

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Thibodaux Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Percy Brown Road Thibodaux, LA 70301	

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>46361</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure to ensure staff maintained fluids within a resident's reach for a resident identified as being at risk for dehydration.</p> <p>This deficient practice was identified for 1 (Resident #2) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents reviewed for hydration.</p> <p>Findings:</p> <p>Review of the facility's Hydration Management policy and procedure dated January 2023 revealed, in part, residents identified with potential/actual dehydration would be evaluated for contributing risk factors/conditions. Further review revealed risk factors for dehydration may include diarrhea/vomiting and a plan of care for the resident would be developed to ensure provisions of adequate fluid intake. Further review revealed water pitchers would be placed at a resident's bedside unless otherwise indicated.</p> <p>Review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/2024 revealed, in part, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. Further review revealed Resident #2 had a diagnosis of dementia and malnutrition, was dependent on staff for transfers and mobility, and required supervision with setup assistance from staff for eating.</p> <p>Review of Resident #2's care plan with a revision date of 06/13/2024 revealed, in part, Resident #2 was identified as being at risk for dehydration or fluid deficit related to diarrhea. Further review revealed Resident #2 had interventions which included water was to be kept at bedside, and staff to encourage resident to drink fluids.</p> <p>Observation on 09/08/2024 at 8:32 a.m. revealed Resident #2 was in bed and her water pitcher was out of reach and across the room sitting on top of a large dresser. Further observation revealed Resident #2 had no water/fluids within reach at her bedside.</p> <p>In an interview on 09/08/2024 at 8:32 a.m., Resident #2 was unable to state if she was thirsty or how long it had been since she was offered fluids.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 09/08/2024 at 10:16 a.m. revealed Resident #2 was in bed and her water pitcher was out of reach and across the room sitting on top of a large dresser. Further observation revealed Resident #2 had no water/fluids at her bedside.</p> <p>Observation on 09/08/2024 at 12:32 p.m. revealed Resident #2 was in bed and her water pitcher was out of reach and across the room on top of a large dresser. Further observation revealed Resident #2 had no water/fluids at her bedside.</p> <p>In an interview on 09/08/2024 at 12:55 p.m., S2Certified Nursing Assistant (CNA) indicated Resident #2 was able to eat and drink on her own after she was set up by staff.</p> <p>Observation on 09/08/2024 at 1:20 p.m. revealed Resident #2 was sitting upright in her bed with her lunch tray in front of her. Further observation revealed Resident #2 picked up a cup of red fluids and drank from the cup independently.</p> <p>Observations on 09/08/2024 of Hall D, where Resident #2 resided and was confirmed after facility staff confirmed with the review of surveillance camera footage, revealed no evidence ice and/or water was passed on the 6:00 am to 2:00 pm shift.</p> <p>In an interview on 09/09/2024 at 11:03 a.m., S1Director of Nursing (DON) indicated the CNAs were responsible to pass water and/or ice down the halls at least once a shift.</p> <p>In an interview on 09/09/2024 at 11:55 a.m., S1DON confirmed Resident #2 had a care plan for dehydration with an intervention which included to keep water at bedside. S1DON indicated the facility's camera footage for Hall D on 09/08/2024 for the 6:00 a.m. to 2:00 p.m. shift was reviewed, and the facility had no evidence the staff passed ice/water on Hall D at any time during the shift, and should have.</p>		