STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195510	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruston Nursing and Rehabilitation Center, LLC	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain the door locking mechanism on an exterior door in the secured unit to prevent elopement from the secured unit for 1 (#1) of 3 (#1, #2, #3) residents reviewed. The deficient practice resulted in an immediate jeopardy for Resident #1 on 05/23/2025 at 11:07 a.m. when Resident #1 who was an elopement risk was able to exit the secured unit to the outside of the building through a door with a malfunctioning locking mechanism. Resident #1 was picked up on the two lane highway with a speed limit of 55 miles per hour approximately 0.2 miles from the facility by S8Housekeeper. The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 05/29/2025, thus it was determined to be a past noncompliance citation. Findings: Review of the record revealed Resident #1 was admitted to the facility on [DATE] from an inpatient psychiatric facility to the secured unit with diagnoses of unspecified dementia unspecified severity with other behavioral disturbances, depression, anxiety, auditory hallucinations, visual hallucinations, and unspecified psychosis. Review of the progress note from the inpatient psychiatric facility dated 02/11/2025 revealed in part: hyperreligious, trying to get everyone to exit the building thinking God was going to put the building on fire. Patient was labile and potentially aggressive. Patient was agitated, anxious and irritable. Patient was experiencing confusion, cognitive deficit, hallucinations, and delusional thinking. Criteria for continued stay: titrating medications, psychosis, danger to self/others, and gravely disabled: unable to support functional life skills. Review of Resident #1's admission MDS (Minimum Data Set) assessment dated [DATE] revealed in part, Resident #1 had a BIMS (Brief Interview of Mental Status) score of 12 indicating Resident #1 had moderate cognitive impairment. Resident #1 was independent with mobility. Review of the plan of care in part revealed: (continued on next page)

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
	195510	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruston Nursing and Rehabilitation Center, LLC	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ADLs (Activities of Daily Living) - Ambulates independently, continent of bowel and bladder, supervised bathing, supervision for wandering. Updated 03/06/2025 elopement risk wander guard to left ankle, 03/18/2025 resides on secure unit. The resident is an elopement risk/wanderer related to diagnosis of dementia. Interventions- census checks every hour, elopement assessment per policy and as needed, 03/06/2025 - wander guard bracelet to left ankle. Review of the elopement assessment completed 02/25/2025 revealed Resident #1 was scored not at high risk for elopement. Review of the elopement assessment completed 03/06/2025 revealed Resident #1 scored at high risk for elopement. Review of the nurses' notes dated 03/06/2025 and 03/07/2025 revealed Resident #1 followed a staff member out of the secured unit and was brought back to the secured unit by another staff member. Further review of the nurses' notes revealed Resident #1 had exit seeking behaviors on 03/11/2025, 03/23/2025, 03/25/2025, 03/27/2025, 04/14/2025, 04/28/2025, 04/30/2025, 05/02/2025, 05/19/2025, and 05/20/2025. Review of the nurses' notes dated 03/06/2025 revealed the resident said police have his family outside and says he can hear it through the wire. Further review of the nurses' notes revealed on 03/07/2025 the resident was self-talking and resident stated, If the police came in here, I'm going to knock them out. I don't swing to hit, I swing to hurt something. Resident continues to self-talk throughout the shift. Review of the nurses' notes dated 03/23/2025 revealed the resident had visual and auditory hallucinations, hearing voices and talking back to them. The resident was sent to the emergency room per ambulance. Review of the nurses' noted dated 03/26/2025 revealed the resident had increased confusion and agitation and talking to self. Review of the nurses' notes dated 04/30/2025 revealed the resident had increase agitation, talking and arguing with self. Review of the nurses' notes dated 05/23/2025 at 11:07 a.m. - Resident reported per staff to have exited facility via door on the secured unit and was walking fast. Staff member stated she attempted to call resident's name while gardening and he kept walking. She stated that other members of staff were running across yard and he was insistent on leaving. Housekeeper was able to get resident in her car, picked resident up, and returned to facility. Resident stated Oh, she brought me back here. Resident was placed on 1:1 for the remainder of the day shift and every 30 minutes from 2:30 p.m. -10:30 p.m. and every 1 hour to continue from 10:30 p.m. - 6:30 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195510	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruston Nursing and Rehabilitation Center, LLC	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/29/2025 at 10:30 a.m., an interview with S8Housekeeper confirmed she was working on 05/23/2025 when Resident #1 was able to get out of the facility. S8Housekeeper said she was going to her car for something and a CNA (Certified Nursing Assistant) told her a resident got out of the facility. S8Housekeeper said she got in her car to go and find the resident. S8Housekeepr confirmed she located Resident #1 on the two lane highway, up the road to the right of the facility at the dirt road. S8Housekeeper confirmed no staff would have been able to see Resident #1 from the facility from where she picked him up. Further interview with S8Housekeeper revealed she said she was able to get Resident #1 in the car and he asked her to take him to another town. S8Housekeeper said she drove up the highway, turned around and came back to the facility. On 05/29/2025 at 10:45 a.m., an interview with S9Maintenance Director revealed he was not at the facility when Resident #1 exited the building. He arrived and checked the door Resident #1 exited through and it was not broken. S9Maintenance Director further said he called the company that installed the doors with the secure locking features to come and inspect the door. Further interview with S9Maintenance Director revealed he said that if you push on any of these doors hard enough you can get them to open. On 05/29/2025 at 10:50 a.m. while inspecting the door that Resident #1 exited through with S9Maintenance Director, S10Housekeeping Director was also present. Interview at that time with S10Housekeeping Director revealed he was working on 05/23/2025 when Resident #1 exited the facility. S10Housekeeping Director said Resident #1 just pushed on the handle of the door, it opened and he walked out. S9Maintenance Director used the code pad to unlock the door and S10Housekeeping Director demonstrated how the metal bar at the top of the door which created a magnet and secured the door shut was loose and hanging down at an angle when Resident #1 opened the door. Further interview with S9Maintenance Director revealed the door did not have a wander guard locking mechanism. On 05/29/2025 at 1:25 p.m., an interview with S5Rehab Director revealed she was outside at the therapy garden and all of a sudden she saw a man running down the tree line. She said she did not know he was a resident and thought he was maintenance personnel. S5Rehab Director said she was not able to catch Resident #1 because he was running so fast and he was very tall and big. S5Rehab Director confirmed Resident #1 did get out to the 2 lane highway and down the road out of sight of the facility. On 06/02/2025 at 8:15 a.m., an interview with Resident #1 revealed he pushed the door and it opened. Resident #1 further revealed when he opened the door, no alarm sounded and the door shut right behind him. Resident #1 said he was going to an apartment in town. He said he made it to the highway and up the road about a quarter of a mile. On 06/02/2025 at 3:00 p.m., an interview with S7LPN (Licensed Practical Nurse) revealed she was working on 05/23/2025 when Resident #1 eloped from the secured unit. S7LPN revealed S6CNA came running into the secured unit and said she thought she saw Resident #1 running outside. S7LPN said she and S6CNA went out the facility's front door and ran through the grassy field in front of the facility all the way to the two lane highway and only at that point where they able to visually see Resident #1 being picked up by S8Housekeeper. S7LPN confirmed Resident #1 was not at the end of the driveway or even at the facility's tree line and was not visible from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195510	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruston Nursing and Rehabilitation Center, LLC	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/02/2025 at 3:40 p.m., an interview with S6CNA revealed on 05/23/2025 she was returning to the facility on an ambulance with another resident from a medical appointment. S6CNA said she saw someone walking very fast over by the tree line of the facility. She further said she tried to call into the facility to alert them of the resident being out but her phone would not work. S6CNA said she ran in the facility and alerted the staff in the front of the building that there was a resident out of the facility. She continued to run back to the secured unit and asked S7LPN if Resident #1 was still in the facility. S6CNA said they determined Resident #1 was not in the secured unit and ran back out to the front of the building. S6CNA said she and S7LPN ran all the way through the grass to the highway and only then were they able to see Resident #1 being picked up by S8Housekeeper. S6CNA confirmed Resident #1 made it to the two lane highway and up the highway to the dirt road. S6CNA said you could not see the resident from the front of the facility or even while in the grassy area. S6CNA said she was only able to visually see Resident #1 once they got to the end of the property and on the two lane highway. On 06/03/2025 at 10:50 a.m., an interview with S1Administrator and S2DON (Director of Nursing) confirmed the facility immediately closed off the doors to the area that Resident #1 eloped from and further corrective actions were put into place on 05/23/2025. 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 on 05/29/2025. On 05/23/2025 the facility implemented the following actions to correct the deficient practice: 1. On 05/23/2025, the door allowing access to the outside from the secured unit was immediately closed off from any resident access. 3. On 05/23/2025, Resident #1 was assessed for any injuries or ill effects. 2. Resident #1 was placed 1 on 1 supervision for the remainder of the day shift on 05/23/2025, then placed on every 30 minute observation from 2:30 p.m.-10:30 p.m. and then every 1 hour observation thereafter. 2. On 05/23/2025 after Resident #1 was returned to the facility, 100 % of building was checked for resident census. 3. On 05/23/2025 after Resident #1 was returned to facility the company that installed the doors with security code locking mechanism was contacted to have them come and inspect the door. 4. On 05/23/2025 after Resident #1 was returned to the facility 100% inspection of all doors within the facility were checked to ensure working properly. 5. In-service initiated on 05/23/2025 for all staff: Title: Wander guards/monitoring residents/checking alarms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195510	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ruston Nursing and Rehabilitation Center, LLC	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Subject: Please monitor all residents especially those with wander guards. They are in place for safety and to prevent the resident from exiting the facility. When an alarm is going off, please check the alarm no matter where it is. Door by ice room will be left unlocked and doors by nurses' station will be locked. Do not leave door until verifying it is locked. 6. Monitoring of 5 doors 5 days per week for 4 weeks was initiated on 05/26/2025 to ensure it is locked and wander guard was working adequately. Date facility asserts the likelihood for serious harm to any recipient no longer exists: 05/26/2025.