of 3 residents sampled. Findings:Resident #1 Review of Resident #1's medical record revealed an admission date of 02/12/2026 with the following diagnoses in part. Chronic Kidney Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Dementia, Essential Hypertension, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of Resident #1's admission MDS with an ARD of 02/13/2026 revealed a BIMS score of 6, which indicated severe cognitive impairment. Review of an admission progress note dated 02/12/2026 at 12:25 p.m. revealed Resident #1 was admitted to the facility on [DATE] following hospitalization. Hospital discharge diagnoses included Diabetic Ketoacidosis and Hyperkalemia. Review of Resident #1's physician order, with a start date of 02/12/2026, revealed an order for blood glucose monitoring before meals and at bedtime. Review of the February 2026 Medication Administration record (MAR) revealed no documented blood glucose results for Resident #1 on 02/12/2026 at 4:00 p.m. and 8:00 p.m. On 06/01/2026 at 3:45 p.m., an interview with S2LPN revealed she worked the 3:00 p.m. - 11:00 p.m. shift on 02/12/2026. S2LPN confirmed Resident #1 had a physician order for blood glucose monitoring before meals and at bedtime. S2LPN confirmed there was no documentation blood glucose monitoring was performed for Resident #1 at 4:00 p.m. or 8:00 p.m. on 02/12/2026. Resident #2Review of Resident #2's medical record revealed an admit date of 05/11/2026 with the following diagnoses in part. Pneumonia, Acute on Chronic Systolic Heart Failure, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Dementia, Long Term Use of Oral Hypoglycemic Drugs, and Hypertension. Review of Resident #2's admission MDS with an ARD of 05/18/2026 revealed a BIMS score of 6, which indicated severe cognitive impairment. Review of Resident #2's physician order, with a start date of 05/12/2026, revealed an order for blood glucose monitoring twice a day. Review of the May 2026 MAR revealed no documented blood glucose results for Resident #2 on 05/12/2026 or 05/13/2026. On 06/03/2026 at 2:47 p.m., an interview with S1DON confirmed Resident #1 and Resident #2 had physician orders for blood glucose monitoring upon admission. S1DON acknowledged blood glucose monitoring was not performed for Resident #1 on 02/12/2026 and for Resident #2 on 05/12/2026 and 05/13/2026, but should have been.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide pharmaceutical services to ensure procedures that assure accurate acquiring, receiving, dispensing and administration of medications to meet the needs of each resident. The facility failed to provide medications and/or biologicals to meet the needs of residents for 2 (Resident #1 & Resident #3) of 3 residents sampled. FindingsResident #1Review of Resident #1's medical record revealed an admit date of 02/12/2026 with the following diagnoses in part. Chronic Kidney Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Dementia, Essential Hypertension, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of Resident #1's admission MDS with an ARD of 02/13/2026 revealed a BIMS score of 6, which indicated severe cognitive impairment. Review of Resident #1's physician orders revealed that the following medications were ordered to be administered on 02/12/2026:Rosuvastatin Calcium 10mg- administer 1 tablet orally at 9:00 p.m.Seroquel 100mg- administer 1 tablet orally at 9:00 p.m.Singulair 10mg- administer 1 tablet orally at 9:00 p.m.Sodium Bicarbonate 650mg- administer 1 tablet orally at 5:00 p.m.Tresiba FlexTouch 100 units/ml- administer 15 units subcutaneously at 9:00 p.m.Carvedilol 25mg- administer 1 tablet orally at 9:00 p.m.Humalog Kwikpen 100 units/ml- administer 2 units subcutaneously before meals at 4:00 p.m.Humalog Kwikpen 100 units/ml- administer per sliding scale at 4:00 p.m. and 8:00 p.m.Hydralazine 50mg- administer 1 tablet orally at 9:00 p.m.Revatio 20mg- administer 1 tablet orally at 9:00 p.m. Review of the February 2026 Medication Administration record (MAR) revealed code 5 was documented for each of the medications listed above on 02/12/2026. Review of facility's MAR legend revealed code 5 indicated medication was not administered and directed staff to refer to the progress notes. Review of an admission progress note dated 02/12/2026 at 12:25 p.m. revealed Resident #1 was admitted to the facility on [DATE] following hospitalization. Hospital discharge diagnoses included Diabetic Ketoacidosis and Hyperkalemia. Review of a progress note dated 02/12/2026 at 10:29 p.m. revealed Resident #1's medications were on hold pending delivery from the pharmacy. On 06/01/2026 at 12:34 p.m., an interview with Resident #1's family member revealed Resident #1 did not receive her scheduled medications on 02/12/2026 after admission to the facility. On 06/01/2026 at 3:45 p.m., an interview with S2LPN confirmed Resident #1 did not receive the medications listed above on 02/12/2026 because the medications had not been delivered by the pharmacy. On 06/02/2026 at 8:29 a.m., an interview with the pharmacist servicing the facility revealed the pharmacy did not receive Resident #1's medication orders until 9:07 p.m. on 02/12/2026. The pharmacist confirmed that if the medication orders had been faxed to the pharmacy at the time of Resident #1's admission on [DATE] at 12:25 p.m., the medications would have been delivered that same afternoon. Resident #3Review of Resident #3's medical record revealed an admit date of 03/10/2026 with the following diagnoses in part. Heart Failure, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes with Hyperglycemia, Chronic Kidney Disease, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Atherosclerotic Heart Disease, and Essential Hypertension. Review of Resident #3's admission MDS with an ARD of 03/16/2026 revealed a BIMS score of 13, which indicated intact condition. Review of Resident #3's physician orders revealed that the following medications were ordered to be administered on 03/11/2026:Amlodipine 10 mg- administer 1 tablet orally at 8:00 a.m.Cholecalciferol 5000 unit- administer 1 tablet orally at 8:00 a.m.Clopidogrel 75mg- administer 1 tablet orally at 8:00 a.m.Farxiga 5mg- administer 1 tablet orally at 8:00 a.m.Furosemide 20mg- administer 1 tablet orally at 8:00 a.m.Tamsulosin 0.4 mg- administer 1 tablet orally at 8:00 a.m.Lisinopril 40mg- administer 1 tablet orally at 8:00 a.m.Pantoprazole Sodium 40mg- administer 1 tablet orally at 2:00 p.m.Plaquenil 200mg- administer 1 tablet orally at 8:00 a.m. Review of the March 2026 MAR revealed code 5 was documented for each of the medications listed above on 03/11/2026. Review of facility's MAR legend revealed code 5 indicated medication was not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered and directed staff to refer to the progress notes. Review of an admission progress note dated 03/10/2026 at 5:25 p.m. revealed Resident #3 was admitted to the facility on [DATE] with a primary diagnosis of Heart Failure. Review of a progress note dated 03/11/2026 at 11:23 a.m. revealed Resident #3's medications were on hold pending delivery from the pharmacy. On 06/02/2026 at 1:14 p.m., an interview with the pharmacist servicing the facility revealed the pharmacy did not receive Resident #3's medication orders until 10:09 p.m. on 03/10/2026. The pharmacist stated the pharmacy maintains an on-call pharmacist for after hours; however, the facility did not contact the on-call pharmacist, resulting in a delay in medication delivery. The pharmacist confirmed that if the medication orders had been faxed to the pharmacy at the time of Resident #3's admission on [DATE] at 5:25 p.m., the medications would have been delivered that same afternoon. On 06/02/2026 at 3:46 p.m., S1DON acknowledged that the facility experienced delays in obtaining Resident #1 and Resident #3's medications from the pharmacy. S1DON confirmed medications should have been available for administration in accordance with physician orders, but were not.