

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 05/07/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure a resident received adequate supervision to prevent incidents and accidents. The facility failed ensure a resident received supervision during a bed bath for 1 (#1) of 3 (#1, #2, #3) residents reviewed for falls.</p> <p>The deficient practice resulted in an immediate jeopardy for Resident #1 on 04/15/2025 at 10:00 a.m. when Resident #1 fell out of the left side of the bed during a bed bath when S3CNA (Certified Nursing Assistant) failed to ensure the resident was secured and safe in the bed to prevent him from falling before she turned away to retrieve Resident #1's clothing from the closet. S3CNA had removed Resident #1's fall mat from the left side of the bed to provide ADL (Activities of Daily Living) care and Resident #1 landed on the floor on his right side. Resident #1 was transferred to a local emergency room (ER) related to a laceration to Resident #1's forehead. Resident #1's laceration was sutured closed and Resident #1 returned to the facility on [DATE]. Resident #1 was sent to a local hospital on [DATE] after Resident #1's RP (Responsible Party) noted swelling to Resident #1's right leg. Review of Resident #1's hospital record dated 04/21/2025 revealed, Resident #1 was diagnosed to have a right humerus fracture and a right hip fracture. Resident #1 was discharged back to the facility on [DATE] as a non-operative patient, unable to undergo physical therapy or any other intervention other than pain control.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a past noncompliance citation.</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses, which included in part, other sequelae of other non-traumatic intracranial hemorrhage, aphasia following cerebral infarction, functional quadriplegia, anxiety disorder and joint derangement.</p> <p>Review of Resident #1's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed in part, Resident #1 had a BIMS (Brief Interview of Mental Status) score of 99. Further review indicated Resident #1 was rarely or never understood. Resident #1 was always incontinent of bowel and bladder and dependent on staff for ADL care.</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's comprehensive care plan revealed in part, Resident #1 was at risk for falls related to impaired mobility, uncontrolled movements and impaired communication with approaches in place for 1 person assist with bath, bed bolsters to bed, and fall mats to bilateral sides of the bed. Resident #1 was care planned for impaired cognition and communication deficits related to diagnosis of aphasia and rarely-never able to make himself understood.</p> <p>Review of Resident #1's physician orders revealed in part:</p> <p>03/17/2025 Fall mats x 2 every shift for falls.</p> <p>03/17/2025 Bed bolster to bed x 2, every shift for falls.</p> <p>Review of the facility's Incident Log for the past 3 months revealed Resident #1 had a witnessed fall on 04/15/2025 with no other incidents or accidents related to a fall after 04/15/2025.</p> <p>Review of the Incident Report dated 04/15/2025 at 10:00 a.m., revealed in part, S3CNA stated during Resident #1's bed bath, she (S3CNA) turned to get something out of Resident #1's closet right behind her and Resident #1 slid out of bed . Resident #1 had an abrasion on the right of his head. Resident #1 was not removed from floor until the arrival of EMS (Emergency Medical Services).</p> <p>Review of S3CNA's signed witness statement dated 04/15/2025 revealed, at approximately 9:30 a.m. to 10:00 a.m., I (S3CNA) had just finished giving Resident #1 a bed bath. I (S3CNA) proceeded to turn around to get his clothes out of the closet and he (Resident #1) rolled out of the bed onto the floor which caused Resident #1 to hit his head on the floor.</p> <p>Review of Resident #1's interdisciplinary notes revealed a nursing note dated 04/14/2025 at 10:55 a.m. by S4LPN (Licensed Practical Nurse), which read in part: 10:00 a.m., summoned to Resident #1's room; Resident #1 on floor on his right side; an abrasion noted . Resident #1 was never moved from the floor; EMS transferred Resident #1 from the floor to stretcher then to ER to evaluate and treat . Further review of Resident #1's interdisciplinary notes revealed Resident #1 returned to the facility on [DATE] with staples in place to Resident #1's head. Resident #1 was sent to the hospital on [DATE] at the request of Resident #1's RP (Responsible Party) who had concerns of Resident #1's right great toe and facial swelling from his past fall and decline. Resident #1 returned to the facility on [DATE] at 8:00 p.m. with a diagnosed right humerus fracture and right hip fracture.</p> <p>Review of Resident #1's hospital records with a visit date of 04/21/2025 revealed in part, a chief complaint of a fall that occurred 1 week ago and Resident #1's feet having become discolored since the fall. An x-ray of Resident #1's right hip dated 04/21/2025 revealed an acute right femoral neck trans-cervical fracture. An x-ray of Resident #1's right humerus dated 04/21/2025 revealed an acute comminuted humeral head and greater tuberosity fracture. Resident #1 was discharged back to the facility on [DATE] as a non-operative patient, unable to undergo physical therapy or any other intervention other than pain control.</p> <p>An observation on 05/05/2025 at 11:30 a.m. revealed Resident #1 was asleep in bed with a sling to his right arm. Further observation revealed bed bolsters in place bilaterally and fall mats to both sides of bed with a safety mat on top of each fall mat. Further observation revealed Resident #1's left side of the bed sat parallel to his closet and was approximately 4 feet away in distance.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/05/2025 at 4:00 p.m., S4LPN reported she was the nurse who entered Resident #1's room immediately after his fall out of the bed on 04/15/2025. S4LPN reported Resident #1 was lying on his right side on the floor at the left side of his bed. S4LPN reported Resident #1's fall mat had been removed from the left side of the bed. S4LPN further reported S3CNA told her she had just finished Resident #1's bed bath and when she turned to get something out of the closet, Resident #1 slipped off of the bed.</p> <p>During an interview on 05/06/2025 at 9:15 a.m., S2DON (Director of Nursing) reported S3CNA had removed the safety mat to provide ADL care on 04/15/2025 and when Resident #1 fell out of the bed he landed on the floor. S2DON acknowledged S3CNA had turned away during Resident #1's bed bath and should not have.</p> <p>During an interview on 05/06/2025 at 10:00 a.m., S3CNA reported on 04/15/2025 she gave Resident #1 a bed bath and when she entered the room, she removed the fall mat that was positioned at the left side of his bed and raised the bed. S3CNA reported after she had completed the bath, she removed the wet sheets and moisturized Resident #1 with a mixture of baby oil and baby lotion. S3CNA further reported she then turned away in a right direction to get Resident #1's clothes from his closet and Resident #1 turned over the bolster and fell to the floor. S3 CNA confirmed Resident #1 fell out of the left side of the bed and landed on the floor on his right side. S3CNA stated, Resident #1 was too slick; I put too much baby oil and lotion on him. S3CNA acknowledged she should have had Resident #1's clothes within reach prior to the bed bath and should not have turned away during care.</p> <p>During an interview on 05/06/2025 at 12:00 p.m. Resident #1's RP reported on 04/21/2025, Resident #1's toes on his right foot looked bruised and Resident #1 had swelling to his right leg. Resident #1's RP further reported, she requested the facility to send Resident #1 to his primary hospital.</p> <p>During an interview on 05/07/2025 at 2:00 p.m., S1Administrator reported S3CNA turned her back during the bath to grab Resident #1's clothes. S1Administrator acknowledged Resident #1 was not supervised in a safe manner during the bed bath and S3CNA should not have turned away.</p> <p>During an interview on 05/08/2025 at 2:25 p.m., S1Administrator confirmed the corrective actions put into place were completed on 04/28/2025.</p> <p>During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>The facility implemented the following actions to correct the deficient practice beginning on 04/15/2025 with a completion date of 04/28/2025:</p> <ol style="list-style-type: none"> 1. On 04/15/2025, Resident #1 was made a 2 person assist with bathing. 2. Bed bath competency completed with S3CNA on 04/15/2025. 3. Upon notification of fractures, on 04/21/2025 all residents with BIMS score 10 or lower had skin assessments initiated and completed to rule out any signs or symptoms of abuse. <p>(continued on next page)</p>		

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