STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195517	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Jude's Health & Wellness Center	450a S Claiborne Ave, FL 6 New Orleans, LA 70112

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46361 Based on record reviews and interviews, the facility failed to ensure a thorough investigation was completed for an allegation of neglect related to an injury of unknown origin for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for abuse/neglect. Findings: Review of the facility's Abuse Prevention policy dated 2002 revealed, in part, a full investigation will include any other witness who was in the area, and written and signed statements will be obtained. Further review revealed all records of the investigation will be kept on file. Review of the facility's initiated incident report dated 07/09/2024 revealed, in part, Resident #1 had a dislocation of the left hip which was discovered on 07/09/2024 at 8:20 a.m. Further review revealed Resident #1 was unable to voice how the injury occurred, and no falls involving Resident #1 were reported. The above mentioned incident report also revealed on 07/08/2024, S7Certified Nursing Assistant (CNA) put resident #1 to bed at approximately 6:15 p.m. in a supine position with an abductor cushion (a cushion that prevents a person from moving following a hip replacement) in place between his legs. Approximately 20 minutes later the CNA heard Resident #1 calling for the nurse and he was found to have rolled over onto his right side without the abductor pillow in place. In the morning the CNA staff who provided care to Resident #1 discovered his hip to be swollen. An order to obtain an x-ray was received and x-ray results showed a dislocation to his left hip. Review of the facility's Nursing Staff Schedule dated 07/08/2024 revealed 2 nurses and 4 CNA's were assigned to floor x on 07/08/2024. Review of the facility's investigation documentation revealed, in part, only 2 statements from CNA staff were obtained and maintained in the facility's investigation records. Further review revealed 2 nurse notes dated 07/08/2024 were included in the investigation documentation. Review of Resident #1's nurse note dated 07/08/2024 documented by S3LPN revealed, in part, S3LPN did not indicate if she observed or assessed Resident #1's left hip. Review of Resident #1's nurse note dated 07/08/2024 documented by S4LPN revealed, in part, S4LPN did not indicate if she observed or assessed Resident #1's left hip. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of S9CNA's statement dated July 17th revealed, in part, S9CNA worked from 7:00 p.m. to 7:00 a.m. on the night of 07/08/2024. Further review revealed Resident #1 required the assistance of two staff members for incontinence care and a nurse assisted S9CNA with incontinence care several times during the shift. Further review revealed S9CNA documented during incontinence care, Resident #1's hip appeared to be swollen. In an interview on 07/31/2024 at 10:18 a.m. S9CNA stated she provided care to Resident #1 on the night of 07/08/2024 from 7:00 p.m. to 7:00 a.m. S9CNA indicated S3Licensed Practical Nurse (LPN) assisted her multiple times during the shift to provide incontinence care and/or to turn Resident #1. S9CNA stated during care she and S3LPN observed Resident #1's left hip was swollen. Review of the facility's investigation documentation revealed no evidence a statement was obtained from S3LPN regarding her knowledge of and/or observation of Resident #1's left hip on 07/08/2024. In an interview on 07/31/2024 at 9:58 a.m. S7CNA stated she worked the day shift on 7/09/2024 and Resident #1 was in the bed when she arrived on shift. S7CNA was informed by S8CNA that she (S8CNA) brought Resident #1 his breakfast tray and she noticed his left hip was swollen. S7CNA indicated she observed Resident #1's left hip and it was found to be swollen, red, and positioned at an odd an angle, so she reported it to S4LPN. In an interview on 07/31/2024 at 11:49 a.m. S8CNA confirmed she worked the day shift on floor x on 07/09/2024 and indicated when she brought Resident #1 his breakfast tray she noticed his left leg was bent strangely inward, swollen over the entire left hip area, and Resident #1's positioning wedge cushion was not in place. S8CNA indicated she was not questioned by administration or asked to provide a statement as to what she knew about Resident #1's injury of unknown origin Review of the facility's investigation documentation revealed no documented evidence and the facility did not present any documented evidence that a statement was obtain from S8CNA regarding knowledge of and/or observation of Resident #1's left hip on the morning of 07/09/2024. In an interview on 07/31/2024 at 1:05 p.m., S4LPN indicated she was responsible for Resident #1 on the night shift of 07/08/2024 and the morning shift on 07/09/2024. S4LPN further indicated she did observe Resident #1's left hip to be swollen during the night when she assisted S9CNA with incontinence care and turning. S4LPN indicated in her opinion Resident #1's left hip was only slightly swollen and felt it was nothing to be concerned with due to his history of surgical repair. S4LPN further indicated Resident #1 slept through the night and did not complain of pain. S4LPN indicated in the morning on 07/09/2024, S7CNA asked her to assess Resident #1's left hip. S4LPN indicated she found Resident #1's left hip had increased swelling and she notified Resident #1's physician. S4LPN was unable to confirm if she documented in Resident #1's record that Resident #1's left hip was slightly swollen on the night shift of 07/08/2024. S4LPN confirmed administrative staff did not ask her to provide a written statement of her observations of Resident #1's left hip during the night shift on 07/08/2024 or the morning shift on 07/09/2024 to see if she had any knowledge as to what happened to Resident #1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/31/2024 at 4:21 p.m. S2Director of Nursing (DON) confirmed she did not obtain statements from S8CNA, S10CNA, S3LPN, or S4LPN. S2DON stated she did not question or get a statement from S8CNA because she was not aware of her involvement. S2DON confirmed she did not ask S3LPN or S4LPN to provide a statement as to what they knew about Resident #1's injury of unkown origin. S2DON confirmed she was aware S4LPN had identified Resident #1's left hip was slightly swollen during the night shift on 07/08/2024. S2DON confirmed she could not provide any evidence S4LPN documented Resident #1's left hip was found to be slightly swollen during the night shift on 07/08/2024 in Resident #1's clinical record or in the facility's incident documentation of 07/09/2024's hip injury. In an interview on 07/31/2024 at 5:13 pm S1Administrator indicated she did not interview and/or get statements from all of the nursing staff who worked on the floor x on 07/08/2024 and believed it was only necessary to get statements from Resident #1's direct care staff. S1Administrator indicated she was aware S4LPN had first observed Resident #1's left hip to be swollen during the night shift on 07/08/2024 and confirmed she did not obtain a statement as to what S4LPN knew about Resident #1's injury of unknown origin.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46361 Based on record reviews, and interviews the facility failed to ensure a resident's care plan: 1. Was revised to include a decline in a resident's activities of daily living [ADLs] (Resident #1); and, 2. Was revised after a resident sustained a fall(s) (Resident #1). This deficient practice was identified for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: Review of Resident #1's Significant Change Minimum Data Set (MDS) with an ARD of 06/11/2024 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 3 which indicated severely impaired cognition. Further review revealed Resident #1 was dependent on staff for transfers and functional mobility, and had one fall which resulted in a major injury since his previous assessment. Review of Resident #1's Incident Report dated 05/29/2024 revealed Resident #1 had a witness fall from his wheelchair in the dining/day room resulting in a left hip fracture. Review of Resident #1's Incident Report dated 07/20/2024 revealed, in part, Resident #1 had an unwitnessed fall from his bed with no apparent injury. Review of Resident #1's care plan revealed, in part, there was no documented evidence and the facility did not present any documented evidence Resident #1's care plan was revised to reflect the above mentioned falls and/or the related interventions to prevent future falls. Further review revealed Resident #1's care plan was not revised to reflect his decline in bed mobility and transfers related to his left hip fracture. In an interview on 07/30/2024 at 3:27 p.m., S1Administrator reviewed Resident #1's fall care plan and confirmed Resident #1's care plan was not revised as required related to the above mentioned falls and ADL declines.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50452 Based on record reviews, observation, and interviews, the facility failed failed to ensure staff was available at all times to provide care and services to meet the resident's needs by failing to ensure staff was not sleeping while on duty. This deficient practice was identified for 1 staff member S6Certified Nursing Assistant (CNA) observed for 1 of 3 days during the survey. Findings: Review of facility's Employee Code of Conduct revealed, in part, sleeping while on duty was a violation that would constitute cause for immediate termination. Review of S6CNA's personnel record revealed, in part, S6CNA signed the Employee Code of Conduct on 07/08/2024 which indicated he understood and would abide by the rules of conduct while on or off duty on the facility premises. Review of facility's Daily Nursing Staff Schedule dated 07/29/2024 revealed, in part, S6CNA was assigned to provide services to residents on the day shift from 7:00 a.m. to 7:00 p.m. on floor x. Further review revealed S6CNA was assigned to provide care and services to 7 residents during this time frame. Observation on 07/29/2024 at 2:27 p.m. revealed S6CNA was sitting slouched over in a chair with his eyes closed in the hallway on floor x. S6CNA stayed asleep in this position while Administrative staff was asked to come to the unit to observe. Observation on 07/29/2024 at 2:42 p.m. revealed S2Director of Nursing (DON) arrived to floor x and woke up S6CNA. Further observation revealed, S2DON stated to S6CNA, this is unacceptable and S6CNA then replied, I'm sorry. In an interview on 07/29/2024 at 4:10 p.m., S6CNA indicated he was asleep in the chair in the hallway on floor x earlier today and should not have been. In an interview on 07/31/2024 at 4:58 p.m., S1Administrator indicated that S6CNA was working on floor x from 7:00 a.m. through 7:00 p.m. on 07/29/2024 and confirmed S6CNA should not have been asleep while on duty.