STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195460	A. Building B. Wing	06/02/2026

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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident who required assistance with activities of daily living (ADLs) received good grooming and personal hygiene for 1 (Resident #1) of 4 sampled residents.Findings:Review of Resident #1's electronic health record (EHR) revealed she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic nephropathy, morbid (severe) obesity due to excess calories, chronic obstructive pulmonary disease with (acute) exacerbation, muscle wasting and atrophy left and right hand, and need for assistance with personal care.Review of Resident #1's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/13/2026, revealed the following:-In Section C, the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating her cognition was intact.-In Section GG, the resident required substantial maximal assistance to shower/bathe. Review of Resident #1's care plan revealed the following focus areas in part:03/17/2025 Self-care deficit: resident will receive person-centered care; needs assist with bathing, hygiene, dressing and grooming.Interventions in part. Bathe per schedule, staff to assist as needed to complete task.On 06/01/2026 at 9:50 a.m., an interview was conducted with Resident #1. The resident stated that she was supposed to receive a full bed bath on 05/05/2026, 05/07/2026 and 05/09/2026. Resident #1 stated she was not sure why she did not receive her scheduled baths. Review of Resident #1's task documentation report revealed she received a partial bath on 05/05/2026 and 05/07/2026, and no bath on 05/09/2026. On 06/02/2026 at 8:17 a.m., an interview and review of Resident #1's May 2026 task documentation report was conducted with S4CNASup. She confirmed the above findings on the report and stated the resident should have received her scheduled baths.On 06/02/2026 at 10:08 a.m., an interview and review of Resident #1's task documentation was conducted with S1ADMIN. He stated he had conducted an investigation, and confirmed the findings on the documentation report. S1ADMIN stated the resident should have received her scheduled full baths.

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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Belle Teche Nursing & Rehab Center	1306 W Admiral Doyle Dr New Iberia, LA 70560

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure there was a sufficient number of Certified Nurse Aides (CNAs) to provide services in accordance with resident care plans for 1 (Resident #1) of 4 sampled residents.Findings:On 06/02/2026, a review of the CNA (Certified Nursing Assistant) skills training hire packet dated 01/2026, read in part: Incontinent Care: Any of the residents on your assigned set who are incontinent of their bowel and/or bladder need to have incontinent care completed by you at least every 2 hours.You need to check all residents on your set for incontinence every 2 hours.Review of Resident #1's electronic health record (EHR) revealed she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic nephropathy, morbid (severe) obesity due to excess calories, chronic obstructive pulmonary disease with (acute) exacerbation, personal history of urinary (tract) infections, muscle wasting and atrophy left and right hand, and need for assistance with personal care.Review of Resident #1's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/13/2026, revealed the following:-In Section C, the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating her cognition was intact.-In Section GG, the resident required partial/moderate assistance with toileting hygiene.-In Section H, the resident was always incontinent of urine.-In Section N, the resident was on a diuretic (a medication that causes increased urination).Review of Resident #1's current physician's orders revealed an order dated 01/20/2026 for Lasix Oral Tablet 20 mg (milligram) (Furosemide) Give 20 mg by mouth one time a day related to generalized edema.Review of Resident #1's care plan revealed the following, in part:03/16/2025 Toileting deficit: Needs assist r/t (related to) dx (diagnoses) morbid obesity.Interventions in part.Incontinence care check for incontinence at least every 2 hours. On 06/01/2026 at 9:50 a.m., an interview was conducted with Resident #1. The resident stated that S9CNA who worked the 11:00 p.m. to 7:00 a.m. shift kept her a nervous wreck. She stated she was not afraid of S9CNA but she was tired of her rude attitude. Resident #1 stated that S9CNA doesn't like to be called outside of her rounds. She stated she was wet with urine that soaked her bed and gown after 4 1/2 hours on the night of 05/31/2026. She stated she needed to be changed but was waiting for S9CNA to come in on her rounds because when she called S9CNA outside of her rounds she always came in her room with a bad attitude. Resident #1 stated that on Friday night (05/29/2026) she mentioned to S9CNA that she was scheduled for a bath on Saturday (05/30/2026), and S9CNA said in an angry tone, Tell them b****** to bathe you before I get here. Because them b****** don't have nothing else to do. If it ain't done by the time I'm here; I'm not doing it. She stated when S9CNA did not round on her on Sunday (05/31/2026) between 7:00 p.m. and 11:00 p.m. She didn't call because she was tired of her attitude. Resident #1 stated she discovered later that S9CNA did not start her shift until 11:00 p.m. Review of the facility's staffing schedule revealed S9CNA was scheduled to work on Hall B from 7:00 p.m. to 7:00 a.m. on the following dates: 05/28/2026; 05/29/2026, 05/31/2026, and 7:30 p.m. to 7:00 a.m. 05/30/2026. Review of the Condensed Employee Time Detail (clock in and out) for S9CNA revealed the following:-05/28/2026, S9CNA clocked in at 8:05 p.m. and out at 7:00 a.m.-05/29/2026, S9CNA clocked in at 7:56 a.m. and out at 7:00 a.m.-05/30/2026, S9CNA clocked in at 7:47 p.m. and out at 7:00 a.m.-05/31/2026, S9CNA clocked in at 10:55 p.m. and out at 7:01 a.m.Three calls were made to S9CNA throughout the survey on 06/01/2026 and 06/02/2026 with no response. On 06/01/2026 at 2:25 p.m., an interview and review of the facility's schedule from 05/28/2026 to 05/31/2026 with S2DON and S4CNASup. They both confirmed the times on the schedule were the times S9CNA was supposed to work. S2DON and S4CNASup acknowledged the times S9CNA clocked in and confirmed that she had clocked in late. S2DON was asked if that was normal and she stated, That is a big issue. S2DON further stated that if a CNA was clocking in late, the nurse on the unit was supposed to report (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to her supervisor that the staff member was not at work. S2DON and S4CNASup both stated that they were not aware S9CNA had been clocking in late. S2DON stated S3ADON was the nurse in charge on 05/31/2026.On 06/01/2026 at 2:28 p.m., an interview was conducted with S3ADON. She stated that she left the facility before 7 p.m. on 05/28/2026 and 05/29/2026 and did not work on 05/30/2026. S3ADON confirmed she worked on Hall B on 05/31/2026 from around 5:00 p.m. to 10:15 p.m. She confirmed that she was aware that S9CNA did not show up for her scheduled shift. She stated S4CNASup stayed over a little and did not confirm if she was able to reach S9CNA. When asked if she had reported it to her supervisor, S3ADON stated S2DON was on vacation. S3ADON was asked if she reported it to the administrator and she stated she did not.On 06/02/2026 at 8:05 a.m., a follow-up interview was conducted with S2DON. She stated that there was a chain of command from S4CNASup - S3ADON - S2DON - S1ADMIN. She stated that S4CNASup and S3ADON were both at work on 05/31/2026, and S4CNASup was responsible for ensuring S9CNA was there for her scheduled shift. S2DON then stated that she had been aware of CNAs clocking in late and had done some retraining, but confirmed that she had not been monitoring the behavior and should have been monitoring.