

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to distribute, store, and serve food in accordance with professional standards for food service safety by failing to ensure: 1. The food service area remained in a sanitary condition during the meal prep process; and 2. Residents' dishware consisting of plates, plate warmer covers and saucers were stored inverted or covered. This deficient practice had the potential to affect the 93 residents who were served food from the kitchen. Findings: On 07/06/2026 at 9:20 a.m., an observation of the kitchen was conducted with S3DM which revealed two uncovered rectangular pans of cornbread sitting on top of the serving table. Closer observations of the ceiling tiles and vent positioned above the uncovered cornbread revealed the ceiling tiles and ceiling vent had small amounts of visible dust particles covering them. An immediate interview was conducted with S4AC, who stated the cornbread was hot and could not be covered at that time. An interview was conducted with S3DM, who stated there were visible dust particles on the ceiling tiles and vent. She further stated that the ceiling tiles and vents were supposed to be cleaned weekly by kitchen staff. S3DM confirmed the cornbread should have been covered near ceiling tiles and vents that were dust filled. On 07/06/2026 at 9:25 a.m., further observation was made of dishware sitting in the plate warmer stored facing upward and was not covered. Further observation revealed saucers on the shelf below the service line that were facing upward and were not covered and plate covers sitting on the top of the counter that were stored right side up. An immediate interview was conducted with S3DM who confirmed the dishware consisting of plates in the plate warmer, saucers, and plate covers should have been stored inverted and were not. On 07/06/2026 at 3:55 p.m. and again on 07/07/2026 at 12:48 p.m., the facility's policy for storage of dishware and food preparation was requested from S3DM. On 07/07/2026 at 1:22 p.m., S7AA provided the facility's policy and procedure titled, Cleaning Procedures Item: Plastic storage Containers- NFS, which failed to address the deficient practice that was observed of preparing food under unsanitary conditions and the improper storage of dishware. On 07/07/2026 at 3:38 p.m., S1ADM provided the facility's policies and procedures titled, Storage of Cooked Food and Cleaning Procedures Item: Pots and pans, which failed to address the deficient practice that was observed of preparing food under unsanitary conditions and the improper storage of dishware.		

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the Responsible Party (RP), immediately after a change in the resident's physical condition for 1(Resident #91) of 36 sampled residents. Findings: On 07/08/2026, a review of the facility's policy titled Resident and Family Notification Guidelines with a last reviewed date of 01/19/2026, read in part: Notification of resident and the resident representative of changes in the resident's condition is the primary responsibility of the nurse assigned to the resident. Listed below are scenarios of when such notification is to occur and be documented as occurring in the nurses notes .2. Any order change, addition or discontinuance .3. Any significant change in the resident's condition (i.e. changes in condition). Review of Resident #91's clinical records revealed he was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, metabolic encephalopathy, unspecified protein-calorie malnutrition, and abnormality of albumin. Review of the nurses' progress notes revealed that on 06/11/2026 at 10:41 p.m., S8LPN wrote in part, Resident noted sitting at the main nursing station sitting in wheelchair slumped over with brown emesis falling out of mouth. Alert to physical stimuli, not to verbal stimuli. Resident transferred into bed, vitals taken. 114/63, P (pulse) 90, 97.1, O2 (oxygen) 95% RA (room air), R (respirations) 18. Writer listened to bowel sounds, no bowel sounds noted. Abdomen soft, not distended. Writer informed S9NP. New orders for Zofran 4mg (milligram) ODT (orally disintegrating tablet) sublingual, 1st dose now and then q6h (hour) prn (as needed) x (times) 7 days. STAT (immediately) KUB (kidneys, Ureters, and Bladder test) and STAT (immediate) CBC (Complete Blood Count). Further review of the nurses' progress notes did not reveal Resident #91's RP was notified of the change in the resident's condition, or the new orders. On 07/06/2026 at 1:09 p.m., an interview was conducted with Resident #91's RP. The resident's RP stated that about two weeks ago on a Sunday, he visited the resident in the facility and was informed by his assigned nurse that he had not been feeling well since Friday. He stated that he asked why no one had notified the family and she could not give an answer. On 07/07/2026 at 3:22 p.m., an interview was conducted with S8LPN who confirmed that she did not notify the family of the change in Resident #91's physical condition or the new orders by S9NP. She further confirmed that she was aware of the facility's policy to immediately notify the resident's RP for changes in physical condition and new orders at all times. On 07/07/2026 at 3:30 p.m., an interview was conducted with S1ADM and S2DON. They both confirmed that it was the facility's policy to immediately notify the family when there is a change in a residents' condition or new orders, and S8LPN should have immediately notified Resident #91's RP.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the provider failed to transmit MDS (Minimum Data Set) Assessments within 14 days after completion for 3 (#34, #50, #71) out of 3 residents triggered for resident assessment review in a sample of 36 residents. Findings: Review of the facility's policy titled Resident Assessment Instrument (RAI) Policy, with a last reviewed date of 01/19/2026, read in part: Within seven (7) days after completing the resident assessment, the data will be encoded for transmittal to the state. Electronic transmittals will occur weekly, when possible, but at least monthly. Review of Resident #34's electronic clinical record revealed a quarterly MDS assessment, with an ARD (Assessment Reference Date) of 03/07/2026, was completed on 03/21/2026. Review of the facility's CMS (Center for Medicare Services) transmittal validation report indicated Resident #34's quarterly MDS assessment with the ARD of 03/07/2026 was transmitted on 04/06/2026 and was more than 14 days late. Review of Resident #50's electronic clinical record revealed a quarterly MDS assessment, with an ARD of 06/06/2026 was completed on 06/19/2026. Review of the facility's CMS transmittal validation report indicated Resident #50's quarterly MDS assessment with the ARD of 06/06/2026 was transmitted on 07/07/2026 and was more than 14 days late. Review of Resident #71's electronic clinical record revealed a quarterly MDS assessment, with an ARD (Assessment Reference Date) of 06/06/2026 was completed on 06/19/2026. Review of the facility's CMS transmittal validation report indicated Resident #71's quarterly MDS assessment with the ARD of 06/06/2026 was transmitted on 07/06/2026 and was more than 14 days late. On 07/08/2026 at 10:48 a.m., an interview and record review was conducted with S10MDS. S10MDS reviewed Resident #34, #50, and #71's electronic clinical records and CMS transmittal validation reports. S10MDS confirmed that each resident's MDS assessment had been submitted greater than 14 days after completion and were late.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure a person-centered care plan was implemented for each resident, by failing to implement fall interventions for 1 (Resident #55) of 2 residents investigated for accidents of 36 sampled residents. Findings: On 07/08/2026, a review of the facility's policy titled Fall Prevention Program with a last reviewed date of 01/19/2026, read 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. It is our goal to prevent falls by enabling staff to recognize those residents who have been identified as high risk for potential falls so appropriate interventions can be implemented .g. Plan of Care: Based on the nursing assessment, preventive measures will be implemented and care planned for residents identified at high risk for falls .Resident #55 was admitted to the facility on [DATE], with diagnoses that included, but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, history of falling, and restlessness and agitation. Review of incident reports for Resident #55 revealed he had an un-witnessed fall with no injury on 05/04/2026. The resident stated he was going to smoke. Further review revealed another un-witnessed fall with no injury on 05/10/2026. The resident stated he was trying to get to his wheelchair and fell. Review of Resident #55's current care plan revealed a focus area initiated on 09/12/2023 and revised on 06/10/2026 which read in part: At high risk for falls. Further review revealed the following interventions, in part: Place resident's wheelchair outside of room when resident is in bed per family request, and to keep call light in reach and respond in a timely manner. On 07/06/2026 at 10:11 a.m., an observation was made of Resident #55 in his bed. The resident's call light was placed on his night stand which was at the foot of his bed and outside his reach. On 07/06/2026 at 10:17 a.m., an observation and an interview was conducted with S13LPN. She confirmed Resident #55's call light was on his night stand and outside his reach. S13LPN stated that the resident was at risk for falls and stated his call light should have been within his reach. On 07/08/2026 at 8:08 a.m., an observation was made of Resident #55 in his room. The resident was in his bed having breakfast and his wheelchair was at his bedside. On 07/08/2026 at 8:14 a.m., an observation of Resident #55's room and an interview was conducted with S12LPN/CNA Sup. She confirmed Resident #55's wheelchair was at his bedside and stated that it should have been placed outside his room.		

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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 observations, interviews, and record reviews, the facility failed to ensure a resident who required assistance with personal care received assistance with activities of daily living (ADLs) to maintain good grooming for 1 (Resident #67) of 3 residents investigated for ADL care. Findings On 07/09/2026, a review of the CNA (Certified Nursing Assistant) skills training hire packet dated 01/26, read in part, CNA skill Resident Basic Care Review. Shaving: . If your resident needs a shave you are to assist or shave the person regardless of the time of day or shift. On 07/09/2026, a review of the facility's policy titled, Hygiene and Grooming with a last reviewed date of 01/19/2026, read in part, Policy: . Staff will provide resident with whatever assistance is necessary to keep their facial hair properly groomed. Essential Points: . 4. Staff members should be conscious of female hygiene, like shaving legs and underarms when desired by resident as well as chin hair. A Review of Resident #67's electronic health record (EHR) revealed that she was admitted to the facility on [DATE], with diagnoses that included, but were not limited to sequelae of other cerebrovascular disease, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, and primary generalized osteoarthritis. A review of Resident #67's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Section C: Cognitive Patterns - BIMS (Brief Interview for Mental Status) was 10, indicating the resident's cognition was moderately impaired. Section GG: Functional Abilities - Personal Hygiene . including combing hair, shaving . was scored 2, indicating the resident required substantial/maximal assistance. A review of Resident #67's current comprehensive care plan initiated on 01/09/2015, read in part, the resident needs assist with bathing, hygiene, dressing, and grooming. On 07/06/2026 at 9:44 a.m., an interview and observation of Resident #67 was conducted. Resident #67 was lying in bed and stated she was waiting for the staff to get her ready for the day. Overgrown facial hair that was long and curled was observed on her chin. A review of Resident 67's task documentation report failed to reveal that Resident #67 was shaved from 06/20/2026 to 07/07/2026. On 07/06/2026 at 11:01 a.m., an interview and observation of Resident #67 was conducted. Resident #67 was sitting up in her wheelchair in her room. Overgrown facial hair was still observed on her chin. She stated staff got her ready for the day, and the last time her facial hair was shaved was months ago. She stated she did not like her facial hair and wanted it shaved. On 07/07/2026 at 10:53 a.m., an observation was conducted of Resident #67 in her room, and overgrown facial hair was still observed on her chin. On 07/07/2026 at 2:15 p.m., an observation was conducted of Resident #67 sitting in her wheelchair in the dining room, and overgrown facial hair was noted on her chin. On 07/07/2026 at 2:47 p.m., an interview and observation of Resident #67 was conducted with S11CNA. S11CNA stated her responsibility was grooming the resident which, consisted of bathing, shaving, and combing her hair. S11CNA stated that even if it was not Resident #67's bath day or time, she should always be groomed. She confirmed Resident #67 was dependent on staff with ADL care. At this time, an observation of Resident #67 was conducted with S11CNA, and she confirmed the resident had overgrown, long, and curled facial hair on her chin, and it should have been shaved. On 07/07/2026 at 3:00 p.m., an interview and observation of Resident #67 was conducted with S12LPN/CNA Sup. S12LPN/CNA Sup. stated residents were to be groomed by their designated CNA every day. S12LPN/CNA Sup. stated if a resident's facial hair was long, it should be shaved right away. At this time, an observation of Resident #67 was conducted with S12LPN/CNA Sup., and she confirmed Resident #67 had overgrown, long, and curled facial hair and it should have been shaved.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure nurses followed the facility's policy to accurately document the count of controlled medications in Med Cart A for Resident #38 out of 2 medication carts reviewed. Findings: A review of the facility's policy titled, Controlled Medication with a last review date of 01/19/2026, read in part, Policy: In accordance with federal and state laws, medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility. Procedure:. 2. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record; a. date and time of administration. b. amount administered. c. signature of nurse administering the dose, immediately after the medication is actually administered, d. amount remaining.A review of Resident #38's electronic medical record revealed he was admitted to the facility on [DATE] with a diagnosis that included in part, encounter for other orthopedic aftercare. A review of Resident #38's physician orders revealed an order dated 06/24/2026 for Hydrocodone Acetaminophen Oral Tablet 7.5-325 mg (milligram), give 1 tablet by mouth every 6 hours as needed for pain related to encounter for other orthopedic aftercare. On 07/07/2026 at 3:15 p.m., a narcotic count was performed on Med Cart A with S5LPN which revealed the following inaccurate narcotic count: Resident #38's Individual Narcotic Record for medication hydrocodone acetaminophen 7.5-325 mg revealed a count of 18 tablets with last dose documented on 07/06/2026 at 8:00 p.m. The current count of tablets observed and counted was 17 tablets. A review of Resident #38's MAR (Medication Administration Record) with S5LPN for July 2026 revealed that the last dose of Hydrocodone Acetaminophen 7.5-325 mg, 1 tablet was administered on 07/07/2026 at 11:55 a.m. A review of the facility's form, labeled Individual Narcotic Record for Resident #38, failed to reveal the administration of Hydrocodone Acetaminophen Oral Tablet 7.5-325 mg on 07/07/2026 at 11:55 a.m. S5LPN confirmed that she gave Resident #38 Hydrocodone Acetaminophen 7.5-325 mg at 11:55 a.m. S5LPN confirmed that she did not document the administration of the narcotic medication immediately on the Individual Narcotic Record and she should have. On 07/07/2026 at 3:30 p.m. an interview was conducted with S2DON. S2DON confirmed that the nurse should have documented administration of the narcotic medication on the Individual Narcotic Record immediately after it was given.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews and policy review, the facility failed to appropriately store medications in Med Cart B for Resident #23. Findings: On 07/06/2026, a review of the facility's policy titled Medication Storage in the Facility with a last reviewed date of 01/19/2026, read in part: Policy Statement: The medication supply is accessible only to licensed nursing or medical personnel and pharmacy personnel. Procedure: Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications are allowed access to medications. Medication room, carts, and medication supplies are locked or attended by persons with authorized access. On 07/06/2026 at 9:15 a.m., an observation was made of Med Cart B on Hall E. Med Cart B was observed as unattended for 3 minutes. Three unsecured blister cards containing pills were observed on top of Med Cart B. On 07/06/2026 at 9:18 a.m. an interview was conducted with S6LPN. S6LPN returned to Med Cart B and confirmed that she had left the three blister cards of medication belonging to Resident #23 on top of Med Cart B and left it unattended. S6LPN confirmed these medications were accessible to unauthorized personnel and residents. S6LPN confirmed that the following medications were left on top of Med Cart B and accessible to anyone who walked by: Olanzapine 5mg (milligrams), 3 pills were in the blister card; Citalopram 40mg, 1 pill was in the blister card; Levothyroxine 50 mcg (micrograms), 3 pills were in the blister card. S6LPN stated that she should have placed the medications inside Med Cart B and locked it before leaving it unattended. 07/06/2026 at 9:52 a.m., an interview was conducted with S2DON. S2DON confirmed that medications should not be left on top of medication carts when they are unattended. S2DON confirmed that the nurse should have placed the medications inside the cart and locked it before leaving the cart unattended.		