STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matthews Health & Rehab Center	600 Fullwood Lane Matthews, NC 28105

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, staff and Ombudsman interviews, the facility failed to notify the resident and his family member in writing of a transfer to the hospital for 1 of 3 residents reviewed for hospitalization (Resident #73) and failed to notify the Ombudsman each month of facility transfers and discharges for 3 of 3 months (November 2024, December 2024, and January 2025). The findings included: 1. Resident #73 was admitted to the facility on [DATE] and readmitted [DATE]. A nursing note dated 12/27/24 documented Resident #73 was transferred to the hospital for a change in condition. A nursing note dated 1/7/25 documented Resident #73 was readmitted to the facility after hospitalization for an upper respiratory infection. The quarterly Minimum Data Set assessment dated [DATE] assessed Resident #73 to be cognitively intact. Review of Resident #73's electronic medical record revealed no letter of transfer was provided to Resident #73 or his representative. Resident #73 was interviewed on 2/2/25 at 12:27 PM and he reported he was hospitalized for an upper respiratory infection in December 2024 and returned to the facility in January 2025. Resident #73 reported he had not received a letter from the facility regarding his transfer. Social Worker (SW) #1 was interviewed on 2/4/25 at 1:33 PM. The SW reported she was not certain which staff member was responsible for the letters of transfer. The Business Office Manager was interviewed on 2/4/25 at 1:42 PM and she reported she was not certain who was responsible for the letters of transfer. An interview was conducted with SW #2 at 2/4/25 at 4:00 PM and she reported she did not know who was responsible for the letters of transfer. (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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator reported the facility had a change in the social work department and the social work department should be writing letters of transfer to the resident and their representative. 2. The record of discharges report from 8/1/24 to 10/31/24 was reviewed. Attached to the report was an email dated 11/4/24 that indicated that the file had been emailed to the Ombudsman. The record of discharges report from 11/1/24 to 12/31/24 was reviewed. Attached to the report was an email dated 1/6/25 that indicated that the files had been emailed to the Ombudsman. There were no discharge reports that had been sent to the Ombudsman for January 2025. An interview was conducted with Social Worker (SW) #1 on 2/4/25 at 12:27 PM. SW #1 reported the former Administrator was sending the list of transfers and discharges to the Ombudsman, and when he left the company, she had been told she would be responsible for the communication to the Ombudsman. SW #1 explained that the former Administrator left in July 2024 and the interim Administrator sent the discharge reports to the regional Ombudsman in November 2024. SW #1 explained that she had not emailed January 2025 discharges to the Ombudsman. The Ombudsman was interviewed by phone on 2/5/25 at 11:09 AM. The Ombudsman reported she had not received August, September, or October 2024 discharges until November 2024, and had not received any discharge report from the facility since November 2024. The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator reported the facility had a change in the Administrator and the social work department would be responsible for notifying the Ombudsman of transfers and discharges.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, staff and Ombudsman interviews, the facility failed to provide a bed hold notice for 1 of 3 residents reviewed for hospitalization (Resident #73). The findings included: Resident #73 was admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses for Resident #73 included lung disease. The quarterly Minimum Data Set assessment dated [DATE] assessed Resident #73 to be cognitively intact. A nursing note dated 12/27/24 documented Resident #73 was transferred to the hospital for a change in condition. A nursing note dated 1/7/25 documented Resident #73 was readmitted to the facility after hospitalization for an upper respiratory infection. Review of Resident #73's electronic medical record revealed no bed hold notice. Resident #73 was interviewed on 2/2/25 at 12:27 PM and he reported he was hospitalized for an upper respiratory infection in December 2024 and returned to the facility in January 2025. Resident #73 reported he had not received a bed hold notice when he was transferred to the hospital. Social Worker (SW) #1 was interviewed on 2/4/25 at 1:33 PM. The SW reported she was not certain which staff member was responsible for providing the written bed hold notice when a resident was transferred to the hospital. The Business Office Manager was interviewed on 2/4/25 at 1:42 PM and she reported she was not certain who was responsible for bed hold notices. An interview was conducted with SW #2 at 2/4/25 at 4:00 PM and she reported she did not know who was responsible for the bed hold notices. The Administrator was interviewed on 2/5/25 at 1:20 PM. The Administrator reported the facility had a change in the social work department and the social work should be providing the written bed hold notice to residents or their representative when the resident was transferred to the hospital.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13811 Based on observations, record review, staff and Physician interviews, the facility failed to maintain wound vac (negative pressure wound therapy to help heal wounds) treatment as ordered and failed to follow treatment orders for when the wound vac malfunctioned or was broken for stage 4 sacral pressure ulcer for 1 of 3 residents reviewed for pressure ulcer (Resident #318). Findings included: Resident #318 was admitted to the facility on [DATE] with diagnoses that included chronic sacral decubitus, type 2 diabetes and peripheral artery disease. The hospital discharge summary on 1/31/25 revealed that Resident #318 was seen for stage 4 sacral full-thickness pressure ulcer with non-viable tissue on admission to the hospital. Resident #318 was found septic due to the infected large sacral pressure ulcer. She received intravenous antibiotics and completed the treatment. Resident #318 deferred surgical intervention and opted wound care with wound vac. The hospital discharge summary recommended to continue with wound vac after her discharge. It stated that without the wound vac, there would be a high risk of the sacral pressure ulcer to have active infection and potentially leading to worsening clinical status. The initial admission assessment worksheet dated 1/31/25 revealed that Resident #318 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. The admission notes on 1/31/25 revealed that Resident #318 was weak on both upper extremities and unable to bend finger to finger on both hands. The resident had a contracture to her left hand and complained of pain when moving her arms. It was documented that the resident used mechanical lift for transfer and required total care for all activities of daily living (ADL). The skin was dry and warm to touch with a stage 4 sacral wound with wound vac in place. A physician order on 1/31/25 revealed wound vac therapy at 125 mm/Hg (millimeter of mercury a pressure measurement for the vacuum). The order instruction was to change the wound vac on Monday, Wednesday, and Friday (MWF). The order instruction included that if the wound vac malfunctioned or broken, they can remove the wound vac. Then clean the sacral wound with wound cleanser, fill the cavity with a disinfectant solution to moisten the gauze, and cover with a protective dressing as needed. The Treatment Nurse wrote on her note on 1/31/25 that she cleaned and applied the wound vac on Friday at 4:12 pm. A nurse's note written by Nurse #1 on 2/1/25 at 6:55 pm showed that wound care was completed with wet to dry dressing until the wound vac can be replaced on Monday. An observation of Resident #318 on 2/2/25 at 11:40 am showed that the wound vac machine was sitting on the windowsill of the resident's room. Resident #318 was lying flat on the bed with no tube connection seen to the wound vac. The resident was too sleepy to talk and excused herself to go back to sleep. A follow-up observation to the room of Resident #318 at 2:37 pm revealed the wound vac machine was still in the windowsill. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another nurse's note written by Nurse #1 on 2/2/25 at 6:08 pm revealed the wet to dry wound dressing was intact from 2/1/25. A physician order dated 2/2/25 written by Nurse #1 revealed to treat the sacral pressure ulcer with wet to dry dressing until treatment nurse assess the wound. Nurse #1 was interviewed on 2/4/25 at 9:00 am. She stated that she did the sacral pressure ulcer treatment on Saturday (2/1/25) with normal saline (NS) wet-to-dry dressing and reinforced the wound dressing on Sunday (2/2/25). She stated she was told by her supervisor to do wet to dry dressing on 2/1/25 when she reported that the wound vac suction was leaking from the dressing. Nurse #1 stated the Treatment Nurse would place the wound vac on Monday (2/3/25). She stated that the wound vac machine was not broken. An interview with Nurse # 4 on 2/5/25 at 10:41 am revealed she worked on Saturday (2/1/25) and Sunday (2/2/25) night with the resident. She stated that the wound vac was not in use. She was also told at shift changed that they would use wet to dry dressing when needed. Nursing Aide (NA) #4 was interviewed on 2/4/25 at 9:29 am and stated that she worked on Baylor Shift (weekend staffing) and took care of Resident #318 on 2/1/25 and 2/2/25. She said there was no wound vac used as she checked and cleaned the resident. The follow-up observation on 2/3/25 at 9:56 am revealed the wound vac was still on Resident #318's windowsill and was not in use. The Treatment Nurse was observed on 2/3/25 at 1:55 pm for wound treatment dressing. The Treatment Nurse removed the old dressing from the wound and showed the stage 4 sacral pressure ulcer with tunneling. The Treatment Nurse followed the treatment orders for the wound vac. The wound vac functioned well. Interview with the Treatment Nurse on 2/3/25 at 2:22 pm stated that the wound vac machine was in proper working order and was not broken. The Treatment Nurse stated that wet to dry (NS) was not acceptable treatment. The use of disinfectant solution with wet gauze was ordered on admission. She further stated that she would discontinue the order on 2/2/25 for wet-to-dry wound dressing. On 2/5/25 at 9:09 am the Physician was interviewed, and he stated that Resident #318 had a severe sacral pressure ulcer. He stated that wet-to-dry (NS) dressing was not an appropriate treatment and that wound vac should have been used. The Physician stated that he was not made aware of the wet-to-dry dressing and that the treatment was not recommended because of the high possibility of infection. He stated that the only time it's acceptable to not have wound vac was when the wound vac malfunctioned or broken, and they would exchange the wound vac machine just for few hours not all weekend or days. Interview with the Director of Nursing (DON) on 2/5/25 at 11:34 am stated the nurses should have followed the treatment order as written. The interview with the Administrator on 2/5/25 at 11:34 am stated that the nurses should have followed the doctor's order and was not aware the wound vac was not used on the weekend.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13811 Based on observation, record review, and staff and physician interviews, the facility failed to secure the indwelling urinary catheter to reduce tension for 1 of 2 residents (Resident #3) reviewed for urinary catheter. Findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of bladder. The physician order dated 7/25/24 was to use indwelling urinary catheter for neuromuscular dysfunction of bladder. There was no order for urinary catheter securing device to be used. The Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was moderately cognitively impaired and was coded to have a urinary catheter. The care plan dated 1/23/25 for the indwelling urinary catheter revealed a goal to have reduced risk for signs and symptoms of Urinary Tract Infection (UTI). The approaches included enhanced barrier precaution, and to assess signs and symptoms of UTI. The care plan, goals, or approaches did not mention securing the indwelling urinary catheter tubing. An observation on 2/2/25 at 11:44 am revealed Resident #3 was lying on her bed with the indwelling urinary catheter tubing observed on the right side of the bed connected to the urinary drainage bag. The urinary drainage bag was hanging on the right side of the bed. The resident stated that she had had her indwelling catheter for a long time. An observation of the indwelling urinary catheter tubing revealed there was no securing device attached to the urinary catheter. She stated that she didn't know what a securing device looked like and that the nursing staff didn't put any in place. Resident #3 was observed on 2/3/25 at 9:59 am and 2:31 pm. Both observations revealed the indwelling urinary catheter tubing was not secured. Another observation of Resident #3 on 2/4/25 at 9:56 am revealed that there was no securing device attached to the indwelling urinary catheter tubing. An observation of urinary catheter care was conducted in conjunction with an interview with Nurse Aide (NA) #5 and NA #6 at 1:34 pm. NA #5 and NA #6 revealed the indwelling urinary catheter tubing was not secured. NA #5 stated the resident didn't have a device to secure her indwelling urinary catheter tubing. NA#5 and NA#6 stated some residents in the facility had securing devices for indwelling urinary catheters, but they had not seen such devices to secure the indwelling urinary catheter tubing for Resident #3. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #3 was interviewed on 2/5/25 at 9:28 am and stated Resident #3's catheter was not secured because they didn't have a supply of devices to secure indwelling urinary catheter tubing in the facility. During an observation Nurse #3 opened a drawer of her medication cart and an indwelling urinary catheter securing device was observed in the drawer of the medication cart. The Physician was interviewed on 2/5/25 at 9:19 am and stated an indwelling urinary catheter securing device should be used for all residents with indwelling urinary catheters. The physician stated it was a standard recommendation to secure indwelling catheters to prevent injury. The Administrator and the Director of Nursing (DON) were interviewed on 2/5/25 at 9:30 am. The DON and Administrator stated the facility had a supply of securing devices for indwelling urinary catheter tubing and nursing staff should use them.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43643 Based on resident and staff interviews the facility failed to have systems in place for providing evening snacks to residents for 2 of 3 halls (100 hall and 400 hall). The deficient practice had the potential to affect residents requesting an evening snack. The findings included: An interview conducted during a Resident Council Meeting on 02/04/25 at 10:00 AM revealed residents had not received or been offered snacks in the evenings by nursing staff. The Resident Council President (Resident #106), Resident #4, Resident #5, Resident #8, and Resident #81 stated nursing staff did not offer evening snacks frequently and when residents asked nursing staff for snacks, they were told nursing staff were unable to get in the kitchen or there were no snacks available. It was further revealed it had been reported to the Dietary Manager (DM) and it continued to be an issue. An interview conducted with Nurse #5 on 02/04/25 at 7:35 PM revealed nursing staff were often unable to access the kitchen at night to retrieve snacks. The Nurse further revealed there had been multiple evenings snacks were not provided for distribution to residents. Nurse #5 stated she had reported the concerns to the DM. An interview conducted with Nurse Aide (NA) 7 on 02/05/25 at 7:50 PM revealed she worked second shift and residents during second shift (3:00 PM to 11:00 PM) had not received a bedtime snack on multiple days because kitchen staff had failed to deliver evening snacks and nursing staff was unable to get access to the kitchen. The NA indicated she had reported this to a Nurse on duty over the past few months but could not recall which Nurse. An interview conducted with the Dietary Manager on 02/05/25 at 10:05 AM revealed she had recently been made aware nursing staff had reported snacks had not been provided. The Dietary Manager indicated dietary staff checked and stocked snack bins daily and felt that nursing were not offering bedtime snacks as needed for the residents. The Dietary Manager indicated she had tried to educate staff on providing bedtime snacks to all residents. An interview conducted with the Director of Nursing (DON) and the Administrator on 02/05/25 at 11:30 AM revealed they had expected there to always be snacks available for residents. The Administrator indicated he was not aware evening snacks had been an issue.