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	06/24/2026

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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's responsible party (RP) was invited to, attended, and/or participated in a care plan meeting for 1 (Resident #2) of 3 sampled residents reviewed for care planning requirements. Findings:Review of the facility's Care Plan policy and procedure, with a revision date of 04/22/2009, revealed, in part, the resident's RP should be invited to attend the plan of care conference at least one week in advance of the tentatively scheduled date. Further review revealed the interdisciplinary team would meet with the resident and the resident's RP to develop quantifiable objectives for the highest level of functioning the resident may be expected to attain. Review of Resident #2's medical record revealed, in part, Resident #2 was admitted to the facility on [DATE] with a diagnosis, in part, of vascular dementia. Review of Resident #2's admission packet, dated 04/16/2026, revealed, in part, Resident #2 was incapable of making medical decisions. Further review revealed Resident #2's sister was identified as Resident #2's RP. Review of Resident #2's admission Minimum Data Set with an Assessment Reference Date of 05/04/2026 revealed, in part, Resident #2 had a Brief Interview for Mental Status score of 4, which indicated Resident #2 was severely cognitively impaired. Review of Resident #2's initial care plan, with a start date of 04/22/2026, revealed, in part, Resident #2 had impaired cognitive function and/or impaired thought processes related to dementia, with an approach of communicating with Resident #2's caregivers regarding Resident #2's capabilities and needs. Review of Resident #2's care plan conference notes, dated 04/29/2026, revealed, in part, Resident #2's RP did not attend Resident #2's care plan conference in person or by telephone. Review of the facility's care conference planning form, dated 04/29/2026, revealed, in part, Resident #2's RP was not identified as needing to be present and/or contacted for Resident #2's care plan conference. In an interview on 06/23/2026 at 11:20AM, Resident #2's RP indicated she was unaware Resident #2 had a care plan conference on 04/29/2026. Resident #2's RP further indicated she would have attended the care plan conference if she had been notified to discuss Resident #2's physical therapy concerns. In an interview on 06/23/2026 at 11:30AM, S7Therapy Director (TD) indicated she was unaware Resident #2's RP wanted Resident #2 to start physical therapy until S7TD was notified by the ombudsman. In an interview on 06/24/2026 at 10:02AM, S4Social Services Manager (SSM) indicated she was unaware Resident #2's sister was his RP. S4SSM further indicated Resident #2's RP should have been notified and allowed to attend Resident #2's care plan conference on 04/29/2026. In an interview on 06/24/2026 at 1:47PM, S2Director of Nursing (DON) indicated Resident #2's RP should have been notified and allowed to attend Resident #2's care plan conference on 04/29/2026. In an interview on 06/24/2026 at 2:15PM, S1Administrator confirmed Resident #2's RP should have been identified as needing to attend Resident #2's care plan conference on 04/29/2026.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and interviews, the facility failed to post the names, addresses, and telephone numbers of all pertinent state agencies and/or advocacy groups, and/or a statement as to how a resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements and requests for information regarding returning to the community. Findings:Observation of all the facility's resident common areas on 06/22/2026 at 10:30AM, revealed no postings of the names, addresses and telephone numbers of all pertinent state agencies and advocacy groups, and/or no postings regarding the process as to how and/or when a resident may file a complaint with the State Survey Agency. Observation of all the facility's resident common areas on 06/24/2026 at 1:15PM, revealed no postings of the names, addresses and telephone numbers of all pertinent state agencies and/or advocacy groups, and/or no postings regarding the process as to how and/or when a resident may file a complaint with the State Survey Agency. Review of Resident #1's quarterly Minimum Data Set with an Assessment Reference Date of 05/20/2026 revealed, in part, Resident #1 had a Brief Interview for Mental Status score of 15, which indicated Resident #1 was cognitively intact. In an interview on 06/23/2026 at 9:15AM, Resident #1 indicated the facility did not have the above mentioned postings in a prominent location for all residents and families to view. In an interview on 06/23/2026 at 11:20AM, Resident #2's responsible party (RP) indicated the facility did not have the above mentioned postings in a location and/or format that made the information accessible. In an interview on 06/23/2026 at 2:30PM, S3Activities Director indicated the facility did not have the above mentioned postings as required. In an interview on 06/24/2026 at 2:00PM, S4Social Services Manager indicated the facility did not have the above mentioned postings as required. In an interview on 06/24/2026 at 2:15PM, S1Administrator confirmed there were no postings of the names, addresses and telephone numbers of all pertinent state agencies and/or advocacy groups, and/or no postings regarding the process as to how and/or when a resident may file a complaint with the State Survey Agency. S1Administrator further indicated she was unaware that information was required to be posted.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews, the facility failed ensure a notice that the availability of all reports related to all annual and complaint surveys from the past 3 years and any plans of corrections (POC) in effect were available for review upon request was posted in a prominent and accessible area. Findings:Observation on 06/22/2026 at 10:30AM of the facility's common areas revealed no notices posted that any reports related to all annual and complaint surveys from the past 3 years and any POC in effect were available for review upon request. Review of Resident #1's quarterly Minimum Data Set with an Assessment Reference Date of 05/20/2026 revealed, in part, Resident #1 had a Brief Interview for Mental Status score of 15, which indicated Resident #1 was cognitively intact. In an interview on 06/23/2026 at 9:15AM, Resident #1 indicated the facility did not have the above mentioned notice posted in a prominent location for all residents and families to view. In an interview on 06/23/2026 at 11:20AM, Resident #2's responsible party (RP) indicated the facility did not have the above mentioned notice posted in a location that made the information readily accessible to residents and families. In an interview on 06/23/2026 at 2:30PM, S3Activities Director indicated the facility did not have the above mentioned notice posted as required. Observation on 06/24/2026 at 1:15PM of the facility's common areas revealed no notices posted that any reports related to all annual and complaint surveys from the past 3 years and any POC in effect were available for review upon request. In an interview on 06/24/2026 at 2:00PM, S4Social Services Manager indicated the facility did not have the above mentioned notice posted as required. In an interview on 06/24/2026 at 2:15PM, S1Administrator confirmed there was no notices posted that any reports related to all annual and complaint surveys from the past 3 years and any POC in effect were available for review upon request. S1Administrator further indicated she was unaware that information was required to be posted.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to deliver care per professional standards by failing to ensure a resident's medication order was clarified by the physician for 1 (Resident #R7) of 3 sampled residents investigated for pharmacy services. Findings:Review of the February 2026 Louisiana Administrative Code, Title 46, Part XLVII S3915. Standard Number 7: Professional Performance revealed, in part, the Registered Nurse (RN) demonstrates the following professional nursing practice behaviors. The RN clarifies any order or treatment regimen believed to be inaccurate, or contraindicated by consulting with the appropriate licensed practitioner and by notifying the ordering practitioner when the registered nurse makes the decisions not to administer the medication or treatment. Review of the facility's RN job description revealed, in part, the RN was responsible for providing and supervising quality nursing care to residents in accordance with facility policies, state and federal regulations, and accepted nursing standards. Further review revealed RNs should lead and supervise Licensed Practical Nurses (LPN) to ensure high quality care. Review of Resident #R7's admission documentation revealed, in part, Resident #R7 was discharged from a rehabilitation hospital and admitted to the facility on [DATE]. Further review revealed Resident #R7's medications included 50 milligrams (mg) of allopurinol (a medication used to treat high levels of uric acid). Review of Resident #R7's hospital discharge report, dated 05/06/2026, revealed, in part, Resident #R7 was discharged from an acute care hospital and returned back to the facility on [DATE]. Further review revealed Resident #R7's list of medications to continue did not include allopurinol. Review of Resident #R7's June 2026 physician's orders revealed, in part, an order with a start date of 03/06/2026 for Resident #R7 to be administered one oral tablet of allopurinol one time a day. Further review revealed Resident R7's physician order did not include the dosage of the allopurinol. Review of Resident #R7's April 2026 through June 2026 Electronic Medication Administration Record (eMAR) revealed, in part, no dosage for Resident #R7's allopurinol order. Further review revealed nursing staff administered one tablet of allopurinol daily to Resident #R7 from 04/01/2026 through 06/24/2026 while she was at the facility. The facility could not provide any documented evidence Resident #R7's 03/05/2026 physician's order for one tablet of allopurinol with no dosage was clarified to ensure Resident #R7 received the correct dosage of medication. Observation on 06/24/2026 at 9:00AM revealed Resident #R7's medication blister pack of allopurinol indicated the dosage was 100 mg of the medication. Further observation revealed S9LPN administered Resident #R7 100 mg of allopurinol by mouth. In an interview on 06/24/2026 at 9:15AM, S9LPN indicated she administered 100 mg of allopurinol to Resident #R7. S9LPN further indicated she was unable to verify that 100 mg was the correct dosage to administer to Resident #R7 because there was no dosage listed on Resident #R7's allopurinol medication order and should have been. S9LPN further indicated she should have clarified with Resident #R7's physician what the dose of allopurinol should have been. In a telephone interview on 06/24/2026 at 1:02PM, Resident #R7's primary care physician indicated he was unaware Resident #R7's medication order for allopurinol did not include the dosage. Resident #R7's primary care physician indicated he was also unaware of the daily allopurinol dosage Resident #R7 had received since her 03/05/2026 readmission. Resident #R7's primary care physician further indicated he had not been contacted by anyone at the facility to clarify Resident #R7's medication order for allopurinol. In an interview on 06/24/2026 at 1:47PM, S2Director of Nursing (DON) confirmed Resident #R7's 03/05/2026 physician's order for allopurinol should have included a dosage. S2DON further confirmed nursing staff should not have administered Resident #R7's allopurinol medication from 04/01/2026 through 06/24/2026 without first clarifying the incomplete order with Resident #R7's physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure insulin (a medication that lowers blood glucose) multi-dose flex pens were dated when opened and/or removed from refrigerated storage or discarded as required for 1 (Medication Cart a) of 3 sampled medication carts observed for medication storage requirements. Findings:Review of the facility's Insulin policy and procedure, with a revision date of [DATE], revealed, in part, insulin must be refrigerated until needed, and open insulin must be dated the day it is opened. Further review revealed the life span for insulin is only 28 days from the time it is opened. Further review revealed after 28 days, the unused portion must be discarded. Review of the facility's undated Liberalized Medication policy and procedure revealed, in part, when opening a multi dose container, the date opened is recorded on the container. Observation on [DATE] at 7:55AM of Medication Cart a revealed the following:-Resident #3's opened insulin Novolog (a fast-acting insulin medication) multi-dose flex pen had an opened date of [DATE] documented; -Resident #R4's opened insulin Novolog multi-dose flex pen did not have an opened date documented;-Resident #R5's opened insulin Lantus multi-dose flex pen did not have an opened date documented; and,-Resident #R6's opened insulin Lispro (a fast-acting insulin medication) multi-dose flex pen had an opened date of [DATE] documented. In an interview on [DATE] at 7:55AM, S10Licensed Practical Nurse (LPN) indicated Resident #3's and Resident #R6's opened insulin pens should not have been stored at room temperature, expired, and/or available for use. S10LPN further indicated Resident #R4's and Resident #R5's insulin pens were opened and undated, and should not have been available for use. In an interview on [DATE] at 1:47PM, S2Director of Nursing confirmed the above mentioned insulin multi-dose flex pens should have been dated when opened and discarded 28 days after opening as required.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident's medication administration and order completion were accurately documented for 1 (Resident #2) of 3 sampled residents investigated for accurate medical record documentation. Findings:Review of the facility's undated Liberalized Medication policy and procedure revealed, in part, the individual administering the medication should document the administration in the electronic Medication Administration Record (eMAR) after giving each medication. Review of the facility's undated Director of Nursing (DON) job description revealed, in part, responsibilities included monitoring clinical documentation for accuracy, completeness, and regulatory compliance. On 06/24/2026 at 11:00AM, S2DON was presented with a request for all 06/19/2026 medication administration records and progress notes for Resident #2. Review of Resident #2's medical record revealed, in part, Resident #2 was admitted to the facility on [DATE] with diagnoses which included, in part, vascular dementia, type 2 diabetes, and Benign Prostatic Hyperplasia (BPH) (a non-cancerous enlargement of the prostate). Review of Resident #2's admission Minimum Data Set with an Assessment Reference Date of 05/04/2026 revealed, in part, Resident #2 had a Brief Interview for Mental Status score of 4, which indicated Resident #2 was severely cognitively impaired. Review of Resident #2's June's 2026 physician's orders revealed, in part, an order for the following:- Atorvastatin (a medication used to treat excess fat in the blood) one 80 milligram (mg) oral tablet by mouth at bedtime;- Donepezil hydrochloride (HCl) (a medication used to treat dementia) one 5 mg oral tablet by mouth at bedtime;- Ezetimibe (a medication used to lower bad cholesterol levels) one 10 mg oral tablet by mouth at bedtime;- Lantus Insulin (a medication used to lower blood glucose levels) 100 units/milliliter (mL) inject 20 units subcutaneously at bedtime;- Tamsulosin HCl (a medication used to treat BPH) one 0.4 mg oral capsule by mouth at bedtime;- Colostomy care and assess stoma site for changes every shift; and,- Blood glucose monitoring at bedtime, call medical doctor if blood sugar is less than 60 or greater than 500. Review of Resident #2's June 2026 eMAR revealed, in part, no documented evidence Resident #2 was administered the following medications on 06/19/2026 at 9:00PM as ordered:- Atorvastatin one 80 mg oral tablet;- Donepezil HCl one 5 mg oral tablet;- Ezetimibe one 10 mg oral tablet;- Lantus Insulin 20 units injected subcutaneously; and,- Tamsulosin HCl one 0.4 mg oral capsule. Further review revealed no documented evidence Resident #9's capillary blood glucose was checked and/or Resident #2's colostomy care was completed on 06/19/2026 at 9:00PM as ordered. Further review revealed S8Registered Nurse (RN) documented other/see progress notes for Resident #2's above mentioned orders on 06/19/2026 at 9:00PM. In an interview on 06/23/2026 at 11:20AM, Resident #2's responsible party (RP) indicated she did not administer Resident #2 any medication during his leave from the facility on 06/19/2026. In an interview on 06/23/2026 at 3:48PM, S8RN indicated upon Resident #2's return to the facility on [DATE], between 8:30PM and 9:00PM, S8RN had administered Resident #2 his above mentioned medication, assessed his blood glucose, and performed colostomy care on Resident #2. S8RN further confirmed she did not document any of the previous mentioned interventions. In an interview on 06/24/2026 at 1:47PM, S2DON confirmed Resident #2's June 2026 eMAR documentation was not completed, and should have been as required. In an interview on 06/24/2026 at 2:15PM, S1Administrator indicated the facility could not provide any documented evidence to dispute the above mentioned deficient practice.