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	04/10/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident was administered medications per a physician's order for 1 (Resident #1) of 3 sampled residents investigated for medication administration. Findings:Review of Resident #1's April 2026 physician's orders revealed, in part, an order dated 09/30/2025 to administer Resident #1 one Levothyroxine Sodium 25 mcg tablet in the morning daily. Review of Resident #1's electronic medical record (EMR) revealed, in part, Resident #1's Levothyroxine Sodium (a medication used to treat an underactive thyroid) 25 microgram (mcg) tablets were reordered by the facility on 03/30/2026. Review of facility's contracted pharmacy's Pharmacy Consolidated Delivery Sheet revealed, in part, S2Licensed Practical Nurse (LPN) had documented via her signature that Resident #1's Levothyroxine Sodium 25 mcg tablets were delivered to the facility on [DATE]. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed, in part, no documented evidence Resident #1 was administered a Levothyroxine Sodium 25 mcg tablet on 04/04/2026 and 04/05/2026 by S2Licensed Practical Nurse. Further review revealed S2LPN had documented/indicated to see Resident #1's progress notes on 04/04/2026 and 04/06/2026. Review of Resident #1's progress note dated 04/04/2026 at 5:19AM revealed, in part, Resident #1's Levothyroxine is on order. Review of Resident #1's progress note dated 04/05/2026 at 5:33AM revealed, in part, Resident #1 was informed the Levothyroxine Sodium 25 mcg tablet was still on order. Further review revealed Resident #1 stated, I don't know how they didn't realize to order it before it ran out. In an interview on 04/06/2026 at 4:23AM, Resident #1 indicated she had not been administered Levothyroxine Sodium 25 mcg all weekend because the facility's staff said they were out of the medication. In an interview on 04/06/2026 at 4:46AM, S2LPN indicated she did not administer Resident #1's Levothyroxine Sodium 25 mcg tablets on 04/04/2026 and 04/05/2026. In a telephone interview on 04/07/2026 at 2:31PM, the pharmacy technician at the facility's contracted pharmacy indicated S2LPN had documented via her signature that Resident #1's Levothyroxine Sodium 25 mcg tablets had been delivered to the facility on [DATE] at midnight on the Consolidated Delivery Sheet. In an interview on 04/07/2026 at 2:40PM, S1Director of Nursing indicated if Resident #1's Levothyroxine Sodium 25 mcg tablets were available in the facility, it should have been administered to Resident #1 as ordered on 04/04/2026 and 04/05/2026.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and record reviews, the facility failed to ensure the menus approved by the facility's dietician were followed for 2 (04/02/2026 and 04/06/2026) of 3 days of observation of the facility's served meals. Findings:Review of the facility's dietician approved Week 1 menu revealed, in part, a biscuit was to have been served to residents on Mondays for breakfast. Review of the facility's dietician approved Week 5 menu revealed, in part, mock pecan pie was to have been served to residents on Thursdays for lunch. Review of the Menus Substitution Log with dates from 03/13/2026 to 04/08/2026 revealed, in part, there was no substitution listed for lunch menu items on 04/02/2026 and for breakfast menus items on 04/06/2026. Observation on 04/02/2026 (Thursday) at 9:50AM revealed pecan pie was the dessert listed on the facility's posted lunch menu. Observation on 04/02/2026 (Thursday) at 11:51AM revealed at least 37 of the residents eating in the facility's dining room were served a cake like dessert with a white icing and not mock pecan pie as noted on the facility's lunch menu for Thursday. In an interview on 04/06/2026 at 4:23AM, Resident #1 indicated for dinner on 04/03/2026, she was not served all of the items that were on the facility's menu. Observation on 04/06/2026 (Monday) at 7:41AM revealed the residents in the dining room were being served toast halves as part of their breakfast and not a biscuit as noted on the facility's breakfast menu for Monday. In an interview on 04/08/2026 at 1:27PM, S4Contracted Dietary Manger (DM) indicated the facility served the Week 1 menu on 04/06/2026 through 04/12/2026 and served the Week 5 menu last week on 03/30/2026 through 04/05/2026. S4Contracted DM further indicated a different dessert was served on Thursday 04/02/2026 because the mock pecan pie that was listed to be served on Thursdays of the Week 5 menu was something she could no longer get. S4Contracted DM further indicated she was not aware toast halves were served for breakfast on Monday 04/06/2026 and confirmed it was biscuits that were listed to be served for breakfast on Mondays of the Week 1 menu. S4Contracted DM further indicated the facility's dietician came to the facility on 4/07/2026. S4Contracted DM further indicated the process for making menu substitutions was when a substitution for a food item was made on the menu, the dietician would sign and approve the substitution/menu change on the dietary menu substitution log. S4Contracted DM confirmed the substitutions for the lunch dessert on 04/02/2026 and the breakfast toast on 04/06/2026 were not on the menu substitution log on 04/07/2026. In a telephone interview on 04/08/2026 at 1:41PM, S3Contracted [NAME] indicated he had prepared toast instead of biscuits for breakfast on 04/06/2026 because the facility was out of biscuits. In a telephone interview on 04/08/2026 at 2:00PM, S5Regional Dietician indicated it was the facility/company's process that if a substitution was made to a menu item, documentation of the substitution/menu change should be written on the menu substitution log and the substitution should be reviewed/signed by the facility's dietician when she visited the facility. S5Regional Dietician indicated if the above mentioned menu substitutions were made, documentation of the substitutions should have been added to the menu substitution log for the facility's dietician to review.