

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/18/2026
NAME OF PROVIDER OR SUPPLIER  Belle Teche Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1306 W Admiral Doyle Dr New Iberia, LA 70560	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to maintain accurately documented medical records in accordance with accepted professional standards and practices. The facility's CNA (Certified Nursing Assistant) staff failed to accurately document in a resident's electronic medical record for 1 (#1) out of 3 (#1, #2, and #3) sampled residents. The facility's total census was 95. Findings: On date of review, a review of the facility's undated policy titled, Documentation Guidelines read in part, Documenting information on the resident in the medical record provides: 4. A way to record the care received by the resident. Essential Points: Charting will be done on all residents to maintain a complete and accurate medical record. Review of a facility document titled CNA Orientation-Healthstream and PCC Information read in part, 3. As a CNA employed by this facility you are required to document the tasks in the facility kiosks you performed on each resident in your care everyday if you work a partial shift, a full shift or even an entire double shift. Prior to leaving the facility accurate kiosk documentation is to be completed on the residents you cared for. 4. Kiosk documentation is not an option or a if I have time action. This is mandatory. Kiosk Charting Requirements: Turn and Reposition Resident #1: Review of the resident's electronic medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to: pressure ulcer of sacral region, stage 4 hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; non-pressure chronic ulcer of skin of other sites with unspecified severity; chronic embolism and thrombosis of left femoral vein; right and left leg contractures; and Type 2 DM (diabetes mellitus). Review of Resident #1's February and March 2026 CNA task record revealed no documentation for turn and position for the following: February 2026: 7 a.m.-3 p.m. shift: 02/01/2026; 02/04/2026 through 02/06/2026; 02/09/2026 through 02/12/2026; 02/14/2026 through 02/15/2026; 02/17/2026 through 02/18/2026; 02/21/2026 through 02/27/2026. 3 p.m. -11p.m. shift: 02/04/2026 through 02/06/2026; 02/08/2026; 02/10/2026 through 02/17/2026; and 02/20/2026 through 02/28/2026. 11 p.m.-7 a.m. shift: 02/28/2026. March 2026: 7 a.m.-3 p.m. shift: 03/01/2026 through 03/02/2026; and 03/04/2026 through 03/16/2026. 3 p.m.-11p.m. shift: 03/01/2026 through 03/02/2026; 03/04/2026; 03/06/2026; 03/08/2026 through 03/09/2026; 03/11/2026 through 03/12/2026; and 03/14/2026 through 03/16/2026. An interview was conducted on 03/16/2026 at 12:45 p.m. with Resident #1. He stated that the CNAs did offer to turn him, but often refused as he preferred to remain on his back. An interview was conducted on 03/17/2026 at 11:00 a.m. with S3CNA. S3CNA stated that she was working with Resident #1 and was familiar with him. She stated that the resident refused to let the CNAs turn/reposition him when he is in bed. She stated they let the resident know how important it is for him to turn to avoid skin breakdown, but he still refused most of the time. She stated that they notify the nurse when the resident refuses to be turned, and are to document it in the Kiosk under the turn/position task. An interview was conducted on 03/17/2026 at 4:30 p.m. with S2DON who directed nursing services. She confirmed the above CNA's task records for turning/repositioning was missing documentation on multiple days for each month. She confirmed that the CNAs were supposed to place their initial on the task every shift, and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 195460	If continuation sheet Page 1 of 2

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>confirmed that the CNA task records did not reflect when the resident refused to be turned/repositioned on the above dates. An interview was conducted on 03/18/2026 at 9:15 a.m. with S1ADM who oversaw the day to day operations of the facility. He confirmed that the above CNA task records for turning/repositioning were missing documentation on multiple days. He stated that all the CNAs received training on documenting in the Kiosk during orientation. He stated that the CNAs should be documenting their completed tasks at the end of every shift, even when the resident refused care.</p>