

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 03/25/2025
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on observations, interviews, and record reviews the facility failed ensure a resident's Percutaneous Endoscopic Gastrostomy (PEG) tube (a soft, plastic feeding tube that goes into the stomach used to provide nutrition when oral intake is inadequate) feeding was not administered while a resident was in a flat position for 1 (Resident #37) of 1 (Resident #37) resident investigated for PEG tube feedings.</p> <p>Findings:</p> <p>Review of Resident #37's electronic medical record revealed, in part, Resident #37 was admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing).</p> <p>Review of Resident #37's March 2025 physician orders revealed, in part, an order to administer Resident #37's Glucerna 1.2 (a form of liquid nutrition) at 70 milliliters/hour (mls/hr) through Resident #37's PEG tube. Further review revealed an order for staff to keep the head of Resident #37's bed elevated during PEG tube feedings.</p> <p>Review of Resident #37's care plan revealed, in part, an intervention to keep the head of Resident #37's bed elevated during PEG tube feedings.</p> <p>Observation on 03/23/2025 at 10:20AM revealed Resident #37 was administered Glucerna 1.2 at 70 mls/hr through Resident #37's PEG tube. Further observation revealed S8Certified Nursing Assistant (CNA) repositioned Resident #37's head of bed to a flat position to provide incontinence care while Resident #37's PEG tube feeding was administered.</p> <p>In an interview on 03/23/2025 at 10:23AM, S8CNA indicated she was unaware Resident #37's PEG tube feeding should have been paused prior to positioning Resident #37's head of bed to a flat position.</p> <p>In an interview on 03/23/2025 at 10:24AM, S4Licensed Practical Nurse indicated Resident #37's PEG tube feeding should have been paused prior to positioning Resident #37's head of bed to a flat position.</p> <p>In an interview on 03/24/2025 at 9:10AM, S2Director of Nursing confirmed Resident #37's tube feedings should have been paused prior to positioning Resident #37's head of bed to a flat position.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on observations, interviews, and record reviews, the facility failed to store a resident's respiratory equipment in a sanitary manner for 1 (Resident #54) of 3 (Resident #25, #35, #54) residents investigated for respiratory care.</p> <p>Findings:</p> <p>Review of Resident #54's electronic medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure.</p> <p>Review of Resident #54's March 2024 Physician's Orders revealed, in part, the following orders:</p> <ul style="list-style-type: none"> - continuous positive airway pressure (CPAP) full mask with oxygen at 2 liters (L) per minute every night and as needed; - ipratropium-albuterol solution (a breathing treatment) 0.5-2.5 (3) milligrams (mg)/3 milliliters (mls), inhale 3 mls orally every 4 hours, as needed, for shortness of breath or wheezing via nebulizer; and, - oxygen at 2L per minute via nasal cannula continuously every shift related to chronic respiratory failure. <p>Observation on 03/24/2025 at 7:55AM revealed Resident #54's CPAP mask and nebulizer/breathing treatment mask were on the bedside table and not contained in a bag.</p> <p>Observation on 03/24/2025 at 9:48AM revealed Resident #54's CPAP mask and nebulizer/breathing treatment mask were on the bedside table and not contained in a bag.</p> <p>Observation on 03/24/2025 at 4:05PM revealed Resident #54's CPAP mask and nebulizer/breathing treatment mask were on the bedside table and not contained in a bag.</p> <p>In an interview on 03/24/2025 at 4:23PM, S9Licensed Practical Nurse (LPN) confirmed Resident #54's CPAP mask and nebulizer/breathing treatment masks were not contained in bags. S9LPN further indicated Resident #54's CPAP mask and nebulizer/breathing treatment mask should be contained in bags when not in use.</p> <p>In an interview on 03/24/2025 at 5:00PM, S2Director of Nursing (DON) indicated CPAP masks and nebulizer/breathing treatment masks should be contained when not in use.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>45877</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure a resident's medications was maintained in the original manufacturer's or pharmacy's label for 1 (Medication Cart e) of 3 (Medication Cart e, Medication Cart f, and Treatment Cart g) medication carts observed.</p> <p>Findings:</p> <p>Review of the facility's Medication Administration policy and procedure, dated 04/01/2019 and last reviewed 07/08/2024, revealed, in part, the individual administering the medications should check the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before administering the medications.</p> <p>Observation on 03/24/2025 at 3:33PM revealed Medication Cart e contained a medication cup for Resident #1, Resident #17, Resident #28, Resident #32, Resident #30, Resident #45, Resident #55 and Resident #39 and two medication cups for Resident #14 and Resident #22. Further observation revealed the above mentioned medication cups contained each residents' medications, but were only labeled with the residents' names. Further observation revealed the second cup for Resident #14 and Resident #22 were also labeled with the time 9:00PM. Further observation revealed no evidence that any of the above mentioned cups were labeled with the names or doses of the medications they contained.</p> <p>In an interview on 03/23/2025 at 3:34PM, S5Licensed Practical Nurse (LPN) indicated she had pre-prepared the above mentioned residents' medications for later administration during her shift. S5LPN confirmed she should not have prepared the above mentioned residents' medications until she was ready to administer them.</p> <p>In an interview on 03/23/2025 at 3:45PM, S2Director of Nursing confirmed medications should not be prepared and placed in medication cups until they were ready to be administered.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47487</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Food was stored in a sanitary manner for 2 (Refrigerator a and Refrigerator c) of 3 (Refrigerator a, Refrigerator b, Refrigerator c) refrigerators and 1 (Freezer d) of 1 (Freezer d) freezers observed for food storage; and, 2. Ensure the facility's kitchen was maintained in a sanitary manner. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Observation of Refrigerator a on 03/23/2025 at 8:40AM revealed an opened and undated bag of browned lettuce, an opened and undated container of parmesan cheese, an onion with a black spot that was approximately 1/4 of the size of the onion inside of a clear plastic tub with other onions.</p> <p>Observation of Freezer d on 03/23/2025 at 8:40AM revealed a bag of white beans which was unlabeled with the contents of the bag.</p> <p>Observation of Refrigerator c on 03/23/2025 at 8:45AM revealed shredded cheese was scattered across the bottom of Refrigerator c.</p> <p>Observation of the kitchen with S3Dietary Manager on 03/24/2025 at 11:07AM revealed an opened and undated container of parmesan cheese and an onion with a black spot that was approximately 1/4 of the size of the onion inside of a clear plastic tub with other onions which was in Refrigerator a. Further observation revealed a bag of white beans which was unlabeled with the contents of the bag in Freezer d.</p> <p>In an interview on 03/24/2025 at 11:15AM, S3Dietary Manager indicated the bag of browned lettuce and the container of parmesan cheese should have been labeled with an opened date. S3Dietary Manager further indicated the onion with the black spot that was 1/4 the size of the onion should not have been in the container and available for resident consumption. S3Dietary Manager further indicated the shredded cheese should not have been on the bottom of Refrigerator c. S3Dietary Manger further indicated the bag of white beans in Freezer d should have been labeled with the contents of the bag.</p> 2. <p>Observation of the facility's kitchen on 03/23/2025 at 8:39AM revealed a rack of clean dishes contained various stacks of blue bowls. Further observation revealed 3 of the bowls on top of the various stacks had debris and a greasy film on them.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the facility's kitchen on 03/23/2025 at 8:44AM revealed a rack of clean dishes contained various stacks of dome covers (a cover that helps to keep a resident's food warm during transport) and various stacks of pellets (a metal plate that is placed under a resident's plate to help keep food warm during transport). Further observation revealed 4 of the pellets on top of the various stacks had dust and a greasy film on them and 5 of the dome covers had dust on them.</p> <p>Observation of the kitchen with S3Dietary Manager on 03/24/2025 at 11:07AM revealed a rack of clean dishes contained various stacks of blue bowls. Further observation revealed 3 of the bowls on top of the various stacks had debris and a greasy film on them. Further observation revealed a rack of clean dishes contained various stacks of dome covers and various stacks of pellets. Further observation revealed 4 of the pellets on top of the various stacks had dust and a greasy film on them and 5 of the dome covers had dust on them. Further observation revealed a dried brown substance in a splash pattern located on the wall directly behind the facility's steam table.</p> <p>In an interview on 03/24/2025 at 11:15AM, S3Dietary Manager indicated the above mentioned bowls, dome covers, and pellets should not have dust, debris, and/or a greasy film on them.</p> <p>In an interview on 03/24/2025 at 1:20PM, S3Dietary Manager indicated the dried brown substance should not have been on the wall behind the steam table.</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>47487</p> <p>Based on interview and record reviews, the facility's administration failed to ensure the facility provided 2.35 hours of direct nursing care per resident for 4 (09/15/2024, 10/27/2024, 11/10/2024, 12/08/2024) of 27 (09/15/2024, 10/05/2024, 10/06/2024, 10/12/2024, 10/13/2024, 10/19/2024, 10/20/2024, 10/26/2024, 10/27/2024, 11/02/2024, 11/03/2024, 11/09/2024, 11/10/2024, 11/16/2024, 11/17/2024, 11/23/2024, 11/24/2024, 11/30/2024, 12/01/2024, 12/07/2024, 12/08/2024, 12/14/2024, 12/15/2024, 12/21/2024, 12/22/2024, 12/28/2024, and 12/29/2024) weekend days reviewed for required staffing hours.</p> <p>Findings:</p> <p>Review of the facility's Administrator job description, dated March 2017, revealed, in part, the Administrator's responsibilities were to maintain and guide the implementation of the facility's policies and procedures in compliance with corporate, state, federal and other regulatory guidelines.</p> <p>Review of the Louisiana Administrative Code Chapter 97-Nursing Facilities, last updated in 11/2023, revealed, in part, the nursing facility shall provide 2.35 hours of care per resident per day.</p> <p>Review of the facility's staffing sheet dated 09/15/2024 revealed, in part, the facility's census was 72 residents.</p> <p>Review of the facility's time sheets from 09/15/2024 revealed, in part, the total number of nurse staffing hours provided by the facility's nursing staff was 150.18 hours, which was 19.02 hours less than the required 169.2 hours.</p> <p>Review of the facility's Nursing/Ancillary Personnel Staffing Pattern Reporting Forms, dated 10/02/2024 through 12/29/2024, signed as complete and accurate by S1Administrator on 03/24/2025 revealed, in part, the following weekend days:</p> <p>On 10/27/2024 the facility was required to provide 171.55 hours of direct care based on their facility census of 73 residents. Further review revealed the facility provided 167.73 hours, which was 3.82 hours less than the required 171.55 hours.</p> <p>On 11/10/2024 the facility was required to provide 178.60 hours of direct care based on their facility census of 76 residents. Further review revealed the facility provided 177.63 hours, which was 0.97 hours less than the required 178.60 hours.</p> <p>On 12/08/2024 the facility was required to provide 180.95 hours of direct care based on their facility census of 77 residents. Further review revealed the facility provided 177.26 hours, which was 3.69 hours less than the required 180.95 hours.</p> <p>In an interview on 03/24/2025 at 3:07PM, S1Administrator indicated the facility did not provide 2.35 hours of direct nursing care per resident on 09/15/2024, 10/27/2024, 11/10/2024, and 12/08/2024 as required.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34060</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure enhanced barrier precautions (EBP) were maintained while emptying a urinary catheter bag for 1 (Resident #54) of 1 (Resident #54) sampled residents investigated for urinary catheter care.</p> <p>Findings:</p> <p>Review of the facility's Enhanced Barrier Precautions policy and procedure, dated 04/01/2024 and revised on 03/19/2025, revealed EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. Further review revealed EBP was used in conjunction with standard precautions and expanded the use of Personal Protective Equipment (PPE) to don (put on) a gown and gloves during high-contact resident care activities. Further review revealed, in part, EBP was indicated for residents with indwelling medical devices which included, in part, urinary catheters.</p> <p>Review of Resident #54's medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type 2, hypertension, gout, acute cystitis without hematuria, obstructive and reflux uropathy (a blockage in the urinary tract), and urinary retention.</p> <p>Review of Resident #54's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2024 revealed, in part, Resident #54 had an indwelling catheter.</p> <p>Observation on 03/25/2025 at 2:00PM revealed Resident #54 had a sign posted on his bedroom door for Enhanced Barrier Precautions.</p> <p>Observation on 03/25/2025 at 2:02PM revealed S7Certified Nursing Assistant (CNA) did not put on a gown when she entered Resident #54's room and emptied Resident #54's urinary catheter bag.</p> <p>In an interview on 03/25/2025 at 2:08PM, S7CNA confirmed she did not put on a gown before she entered Resident #54's room and emptied Resident #54's urinary catheter bag. S7CNA further indicated she should have put on a gown.</p> <p>In an interview on 03/25/2025 at 2:10PM, S6Assistant Director of Nursing confirmed S7CNA should have put on a gown before she entered Resident #54's room to empty Resident #54's urinary catheter bag.</p> <p>45877</p>		