STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195204	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jo Ellen Smith Convalescent Center	4502 General Meyer Avenue New Orleans, LA 70131

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's right to refuse life sustaining treatment would be carried out for 2 (Resident #51, Resident #65) of 30 sampled residents screened for advanced directives. Findings:Review of the Louisiana Physician Orders for Scope of Treatment (LaPOST) Handbook for Long Term Care Professionals, dated 01/2024, revealed, in part, if a resident chose to complete the LaPOST form, it must be followed by healthcare providers and must be signed by a physician to be valid. Further review revealed if there was a substantial change in the person's treatment goals including a reversal of a prior directive, a new LaPOST should have been completed and the old LaPOST properly voided. Further review revealed to void the LaPOST form, a line should be drawn through Physician's Orders, VOID written in large letters, and the form should be signed/dated. Review of the facility's Emergency Cardiopulmonary Resuscitation (CPR) (an emergency procedure that combines chest compressions and rescue breathing to keep blood circulating) policy and procedure, with a revision date of [DATE], revealed, in part, if the resident's Do Not Resuscitate (DNR) (a healthcare provider should not perform CPR if a resident's heart stopped beating or a resident stopped breathing) status is unclear, CPR would be initiated. Review of the facility's Advanced Directive policy and procedure, with a revision date of [DATE], revealed, in part, residents had the right to refuse treatment, and residents would not be treated against their own wishes. Resident #51Review of Resident #51's electronic medical record (EMR) revealed, in part, Resident #51 had requested DNR code status. Review of Resident #51's [DATE] physician's orders revealed, in part, an order dated [DATE] for Resident #51 to be a DNR. Review of Resident #51's physical chart revealed, in part, Resident #51 signed a LAPOST form on [DATE] which indicated his wishes were to have a DNR code status. Further review revealed Resident #51's LaPOST form was not signed and/or dated by a physician as required. Further review revealed no other LaPOST forms were noted in Resident #51's physical chart. In an interview on [DATE] at 10:47AM, S9Licensed Practical Nurse (LPN) indicated Resident #51's LaPOST form, which indicated Resident #51 should have a DNR code status, was not signed and dated by a physician as required and therefore was not valid. S9LPN further indicated she would perform CPR on Resident #51 in the event Resident #51 went into cardiac arrest due to the above mentioned LaPOST not being valid. In an interview on [DATE] at 10:50PM, S8LPN indicated Resident #51's LaPOST form, which indicated Resident #51 should have a DNR code status, was not signed and dated by a physician as required and therefore not valid. S8LPN further indicated she would perform CPR on Resident #51 in the event Resident #51 went into cardiac arrest. On [DATE] at 11:20AM, S2Director of Nursing (DON) was presented with a request for all of Resident #51's advanced directive paperwork, LaPOST, and/or code status paperwork. In an interview on [DATE] at 11:20AM, S10LPN indicated if a resident's LaPOST indicated a resident should have a DNR code status, but was not signed by a physician, she would have initiated CPR on that resident in the event the resident went into cardiac arrest. In an interview on [DATE] at 11:30AM, S12LPN indicated if a resident had an electronic order for a DNR, and had a LaPOST that indicated DNR but was not signed by the physician in their physical chart, she would (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have initiated CPR in the event the resident went into cardiac arrest. In an interview on [DATE] at 11:30AM, S2DON confirmed Resident #51's LaPOST was not signed and dated by a physician. S2DON further confirmed Resident #51's request to be a DNR status and therefore nursing staff should not perform CPR in the event Resident #51 went into cardiac arrest. Resident #65Review of Resident #65's Electronic Medical Record (EMR) revealed, in part, Resident #65 had requested DNR code status. Review of Resident #65's [DATE] physician's orders revealed, in part, an order dated [DATE] which indicated Resident #65's code status was changed to DNR. Review of Resident #65's physical chart revealed, in part, a green sheet of paper with the words full code inside under the advanced directive section. Further review revealed a LaPOST form, dated [DATE], which indicated Resident #65 was a full code status (a healthcare provider should perform CPR if a resident's heart stopped beating or a resident stopped breathing). Further review revealed no other LaPOST forms in Resident #65's physical or electronic charts. Review of Resident #65's care plan, initiated on [DATE], with a target date of [DATE], revealed, in part, Resident #65's code status was full code with an approach that included begin CPR and call 911 as soon as possible and ensure all caregivers were aware of resident's full code status. In an interview on [DATE] at 2:00PM, S4Assistant Director of Nursing (ADON) indicated the resident's updated LaPOST forms are kept in the resident's medical record binders located at the nurse's stations. In an interview on [DATE] at 10:47AM, S9LPN indicated she would check the Resident #65's physical chart to verify Resident #65's code status. S9LPN further indicated inside Resident #65's physical chart, was Resident #65's LaPOST, dated [DATE], which indicated staff should perform CPR and/or attempt resuscitation, was the only LaPOST in Resident #65's physical chart. S9LPN further indicated since Resident #65's LaPOST indicated Resident #65 had a full code status, she would perform CPR on Resident #65 in the event Resident #65 went into cardiac arrest. In an interview on [DATE] at 10:50PM, S8LPN indicated inside Resident #65's physical chart, was Resident #65's LaPOST, dated [DATE], which indicated staff should perform CPR and/or attempt resuscitation, was the only LaPOST in Resident #65's physical chart. S8LPN further indicated since Resident #65's LaPOST indicated Resident #65 had a full code status, she would perform CPR on Resident #65 in the event Resident #65 went into cardiac arrest. On [DATE] at 11:20AM, S2DON was presented with a request for all of Resident #65's advanced directive paperwork, LaPOST, and/or code status paperwork. In an interview on [DATE] at 11:20AM, S10LPN indicated if a resident's record indicated resident was a DNR, she would check the resident's LaPOST for details. S10LPN further indicated there should not be a discrepancy between the code status orders in the computer and the LaPOST or advances directives in the resident's physical chart. In an interview on [DATE] at 11:30AM, S11LPN indicated she would check code status for a resident in the resident's physical chart first using LaPOST. S11LPN further indicated if a resident was a full code, the resident's chart would have a green cover sheet that stated full code. S11LPN further indicated the physical chart and EMR should have the same designation. In an interview on [DATE] at 11:30AM, S12LPN indicated that there should not be a discrepancy in the resident's code statuses. In an interview on [DATE] at 11:30AM, S2DON indicated she could not find any advanced directive and/or LaPOST in Resident #65's EMR that indicated Resident #65 had elected to be a DNR. S2DON further indicated nurses should follow the physician's orders and should not perform CPR on Resident #65 in the event Resident #65 went into cardiac arrest. In an interview on [DATE] at 11:35AM, S5Admissions indicated inside Resident #65's physical chart, was Resident #65's LaPOST, dated [DATE], which indicated staff should perform CPR and/or attempt resuscitation, was the only LaPOST in Resident #65's physical chart. S5Admissions confirmed the LaPOST in Resident #65's physical chart should match the code status on Resident #65's EMR. In an interview on [DATE] at 3:00PM, S1Administrator confirmed Resident #51 and Resident #65 should have had DNR as their code statuses as per their EMR and physician orders. S1Administrator further indicated physical charts were available at the nurse's station but facility staff should not have used resident's physical charts to make decisions regarding a resident's code status. In an interview on [DATE] at 2:55PM, (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S3Clinical Quality Improvement Nurse (CQIN) confirmed Resident #51's and Resident #65's physical charts were available at the nurse's station but the physical charts should not have been used by the nurses. S3CQIN further indicated Resident #65's care plan should have reflected that Resident #65's code status had changed to a DNR. S3CQIN further confirmed Resident #65's physical chart had a green sheet of paper inside with the words Full Code on it. S3CQIN further confirmed Resident #65's physical chart conflicted with Resident #65's EMR physician's orders and should not have.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, interviews, and record reviews, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services for 1(Resident #65) of 1 resident reviewed for limited range of motion. Findings:Review of Resident #65's March 2026 physician's orders revealed, in part, an occupational therapy clarification order, dated 01/26/2026, for skilled occupational therapy provided Resident #65 bilateral upper extremity (BUE) hand rolls, and upon discharge nursing to carryover for application/removal and range of motion. Review of Resident #65's rehabilitation screen, dated 07/07/2025, revealed, in part, Resident #65 had bilateral hand contractures and would be evaluated by Occupational Therapy for hand roll fitting to prevent further decline. Observation on 03/09/2026 at 10:00AM revealed Resident #65 was in her room in her bed. Further observation revealed Resident #65 had bilateral hand contractures without hand rolls in place. In an interview on 03/11/2026 at 11:57AM, S6Occupational Therapist (OT) indicated Resident #65 was last seen by OT on 09/05/2025. S6OT further indicated Resident #65 was provided with bilateral hand rolls and they should be used daily to maintain skin integrity due to Resident #65's bilateral hand contractures. Observation on 03/11/2026 at 12:03PM revealed Resident #65 was in her room in her bed. Further observation revealed Resident #65 had bilateral hand contractures without hand rolls in place. Observation on 03/11/2026 at 12:50PM with S9Licensed Practical Nurse (LPN) revealed Resident #65's right and left hands were contracted, with her fingertips touching Resident #65's palms without hand rolls in place. In an interview on 03/11/2026 at 12:45PM, S9LPN confirmed Resident #65 did not have hand rolls. In an interview on 03/11/1026 at 3:00PM, S2DON confirmed Resident #65 should have hand rolls in place for her hand contractions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and record reviews, the facility failed to maintain a system to accurately reconcile controlled substances for 2 (Medication Cart b, Medication Cart c) of 3 medication carts reviewed for the reconciliation documentation of controlled substances. Findings: Review of the facility's Controlled Substances policy and procedure, with a revision date of 12/2012, revealed, in part, nursing staff must count controlled medications at the end of each shift. Further review revealed the nurse coming on duty and the nurse going off duty must make the count together. Review of the facility's undated Controlled Drugs-Count Record form, revealed, in part, the nurse's signature acknowledges that they have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record. Review of the facility's December 2025 Medication Cart b Controlled Drugs Count Record revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart b's controlled substances with the oncoming nurse on:- 12/09/2025 for the 11:00PM to 7:00AM shift; and,- 12/13/2025 for the 3:00PM to 11:00PM shift.Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart b's controlled substances with the off going nurse on 12/13/2025 for the 7:00AM to 3:00PM shift. Review of the facility's January 2026 Medication Cart c Controlled Drugs Count Record revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart c's controlled substances with the oncoming nurse on:- 01/29/2026 for the 3:00PM to 11:00PM shift; and,- 01/30/2026 for the 11:00PM to 7:00AM shift. Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart c's controlled substances with the off going nurse on:- 01/29/2026 for the 7:00AM to 3:00PM shift; and,- 01/30/2026 for the 3:00PM to 11:00PM shift. Review of the facility's February 2026 Medication Cart c Controlled Drugs Count Record revealed, in part, there was no signature that indicated the off going nurse had reconciled Medication Cart c's controlled substances with the oncoming nurse on 02/16/2026 for the 11:00PM to 7:00AM shift. Further review revealed there was no signature that indicated the oncoming nurse had reconciled Medication Cart c's controlled substances with the off going nurse on 02/16/2026 for the 3:00PM to 11:00PM shift. In an interview on 03/10/2026 at 10:05AM, S8Licensed Practical Nurse (LPN) indicated the nurses' signature on the Controlled Drugs Count Record indicated the nurse had counted and accurately reconciled all the controlled substances on that medication cart. S8LPN further indicated the oncoming nurse and the off going nurse should have completed the controlled substance reconciliation and signed the medication cart's Controlled Drugs Count Record at the beginning of every shift. In an interview on 03/11/2026 at 7:50AM, S10LPN indicated the oncoming and off going nurses should have signed the Controlled Drugs Count Record at the end of every shift indicating the controlled substances were correctly reconciled. In an interview on 03/12/2026 at 12:45PM, S2Director of Nursing confirmed the above mentioned Controlled Drugs Count Records were not completed with a nurse's signature at the beginning and/or at the end of the nurse's shift as required, and should have been.