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	03/05/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record reviews, the facility failed to protect the resident's right to be free from physical and verbal abuse by a staff member for 1 (Resident #1) of 3 sampled residents investigated for abuse.The deficient practice resulted in an immediate jeopardy situation for Resident #1 on 02/17/2026 at approximately 4:00PM, when S4Licensed Practical Nurse (LPN) physically and verbally abused Resident #1 by hitting him repeatedly on his face, head, and shoulders with a closed fist, by putting her knee on Resident #1's neck, by grasping Resident #1's shirt and attempting to drag Resident #1 across the floor, and by yelling at Resident #1, b***h, don't hit me and b***h, I'm tired of you. The immediate jeopardy situation continued on 02/17/2026 when S4LPN stated to S5Certified Nursing Assistant (CNA) and S6CNA, in front of Resident #1, leave that b***h on the floor, don't help him up. The above mentioned physical and verbal abuse was witnessed by S5CNA, S6CNA, and Resident #2. The immediate jeopardy situation remained present on 02/17/2025 when S5CNA and S6CNA left Floor b for approximately 8 minutes, leaving Resident #1 and the other 20 residents alone on Floor b with S4LPN. The immediate jeopardy situation was ongoing on 02/17/2026 at approximately 5:00PM, when S4LPN instructed S5CNA, in front of Resident #1, to leave that b***h, in his chair. The immediate jeopardy situation remained unresolved on 02/17/2025 at approximately 5:00PM when S5CNA left S4LPN unmonitored and with access to all 21 residents that resided on Floor b while she went in and out of the rooms on Floor b to complete her rounds. The immediate jeopardy situation remained present until 02/17/2025 at 11:20PM when S4LPN clocked out from the facility.The facility implemented corrective actions which were completed prior to the state agency's investigation, thus it was determined to be a past noncompliance citation.Findings:Review of the facility's undated Abuse Recognition, Reporting, and Investigation policy revealed, in part, the facility would not permit residents to be subjected to abuse by anyone, including staff members. Further review revealed physical abuse was defined as hitting, slapping, pinching, and controlling behavior through corporal punishment. Further review revealed verbal abuse was defined as any use of oral or gestured language that included disparaging and derogatory terms to residents, or within their hearing distance, regardless of their ability to comprehend.Review of the facility's Abuse Prevention policy last revised on 06/17/2002 revealed, in part, any employee who had been identified in a report of alleged abuse would have been immediately suspended from work during the investigation.Review of the facility's Abuse Reporting and Investigation policy, last revised on 04/22/2009 revealed, in part, the facility would not permit residents to be subjected to abuse by anyone, including staff members. Review of the facility's investigative documentation for the above mentioned physical and verbal abuse allegations revealed, in part, the facility reported an incident of physical and verbal abuse of a resident to the state agency on 02/18/2026 at 11:08AM. Further review revealed, on 02/17/2026, S4Licensed Practical Nurse (LPN) physically and verbally abused Resident #1 by hitting him repeatedly on his face, head, and shoulders with a closed fist, by putting her knee on Resident #1's neck, by grasping Resident #1's shirt and attempting to drag Resident #1 across the floor, and by, and yelling at Resident #1, b***h, don't hit me and b***h, I'm tired of you. Further reviewed revealed S4LPN continued to verbally abuse Resident #1 by stating to S5Certified Nursing Assistant (CNA) and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	S6CNA, in front of Resident #1, leave that b***h on the floor, don't help him up. S4LPN continued to verbally abuse Resident #1 on 02/17/2026 when S4LPN instructed S5CNA, in front of Resident #1, to leave that b***h, in his chair. Further review revealed S1Administrator had investigated the above mentioned allegations of abuse and had substantiated S4LPN physically and verbally abused Resident #1.Review of Resident #2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/24/2025, revealed, in part, Resident #2 had a Brief Interview for Mental Status Score of 15, which indicated Resident #2 was cognitively intact.In an interview on 03/02/2026 at 9:35AM, Resident #2 indicated she witnessed the above mentioned incident between Resident #1 and S4LPN on 02/17/2026. Resident #2 further indicated she had witnessed S4LPN hit Resident #1 on 02/17/2026.In an interview on 03/02/2026 at 9:37AM, S5CNA indicated she witnessed the above mentioned incident of physical and verbal abuse of Resident #1 by S4LPN. S5CNA further indicated when she (S5CNA) and S6CNA got off the elevator on Floor b, she witnessed S4LPN and Resident #1 on the floor. S5CNA also indicated she went up to Resident #1 and S4LPN on the floor and got Resident #1 to let go of S4LPN and give her his hands. S5CNA further indicated after Resident #1 let go of S4LPN, S4LPN got up, as if she would have been walking away, turned around, and put her knee on Resident #1's neck to pin him down. S5CNA indicated S4LPN then began to hit Resident #1 multiple times in his arms, face, and chin area. S5CNA further indicated while S4LPN was hitting Resident #1, S4LPN was yelling b***h, don't hit me and b***h, don't touch me. S5CNA indicated she did not know what to do regarding the above mentioned physical and verbal abuse because she had heard about elder abuse before, but she was in shock and just stood against the wall. S5CNA further indicated she attempted to get Resident #1 up off of the floor, and S4LPN told her, in front of Resident #1, to leave that b***h on the floor. S5CNA also indicated on 02/17/2026, at approximately 5:00PM, she (S5CNA) was going to make rounds and S4LPN instructed her to leave that b***h, in his chair in front of Resident #1. S5CNA further indicated, because she had to complete her 5:00PM rounds to provide care to the other residents that resided on Floor b, she left Resident #1 alone while S4LPN was still working on Floor b. S5CNA further indicated since the incident, she had been re-trained on the facility's abuse reporting procedures and knew where to locate the phone numbers for the facility's administrative staff.Review of Resident #1's quarterly MDS with an ARD of 11/24/2025 revealed, in part, Resident #1 had a BIMS of 12, which indicated Resident #1 was moderately cognitively intact. In an interview on 03/02/2026 at 9:47PM, Resident #1 indicated S4LPN previously hit him.In an interview on 03/02/2025 at 9:55AM, S12CNA indicated if abuse was witnessed, it should have been reported to the facility's Administrator immediately.In an interview on 03/02/3036 at 9:58AM, S9CNA indicated if she witnessed any resident abuse, she would report it to a nurse. S9CNA further indicated if it was a nurse that had committed resident abuse, she would report it to the administrative team. S9CNA further indicated any resident abuse that was witnessed should have been reported as soon as possible.In an interview on 03/02/2026 at 10:01AM, S10Housekeeper indicated she would report abuse to the nurse or the charge nurse immediately. Further, she was knowledgeable of the telephone numbers for S1Administrator and S2Director of Nursing (DON) located at the facility's front desk. In an interview on 03/02/2026 at 10:04AM, S7CNA indicated she had both S2DON and S1Administrator's telephone numbers to report abuse immediately.In an interview on 03/02/2026 at 11:44AM, S1Administrator indicated on 02/18/2026, S5CNA reported the above mentioned physical and verbal abuse of Resident #1 by S4LPN to him. S1Administrator further indicated S5CNA and S6CNA should not have left S4LPN alone with the residents on Floor b after she had committed the above mentioned physical and verbal abuse.In a telephone interview on 03/03/2025 at 8:50AM, S11CNA indicated if he had witnessed abuse, he would tell the nurse immediately. S11CNA further indicated, if it was the nurse that had committed the abuse, he would then tell her supervisor. S11CNA further indicated that he was re-trained on reporting witnessed abuse. In a phone interview on 03/03/2026 at 9:00AM, S13Dietary Staff indicated if she witnessed a staff member committing abuse against a resident, she would report it to the facility's (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator.In an interview on 03/03/2026 at 9:12AM, S6CNA indicated on 02/17/2026, she saw S4LPN and Resident #1 on the floor. S6CNA further indicated S4LPN was hitting Resident #1 and yelling at Resident #1 b***h I'm tired of you and b***h get off of me. S6CNA further indicated S4LPN then walked off from Resident #1, came back, and tried to drag Resident #1 by his shirt on the floor. S6CNA further indicated S4LPN then got down onto the floor next to Resident #1 and put her knee on Resident #1's neck. S6CNA then indicated, it appeared as if Resident #1 could not breathe with S4LPN kneeling on his neck, so she (S6CNA) and S5CNA pulled S4LPN off of Resident #1. S6CNA further indicated S4LPN then walked off, came back, and again tried to drag Resident #1 by his shirt on the floor. S6CNA indicated S4LPN then told them (S6CNA and S5CNA) to leave that b***h on the floor, don't help him up. S6CNA further indicated both she (S6CNA) and S5CNA left Floor b for approximately 8 minutes to find assistance to get Resident #1 up off of the floor. S6CNA further indicated S4LPN was alone with Resident #1 and the other 20 residents that resided on Floor b during the above 8 minutes they (S6CNA and S5CNA) were not present on Floor b. S6CNA also indicated S4LPN should not have been left alone with the residents on Floor b. S6CNA further indicated, at the time of the incident, she did not know who to report resident abuse to, but after retraining, she now had the telephone numbers of both S2DON and S1Administrator to report abuse immediately.In an interview on 03/03/2026 at 9:56AM, S2DON acknowledged S4LPN should have been separated from Resident #1 and the other residents, in order to keep Resident #1 and the other residents on Floor b safe from S4LPN after the above mentioned incident of physical and verbal abuse occurred.In a telephone interview on 03/04/2026 at 1:02PM, S5CNA indicated on 02/17/2026 from approximately 5:00PM to 6:00PM, she only periodically visualized Resident #1 and S4LPN while completing her rounds on Floor b, and was not constantly monitoring them.In an interview on 03/02/2026 at 1:35PM, S2DON indicated S5CNA and S6CNA should not have left S4LPN alone with the residents on Floor b after they had witnessed the above mentioned physical and verbal abuse. S2DON further indicated the physical and verbal abuse of Resident #1 by S4LPN should not have occurred.In an interview on 03/04/2026 at 8:50AM, S14LPN indicated she would report abuse immediately to S1Administrator.In an interview on 03/05/2026 at 9:41AM, S1Administrator acknowledged Resident #1 should not have been physically and verbally abused by S4LPN on 02/17/2026 at approximately 4:00PM. S1Administrator further acknowledged the continued verbal abuse of Resident #1 by S4LPN that occurred on 02/17/2026 at approximately 5:00PM should have been prevented.Beginning on 02/18/2026, the facility implemented the following actions to correct the deficient practice:1. On 02/18/2026, S1Administrator verbally in-serviced S5CNA and S6CNA on immediately reporting abuse to S1Administrator.2. On 02/18/2026, S1Administrator started an investigation into the allegation of physical and verbal abuse of Resident #1 by S4LPN and requested S5CNA and S6CNA give written statements of the abuse they had witnessed.3. On 02/18/2026, S1Administrator immediately suspended S4LPN from working with residents and requested she give a written statement. S4LPN's last day working with residents was 02/17/2026.4. On 02/18/2026 at 11:00AM, S1Administrator had staff perform an assessment of Resident #1 for any injuries and/or pain. The assessment revealed Resident #1 had no injuries and no pain. Resident #1 refused to be transferred to the local emergency room for evaluation.5. On 02/18/2026 at 11:08AM, S1Administrator entered a report regarding the above mentioned physical and verbal abuse in the State Incident Management System (SIMS).6. On 02/18/2026, Resident #1's medical provider conducted a psychological evaluation on Resident #1.7. On 02/18/2026, S1Administrator had staff do an audit of the 20 other residents that resided on Floor b to determine if they have suffered any abuse. All 20 residents denied experiencing abuse.8. On 02/18/2026, S1Administrator obtained a witness statement from Resident #2. 9. On 02/18/2026, S2DON and S8Director of Education started retraining staff to immediately report any abuse to S1Administrator. S2DON and S8Director of Education had retrained a majority of the staff on abuse reporting procedures on 02/18/2026 and a majority of staff when interviewed, were aware of the when to report abuse.10. On 02/18/2026 at 1:30PM, S1Administrator reported the above mentioned (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physical and verbal abuse to the local police department.11. On 02/24/2026, S1Administrator reported S4LPN's physical and verbal abuse of Resident #1 to the Louisiana State Board of Practical Nurse Examiners. S4LPN's Practical Nursing License was suspended on 02/25/2026.The facility asserts the likelihood for serious harm no longer existed for the residents residing on floor b on 02/18/2026 at 1:30PM, when the above mentioned physical and verbal abuse was reported to the local police department by S1Administrator.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record reviews, the facility failed to ensure witnessed physical and verbal abuse was reported to the facility's administrator/designee and the state agency within 2 hours for 1 (Resident #1) of 3 sampled residents investigated for abuse.The deficient practice resulted in an immediate jeopardy situation for Resident #1 on 02/17/2026 at approximately 4:00PM, when S4Licensed Practical Nurse (LPN) physically and verbally abused Resident #1 by hitting him repeatedly on his face, head, and shoulders with a closed fist, by putting her knee on Resident #1's neck, by grasping Resident #1's shirt and attempting to drag Resident #1 across the floor, and by yelling at Resident #1, b***h, don't hit me and b***h, I'm tired of you. The immediate jeopardy situation continued on 02/17/2026 when S4LPN stated to S5Certified Nursing Assistant (CNA) and S6CNA, in front of Resident #1, leave that b***h on the floor, don't help him up. The above mentioned physical and verbal abuse was witnessed by S5CNA, S6CNA, and Resident #2. The immediate jeopardy situation remained present on 02/17/2025 when S5CNA and S6CNA left Floor b for approximately 8 minutes, leaving Resident #1 and the other 20 residents alone on Floor b with S4LPN. The immediate jeopardy situation was ongoing on 02/17/2026 at approximately 5:00PM, when S4LPN instructed S5CNA, in front of Resident #1, to leave that b***h, in his chair. The immediate jeopardy situation remained unresolved on 02/17/2025 at approximately 5:00PM when S5CNA left S4LPN unmonitored and with access to all 21 residents that resided on Floor b while she went in and out of the rooms on Floor b to complete her rounds. The immediate jeopardy situation remained ongoing when S5CNA failed to report the above witnessed physical and verbal abuse to S1Administrator and/or his/her designee within 2 hours. The immediate jeopardy situation remained unresolved on 02/17/2025 at 11:20PM when S4LPN clocked out from the facility. The immediate jeopardy situation continued until the above witnessed physical and verbal was reported to S1Administrator on 02/18/2026 at approximately 10:30AM.The facility implemented corrective actions which were completed prior to the state agency's investigation, thus it was determined to be a past noncompliance citation.Cross Reference F600Review of the facility's Abuse Prevention policy last revised on 06/17/2002 revealed, in part, any person who witnessed or suspected abuse would immediately inform the facility's House Supervisor who will in turn notify the facility's Administrator or his/her designee.Review of the facility's undated Abuse Recognition, Reporting, and Investigation policy revealed, in part, the administrator or his/her designee, would report all allegations of suspected or actual abuse through the SIMS reporting portal.Review of the facility's Abuse Reporting and Investigation policy, last revised 04/22/2009 revealed, in part, should an investigation reveal suspected or actual abuse occurred, the administrator must report the allegation to the proper parties as required by current state and federal laws, such as the state licensing agency.In an interview on 03/02/2026 at 9:37AM, S5CNA indicated she did not report the above mentioned physical and verbal abuse of Resident #1 by S4LPN that occurred on 02/17/2026 to any of the facility's administrative staff or nurses until the morning of 02/18/2026. S5CNA further indicated she did not report the above mentioned physical and verbal abuse to any administrative staff because she did not know how to get in touch with them. S5CNA also indicated, before the above mentioned incident of physical and verbal abuse, she was not aware of the process to get in contact with the facility's administrative staff to report abuse, when none of the facility's administrative staff were present in the facility. S5CNA further indicated since the incident, she had been re-trained on the facility's abuse reporting procedures and knew where to locate the phone numbers for the facility's administrative staff.In an interview on 03/02/2025 at 9:55AM, S12CNA indicated if resident abuse was witnessed, it should have been reported to the facility's Administrator immediately.In an interview on 03/02/3036 at 9:58AM, S9CNA indicated if she witnessed any resident abuse, she would report it to a nurse. S9CNA further indicated if it was a nurse that had committed resident abuse, she would report it to the (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administrative staff. S9CNA further indicated any resident abuse that was witnessed should have been reported as soon as possible.In an interview on 03/02/2026 at 10:01AM, S10Housekeeper indicated she would report abuse to the nurse or the charge nurse immediately. Further, she was knowledgeable of getting contact numbers for S1Administrator and S2DON at the facility's front desk. In an interview on 03/02/2026 at 10:04AM, S7CNA indicated she had assisted with getting Resident #1 off of the floor on 02/17/2026, but had not witnessed the above mentioned physical and verbal abuse of Resident #1 by S4LPN herself. S7CNA further indicated S5CNA reported to her on 02/17/2026, the above mentioned physical and verbal abuse had occurred. S7CNA further indicated she had not reported the above mentioned physical and verbal abuse on 02/17/2026 to any of the facility's administrative staff. S7CNA indicated she had both S2DON and S1Administrator's phone numbers to report abuse immediately.In an interview on 03/02/2026 at 11:44AM, S1Administrator indicated S5CNA did not report the above mentioned physical and verbal abuse of Resident #1 by S4LPN until the morning of 02/18/2026. S1Administrator further indicated S5CNA and S6CNA should have reported the above mentioned physical and verbal abuse to him immediately.In an interview on 03/02/2026 at 1:35PM, S2Director of Nursing (DON) indicated the above mentioned CNAs that had witnessed and/or knew of the above mentioned physical and verbal abuse that occurred on 02/17/2026, should have been reported immediately to the facility's administrative staff.In a telephone interview on 03/03/2025 at 8:50AM, S11CNA indicated if he had witnessed abuse, he would tell the nurse immediately. S11CNA further indicated, if it was the nurse that had committed the abuse, he would then tell the nurse's supervisor. S11CNA further indicated that he was re-trained on reporting witnessed abuse.In a telephone interview on 03/03/2026 at 9:00AM, S13Dietary Staff indicated if she witnessed a staff member committing abuse against a resident, she would report it to the facility's Administrator.In an interview on 03/03/2026 at 9:12AM, S6CNA indicated the above mentioned physical and verbal abuse of Resident #1 by S4LPN should have been reported to the facility's administrative staff immediately, but she did not report it to anyone until the next day (02/18/2026). S6CNA further indicated, at the time of the incident, she did not know who to report resident abuse to, but she now had the telephone numbers of both S2DON and S1Administrator to report abuse immediately.In an interview on 03/03/2026 at 9:56AM, S2DON indicated S5CNA should have contacted her, S1Administrator, and/or S3Registered Nurse Supervisor immediately to report the above mentioned physical and verbal abuseIn an interview on 03/04/2026 at 8:50AM, S14LPN indicated she would report abuse immediately to S1Administrator.In an interview on 03/05/2026 at 12:31PM, S1Administrator acknowledged the above mentioned physical and verbal abuse should have been reported to the state agency within 2 hours.Beginning on 02/18/2026, the facility implemented the following actions to correct the deficient practice:1. On 02/18/2026, S1Administrator verbally in-serviced S5CNA and S6CNA on immediately reporting abuse to S1Administrator.2. On 02/18/2026, S1Administrator started an investigation into the allegation of physical and verbal abuse of Resident #1 by S4LPN and requested S5CNA and S6CNA give written statements of the abuse they had witnessed.3. On 02/18/2026, S1Administrator immediately suspended S4LPN from working with residents and requested she give a written statement. S4LPN's last day working with residents was 02/17/2026.4. On 02/18/2026 at 11:00AM, S1Administrator had staff perform an assessment of Resident #1 for any injuries and/or pain. The assessment revealed Resident #1 had no injuries and no pain. Resident #1 refused to be transferred to the local emergency room for evaluation.5. On 02/18/2026 at 11:08AM, S1Administrator entered a report regarding the above mentioned physical and verbal abuse in the State Incident Management System (SIMS).6. On 02/18/2026, Resident #1's medical provider conducted a psychological evaluation on Resident #1.7. On 02/18/2026, S1Administrator had staff do an audit of the 20 other residents that resided on Floor b to determine if they have suffered any abuse. All 20 residents denied experiencing abuse.8. On 02/18/2026, S1Administrator obtained a witness statement from Resident #2. 9. On 02/18/2026, S2DON and S8Director of Education started retraining staff to immediately report any abuse to S1Administrator. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	S2DON and S8Director of Education had retrained a majority of the staff on abuse reporting procedures on 02/18/2026 and a majority of staff when interviewed, were aware of the when to report abuse.10. On 02/18/2026 at 1:30PM, S1Administrator reported the above mentioned physical and verbal abuse to the local police department.11. On 02/24/2026, S1Administrator reported S4LPN's physical and verbal abuse of Resident #1 to the Louisiana State Board of Practical Nurse Examiners. S4LPN's Practical Nursing License was suspended on 02/25/2026.The facility asserts the likelihood for serious harm no longer existed for the residents residing on floor b on 02/18/2026 at 1:30PM, when the above mentioned physical and verbal abuse was reported to the local police department by S1Administrator.