STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195425	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patterson Healthcare Center	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)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interviews the facility failed to ensure residents were able to access their personal funds on the weekends for 4 (Resident #12, Resident #57, Resident #61, Resident #72) of 4 residents investigated for access to personal funds. Findings:In an interview on 12/08/2025 at 10:11a.m., Resident #72 indicated she was unable to access her facility managed personal funds on weekends. In an interview on 12/10/2025 at 9:52a.m., S12Business Office Manager (BOM) indicated both she and S11HR did not work on the weekends and she does not know how the residents were able to access their funds on the weekends. In an interview on 12/10/2025 at 10:13a.m., Resident #12 indicated the residents in the facility were unable to get their personal funds on the weekend. In an interview on 12/10/2025 at 10:17a.m., Resident #61 indicated he knew no staff were here on the weekend with access to the facility's funds, so he made sure he got the money he needed before the weekend. Resident #61 further indicated neither S12BOM nor S11HR worked on the weekend, so there was no one that could access the residents' personal funds. In an interview on 12/10/2025 at 10:30a.m., Resident #57 indicated she had previously wanted to get money from her personal funds on the weekend, but was unable to get money from her personal funds. In an interview on 12/10/2025 at 10:33a.m., Resident #72 indicated she was not educated by the facility's staff on the process of notifying the weekend staff she wanted access her personal funds so that they could contact S11HR. In an interview on 12/10/2025 at 11:03a.m., S1Administrator indicated there was no signage posted prior to the entrance of the survey team to inform the facility's residents of the process for accessing their personal funds. S1Administrator further indicated the facility had not educated all the residents on the process for access their personal funds on the weekend.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and record reviews, the facility failed to ensure the walls of a resident's bathroom were in good repair for 1 (Bathroom f) of 1 bathrooms investigated for environmental concerns. Findings:Review of the facility maintenance log dated 11/01/2025 through 12/10/2025 revealed, in part, there were no entries regarding a hole in the wall of Bathroom f. Observation on 12/08/2025 10:32a.m. revealed Bathroom f had an approximately 8 inch (in) x 3.5 in hole near the bottom of the right wall. Observation on 12/09/2025 10:32a.m. revealed Bathroom f had an approximately 8 in x 3.5 in hole near the bottom of the right wall. Observation on 12/10/2025 8:31a.m. revealed Bathroom f had an approximately 8 in x 3.5 in hole near the bottom of the right wall. In an interview on 12/10/2025 at 8:52a.m., S1Administrator acknowledged the wall of Bathroom f should not be in disrepair.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision to a resident to prevent accidents for 1 (Resident #66) of 4 sampled resident investigated for accidents/hazards. Findings:Review of Resident #66's electronic medical record (EMR) revealed, in part, Resident #66 had diagnoses, which included, Alzheimer's disease, dementia, and an altered mental status. Review of Resident #66's Care Plan Conference summary dated 10/01/2025 revealed, in part, Resident #66 had Alzheimer's disease and was consuming non-food items which could cause harm to Resident #66. Further review revealed Resident #66 would possibly benefit from a butterfly unit facility (a facility that had a secured unit for residents that require more supervision due to their mental status/memory). Further review revealed Resident #66 had current and continuous incidents such as drinking shampoo and lotion that could possibly harm Resident #66. Further review revealed Resident #66 was highly active in the facility and was going in other resident's rooms. Review of Resident #66's Wander Data Collection form dated 11/05/2025 revealed, in part, Resident #66 was cognitively impaired with poor decision-making skills and was able to ambulate/perform locomotion independently. Further review revealed Resident #66 has wandered and significantly intruded on the privacy or activities of others. Review of Resident #66's progress note dated 07/03/2025 at 11:48a.m. revealed, in part, the nurse was summoned to the smoking patio and Resident #66 was noted to be digging in potting soil and eating it. Further review revealed Resident #66 was asked to spit out the soil, was brought to her room, had her mouth rinsed out, and had some vomitus substance noted. Review of Resident #66's progress note dated 09/21/2025 at 12:20p.m. revealed, in part, the nurse was notified by a Certified Nursing Assistant (CNA) that Resident #66 was found on Hall c drinking a bottle of skin and hair cleanser. Review of Resident #66's progress note dated 09/30/2025 at 11:58a.m. revealed, in part, the nurse was notified by a staff member that Resident #66 was found in another resident's room consuming a bottle of liquid soap. Review of Resident #66's progress note dated 10/08/2025 at 1:30p.m. revealed, in part, it was reported by staff that Resident #66 was outside on the smoking patio and attempted to drink out of other resident's coffee cups and attempted to dig in ashtrays. Observation on 12/09/2025 at 10:55a.m. revealed Resident #66 was sitting with a coffee mug in her hand that had a small amount of coffee at the bottom of the mug. Further observation revealed S13Transportation took the coffee mug from Resident #66 and indicated to Resident #66 she would get her a new coffee mug. In an interview on 12/09/2025 at 10:55a.m., S13Transportation indicated she had to get Resident #66 a new coffee mug because the coffee mug Resident #66 was holding was not hers, but was another resident's coffee mug. Observation on 12/09/2025 at 1:19p.m. revealed Resident #66 attempted to grab items off of the used lunch tray cart on Hall e. In an interview on 12/09/2025 at 1:22p.m., S14CNA confirmed Resident #66 was attempting to grab items off of the used lunch tray cart in the above observation. In an interview on 12/09/2025 at 3:03p.m., S15CNA indicated Resident #66's wanders. S15CNA further indicated Resident #66 would grab random things and try to put them to her mouth. S15CNA further indicated she had witnessed Resident #66 take other resident's coffee mugs and drink other residents' coffee. S15CNA also indicated Resident #66 had a history of putting the used cigarette butts of others to her mouth. In an interview 12/09/2025 3:07p.m., S16CNA, indicated the staff had to be careful because Resident #66 would pick up anything and start eating it. S16CNA indicated she had witnessed Resident #66 pick a leaf off of a flower arrangement in the facility's dining room and put it in her mouth. S16CNA further indicated Resident #66 had previously gone into Resident # 70's room and drank Resident #70s body wash. S16CNA further indicated Resident #66 drank out of other people's coffee mugs and will eat other resident's food. S16CNA further indicated Resident #66 had previously put either ashes or cigarettes butts into her mouth. S16CNA further indicated that Resident #66 would sometimes go into other residents' rooms. In an interview on 12/09/2025 at 3:17p.m., S10Licensed Practical Nurse (LPN) indicated Resident #66 went into the facility's dining area and would put food and drinks left on the tables in her mouth. In an interview on 12/09/2025 at 3:20p.m., S17LPN, indicated Resident #66 wanders in her wheelchair. S17LPN further indicated other residents informed her Resident #66 put potting soil in her mouth, and when she assessed Resident #66, it was confirmed Resident #66 had potting soil in her mouth. S17LPN further indicated Resident #66 would pick up people's drinks and would eat whatever she could get her hands on. In an interview on 12/09/2025 at 3:32p.m., S14CNA indicated Resident #66 was known to take others' food and drinks. In an interview on 12/09/2025 at 3:34p.m., S5Social Services Director (SSD) indicated if Resident #66 sees food she liked, she would grab it. S5SSD further indicated that she witnessed

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interviews and record reviews the facility failed to obtain laboratory test results for 1(Resident #45) of 1 resident reviewed for laboratory services. Findings:Review of Resident #45's nurse's note dated 10/08/2025 revealed, in part, S10Licensed Practical (LPN) received a verbal order from Resident #45's medical provider to obtain a urine specimen for a urinalysis (UA) and culture and sensitivity (C&S). Review of Resident #45's nurse's note dated 10/09/2025 revealed the S10LPN collected a urine specimen for a UA and C&S. Review of Resident #45's medical record revealed no documented evidence the facility obtained the results of the UA and C&S from the 10/09/2025 urine specimen collection. On 12/09/2025 at 2:03p.m. the surveyor requested the lab results from Resident #45's 10/09/2025 urine specimen collection from S2Director of Nursing (DON) In an interview on 12/09/2025 at 4:10p.m., S2DON indicated Resident #45's lab results were not obtained from the urine specimen collected on 10/09/2025. S2DON further indicated the lab did not have any record of receiving Resident #45's urine specimen collected on 10/09/2025. S2DON further indicated a new specimen should have been collected and was not. In an interview on 12/10/2025 at 8:45a.m., Resident #45's medical provider confirmed she gave a verbal order to obtain a urine specimen for a UA and C&S for Resident #45 on 10/08/2025. Resident #45 medical provider further indicated she had not received the results as of 10/13/2025 and requested the specimen be re-collected.