

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER John J Hainkel Jr Home and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 612 Henry Clay Avenue New Orleans, LA 70118	

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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>49259</p> <p>Based on observations, interviews and record reviews, the facility failed to conduct an accurate comprehensive assessment for 4 (Resident #4, Resident #22, Resident #46, Resident #64) of 34 (Resident #4 Resident #5, Resident #14, Resident #19, Resident #20, Resident #22, Resident #23, Resident #24, Resident #32, Resident #34, Resident #38, Resident #40, Resident #41, Resident #45, Resident #46, Resident #51, Resident #61, Resident #64, Resident #70, Resident #71, Resident #75, Resident #76, Resident #78, Resident #88, Resident #93, Resident #94, Resident #96, Resident #99, Resident #100, Resident #102, Resident #104, Resident #108, Resident #109, Resident #411) sampled residents reviewed for comprehensive assessments.</p> <p>Findings:</p> <p>Resident #4</p> <p>Review of Resident #4's quarterly MDS with an ARD of 02/24/2025 revealed, in part, Section GG Functional Abilities - Omnibus Budget Reconciliation Act (OBRA)/Interim, questions GG0130 B-I and GG0170 A-FF were not completed as required.</p> <p>Resident #22</p> <p>Review of Resident #22's clinical record revealed, in part, Resident #22 had a diagnosis of dysphagia (medical term used to describe difficulty swallowing) with an onset date of 07/03/2024.</p> <p>Review of Resident #22's quarterly, Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed, in part, Section K, titled, Swallowing/ Nutritional Status read no loss of liquids, no holding food in mouth/cheeks, no residual food in mouth after meals, no coughing or choking during meals or when swallowing medications, and no complaints of difficulty or pain when swallowing. Further review revealed Section K titled Swallowing/ Nutritional Status, also read no mechanically altered diet.</p> <p>Review of Resident #22's March 2025 and April 2025 Physician Orders revealed, in part, Resident #22 was ordered a puree mechanically altered diet, and thickened liquids since 08/15/2024.</p> <p>Review of Resident #22's Progress Notes revealed, in part, on 07/5/2024, the Registered Dietitian recommended a pureed diet with nectar-thickened Liquids.</p> <p>(continued on next page)</p>

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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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #22's Care Plan revealed, in part, Resident #22 had a swallowing problem, coughing and choking during meals, and swallowing medications that was initiated on 01/13/2025.</p> <p>Observation on 03/31/2025 at 9:51AM of Resident #22's room revealed a sign posted in his room on the wall indicating Resident #22 was on a nectar-thickened liquid diet.</p> <p>In an interview on 04/02/2025 at 9:25AM, S5Licensed Practical Nurse (LPN) indicated Resident #22 had a prescribed diet of puree texture with nectar-thickened liquids. S5LPN further indicated dietary staff served Resident #22 a pureed textured diet with nectar-thickened liquids.</p> <p>Observation on 04/02/2025 at 12:38PM revealed Resident #22 was served a pureed textured meal with nectar-thickened liquids. Further observation revealed the meal ticket on his tray read nectar-thickened liquid, regular/puree.</p> <p>In an interview on 04/03/2025 at 10:25AM, S3Medicare Case Manager (MCM) confirmed that section K on Resident #22's quarterly MDS with an ARD of 01/13/2025, indicated Resident #22 did not have any swallowing issues and Resident #22 did not receive a mechanically altered diet.</p> <p>Resident #46</p> <p>Review of Resident #46's quarterly MDS with an ARD of 01/14/2025 revealed, in part, Section GG Functional Abilities- OBRA/Interim, questions GG0130 B-I and GG0170 A-K were not completed as required.</p> <p>Resident #64</p> <p>Review of Resident #64's annual MDS with an ARD of 02/05/2025 revealed, in part, Section GG Functional Abilities- OBRA/Interim Questions GG0130 B-I and GG0170 A-K were not completed as required.</p> <p>In an interview on 04/03/2025 at 9:45AM, S3MCM indicated Section GG - Functional Abilities Questions GG0130 A-I and GG0170 A-K are assessed and completed on the admission, annual and quarterly MDS assessments. S3MCM confirmed Resident # 4's section GG Functional Abilities- OBRA/Interim Questions GG0130 B-I and GG0170 A-K were not completed and should have been completed with Resident #4's 2/24/2025 quarterly MDS assessment; Resident #46's section GG Functional Abilities- OBRA/Interim, questions GG0130 B-I and GG0170 A-K were not completed and should have been completed with Resident #46's 1/14/2025 quarterly MDS assessment; and Resident #64's section GG Functional Abilities- OBRA/Interim Questions GG0130 B-I and GG0170 A-K were not completed and should have been completed with Resident #64's 2/5/2025 annual MDS assessment.</p> <p>51373</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>40405</p> <p>Based on interviews and record reviews, the facility failed to ensure a resident (Resident #71) with a new diagnoses of Bipolar Disorder was referred to the appropriate state agency for a Preadmission Screening and Resident Review (PASARR) Level II evaluation as required.</p> <p>Findings:</p> <p>Review of the facility's policy titled PASARR Preadmission Screening and Coordination with an effective date of 01/18/2018 revealed, in part, the preadmission screening and resident review process requires that all applicants to the Medicaid certified nursing facility are screened for possible serious mental disorders or intellectual disabilities and related conditions. Further, the policy review revealed the facility must notify the state designated mental health or intellectual disability authority when a resident with a mental disorder (MD) or an intellectual disorder (ID) experiences a significant change in mental or physical condition. This must occur promptly to ensure that the resident continues to receive the care and services they need in the most appropriate setting.</p> <p>Review of Resident #71's clinical record revealed Resident #71 was diagnosed with Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) on 11/18/2024. Further review revealed there was no evidence a Level II PASARR had been completed as required.</p> <p>Review of Resident #71's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/2025 revealed, in part, a Brief Interview of Mental Status (BIMS) score of 6, which indicated moderate cognitive impairment. Further review revealed Resident #71 was diagnosed with Bipolar Disorder.</p> <p>In an interview on 04/03/2025 at 9:50AM, S8Social Worker indicated a Level II PASARR was not completed on Resident #71 after a new diagnosis of Bipolar Disorder and should have been.</p> <p>In an interview on 04/03/2025 at 3:42PM, S1Administrator indicated a Level II PASARR should have been requested on Resident #71 after a new diagnosis of Bipolar Disorder on 11/18/2024. S1Administrator confirmed Resident #71 did not have a Level II PASARR completed as required.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46361</p> <p>Based on observations, interviews, and record reviews, the facility failed to:</p> <ol style="list-style-type: none"> 1. implement identified interventions for residents at risk for injuries related to falls (Resident #93, Resident #94); and, 2. ensure thin liquids were not accessible to a resident who required thickened liquids (Resident #22). <p>This deficient practice was identified for 3 (Resident #22, Resident #93, and Resident #94) of 5 (Resident #22, Resident #23, Resident #64, Resident #93, Resident #94) sampled residents reviewed for accident hazards.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Resident #93</p> <p>Review of Resident #93's clinical record revealed, in part, diagnoses of arthropathy, physical debility, muscle weakness, abnormal gait and mobility, lack of coordination, and repeated falls.</p> <p>Review of Resident #93's care plan revealed, in part, Resident #93 was at risk for falls with an intervention to have a fall mat on the floor next to the bed when Resident #93 was in bed.</p> <p>Review of Resident #93's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/2025 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #93 was cognitively intact.</p> <p>Observation on 03/31/2025 at 11:00AM revealed Resident #93 was in bed, and the fall floor mat was rolled up and placed between the wall and the dresser. Further observation revealed Resident #93 had a sign in his room, which indicated a floor mat should be on the floor next to the bed while Resident #93 was in bed.</p> <p>In an interview on 04/02/2025 at 9:25AM, S7Certified Nursing Assistant (CNA) indicated Resident #93 was on fall precautions, and a fall mat should have been placed on the floor next to Resident #93's bed.</p> <p>In an interview on 04/02/2025 at 11:42AM, Resident #93 indicated the staff forgot to place the fall mat on the floor next to Resident #93's bed at times.</p> <p>Observation on 04/02/2025 at 3:04PM revealed Resident #93 was in bed, and the fall floor mat was rolled up between the wall and the dresser.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/02/2025 at 4:15PM revealed Resident #93 was in bed, and the fall floor mat was rolled up between the wall and the dresser.</p> <p>Observation on 04/03/2025 at 8:25AM revealed Resident #93 was in bed, and the fall floor mat was rolled up between the wall and the dresser.</p> <p>In an interview on 04/03/2025 at 8:30AM, S2Director of Nursing (DON) indicated Resident #93 should have had a fall floor mat on the floor next to the bed while Resident #93 was in the bed.</p> <p>Resident #94</p> <p>Review of Resident #94's MDS with an ARD of 02/13/2025 revealed, in part, Resident #94 had a BIMS score of 04, which indicated severely impaired cognition.</p> <p>Review of Resident #94's April 2025 Physician Orders revealed, in part, an order dated 02/13/2025 for Resident #94 to have a fall mat placed at the bedside while in bed.</p> <p>Review of Resident #94's care plan revealed, in part, Resident #94 was at risk for falls due to mobility impairments. Further review revealed Resident #94 had an intervention for a fall mat to be placed at the bedside while in bed.</p> <p>Observation on 03/31/2025 at 10:20AM revealed Resident #94 was sitting upright on the side of his bed and there was no fall mat at Resident #94's bedside. Further observation of Resident #94's room revealed a fall mat was leaning against the wall.</p> <p>Observation on 04/02/2025 at 9:58AM revealed Resident #94 was sitting upright on the side of his bed and there was no fall mat at Resident #94's bedside. Further observation of Resident #94's room revealed a fall mat was leaning against the wall.</p> <p>Observation on 04/02/2025 at 10:47AM revealed Resident #94 was sitting upright on the side of his bed and there was no fall mat at Resident #94's bedside. Further observation of Resident #94's room revealed a fall mat was leaning against the wall.</p> <p>In an interview on 04/03/2025 at 2:09PM, S6CNA indicated a fall mat should have been placed next to Resident #94's bed while Resident #94 was in bed.</p> <p>In an interview on 04/03/2025 at 2:47PM, S2DON confirmed Resident #94 should have had a fall mat placed at his bedside while in bed as a fall intervention.</p> <p>2.</p> <p>Resident #22</p> <p>Review of Resident #22's clinical records revealed, in part, diagnoses of dysphasia (difficulty swallowing foods or liquids), hemiplegia, and hemiparesis to the right side.</p> <p>Review of Resident #22's care plan revealed, in part, Resident #22 had a swallowing problem with an intervention to follow the prescribed diet (Puree texture nectar- thickened liquids).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #22's March and April 2025 Physician Orders revealed, in part, Resident #22 was prescribed nectar-thickened liquids (modified consistency for liquids that is thicker than water to prevent aspiration).</p> <p>Review of Resident #22's MDS with an ARD of 03/12/2025 revealed, in part, Resident #22 had a BIMS score of 3, which indicated severely impaired cognition.</p> <p>Review of Resident #22's progress note dated 01/13/2025 revealed, in part, Resident #22 required set-up assistance with eating.</p> <p>Observation on 03/31/2025 at 9:51AM of Resident #22's room revealed that Resident #22 had a sign in his room which indicated Resident #22 was prescribed nectar-thickened liquids. Further observation revealed a water bottle on Resident #22's nightstand containing a thin consistency liquid that Resident #22 could access and consume.</p> <p>Observation on 04/02/2025 at 9:20AM, revealed a water bottle full of thin consistency liquids was on Resident #22's nightstand, where Resident #22 could access and consume the thin liquids.</p> <p>In an interview on 04/02/2025 at 9:25AM, S5Licensed Practical Nurse (LPN) indicated Resident #22 was prescribed thickened-liquids.</p> <p>Observation on 04/02/2025 at 9:28AM with S5LPN revealed a water bottle on Resident #22's nightstand containing a thin consistency liquid that Resident #22 could access and consume.</p> <p>In an interview on 04/02/2025 at 9:29AM, S5LPN confirmed that the water bottle contained thin liquids and should not be accessible to Resident #22 in his room.</p> <p>In an interview on 04/03/2025 at 8:30AM, S2DON confirmed thin liquids should not have been accessible to Resident #22 in his room.</p> <p>51373</p>		