

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER St Jude's Health & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure a resident's right to smoke for 1 (Resident #6) of 1 sampled resident investigated for smoking. Findings: Review of the facility's Resident Smoking and Tobacco Use Policy, with an effective date of 08/01/2025, revealed, in part, residents had the right to smoke. Further review revealed residents who were cognitively impaired or had mobility limitations may only smoke under staff supervision. Further review revealed the facility's staff were responsible for monitoring compliance with this policy. Review of Resident #6's Quarterly Minimum Data Set with and Assessment Reference Date of 12/26/2025 revealed, in part, Resident #6 had a Brief Interview for Mental Status score of 15, which indicated Resident #6 was cognitively intact. Review of the facility's undated list of smokers revealed, in part, Resident #6 was listed as an unsafe smoker. In an interview on 01/22/2026 at 10:31AM, Resident #6 indicated he was not allowed to go outside to smoke at night because he was not on the list to go out to smoke after 7:00PM. In a telephone interview on 01/22/2026 at 11:06AM, S8Licensed Practical Nurse (LPN) indicated Resident #6 was not on the list of smokers that could smoke past the extended hours of 7:00AM to 8:00PM. In an interview on 01/22/2026 at 12:24PM, S2Director of Nursing (DON) indicated the security guard, the evening receptionist, and/or the night receptionist were to supervise the unsafe smokers who would want to smoke after 7:00PM or before 7:00AM. In a telephone interview on 01/22/2026 at 1:01PM, S12Receptionist indicated that unsafe smokers were not allowed to go outside to smoke at night, and only residents listed on the safe smoker list were allowed to go outside at night. S12Receptionist further indicated she had refused Resident #6 the right to smoke at night in the past because Resident #6 was not listed on the safe smoker list. In a telephone interview on 01/22/2026 at 3:10PM, S13Receptionist indicated residents that were not on the safe smokers list were not allowed to go out between the hours of 7:00PM and 7:00AM. S13Receptionist further indicated Resident #6 could not go outside to smoke after hours because he was not on the safe smokers list. S13Receptionsit further indicated she had previously denied Resident #6 the ability to go outside to smoke between the hours of 7:00PM and 7:00AM because Resident #6 was on the unsafe smokers list. In an interview on 01/22/2026 at 1:26PM, S2DON indicated all residents have the right to smoke when requested, and staff should have allowed Resident #6 to smoke at night with staff supervision.		

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents, with a newly evident serious mental disorder, were referred to the appropriate state agency for a Preadmission Screening and Resident Review (PASARR) Level II evaluation for 2 (Resident #21, Resident #49) of 4 sampled residents reviewed for PASARR. Findings: On 01/22/2026 at 2:30PM, S15Social Services Director was presented with a request for Resident #21's and Resident #49's Level II PASARR evaluation. On 01/23/2026 at 8:30AM, S15Social Services Director was presented with a request for Resident #21's and Resident #49's Level II PASARR evaluation. Resident #21 Review of Resident #21's face sheet revealed, in part, Resident #21 was admitted to the facility on [DATE]. Further review revealed Resident #21 was diagnosed with major depressive disorder (MDD) on 01/13/2026. Review of Resident #21's record revealed no evidence a PASARR Level II evaluation was completed for Resident #21. In an interview on 01/23/2026 at 10:07AM, S15Social Services Director indicated Resident #21's PASARR Level II evaluation was not completed after was not completed after Resident #21's new diagnosis of major depressive disorder on 01/13/2026, as required. In an interview on 01/23/2026 at 10:17AM, S2Director of Nursing indicated Resident #21's PASARR Level II evaluation was not completed after Resident #21's diagnosis of MDD on 01/13/2026, as required. Resident #49 Review of Resident #49's face sheet revealed, in part, Resident #49 was admitted to the facility on [DATE]. Further review revealed Resident #49 was diagnosed with major depressive disorder (MDD) on 05/03/2021. Review of Resident #49's record revealed no evidence a PASARR Level II evaluation was completed for Resident #49. In an interview on 01/23/2026 at 10:07AM, S15Social Services Director indicated Resident #49's PASARR Level II evaluation was not completed after Resident #49's diagnosis of MDD on 05/03/2021, as required. In an interview on 01/23/2026 at 10:13AM, S2Director of Nursing indicated Resident #49's PASARR Level II evaluation was not completed after Resident #49's diagnosis of MDD on 05/03/2021, as required. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/23/2026 at 1:45PM, S1Administrator confirmed Resident #21's and Resident #49's PASARR Level II were not completed after a new diagnosis of a serious mental illness was received.		

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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. Based on interviews and record reviews, the facility failed to review a resident's care plan quarterly for 1 (Resident #6) of 18 sampled resident's care plans reviewed. Findings: Review of the facility's Care Plan policy, last revised on 04/22/2009, revealed, in part, the facility's interdisciplinary team (IDT) will reassess the resident no less than once every 3 months, and as needed, and revise the resident's plan of care together with the resident and/or the residents responsibly party. Review of Resident #6's electronic medical record revealed, in part, Resident #6's last quarterly Minimum Data Set (MDS) was completed on 12/26/2025. Review of Resident #6's progress notes revealed no care plan meeting was held with Resident #6, Resident #6's representative, and/or any of the facility's IDT to review Resident #6's care plan since 07/16/2025. In an interview on 01/23/2026 at 10:02AM, S15Social Services Director (SSD) indicated Resident #6's last care plan meeting was on 07/16/2025. S15SSD further indicated a care plan meeting should have occurred since that date, because care plan meetings were to be completed every quarter. In an interview on 01/23/2026 at 10:12AM, S2Director of Nursing (DON) indicated care plan meetings should occur quarterly. In an interview on 01/23/2026 at 11:02AM, S15SSD confirmed Resident #6's care plan had not been reviewed or revised by the IDT, Resident #6, and/or Resident #6's representative since 07/16/2025.		

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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. Based on observation, interviews and record reviews, the facility failed to ensure only authorized personnel had access to medications for 1 (Resident #1) of 1 sampled residents observed with medications at the bedside. Findings: Review of the facility's undated Storage of Medications policy revealed, in part, medications were to be stored in locked compartments and in the packaging in which they were received. Further review revealed, only persons authorized to prepare and administer medications should have access to medications. Review of Resident #47's Quarterly Minimum Data Set with an Assessment Reference Date of 10/29/2025 revealed, in part, Resident #47 had a Brief Interview for Mental Status score of 9, which indicated Resident #47 was moderately cognitively impaired. Observation of Resident #47's room on 01/21/2026 at 12:40PM revealed a white pill was on the ground split in two along with a medication cup that had Resident #47's name written on it. Further observation revealed a second medication cup, labeled with Resident #47's name and present on Resident #47's beside table, contained a white pill. In an interview on 01/21/2026 at 12:43PM, S7Licensed Practical Nurse (LPN) confirmed the pills and medication cups were in Resident #47's room. S7LPN further indicated Resident #47's medication should not have been left at Resident #47's bedside, and Resident #47 did not have the mental capacity to administer her own meds. In an interview on 01/21/2026 at 12:58PM, S2Director of Nursing (DON) acknowledged the above mentioned medications should not have been left at Resident #47's bedside in medication cups, unlocked, and unattended by staff.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to ensure a resident was served a diet that met the resident's special dietary needs for 1 (Resident #9) of 1 sampled residents reviewed for nutrition. Findings: Review of the facility's undated Nutrition policy and procedure revealed, in part, all physician ordered diets shall be implemented promptly upon receipt, and the dietary department shall prepare and serve meals which meet the ordered diet and nutritional requirements. Review of Resident #9's record revealed diagnosis of, in part, stage 4 Chronic Kidney Disease (condition in which the resident's kidneys were damaged and were unable to filter out toxins). Review of Resident #9's January 2026 Physician's Orders revealed, in part, Resident #9 was to be provided a renal diet. Review of Resident #9's Meal Ticket dated 01/21/2026 revealed Resident #9 was to receive a renal diet with no potatoes. Observation on 01/21/2026 at 1:05PM revealed Resident #9 was served cubed potatoes. In an interview on 01/21/2026 at 1:06PM, S16Licensed Practical Nurse indicated Resident #9 should not have been served potatoes, per his renal diet. In an interview on 01/22/2026 at 3:30PM, S2Director of Nursing indicated the process to ensure the residents received the correct diet was for the diet recommendations to be placed on the meal ticket, then the dietary aide should follow the meal ticket when preparing the resident's plate. S2Director of Nursing further indicated the staff on the floor then should check the trays as they were distributing the trays to ensure the diet served matched the diet ordered on the resident's meal ticket. S2Director of Nursing further indicated if the staff distributing the trays identified an inconsistency with the meal ticket and the resident's tray, they would notify the nurse and dietary. S2Director of Nursing further indicated Resident #9 should have not been served potatoes.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure staff completed hand hygiene while performing incontinence care for 1 (Resident #63) of 1 sampled residents observed for incontinence care. Findings:Review of the facility's undated Standard Precautions policy and procedure revealed, in part, hand hygiene must be performed immediately after contact with any resident item that may be contaminated. Review of the Centers for Disease Control and Prevention (CDC)'s October 2022 Guidelines for Hand Hygiene in Health-Care Settings revealed, in part, staff should decontaminate their hands if moving from a contaminated body site to a clean body site during patient care. Observation on 01/21/2026 at 11:39AM revealed S17Certified Nursing Assistant (CNA) and S18CNA entered Resident #63's room to perform incontinence care. S17CNA and S18CNA removed Resident #63's soiled diaper and wiped Resident #63's buttocks and perineal area. S17CNA and S18CNA then placed a clean diaper on Resident #63, rolled Resident #63, placed a clean draw sheet under Resident #63, repositioned Resident #63, and covered Resident #63 with clean linen without changing their gloves and performing hand hygiene. S18CNA then opened and closed Resident #63's dresser door and raised the head of Resident #63's bed with her contaminated gloved hands without performing hand hygiene and changing her gloves. In an interview on 01/21/2026 at 11:50AM, S17CNA indicated he did not change his gloves and perform hand hygiene after removing Resident #63's soiled diaper during incontinence care and should have. In an interview on 01/21/2026 at 11:51AM, S18CNA indicated she did not change her gloves and perform hand hygiene care after removing Resident #63's soiled diaper during incontinence care and should have. In an interview on 01/23/2026 at 10:00AM, S2Director of Nursing (DON) confirmed the above mentioned CNAs should have changed their gloves and performed hand hygiene during incontinence care when they moved from a contaminated body area to a clean body area.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the pneumococcal (an infection caused by streptococcus pneumonia bacteria) and influenza (a respiratory infection caused by a virus) vaccines were administered for 1 (Resident #60) of 5 sampled residents investigated for immunizations. Findings:Review of the facility's undated Influenza and Pneumococcal Vaccine policy and procedure revealed, in part, residents should be vaccinated against the pneumococcal disease and influenza virus unless the vaccination was medically contraindicated or the resident and/or legal representative refused the vaccination. Review of Resident #60's Minimum Data Set with an Assessment Reference Date of 01/07/2026 revealed, in part, Resident #60 was admitted to the facility on [DATE]. Further review revealed a Brief Interview for Mental Status score of 10, which indicated Resident #60's cognition was moderately impaired. Review of Resident #60's Pneumonia Vaccine Consent Form revealed, in part, Resident #60's responsible party signed consent for Resident #60 to receive the pneumococcal vaccine on 07/02/2025. Review of Resident #60's Influenza Vaccine Consent Form revealed, in part, Resident #60's responsible party signed consent for Resident #60 to receive the pneumococcal vaccine on 07/02/2025. Review of Resident #60's clinical record on 01/20/2026 at 3:30PM revealed no documented evidence Resident #60 received the influenza and/or pneumococcal vaccines. On 01/20/2026 at 3:40PM, S1Administrator was presented with a request for Resident #60's vaccination records. In an interview on 01/21/2026 at 12:16PM, Resident #60 indicated he wanted the influenza and pneumococcal vaccines, but had not received them. In a telephone interview on 01/21/2026 at 1:37PM, Resident #60's responsible party indicated she consented for Resident #60 to receive the influenza and pneumococcal vaccines from the facility. Resident #60's responsible party further indicated she was unsure if Resident #60 had received the influenza and pneumococcal vaccines. In an interview on 01/21/2026 at 1:35PM, S3Assistant Director of Nursing/Infection Preventionist indicated the facility had no evidence Resident #60 received the influenza and/or pneumococcal vaccinations since admission. In an interview on 01/21/2026 at 3:40PM, S2Director of Nursing indicated Resident #60 had not received the influenza and/or pneumococcal vaccinations prior to 01/21/2026, and should have. In an interview on 01/21/2026 at 3:40PM, S1Administrator indicated Resident #60 had not received the influenza and/or pneumococcal vaccinations prior to 01/21/2026, and should have.		