STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195319	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thibodaux Healthcare and Rehabilitation Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure soiled laundry and biohazard waste in an isolation room was maintained in a sanitary manner for1 (Resident #65) of 1 sampled residents on transmission based precautions investigated for infection control practices. Findings: Review of the facility's Infection Prevention and Control Program policy, dated 01/2020 and reviewed 03/03/2026, revealed an infection prevention and control program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of the facility's Medical Waste - Segregating and Separating policy, dated 05/2012, revealed everyone who generated or handled medical waste would be responsible for discarding it into appropriate receptacles, and medical waste would be discarded into designated containers. Review of the facility's Isolation Protocol In-Service Training Report dated 01/14/2026 revealed, in part, red biohazard containers should be used for trash and yellow biohazard containers should be used for linen. Review of Resident #65's electronic medical record revealed, in part, Resident #65 was admitted to the facility on [DATE] and had diagnoses of conjunctivitis, bilateral hearing loss, and macular degeneration. Review of Resident #65's March 2026 physician's orders revealed, in part, Resident #65 had an order dated 03/10/2026 for contact isolation due to a diagnosis of bacterial conjunctivitis for 10 days. Review of Resident #65's Minimum Data Set with an Assessment Reference Date of 12/18/2025 revealed, in part, Resident #65 had a Brief Interview Mental Status Score of 13, which indicated Resident #65 was cognitively intact. Further review revealed Resident #65 had no documented mood or behavior issues. Review of Resident #65's current care plan revealed, in part, a plan of care was developed indicating Resident #65 was visually impaired, had difficulty hearing, had an Activities of Daily Living self-care performance deficit, which required a need for assistance to meet emotional, intellectual, physical, and social needs. Observation on 03/16/2026 at 11:15AM revealed Resident #65 was on isolation, and Resident #65's room had a foul odor.Observation further revealed a red biohazard bag in an opened box and a yellow biohazard bag in an opened box were located in Resident #65's room. Further observation revealed Resident #65's yellow biohazard container had unidentified, small flying insects flying above the yellow biohazard container. Further observation of the yellow biohazard container revealed the yellow container contained a soiled towel stained with a brown unknown substance and used disposal gowns and gloves. In an interview on 03/16/2026 at 11:15AM, Resident #65 indicated his room stunk. Resident #65 further indicated his trash had not been emptied. Observation on 03/16/2026 at 3:15PM revealed Resident #65's room had a foul odor. Observation further revealed Resident #65's yellow biohazard container contained a soiled towel stained with a brown unknown substance. Further observation revealed unidentified, small flying insects were in Resident #65's room. Observation on 03/17/2026 at 7:35AM revealed Resident #65's room had a foul odor and the yellow biohazard container contained a soiled towel stained with a brown unknown substance. Further observation revealed the yellow biohazard container also contained Resident #65's soiled clothing along with used disposal gowns and gloves. In an interview on 03/17/2026 at 7:35AM, Resident #65 indicated it stunk in his room and the trash needed to be emptied. In an interview on (continued on next page)

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 - Few	03/17/2026 at 7:51AM, S4Certified Nursing Assistant indicated Resident #65 was on isolation and staff should check on him daily to see if his needs are met. S4Certified Nursing Assistant further indicated the nursing staff were responsible for emptying the biohazard containers in Resident #65's room at least daily. In an interview on 03/17/2026 at 8:11AM, S3Licensed Practical Nurse indicated Resident #65 was on isolation and nursing staff were responsible for managing the biohazard waste in Resident #65's room. S3Licensed Practical Nurse further indicated the red biohazard container should be used to dispose of trash and the yellow biohazard container should be used for soiled linens and Resident #65's soiled clothes. In an interview on 03/17/2026 at 8:21AM, S7Housekeeper indicated nursing staff were responsible for emptying the biohazard containers in Resident #65's room. In an interview on 03/17/2026 at 8:26AM, S4Certified Nursing Assistant indicated the red biohazard containers should be used for trash and the yellow biohazard containers should be used for linen and Resident #65's clothes. S4Certified Nursing Assistant further indicated trash should not be disposed with the linen in the yellow biohazard containers. On 03/17/2026 at 8:42AM, Surveyor and S1Director of Nursing entered Resident #65's room. Observation revealed Resident #65 was sitting in his recliner chair and unidentified, small flying insects were observed in Resident #65's room. On 03/17/2026 at 8:42AM Resident #65 indicated to S1Director of Nursing the trash had not been emptied. In an interview on 03/17/2026 at 8:42AM, S1Director of Nursing indicated Resident #65's biohazard containers would have been emptied if Resident #65 would have asked. In an interview on 03/17/2026 at 1:01PM, S5Certified Nursing Assistant indicated if there was an odor observed in an isolation room, she would identify the source of the odor and remove the identified source of the smell. In an interview on 03/17/2026 at 1:30PM, S6Certified Nursing Assistant indicated if there was an odor observed in an isolation room, she would identify the source of the odor and remove the identified source of the smell. In a telephone interview on 03/17/2026 at 4:05PM, Resident #65's Responsible Party indicated Resident #65 complained to her daily about the odor in Resident #65's room, and the biohazard container not being emptied. Resident #65's Responsible Party further indicated she contacted S2Assistant Director of Nursing on 03/13/2026 and informed her of Resident #65's complaints. Resident #65's Responsible Party further indicated she attempted to contact S2Assistannt Director of Nursing on 03/16/2026 due to Resident #65's continued complaints of the smell in the room, and the trash not being emptied. In a telephone interview on 03/17/2026 at 4:32PM, Resident #65's daughter indicated she visited her father on 03/11/2026 and observed food and clothes were disposed in the yellow biohazard container. Resident #65's daughter further indicated she reported the complaint to S2Assistant Director of Nursing on 03/11/2026 at 4:30PM. Resident #65's daughter further indicated Resident #65 also complained about an odor in Resident #65's room on 03/16/2026. In an interview on 03/18/2026 at 8:15AM, S2Assistant Director of Nursing confirmed she was contacted by Resident #65's Responsible Party on 03/13/2026 and Resident #65's daughter on 03/11/2026 regarding the biohazard containers not being emptied and the trash and linen being disposed together in the yellow biohazard containers. S2Assistant Director of Nursing further indicated she did not communicate Resident #65's concerns to the staff on the hall and did not re-educate the staff on handling biohazard waste in an isolation room at that time. S2Assistant Director of Nursing further indicated it was the responsibility of the nursing staff to empty the biohazard containers and to ensure the environment was sanitary and comfortable for Resident #65. In an interview on 03/18/2026 at 11:40AM, S1Director of Nursing indicated the nursing staff was responsible for emptying the biohazard containers in Resident #65's room. S1Director of Nursing further indicated trash and linen should not be stored in the same biohazard container. In an interview on 03/18/2026 at 1:15PM, S8Corporate Compliance Nurse indicated the provider could not present any documented evidence the provider addressed the odors and gnats observed in Resident #65's room.