

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Patterson Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 910 Lia St Patterson, LA 70392	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>50452</p> <p>Based on interviews and record reviews, the facility the facility failed to ensure residents identified as safe smokers maintained their rights to smoke at their leisure for 4 (Resident#1, Resident #2, Resident #3, Resident #4) of 4 (Resident#1, Resident #2, Resident #3, Resident #4) sampled residents.</p> <p>Findings:</p> <p>Review of facility's smoking policy, revised date 03/2024 revealed, in part, it is the responsibility of the facility to provide a safe and hazard-free environment for those residents having been assessed as being safe for facility smoking privileges. Residents wishing to smoke while at the facility will have a Smoking Safety Evaluation completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely. If a resident is determined to be a Safe Smoker and can smoke unsupervised then the resident can keep their smoking supplies, and smoke in designated areas at their leisure.</p> <p>Review of facility's safe smoker's list, revealed, in part, that Resident #1, Resident #2, Resident #3 and Resident #4 was listed as being safe smokers.</p> <p>Resident #1</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/08/2024 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated Resident #1's cognition was intact.</p> <p>Review of Resident #1's current Care Plan provided by the facility revealed, in part, Resident #1 was a safe smoker.</p> <p>Review of Resident #1's Medical Record revealed, in part, Resident #1 had a Smoking Safety Evaluation completed on 08/09/2024. Further review revealed, in part, Resident #1 was deemed a safe smoker and was able to smoke unsupervised.</p> <p>Resident #2</p> <p>(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: 195425	If continuation sheet Page 1 of 9

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's MDS with an ARD of 08/20/2024 revealed, in part, Resident #2 had a BIMS of 15, which indicated Resident #2's cognition was intact.</p> <p>Review of Resident #2's current Care Plan provided by the facility revealed, in part, Resident #2 was a safe smoker.</p> <p>Review of Resident #2's Medical Record revealed, in part, Resident #2 had a Smoking Safety completed on 10/10/2024. Further review revealed, in part, that Resident #2 was deemed a safe smoker.</p> <p>Resident #3</p> <p>Review of Resident #3's MDS with an ARD of 08/30/2024 revealed, in part, the following: Resident has a BIMS of 14, which indicated Resident #3's cognition was intact.</p> <p>Review of Resident #3's current Care Plan provided by the facility revealed, in part, Resident #3 was a safe smoker.</p> <p>Review of Resident #3's medical record, in part, Resident #3 had a Smoking Safety Evaluation completed on 10/15/2024. Further review revealed Resident #3 was deemed a safe smoker and was able to smoke unsupervised.</p> <p>Resident #4</p> <p>Review of Resident #4's MDS with an ARD of 07/26/2024 revealed, in part, Resident #4 has a BIMS of 15, which indicated Resident #4's cognition was intact.</p> <p>Review of Resident #4's current Care Plan provided by the facility revealed, in part, Resident #4 was a safe smoker.</p> <p>Review of Resident #4's medical record, in part, Resident #4 had a Smoking Safety Evaluation completed on 07/26/2024. Further review revealed Resident #4 was deemed a safe smoker and was able to smoke unsupervised.</p> <p>In an interview on 10/23/2024 at 10:09 a.m., S4Assistant Director of Nursing (ADON), indicated the facility has designated smoking times. S4ADON further indicated smoking items for all residents were kept at nurse's station regardless if they were deemed a safe smoker.</p> <p>Observation on 10/23/2024 at 10:15 a.m. revealed, in part, that smoking times were posted by the facility's smoker's patio with the smoking times 8:30 a.m., 10:45 a.m., 12:45 p.m., 2:45 p.m., 4:45 p.m., 6:45 p.m., and 8:45 p.m.</p> <p>In an interview on 10/23/2024 at 12:15 p.m. Resident #3 indicated he enjoys smoking. Resident #3 indicated he would like to smoke more often and did not like to have to wait for staff.</p> <p>Observation on 10/24/2024 at 10:47 a.m., revealed S3Director of Nursing (DON) entered the facility's smoker's patio with a tackle box and passed out cigarettes to residents.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/24/2024 at 10:50 a.m., S3DON indicated, staff used the smoking safety assessment to indicate which resident was a safe smoker. S3DON indicated the safe smoker list is updated quarterly and as needed by herself, S3DON, S4ADON, and the MDS nurse. S3DON further indicated, the facility provided the most recent Safe Smoker's list to the surveyors.</p> <p>In an interview on 10/24/2024 at 10:50 a.m., Resident #2 indicated that he would prefer to keep his own smoking materials. Resident #2 further indicated he would like to be able to smoke at his leisure.</p> <p>In an interview on 10/28/2024 at 01:06 p.m., Resident #4 indicated the new smoking times were impeding on the resident's rights. Resident #4 further indicated he used to be able to go out and smoke at will and smoking at night helped him go to sleep. Resident #4 indicated he was a safe smoker and should be able to smoke at leisure and be keep his own cigarettes on his person.</p> <p>In an interview on 10/28/2024 at 1:46 p.m., S3DON confirmed Resident #1's 08/09/2024 smoking evaluation deemed him a safe smoker and was able to smoke unsupervised. S3DON further indicated residents were only allowed to smoke supervised at times designated by the facility. S3DON further indicated that residents who are safe smokers should be allowed to smoke at their leisure and they are not.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50452</p> <p>Based on interviews and record reviews, the facility failed to ensure grievances was addressed and acted upon promptly per the facility's Grievance procedure for The Resident Council Meeting for 3(08/08/2024, 09/05/2024,10/03/2024) of 3(08/08/2024, 09/05/2024,10/03/2024) months reviewed for grievances.</p> <p>Findings:</p> <p>Review of the facility's policy entitled, Filing Grievances/ Complaints, revised date 06/2024, revealed, in part, that all grievances, complaints, or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to including rationale for the response. The Administrator has delegated the responsibility of grievance and/or complaint investigation to the Grievance Officer. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within 72 hours of receiving the grievance and/or complaint. The Grievance Officer, Administrator, and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation was being investigated. The Administrator will review the findings with the Grievance Officer to determine what corrective actions, if any, need to be taken. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems.</p> <p>Interview on 10/23/2024 at 8:47 S1Administrator indicated the facility did not have any grievances in the last three months.</p> <p>Review of the facility's Resident Council Meeting minutes dated 08/08/2024 revealed, in part, residents had complaints as follows: mail being open prior to residents receiving their mail, not being able to choose bath/shower schedule, ice and water not being passed every shift, Certified Nursing Assistant care, call lights not being answered timely, and coffee being unavailable to residents.</p> <p>Review of the facility's Resident Council meeting minutes dated 09/05/2024 revealed, in part, residents had complaints as follows: CNAs are not helping residents, CNAs come in and turn the light off and leave without providing care, CNAs placing residents to bed in their day clothes, residents have to wait 2-3 hours for CNA help, CNA staff talking down to residents, a LPN administered medications late to a resident, and a LPN having an attitude towards a resident.</p> <p>Review of the facility's Resident Council Meeting minutes dated 10/03/2024 revealed, in part, residents had complaints about the smoking schedule, residents and the resident's responsible party being uninformed to the sudden change in smoking policy, the conditions of linens, and the Administrator being seen as cocky, arrogant and did not talk and discuss situations with residents.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 10/24/2024 at 3:15 p.m. S6Activities Director, indicated she brings all Resident Council meeting grievances and brings them to S1Administrator. S6Activities Director indicated that most grievances have been about cigarettes, the new smoking policy, and S1Administrator being rude and arrogant.</p> <p>In an interview on 10/24/2024 at 3:20 p.m., S5Social Services indicated no formal grievance forms had been filed from any residents.</p> <p>In an interview on 10/24/2024 at 3:30 p.m., S1Administrator indicated that S5Social Services was the Grievance Officer and all grievances from residents and resident council meetings should go through S5Social Services. S1Administrator indicated he handles all grievances, and the facility had not had a grievance in the past three months. S1Administrator further indicated he has no documented evidence and could not provide any evidence that any of the above mentioned grievances were resolved.</p> <p>In an interview on 10/28/2024 at 09:25 a.m. Resident #R5 indicated, residents cannot bring grievances to S1Administrator or any staff member in the facility due to fear of retaliation. Resident #R5 indicated if residents complain to S1Administrator about any staff in the building, he will pull the staff member in and tell them about the complaint in front of the resident with the concern. Resident #R5 indicated he had brought a few issues to S1Administrator and S1Administrator did not actively listen, so the concerns were never addressed. Resident #R5 further indicated most of the staff are related so the only safe person to voice their concerns to was the facility Ombudsman.</p> <p>In an interview on 10/28/2024 at 03:15 p.m. S2Corporate nurse confirmed, grievances should have been entered and acted on for the Resident Council Meeting, complaints and were not.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>50452</p> <p>Based on record reviews and interviews, the facility failed to ensure an allegation of physical abuse was reported to the required state survey agency for 1 (Resident #1) of 4 (Resident #1, Resident #2, Resident #3, and Resident #4) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of facility's Abuse Prohibition Policy dated 05/17/2024 revealed, in part, the facility's policy intent was to prevent and prohibit neglect, mental or physical abuse of residents. Further review revealed the definition of abuse means the willful infliction of injury, withholding or misappropriating property or money, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes, hitting, slapping, kicking, shoving, pinching and controlling behavior through corporal punishment. Further review revealed residents have the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. Further review also revealed, in part, any employee who becomes aware of an allegation of abuse, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination. Further review also revealed, the facility's Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injury within two hours of the allegation.</p> <p>Review of Resident #1's annual Minimum Data Set (MDS) assessment with an assessment reference date of 08/08/2024 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated Resident #1 cognition was intact.</p> <p>Review of Resident #1's nurse progress note dated 10/15/2024 at 4:54 p.m. revealed, in part, S3Director of Nursing (DON) indicated Resident #1 was heard out in the front lobby cursing and yelling after coming from the smoking patio.</p> <p>Review of facility's incidents log dated 08/01/2024 - 10/23/2024 revealed, in part, Resident #1 had no documented incidents on 10/15/2024.</p> <p>Review of facilities Statewide Incident Management System (SIMS) Report revealed no record of Resident #1's allegation of S1Administrator shoving him in the back on 10/15/2024.</p> <p>Review of Resident #1's behavioral hospital progress note dated 10/18/2024 at 3:49 p.m., revealed, in part, Resident #1 reported that he was pushed and grabbed by one side after an altercation with S1Administrator at nursing home.</p> <p>Review of Resident #1's behavioral hospital progress note dated 10/18/2024 at 3:55 p.m., revealed, revealed Resident #1's Social Worker at the behavioral hospital reported S1Administrator pushed and grabbed his side during an altercation at the nursing home.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 10/23/2024 at 09:15 a.m., Resident #1's son indicated Resident #1 his father, Resident #1, reported to him that he (Resident #1) was shoved from the back by S1Administrator on 10/15/2024. Resident #1's son further indicated he received a phone call from S1Administrator that same day and denied Resident #1's allegations the he had shoved Resident #1 from the back on 10/15/2024.</p> <p>In an interview on 10/28/2024 at 9:25 a.m. S2Corporate Nurse indicated she was not made aware of Resident #1's allegation that he was shoved by S1Administrator until 10/25/2024 and further confirmed the incident was not reported to the state agency as required. S2Corporate Nurse further indicated that upon receipt of the allegation on 10/18/2024 by Resident #1, a SIMS report should have been opened and reported to state.</p> <p>In an interview on 10/28/2024 at 10:00 a.m., S5Social Services indicated the social worker at the behavioral hospital informed her on 10/18/2024 that Resident #1 made allegations that S1Administrator had shoved him from the back causing him to hit his leg on the smoker's patio door. S5Social Services indicated she notified S1Administrator of the allegations to which he responded okay. S5Social Services further indicated she did not report the above mentioned allegation to anyone else.</p> <p>In an interview on 10/28/2024 at 10:06 a.m., Resident #1 indicated on 10/15/2024, S1Administrator yelled at him then grabbed him by the shoulders and shoved him from behind inside the smoking patio doors and he almost fell down.</p> <p>There was no documented evidence, and the provider did not present any documented evidence that Resident #1's allegation of staff to resident abuse on 10/15/2024 was reported to the state agency.</p> <p>Review of S1Administrator's witness statement dated 10/28/2024 at 12:13p.m., revealed, in part, S1Administrator became aware of Resident #1's allegations of staff to resident abuse on 10/18/2024 by S5Social Services. Further review revealed S1Administrator did not report Resident #1's allegations of staff to resident physical abuse as required because he stated, I never thought it would go this far.</p> <p>In an interview on 10/28/2024 at 10:10 a.m., S2Corporate Nurse verified S1Administrator had knowledge of Resident #1's allegations of staff to resident abuse on 10/18/2024. S2Corporate Nurse confirmed Resident#1's allegations of staff to resident physical abuse should have been reported to state agency by the facility on 10/18/2024 within two hours of becoming aware of the allegation, but was not. S2Corporate Nurse indicated S1Administrator did not report Resident #1's allegation of staff to resident physical abuse to her until 10/25/2024.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>50452</p> <p>Based on record reviews and interviews, the facility failed to ensure an alleged incident of staff to resident physical abuse was thoroughly investigated for 1 (Resident #1) of 4 (Resident #1, Resident #2, Resident #3, and Resident #4) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of facility's Abuse Prohibition Policy dated 05/17/2024 revealed, in part, the facility's policy intent was to prevent and prohibit neglect, mental or physical abuse of residents. Further review revealed the definition of abuse means the willful infliction of injury, withholding or misappropriating property or money, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes, hitting, slapping, kicking, shoving, pinching and controlling behavior through corporal punishment. Further review revealed residents have the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. Further review also revealed the facility will conduct a thorough investigation of alleged or suspected abuse, neglect, or misappropriation of property, will provide notification of information to the proper authorities according to state and federal regulations and take appropriate actions. Further review also revealed the facility's Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injury within two hours of the allegation. Investigations will be prompt, comprehensive to the situation and contain founded conclusions.</p> <p>Review of Resident #1's annual Minimum Data Set (MDS) with an assessment reference date of 08/08/2024 revealed, in part, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated Resident #1's cognition was intact.</p> <p>Review of Resident #1's behavioral hospital progress note dated 10/18/2024 at 3:49 p.m., revealed, in part, Resident #1 reported that S1Administrator grabbed and pushed him during an altercation at nursing home.</p> <p>Review of Resident #1's behavior hospital progress note dated 10/18/2024 at 3:55 p.m., revealed, in part, Resident #1's social worker at the behavioral hospital reported the above mentioned allegation of physical abuse by S1Administrator to Resident #1 to the facility's social worker, S5Social Services.</p> <p>In a telephone interview on 10/23/2024 at 09:15 a.m., Resident #1's son, indicated his father, Resident #1, reported to him that he (Resident #1) was shoved from the back by S1Administrator on 10/15/2024. Resident #1's son further indicated he received a phone call from S1Administrator that same day and denied Resident #1's allegations the he had shoved Resident #1 from the back on 10/15/2024.</p> <p>In an interview on 10/28/2024 at 9:25 a.m. S2Corporate Nurse indicated the above mentioned allegation of physical abuse should have been properly investigated and it was not.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/28/2024 at 10:00 a.m., S5Social Services indicated the social worker at the behavioral hospital informed her on 10/18/2024 that Resident #1 alleged S1Administrator shoved him from the back causing him to hit his leg on the smoker's patio door. S5Social Services indicated she notified S1Administrator of the allegations to which he responded okay. S5Social Services further indicated she did not report the above mentioned allegation to anyone else.</p> <p>In an interview on 10/28/2024 at 10:06 a.m., Resident #1 indicated on 10/15/2024, S1Administrator yelled at him then grabbed him by the shoulders and shoved him from behind inside the smoking patio doors and he almost fell down.</p> <p>Review of S1Administrator's witness statement dated 10/28/2024 at 12:13 p.m., revealed, in part, S1Administrator became aware of Resident #1's allegations of staff to resident physical abuse on 10/18/2024 by S5Social Services. Further review revealed S1Administrator did not notify S2Corporate Nurse of Resident #1's allegations of staff to resident abuse until 10/25/2024 because he stated, I never thought it would go this far.</p> <p>In an interview on 10/28/2024 at 10:10 a.m., S2Corporate Nurse verified S1Administrator had knowledge of the allegations of staff to resident physical abuse on 10/18/2024. S2Corporate Nurse further indicated the allegation of staff to resident physical abuse should have been investigated by facility upon becoming aware of the allegation on 10/18/2024 by S5Social Services, and the facility did not investigate the allegation and should have. S2Corporate Nurse indicated the investigation of the alleged of staff to resident physical abuse did not begin until 10/25/2024 at 4:00 p.m.</p>