

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER Mathews Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Fullwood Lane Mathews, 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Power of Attorney (POA), Medical Director, and staff, the facility failed to ensure a resident's advance directive information was entered throughout the medical record for 1 of 3 residents reviewed for advance directives (Resident #106).The findings included:Resident #160 was admitted to the facility on [DATE].Resident #160 Medical Orders for Scope of Treatment (MOST) form dated [DATE] revealed resident was a Do Not Resuscitate (DNR).A physician's order dated [DATE] indicated Resident #106's advance directive was DNR, meaning no cardiopulmonary resuscitation (CPR) would be initiated in the event of cardiac or respiratory arrest.Review of Resident #160's Electronic Health Record (EHR) revealed the resident face sheet banner, located at the top of the electronic record and used to display key resident information, did not display a code status of either Full Code or DNR.Review of the Advance Directive dated [DATE] indicated Resident #106's code status was DNR.Review of Resident #160's care plan dated [DATE] revealed no Advance Directive was documented.Resident #160 5-day Minimum Data Set (MDS) assessment dated [DATE] Revealed resident #160 had severe cognitive impairment.Review of Nurse #1's progress note dated [DATE] revealed that at 10:00 AM, Resident #160 was found unresponsive during a medication pass. The code status was not available in the electronic Medication Administration Record (eMAR), which is the electronic system staff use to document medications and review resident treatment information, and CPR was initiated. Th MOST form, a physician-signed medical order that outlines a resident's wishes for life-sustaining treatment, was later found indicating a DNR status, and CPR was stopped and the Power of Attorney (POA) and physician were notified.A phone interview was conducted on [DATE] at 11:28 AM with Resident #109's POA. The POA stated he received a call from the facility on [DATE] and spoke with Nurse #1 that morning, who informed him that Resident #109 was found unresponsive and Emergency Medical Services (EMS) were contacted. The POA reported he received a second call but could not recall the time he was notified that Resident #109 had expired. The POA stated he was not informed that CPR was initiated. The POA further stated he was not concerned that CPR was provided; however, Resident #109's wishes were for a DNR status in the event of a life-threatening incident.A phone interview with Nurse #1 on [DATE] at 12:00PM revealed on [DATE] at around 10:00 AM, Resident #109 was found unresponsive during a medication pass. The code status was not available in the banner at the time of the incident. Nurse #1 stated she initiated CPR and called for assistance from Nurse #2. Nurse #1 reported she was unable to locate the code status in the banner, and Nurse #2 went to the nurse's station to locate the code status binder. Nurse #2 identified that Resident #109 had a DNR order, and Nurse #1 immediately discontinued CPR. Nurse #1 stated CPR was performed for less than one minute, with approximately 25 chest compressions, and the resident did not respond. Nurse #1 reported that EMS were contacted and later canceled once the DNR status was confirmed; however, she was unsure who canceled the call. Nurse #1 stated she notified Resident #109's POA on [DATE] but could not recall the exact times of the notifications or whether she informed the POA that CPR had been initiated. Nurse #1 further stated she notified the Director of Nursing (DON), who provided (continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>education to refer to physician orders to verify code status in the event a resident is found unresponsive. A phone interview was attempted with Nurse #2 on [DATE] at 12:50 PM; however, no response was received. An interview was conducted with Social Worker #1 on [DATE] at 1:00 PM. Social Worker #1 stated Resident #109 was a short-term resident admitted to the facility on [DATE] and that Social Worker #1 was responsible for updating care plan meetings and addressing advance directives for short-term residents. An interview with Unit Manager #1 on [DATE] at 10:47 AM, who was responsible for overseeing short-term residents, revealed that she was responsible for ensuring code statuses were updated for short-term residents upon admission and during their stay. She stated that at admission, orders were entered by nursing staff, and the banner should have been updated to reflect a Full Code or DNR status. Unit Manager #1 reported that a former Assistant Director of Nursing (ADON), who was no longer employed at the facility, had worked with the family at the time of admission and may have missed updating Resident #109's banner to reflect DNR status. Unit Manager #1 stated that when a social worker completed advance directive audits, she was responsible for following up on any code status discrepancies for short-term residents. A phone interview was attempted with the former ADON on [DATE] at 12:55 PM; however, no response was received. An interview with the facility's physician on [DATE] at 11:35 AM revealed that he did not recall the incident and stated that Resident #109 had a DNR order upon admission to the facility on [DATE], initiated by another provider, per Resident #109's POA. An interview with the DON on [DATE] at 11:35 AM revealed that upon admission, each resident would have had an advance directive status ordered by the facility physician. She stated that afterward, each resident's banner should have reflected either Full Code or DNR status. The DON further stated that although the former ADON had not entered the code status in the banner for Resident #109, all nursing staff were responsible for updating and entering code status in the banner. An interview with the Administrator on [DATE] at 11:57 AM revealed that each resident's banner should have reflected either Full Code or DNR status upon admission. The facility provided a Plan of Correction (POC); however, it was not accepted.</p>		