

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: 195185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Terrebonne General Med Ctr Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 8166 Main Street Houma, LA 70360	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, interviews, and record reviews the facility failed to ensure percutaneous endoscopic gastrostomy tube flushes before and after medication administration for 1 (Resident #11) of 1 sampled resident with a percutaneous endoscopic gastrostomy tube (a feeding tube inserted through the abdomen into the stomach, commonly used for long-term nutrition, fluids, and medication delivery). Findings: Review of Resident #11's physician's orders dated 02/08/2026 revealed, in part, flush the feeding tube with the lowest volume necessary to clear the tube before and after administration unless a specific volume is ordered. Review of Elsevier Performance Manager Training for Medication Administration via Feeding Tubes revealed, in part, flush the feeding tube with a minimum of 15 milliliters of purified water before and after the administration of medications. Observation on 02/09/2026 at 12:02PM revealed S4Registered Nurse did not flush Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration. Observation on 02/09/2026 at 4:54PM revealed S4Registered Nurse did not flush Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration. Observation on 02/10/2026 at 8:16AM revealed S4Registered Nurse did not flush Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration. Observation on 02/10/2026 at 9:19AM revealed S4Registered Nurse did not flush Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration. Observation on 02/10/2026 at 12:14PM revealed S4Registered Nurse did not flush Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration. In an interview on 02/10/2026 at 4:45PM, S4Registered Nurse stated he did not flush Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration, and should have. In an interview on 02/11/2026 at 8:36AM, S2Nurse Manager confirmed S4Registered Nurse should have flushed Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration. In an interview on 02/11/2026 at 8:50AM, S1Post Acute Care Director confirmed S4Registered Nurse should have flushed Resident #11's percutaneous endoscopic gastrostomy tube before and after medication administration.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to implement Enhanced Barrier Precautions (EBP) for 2 (Resident #5, Resident #11) of 2 sampled residents observed for infection control practices. Findings: Review of the Centers for Disease Control's 04/02/2024 article Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, revealed, in part, personal protective equipment, which included the use of gowns and gloves, should be used during high-contact resident care activities that provided opportunities for the transfer of methicillin drug resistant organisms (bacteria or other germs that developed resistance to multiple antibiotics) to staff's hands and clothing. Further review revealed examples of high-contact resident care activities included device care, which included care of feeding tubes, and wound care. Review of the facility's Infection Control policy and procedure revealed, in part, the policy did not include a developed policy for the implementation of Enhanced Barrier Precautions (EBP). In an interview on 02/10/2026 at 11:15AM, S3Infection Control Manager indicated the facility's Infection Control policy and procedure did not include a developed policy for the implementation of EBP. In an interview on 02/11/2026 at 8:51AM, S1Post Acute Care Director indicated the facility's Infection Control policy and procedure did not include a developed policy for the implementation of EBP. In an interview on 02/11/2026 at 8:52AM, S2Nurse Manager indicated the facility's Infection Control policy and procedure did not include a developed policy for the implementation of EBP. Observation on 02/09/2026 at 1:51PM revealed S4Registered Nurse initiated Resident #11's percutaneous endoscopic gastrostomy tube feeding without wearing a gown. Observation on 02/10/2026 at 8:14AM S4Registered Nurse performed wound care to Resident #11's percutaneous endoscopic gastrostomy tube without wearing a gown. In an interview on 02/10/2026 at 3:04PM, S4Registered Nurse indicated he was not aware of the Centers for Disease Control's requirements for EBP. S4Registered Nurse further indicated he wore gloves but did not wear a gown when he initiated Resident #11's tube feeding and when he performed wound care to Resident #11's percutaneous endoscopic gastrostomy tube and should have. In an interview on 02/11/2026 at 8:36AM, S2Nurse Manager indicated S4Registered Nurse should have worn a gown when S4Registered Nurse initiated Resident #11's tube feeding formula and when S4Registered Nurse performed wound care to Resident #11's percutaneous endoscopic gastrostomy tube. In an interview on 02/11/2026 at 8:45AM, S1Post Acute Care Director indicated S4Registered Nurse should have worn a gown when S4Registered Nurse initiated Resident #11's tube feeding formula and when S4Registered Nurse performed wound care to Resident #11's percutaneous endoscopic gastrostomy tube. Observation on 02/09/2026 at 8:00AM revealed S4Registered Nurse provided surgical wound care and dressing change to Resident #5's two left lateral thigh surgical wounds wearing only a mask and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves for enhanced barrier precautions. Observation further revealed S4Registered Nurse did not wear a gown during Resident #5's wound care. Observation on 02/10/2026 at 10:10AM revealed S4Registered Nurse provided surgical wound care and dressing change to Resident #5's two left lateral thigh surgical wounds wearing only a mask and gloves. Observation further revealed S4Registered Nurse did not wear a gown during Resident #5's wound care. Observation on 02/09/2026 at 12:02PM revealed S4Registered Nurse administered Resident #11's medications via percutaneous endoscopic gastrostomy tube without wearing a gown. Observation on 02/09/2026 at 4:54PM revealed S4Registered Nurse administered Resident #11's medications via percutaneous endoscopic gastrostomy tube without wearing a gown. Observation on 02/10/2026 at 8:16 AM revealed S4Registered Nurse administered Resident #11's medications via percutaneous endoscopic gastrostomy tube without wearing a gown. Observation on 02/10/2026 at 9:19AM revealed S4Registered Nurse administered Resident #11's medications via percutaneous endoscopic gastrostomy tube without wearing a gown. Observation on 02/10/2026 at 12:14 PM revealed S4Registered Nurse administered Resident #11's medications via percutaneous endoscopic gastrostomy tube without wearing a gown. In an interview on 02/10/2026 at 3:04PM, S4Registered Nurse stated he had not worn a gown when providing wound care to Resident #5. S4Registered Nurse further stated he had not received training for EBP. In an interview on 02/11/2026 at 8:36AM, S2Nurse Manager confirmed S4Registered Nurse should have worn a gown when performing surgical wound care, percutaneous endoscopic gastrostomy tube site care, and medication administration via percutaneous endoscopic gastrostomy tube.		