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 03/25/2026
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the resident's rights to be free from neglect evidenced by staff failing to lower the bed of a resident who was a high risk for falls for 1 (#3) resident out of 9 (#1, #2, #3, #R1, #R2, #R3, #R4, #R5 and #R6) sampled residents. This deficient practice resulted in an actual harm for Resident #3 on 03/13/2026 at 6:50 a.m., when S3CNA observed Resident #3's bed was not in the lowest position and failed to intervene by lowering the bed. S3CNA admitted she was aware the resident's bed should have been in the lowest position, but did not lower the bed nor inform the nurse or other staff that resident's bed was not in the lowest position. Resident #3 was found on the floor, 9 minutes after S3CNA identified Resident #3's bed was not in the lowest position. Staff and a visitor observed Resident #3 yelling out, complaining of left hip/leg pain. Resident #3 was sent to the emergency room (ER) via emergency medical services. ER x-rays revealed the resident sustained a left femoral intratrochanter fracture requiring surgery (open reduction internal fixation/intramedullary nail placement) that was performed on Monday 03/16/2026. Resident #3 was discharged back to the facility on [DATE].The facility implemented corrective action plan on 03/13/2026 which was completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings:On 03/24/2026 review of the facility's undated policy titled, Fall Prevention Program revealed, in part:It is the policy of this facility to promote safety, dignity, and overall quality of life for residents. A safe and hazard free environment, as possible, will be provided as well.Protocol: I. Identification of High Risk Residents: A. Fall Risk Assessment will be completed on all residents within the first 24 hours of admission and with each MDS (Minimum Data Set assessment).Residents with a score of 10 or greater will be considered at high risk.II. Preventative Protocol.c. Elimination of Environmental Hazards: Another key factor in preventing falls is identification and elimination of environmental hazards when possible. Several areas to address include the following: .4. Bed Height: When the resident is seated at the edge of the bed, feet should be flat on the floor.h. Falling Star Program: Any resident who is identified at high risk by the previous criteria will be placed on the Falling Star Program. The purpose of the falling star program is to promote easy recognition of residents who have been identified as being high risks for falls.Review of the facility's policy titled, Abuse/Neglect with a last revision date of 04/03/2025 revealed, in part: This facility will not condone any form of resident abuse or neglect.Each resident has the right to be free from neglect.Definitions:.G. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain,.I. Serious bodily injury is defined as an injury involving extreme physical pain. or requiring medical intervention such as surgery, hospitalization. Review of the medical records for Resident #3 revealed the resident was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, bradycardia, dementia, bipolar disorder, long term use of aspirin major depressive disorder.Review of Resident #3's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/28/2025, revealed the following, in part:BIMS (Brief Interview for Mental Status) score of 06 which indicated the Resident had severe cognitive impairment; and was (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Teche Nursing & Rehab Center	1306 W Admiral Doyle Dr New Iberia, LA 70560

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F 0600 Level of Harm - Actual harm Residents Affected - Few	dependent on staff when performing bed mobility and chair/bed to chair transfers.Review of Resident #3's March 2026 physician's orders revealed an order entry dated 07/23/2024-Resident is high risk for falls and is on the Falling Star Program. Review of Resident #3's fall risk assessments dated 11/28/2025 revealed a score of 17 and assessment on 03/19/2026 revealed a score of 19.Review of Resident #3's current care plan revealed the following, in part: initiated 09/02/2021 .Problem: The resident will remain free from falls and will have no falls with injuries.Approaches: keep bed in the lowest position with the wheels locked.Review of Resident #3's Unwitnessed fall Incident Report dated 03/13/2026 revealed the following, in part: Nurse summoned to room and informed that resident was noted lying on the floor on his back, nurse assessed resident and noted bruising to left temple, complaining of pain to left hip, once hip pain noted resident was left in still position and DON (Director of Nursing) was notified. Emergency medical service was contacted. Resident taken to hospital. Other information included: bed not in lowest position. Review of Resident #3's hospital records revealed an x-ray report dated 03/13/2026 at 8:52 a.m. which noted the resident had a left femoral intertrochanteric fracture with displacement and surrounding soft tissue swelling. Resident #3 underwent surgery; intramedullary nailing of the left femur on 03/16/2026. Review of the facility's Investigative Report revealed the following, in part: on 03/13/2026, S1ADM reviewed facility's video footage (not available at time of survey) from earlier in the morning and identified S3CNA on Resident #3's hall making rounds and looked in Resident #3's room, but did not enter. S3CNA did state when she made rounds at 6:50 a.m., she did see Resident #3's bed was not in a low position. S3CNA was counseled on making sure resident beds remain in the low position.Review of S3CNA's personnel file revealed Certified Nursing Assistant job description duties and responsibilities, in part: 22.Provide maximum resident-care services to assure well- being of resident to greatest degree.24.Assist with execution of resident assessment and plan of care.27.Detect and correct situations that have a probability of causing accidents or injuries to residents.signed by S3CNA on 10/09/2025.On 03/25/2026 at 8:45 a.m., a phone interview was conducted with S3CNA. S3CNA verified she came on shift at 6:50 a.m. on 03/13/2026 and was assigned to provide care to Resident #3. S3CNA explained she conducted a quick round on the hall Resident #3 resided. As she walked down the hallway she observed Resident #3's door was opened and observed his bed was not in its lowest position. S3CNA confirmed she continued walking toward the dining room for breakfast meal service duties and failed to lower Resident #3's bed to the lowest position. When asked why she did not go into Resident #3's room to lower his bed, S3CNA stated she thought other staff were going to get Resident #3 up out of bed. S3CNA confirmed S1ADM reviewed the facility's video surveillance footage with her that showed S3CNA looking in Resident #3's room from the hallway and not entering the resident's room after identifying his bed was not in the lowest position. On 03/23/2026 at 9:20 a.m., an interview was conducted with S1ADM who was responsible for managing the facility. S1ADM confirmed Resident #3 had been hospitalized [DATE] until 03/18/2026 as a result of an unwitnessed fall resulting in a leg fracture that required surgical repair on 03/16/2026. S1ADM explained he immediately reviewed the facility's video footage with S2DON and S6ADON four hours prior to the resident falling at 6:59 a.m. He identified per the video at 6:50 a.m., S3CNA was seen making a round down Resident #3's hall and had looked in Resident #3's room from the hallway. Then at 6:59 a.m., a visitor was seen walking down the hall and heard Resident #3 hollering and when the visitor looked in the room, he saw Resident #3 on the floor near his bed and immediately notified S4HSK who was on the hall. S4HSK then notified S5LPN who immediately notified S2DON. At 7:00 a.m., S2DON and S5LPN entered Resident #3's room. Emergency medical services were notified and Resident #3 was transported to the hospital on [DATE] after complaints of left hip pain and left leg shortening. S1ADM then interviewed S3CNA and pointed out that he observed her on the hall in front of Resident #3's room around 6:50 a.m. S3CNA confirmed she stopped and looked in Resident #3's room and observed his bed was not in its lowest position, but failed to intervene. S1ADM stated he immediately began in-servicing all clinical staff which included: a verbal discussion covering resident bed positions-All resident beds should remain in (continued on next page)

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	195460	A. Building B. Wing	03/25/2026

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F 0600 Level of Harm - Actual harm Residents Affected - Few	low position, unless care planned otherwise. After providing care of leaving a resident's room, the bed needs to be lowered. S1ADM also in serviced non clinical staff on 03/13/2026 and discussed resident bed positions to include if any resident's bed is seen in the high position, immediately alert the nurse and/or CNA (Certified Nursing Assistant) down the hall so they can lower it. Remain with the resident until the bed is lowered. S1ADM explained on 03/13/2026 at 8:00 a.m., S2DON completed an audit on all residents' beds to ensure each bed was in low position unless otherwise care planned. S1ADM stated the facility started a QAPI (Quality Assurance Performance Improvement) meeting on 03/13/2026 to begin investigations and initiate corrective actions. S1ADM reported the facility's monitoring began 03/13/2026 and was ongoing. He denied any negative findings with the monitoring and stated there had been no further incidents regarding facility staff intervening to ensure residents' bed were in the lowest position, unless care planned otherwise. S1ADM reported he and S2DON conducted random monitoring and in-servicing staff on Saturday 03/14/2026 and Sunday 03/15/2026 with negative findings. S1ADM stated he had in-serviced all staff by 03/16/2026 and the administrative staff reviewed all residents' care plans and Fall Risk Assessments to ensure residents with a score greater than 10 included accurate safety interventions. Multiple Nurses and CNAs were interviewed on 03/23/2026, 03/24/2026 and 03/25/2026 about ensuring residents beds were kept in the lowest position unless care planned otherwise. Other non-clinical staff were interviewed, such as housekeeping and maintenance who confirmed the recent in-services to ensure resident beds were kept in the lowest position and if identified a bed not in the lowest position to immediately notify the nurse and/or CNA as well as to stay with the resident until the bed was lowered. Multiple observations of residents care planned for beds in lowest position conducted on 03/23/2026-03/24/2026. Beds were observed in the lowest position. No issues were identified. On 03/24/2026 at 10:30 a.m., an observation of two CNAs and one CNA in training demonstrated proper use of transferring Resident #3 from his wheelchair to his bed using a lifter. After Resident #3 was positioned to comfort, the CNAs lowered the resident's bed in its lowest position prior to exiting the room. No concerns were identified. The facility implemented the following actions to correct the deficient practice: 03/13/2026- Continuous Quality Assessment and Improvement Corrective Action Plan:I. Immediate baseline monitor to check all bed heights in the facility was initiated at 8:00 a.m. by Administrative Staff to ensure resident safety.II. Immediate reeducation of clinical staff focusing on resident bed height and if not care planned, they need to be kept in a low position to prevent any injuries, should a fall occur. Non nursing staff were educated that when making rounds and they find a resident's bed elevated, they need to stay with the resident and alert the resident's nurse/CNA.III. Nursing Facility Administrator (NFA) and DON performed in-services off hours (night and early am staff) on Saturday 03/14/2026 and on Sunday 03/15/2026 and rounds made to checks if any beds were not in the low position; none were found.IV. A rounding monitor was initiated on Friday 3/13/2026 and delegated to Nursing Administrative staff focusing on making room rounds and checking to make sure that beds were kept in low position. Any noncompliance found needs to be addressed at that time. Monitors are to be turned in to NFA weekly for review.V. Monitoring currently ongoing in facility 3x (times)/weekly for 6 weeks and monthly thereafter until compliance is achieved. 03/16/2026- All clinical staff have received re-education; monitoring conducted and documented with ongoing trainings continued. No immediacy was identified after monitors were complete. All resident in the facility were found to be safe.