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	12/04/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe and homelike environment by not ensuring systems were in place to protect residents' personal belongings, resulting in missing items for 2 (Resident #34 and Resident #55) of 34 sampled residents. Findings: Resident #34Review of Resident # 34's Clinical Record revealed an admit date of 07/10/2025 with diagnoses which included: Type 2 Diabetes Mellitus with Hyperglycemia, Hypertension, Acute Kidney Failure, Metabolic Encephalopathy, and Gastro-Esophageal Reflux Disease.Review of Resident # 34's admission MDS with an ARD of 07/22/2025, revealed Resident #34 had a BIMS score of 15, which indicated cognition was intact. Resident #34 required supervision/ touching assistance for bed mobility, transfers, and toileting. Resident #55 Review of Resident # 55's Clinical Record revealed an admit date of 01/30/2025 with diagnoses which included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominate Side, Hyperlipidemia, Major Depressive Disorder, and Anxiety. Review of Resident # 55's Quarterly MDS with an ARD of 11/04/2025, revealed Resident #55 had a BIMS score of 14, which indicated cognition was intact. Resident #55 required moderate/substantial assistance for bed mobility, transfers, and toileting. On 12/02/2025 at 01:18 p.m., an interview with Resident #34 revealed she was missing a blanket and two shirts since September 2025. Resident #34 stated she expressed her concerns during Resident Council meetings and that her missing items had not been replaced as of this date. A review of Resident Council Minutes revealed that Resident #34 and Resident #55 reported missing personal items during the months of September and October 2025. On 12/02/2025 at 10:48 a.m., an interview with S16Activity Director revealed that during September 2025 Resident Council meeting, Resident #34 reported missing clothing items. The Activity Director further reported that during the October 2025 Resident Council meeting, Resident #55 reporting missing clothing items. S16Activity Director stated she informed the supervisors of the appropriate departments following each resident council meeting. On 12/03/2025 at 3:45 p.m., an interview with Resident #55 revealed she was missing two pairs of pants since October 2025. Resident #55 stated she expressed her concerns during Resident Council meetings and that her missing items had not been replaced as of this date. On 12/04/2025 at 9:30 a.m., an interview was conducted with the S1ADM, who stated that staff are expected to notify her when items are missing and cannot be located after searching. The S1ADM reported that she reviews Resident Council Minutes monthly and addresses concerns raised during those meetings. S1ADM confirmed that Resident #34's and Resident #55's complaints regarding missing clothing items had not been addressed, despite staff being aware of the missing items. S1ADM acknowledged that staff should have reported the missing items and that items should have been replaced, but were not.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interviews and record reviews, the facility failed to ensure individuals with a mental disorder were referred for a PASRR Level II review for 2 (Resident #26 and Resident #56) of 2 residents sampled for PASRR.Findings: Resident #26 Review of Resident #26's EMR revealed an admission date of 11/30/2023 with diagnoses including Major Depression Disorder and Anxiety Disorder. Review of Resident #26's EMR revealed a PASRR Level I was completed on 11/27/2023 and indicated Resident #26 had not been diagnosed with a mental illness. Record review revealed Resident #26 was not referred for a PASRR Level II review prior to admission, Further review revealed a diagnosis of Delusional Disorder was entered for Resident #26 on 02/09/2024. Review of Resident #26's EMR failed to reveal referral for a PASRR Level II review after diagnosed with Delusional Disorder. Resident #56 Review of Resident #56's EMR revealed an admission date of 02/11/2022 with diagnoses including Cognitive Communication Deficit, Gastrostomy Status, Cerebral Infarction, Hemiplegia, Major Depression Disorder and Epilepsy. Review of Resident #56's EMR revealed a PASRR Level I was completed on 03/10/2022 and indicated Resident #56 had not been diagnosed with a mental illness. Record review revealed Resident #56 was not referred for a PASRR Level II review prior to admission. Interview with S4SSD on 12/03/2025 at 9:00 a.m. revealed Resident #26 and Resident #56 were diagnosed with a mental illness, and were not referred for a PASRR Level II review. Interview with S12Admissions on 12/03/2025 at 10:21 a.m. confirmed Resident #26 and Resident #56 were diagnosed with a mental illness, and were not referred for a PASRR Level II review, but should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement a comprehensive person-centered care plan for 2 (Resident #16 and Resident #57) of 34 sampled residents. The facility failed to ensure Resident #16 wore a fire resistant apron while smoking and failed to ensure EBP were implemented for Resident #57. Findings:Resident #57 Review of Resident #57's medical record revealed and admission date of 10/02/2024, with diagnoses that included in part .Pressure Ulcer of Right Heel, Un-stageable; Pressure-Induced Deep Tissue Damage of Left Heel; and Pressure Ulcer of Sacral Region, Un-stageable. Review of Resident #57's MDS revealed Resident #57 had a BIMS summary score of 8, which indicated moderate cognitive impairment. Resident #57 required substantial/maximal assistance with toileting hygiene and had unhealed/un-stageable pressure ulcers. Review of Resident #57's care plan revealed in part .At risk for complication related to Right Heel Deep Tissue: At risk for complication related to Left Medial Heel Deep Tissue Injury. Intervention: Enhanced Barrier Precautions in place (initiated: 11/18/2025). At risk for complications related to Un-stageable to Sacrum, 11/26/2025 Right Ischium Pinrose Drain Surgical Site. Interventions: Apply Wound-vac; Enhanced Barrier Precautions in place (initiated: 11/18/2025). Observation on 12/01/2025 at 10:20 a.m. revealed no EBP signage or PPE upon entrance into Resident #57's bedroom. Observations throughout the facility during survey revealed EBP signage and PPE stations located on resident doors for those residents whom required EBP. Observation and interview on 12/01/2025 at 1:31 p.m. revealed no EBP signage or PPE upon entrance into Resident #57's bedroom. Interview with Resident #57 revealed she had an IV (intravenous) in her arm. Observation of right upper arm midline IV. Observation of Resident #57's room revealed no PPE. Observation and interview on 12/02/2025 at 9:10 a.m. revealed no EBP signage or PPE upon entrance into Resident #57's bedroom. Interview with Resident #57 revealed staff does not wear gowns when providing care to her. In an interview on 12/02/2025 at 10:42 a.m., S14 LPN revealed Resident #57 had a wound on her back and a midline IV (intravenous) to her right upper arm for antibiotic treatment. S14 LPN confirmed Resident #57 was on EBP and should have had EBP signage and PPE on her door but did not. In an interview on 12/02/2025 at 10:52 a.m., S13 CNA Supervisor confirmed Resident #57 was on EBP according to her care plan and that there was no EBP signage or PPE on her door. S13 CAN Supervisor confirmed Resident #57 should have had EBP implemented, but did not. Review of the facility's 12/2024 policy titled Care Plan Process read in part. The facility shall use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. The facility staff shall follow the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16 Review of Resident #16's medical record revealed an admit date of 01/25/20 with diagnoses that included: Nicotine Dependence, Major Depressive Disorder, and Cerebral Infarction. Review of Resident #16's Quarterly MDS with an ARD of 09/18/2025 revealed a BIMS score of 11, indicating moderately intact cognition. Review of Resident #16's Care Plan with a review date of 12/22/2025 read in part.Resident is an unsafe smoker. 09/11/2025 offer smoking apron. Review of Resident #16's Smokers assessment dated [DATE] read in part.Resident requires 1:1 supervision while smoking. Resident required fire-resistant smoking apron while smoking. Lighter and matches must be kept at the nurses station. An observation on 12/02/2025 at 9:18 a.m. Resident #16 was observed sitting in the smokers lounge with a staff member, smoking a cigarette, without a smoker's apron being worn. An interview on 12/03/2025 at 1:20 p.m. with S1ADM confirmed that Resident #16 should have had a smoker's apron on while smoking on 12/02/2025, but did not.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure residents who are unable to carry out ADLS (Activities of Daily Living) received the necessary services to maintain good personal hygiene for 2 (#59, and #76) of 4 (#1, #59, and #76, and #86) residents reviewed for ADL care. The facility failed to ensure:11. Resident #59 was provided nail care and was shaved; and 2. Resident #76 was provided proper hair care. Findings:Review of the facility's policy dated 08/2024 titled Resident Quality of Care read in part.Each resident shall receive optimal care to attain and/or maintain the highest possible mental and physical function. The facility will ensure that the resident's abilities to perform activities of daily living do not diminish unless it is clinically unavoidable. At the time of the bath, all residents shall also receive, if applicable, nail care and hair shampoo as needed, shave and oral hygiene. Resident #59 Review of Resident #59's medical record revealed an admission date of 09/09/2025 with diagnoses that included: Rhabdomyolysis and Major Depressive Disorder. Review of Resident #59's Quarterly MDS with ARD of 06/18/2025 revealed a BIMS of 15, indicating intact cognition. Resident #59 required partial/moderate assistance with personal hygiene. Review of Resident #59's care plan with a review date of 12/18/2025 read in part The resident has limited physical mobility weakness. Assistance needed with activities of daily living. An observation on 12/01/2025 at 9:50 a.m., Resident #59 was sitting in chair in room with 1/4 inch long facial hair to chin and 1/4 inch long jagged fingernails. Resident #59 stated that she does not like rock the boat and if they offer to cut her nails and long facial hair she lets them but staff don't often offer. Resident #59 stated that she likes to keep hair facial hair and nails cut. An observation and interview on 12/02/2025 at 8:51 a.m. Resident #59 continues with long facial hair to chin and long jagged nails. Resident stated that she came to the facility months ago and has only had her nails cut once. An interview on 12/02/2025 at 9:45 a.m., S16LPN confirmed Resident #59's long facial hair and long jagged nail and stated that she would get staff to take care of it today. Resident # 76 Review of Resident #76's medical record revealed an admit date of 01/25/2022 with the following diagnoses: Alzheimer's, Dementia, Hypothyroidism, and Anxiety Disorder. Review of Resident #76's Care Plan with a review date of 02/04/2026 read in part.Resident needs assistance with all activities of daily living. Review of Resident #76's Quarterly MDS with an ARD of 11/06/2025 revealed a BIMS score of 99 indicating resident is unable to be interviewed. Resident is dependent on staff for personal hygiene. An observation on 12/01/2025 at 10:03 a.m. Resident #76 I observed lying in bed and the hair to the left side of head is matted into a ball. An observation on 12/02/2025 at 8:44 a.m. Resident observed lying in bed with hair pulled up on top of hair with a hair tie. Unable to see if hair is matted at this time. An observation on 12/02/2025 at 9:40 a.m. Observation of Resident #76's hair with S16 LPN revealed the left side of resident's hair is matted. S16 LPN confirmed Resident #76's matted hair and stated that she would not be able to comb through matted hair. An interview on 12/03/2025 at 12:05 p.m., S17CNA stated that she baths Resident #76 often and has noticed her hair matted like it currently is since 10/2025. S17CNA stated she notified S16LPN on 10/2025 and asked her to call the family to see if it could be cut out but she had not heard back. S17CNA stated she typically washes her hair weekly and will put in conditioner and try to work out the matt. S17CNA stated she stops after a while because she does not want to hurt her. An interview on 12/03/2025 at 10:13 a.m. with S16LPN states that she was not aware that her hair was that matted. S16 LPN stated she did know around not long ago that her hair was matted but was told that they worked it out. S16LPN stated the plan to try to work it out and if it cannot they will speak to family and see if they would be ok with a haircut.

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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. Based on observation, record review and interview, the facility failed to ensure 1 (Resident #10) of 3 (Resident #10, Resident #57, and Resident #86) sampled residents received the necessary treatment and services to prevent and promote the healing of pressure ulcers by failing to perform hand hygiene during treatment of a pressure ulcer. Findings:Review of Resident #10's medical records revealed an admit date of 11/9/2023 with diagnoses that included: Pressure Ulcer of Sacral Region, Stage 3, and Vascular Dementia. Review of Resident #10's 12/2025 Physician Orders read in part.Cleanse Stage 4 to sacrum with wound cleanser, pat dry, skin prep periwound, calcium alginate and cover with a dry dressing daily until resolved. Observation of Resident #10's wound care on 12/03/2025 at 2:25 p.m., S18TXNurse nurse cleaned the sacrum wound with wet gauze, discarded gauze, reached over onto clean field with soiled gloves, removed gauze from cup and cleansed would. S18TXNurse nurse completed this action 4 more times without removing gloves or sanitizing hands. Interview on 12/03/2025 at 2:30 p.m., S18TXNurse confirmed she did not remove gloves and sanitize hands after cleaning the wound and reaching over into clean field to get new gauze.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement, monitor, and modify interventions, consistent with the resident's assessed needs and current professional standards of practice, to maintain acceptable parameters of nutritional status for 1 (Resident #86) of 1 resident sampled for nutrition. Findings: Review of the facility's policy titled Management of Residents with Nutrition Problems revised 05/2018 revealed residents with unintended significant weight loss are referred to the RD for evaluation. A Weight Evaluation Form is completed for residents who have a significant weight change. Review of Resident #86's EMR revealed an admission date of 03/07/2024 with diagnoses including Seizures, DM II, and Benign Neoplasm of Brain. Review of Resident #86's Quarterly MDS with ARD of 10/07/2025 revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #86 required substantial/maximal assistance with eating. Review of Resident #86's orders revealed the following, dated 08/07/2025: House Supplement 4 oz. with med pass four times a day for Weight Gain, Document intake: 0=None, 1=25%, 2=50%, 3=75%, 4=100%, 5=Refused. Review of Resident #86's weight record revealed the following, in part: Weight of 157.5 pounds on 11/26/2025; Weight of 167.4 pounds on 10/29/2025; Weight of 169.2 pounds on 08/27/2025; and Weight of 186.6 pounds on 05/13/2025. Review of Resident #86's RD Nutrition assessment dated [DATE] revealed the following, in part.Significant weight loss of -8.1% x 1 month and -11.6% x 3 months. Monitor weights and po intake. Refer to RD prn. Review of Resident #86's RD Nutrition assessment dated [DATE] revealed the following, in part. Significant Weight Loss: -10.7% x 6 months. Monitor weights and po intake. Refer to RD prn. Review of Resident #86's Weight Evaluation Form dated 11/19/2025 revealed the following, in part.Significant and unintentional weight loss of -5.9% x 30 days, and -14.4% x 180 days. Review of Resident #86's care plan revealed the resident had unplanned/unexpected weight loss related to poor food intake. Goal was for resident to consume 75% of two of three meals per day. Interventions included, in part.observe food intake, give the resident supplements as ordered, and alert nurse/dietician if not consuming on a routine basis. Review of Resident #86's Task - Nutrition dated 11/05/2025 through 12/04/2025 revealed meal intake was not documented for: 11/06/2025: 2 meals; 11/10/2025: 3 meals; 11/11/2025: 2 meals; 11/13/2025: 2 meals; 11/14/2025: 2 meals; 11/15/2025: 3 meals; 11/16/2025: 1 meal; 11/17/2025: 1 meal; 11/18/2025: 2 meals; 11/20/2025: 2 meals; 11/22/2025: 2 meals; 11/23/2025: 3 meals; 11/24/2025: 1 meal; 11/25/2025: 3 meals; 11/26/2025: 3 meals; 11/27/2025: 2 meals; 11/30/2025: 3 meals; 12/02/2025: 1 meal; and 12/03/2025: 2 meals. Review of Resident #86's 11/2025 and 12/2025 MARs revealed the percentage consumed was not documented for the House Supplement, as ordered. Interview with S19CNA on 12/04/2025 at 11:38 a.m. revealed CNAs were to document the percentage of every meal consumed and nurses were to document the percentage of house supplement consumed. Interview with S6ADON/IP on 12/04/2025 at 11:50 a.m. revealed CNAs were to document the percentage of every meal consumed and nurses were to document the percentage of house supplement consumed. Interview with S20RD on 12/04/2025 at 11:55 a.m. confirmed the percentage of meal and house supplement intake was not consistently documented for Resident #86, but should have been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure:1. EBP were utilized for 1 (Resident #57) of 3 residents reviewed for pressure ulcers;2. Staff performed proper hand hygiene while feeding residents; 3. Staff followed proper infection prevention and control practices during transport of soiled linens; and4. Staff followed proper infection prevention and control practices while laundering resident clothing.Findings: 1. Review of a facility policy on 12/02/2025 at 2:26 p.m. titled Enhanced Barrier Precautions, with a revision date of 03/2024 revealed in part.Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing home. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of Resident #57's medical record revealed and admission date of 10/02/2024, with diagnoses that included in part .Pressure Ulcer of Right Heel, Un-stageable; Pressure-Induced Deep Tissue Damage of Left Heel; and Pressure Ulcer of Sacral Region, Un-stageable. Review of Resident #57's MDS revealed Resident #57 had a BIMS summary score of 8, which indicated moderate cognitive impairment. Resident #57 required substantial/maximal assistance with toileting hygiene and had unhealed/un-stageable pressure ulcers. Review of Resident #57's care plan revealed in part . At risk for complication related to Right Heel Deep Tissue: At risk for complication related to Left Medial Heel Deep Tissue Injury. Intervention: Enhanced Barrier Precautions in place (initiated: 11/18/2025). At risk for complications related to Un-stageable to Sacrum, 11/26/2025 Right Ischium Pinrose Drain Surgical Site. Interventions: Apply Wound-vac; Enhanced Barrier Precautions in place (initiated: 11/18/2025). In an interview on 12/03/2025 at 10:27 a.m., S15 CNA stated she was familiar with Resident #57. S15 CNA revealed Resident #57 was incontinent of bowel and bladder and had a bed sore which required a wound vac. S15 CNA stated she's unsure on how to know if a resident is on EBP. S15 CNA stated the only precautions Resident #57 was on is fall precautions. Observation on 12/03/2025 at 10:33 a.m., revealed S15 CNA entered Resident #57's bedroom to provide incontinent care and to turn Resident #57. S15 was observed putting on gloves and not a disposable gown. S15 CNA performed incontinent care to Resident #57 without placing on disposable gown. In an interview on 12/03/2025 at 10:42 a.m., S14 LPN revealed Resident #57 had a wound on her back (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and a midline IV (intravenous) to her right upper arm for antibiotic treatment. S14 LPN confirmed Resident #57 was on EBP. In an interview on 12/03/2025 at 10:52 a.m., S13 CNA Supervisor confirmed Resident #57 was on EBP and that S15 CNA should have worn a disposable gown along with gloves when she provided incontinent care to Resident #57 and did not. #2 Observation of room [ROOM NUMBER] on 12/03/2025 at 8:53 a.m. revealed S10CNA feeding two residents without applying hand sanitizer or performing hand hygiene between direct contacts with residents. Interview with S13CNASupervisor on 12/03/2025 at 11:31 a.m. confirmed staff did not use hand sanitizer or perform hand hygiene between direct contacts with residents, but should have. #3 Observation of Hall A on 12/01/2025 at 11:35 a.m. revealed S7CNA carrying soiled bedding in her hands. S7CNA opened a door and placed the soiled bedding into a yellow barrel inside the room. Interview with S7CNA on 12/01/2025 at 11:36 a.m. confirmed she had been carrying soiled linens in her hands, but should not have been. Interview with S19CNA on 12/01/2025 at 11:36 a.m. revealed soiled linens should have been transported in a yellow barrel. Interview with S13CNASupervisor on 12/03/2025 at 11:31 a.m. confirmed staff had not followed proper infection prevention and control practices during transport of soiled linens, but should have. #4 Observation of Laundry with oversight from S9Laundry on 12/03/2025 at 9:20 a.m. revealed Cart 1 was used to obtain and transport soiled personal clothing of residents from the rooms. Cart 1 was then taken into the laundry room and the clothing was placed into a washing machine and laundered. Upon completion of the wash cycle, the resident clothing was placed into Cart 1, transported to the dryer area, and placed inside a dryer. Upon completion of drying, resident clothing was removed from the dryer and placed into Cart 2. Interview with S9Laundry confirmed Cart 1 was used to transport both soiled and washed resident clothing, but should not have been. Interview with S8Corporate on 12/03/2025 at 3:35 p.m. confirmed soiled clothing and clean clothing should not be transported in the same cart.