

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Ruston Nursing and Rehabilitation Center, llc		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 Hwy 80 East Ruston, LA 71270	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52271</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal hygiene for 1 (#20) of 2 (#20, #104) residents reviewed for ADL care. The facility failed to ensure that resident #20 had neatly groomed and shaved facial hair.</p> <p>Findings:</p> <p>Review of resident #20's record revealed an admitted [DATE] with diagnoses that included unspecified psychosis, end stage renal disease, right hand contracture, type 2 diabetes mellitus, and dependence on renal dialysis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 4 which indicated that resident #20 had severe cognitive impairment. Resident #20 required substantial/maximal assistance with bathing and grooming.</p> <p>On 04/14/2025 at 4:10 p.m., resident #20 was observed seated in a wheelchair at the nurses station and it was noted that his facial hair was poorly groomed and unshaven.</p> <p>On 04/15/2025 at 1:10 pm, resident #20 was observed lying in bed with his head of bed elevated. His facial hair was poorly groomed and unshaven.</p> <p>On 04/16/2025 at 7:44 a.m., resident #20 was observed lying in bed with his head of bed elevated. His facial hair was poorly groomed and unshaven.</p> <p>On 04/16/2025 at 8:01 a.m., an interview was conducted with S7LicensedPracticalNurse (LPN) who confirmed that resident #20 received a bed bath daily. S7LPN confirmed that the bed bath included a shave.</p> <p>On 04/16/2025 at 10:36 a.m., an interview was conducted with S8CertifiedNursingAssistant (CNA) who confirmed that resident #20 received a bath on the night shift. S8CNA confirmed that resident #20 should have been shaved.</p> <p>On 04/16/2025 at 2:15 p.m. S1ExecutiveDirector were notified of the findings related to the facility's failure to provide ADL care to resident #20 who was dependent for ADL care.</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
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51983</p> <p>Based on observation, record review, and interviews the facility failed to ensure that nursing staff had the appropriate competencies and skills necessary to care for resident needs. The facility failed to obtain orders and document treatment performed to a tracheostomy stoma for 1 (#34) of 2 (#34 and #60) residents reviewed for wound care.</p> <p>Findings:</p> <p>Review of the medical record revealed resident #34 was admitted to the facility on [DATE] with diagnoses that included in part, depression, schizoaffective disorder, depressive type, type 2 diabetes mellitus without complications, chronic cough, artificial opening status, and personal history of non-Hodgkin lymphoma.</p> <p>Review of Resident #34's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 7 which indicated resident #34 had severe cognitive impairment for daily decision making.</p> <p>Review of Resident #34's care plan revealed the resident had a neck stoma related to an old tracheostomy and dressing to stoma was to be changed per treatment order.</p> <p>Review of resident #34's April 2025 physician's orders revealed the resident did not have an active wound care order for the tracheostomy stoma.</p> <p>On 04/15/2025 at 2:20 p.m. resident #34 was observed sitting in the day area with a dressing over his anterior throat, and the dressing was dated 04/15/2025.</p> <p>On 04/16/2025 at 8:10 a.m. interview with resident #34 stated the facility staff change his stoma dressing daily.</p> <p>On 04/16/2025 at 9:00 a.m. a review of resident #34's electronic medical records revealed no documentation of the trach stoma care being performed.</p> <p>On 04/16/2025 at 10:10 a.m. an interview with S1Executive Director and S2Project Manager/Regional Support confirmed the order for the tracheostomy stoma wound care was removed from the active orders and electronic treatment administration record (ETAR) on 02/27/2025 and the wound care had not been documented.</p> <p>On 04/16/2025 at 10:20 a.m. an interview with S4Respiratory Therapist revealed she provided tracheostomy stoma care to resident #34; however, S4 Respiratory Therapist confirmed she failed to document the treatments.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was palatable, and served at an appetizing temperature. Findings:</p> <p>Review of the record for resident #29 revealed an admitted [DATE] with diagnoses of type 2 diabetes, cerebral vascular disease and chronic obstructive pulmonary disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #29 was cognitively intact for daily decision making.</p> <p>Interview on 04/14/2025 at 10:00 a.m. with resident #29 revealed the food was terrible. Resident #29 stated that the taste, texture, and choices of food was poor and that no substitutions were offered.</p> <p>A lunch test tray was requested from S10 Dietary Manager (DM) on 04/14/2025. The test tray was placed on the hall meal cart and was observed to leave the kitchen at 12:02 p.m. Further observation revealed that the test tray was given to the surveyor by S9 Certified Nursing Assistant at 12:23 p.m. The test tray meal consisted of BBQ pork loin, beans, vegetable medley, corn bread and cake. The pork loin was tough and the vegetable medley consisted of broccoli, cauliflower and carrots. The vegetable medley was overcooked, had a mushy consistency, had no flavor or seasoning, and the food was cool to taste.</p> <p>On 04/15/2025 at 2:15 p.m., S10 DM was notified of the results of the test tray.</p> <p>On 04/16/2025 at 1:50 p.m., the Executive Director was notified of the results of the test tray.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on observations, record reviews and interviews the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition by having wheelchairs in need of repair for 5 (#6, #7, #22, #32, #33) of 9 (#6, #7, #19, #22, #29, #32, #33, #80, #133) residents reviewed for environment.</p> <p>Findings:</p> <p>Resident 32</p> <p>Review of the medical record for resident #32 revealed an admitted [DATE]. Resident #32 had diagnoses of Parkinson's disease, diabetes mellitus, heart disease, Alzheimer's disease, vascular dementia, anxiety and bipolar disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact for daily decision making. Resident #32 required extensive assistance with bed mobility, transfers and toilet use.</p> <p>On 04/14/2025 at 8:30 a.m. an observation of resident #32 revealed she was in a wheelchair and the armrest on the right side was missing.</p> <p>On 04/16/2025 at 9:15 a.m. an interview with S6Licensed Practical Nurse (LPN) confirmed the armrest on the right side of the wheelchair was missing on resident #32's wheelchair.</p> <p>On 04/16/2025 at 1:00 p.m. S3Director of Nursing Services (DNS) observed resident #32's wheelchair and confirmed the armrest on the right side of the wheelchair was missing on the wheelchair.</p> <p>Resident 22</p> <p>Review of the medical record revealed resident #22 was admitted on [DATE] with diagnoses of Alzheimer's disease, respiratory failure, muscle weakness, cognitive communication deficit, atrial fibrillation, and dementia.</p> <p>Review of the quarterly MDS dated [DATE] revealed resident #22 was cognitively impaired for daily decision making and required extensive assistance with bed mobility, transfers and toileting.</p> <p>On 04/14/2025 at 8:10 a.m., 04/15/2025 at 9:33 a.m., and on 04/16/2025 at 9:00 a.m. observations of resident #22 revealed the bilateral armrests were missing on the wheelchair.</p> <p>On 04/16/2025 at 9:15 a.m. an interview with S6LPN confirmed bilateral armrests were missing on the wheelchair.</p> <p>On 04/16/2025 at 1:00 p.m. S3DNS observed resident #22's wheelchair and confirmed bilateral armrests were missing from the wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>22575</p> <p>Resident 6:</p> <p>Review of the medical record for resident #6 revealed an admitted [DATE] with diagnoses including end stage renal disease, chronic kidney disease, and unspecified dementia.</p> <p>Review of the annual MDS assessment dated [DATE] revealed resident #6 was cognitively intact for daily decision making. Further review revealed resident #6 was independent and/or required supervision for activities of daily living (ADL).</p> <p>On 04/14/2025 at 8:25 a.m. an observation of resident # 6 revealed she was in her room in her wheelchair. The resident's right wheelchair armrest pad was missing and her arm was directly on top of the metal portion of the armrest. Resident #6 reported that her wheelchair brakes do not work very well.</p> <p>On 04/15/2025 at 2:45 p.m. an observation of resident # 6's right wheelchair armrest revealed the padding was missing. Also at this time, resident #6 demonstrated that her brakes were in the locked position but she was still able to roll backwards.</p> <p>On 04/16/2025 at 3:00 p.m. the surveyor informed S2Project Manager/Regional Support that resident #6's right wheelchair armrest was missing and her wheelchair brakes were not working properly.</p> <p>Resident 7:</p> <p>Review of the medical record for resident #7 revealed an admitted [DATE] with diagnoses including quadriplegia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, seizures and Type 2 diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #7 was cognitively intact for daily decision making. Further review revealed resident #7 was totally dependently on staff for ADLs.</p> <p>On 04/14/2025 9:42 a.m. and 04/15/2025 at 9:00 a.m. observations of resident #7's wheelchair revealed his right wheelchair armrest was cracked and was in need of repair.</p> <p>On 04/16/2025 at 3:00 p.m. the surveyor and S2Project Manager/Regional Support observed resident #7's right wheelchair armrest and she confirmed his right wheelchair armrest was cracked and needed to be repaired.</p> <p>52271</p> <p>Resident 33:</p> <p>Review of the medical record for resident #33 revealed an admitted [DATE] with diagnoses that included spinal stenosis, type 2 diabetes mellitus, acquired absence of right leg below knee, acquired absence of other left toe, bipolar disorder, and depression.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated that resident #33 was cognitively intact. Resident #33 required partial/moderate assistance with bed mobility and transfers.</p> <p>On 04/14/2025 at 1:41 p.m., and 04/15/2025 at 3:53 p.m. observations of resident #33's scooter revealed the seat cushion was torn.</p> <p>On 04/16/2025 at 3:00 p.m., the surveyor and S2Project Manager/Regional Support observed resident #33's electric scooter cushion was torn and she confirmed that the cushion needed to be repaired.</p>