

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  01/07/2026
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, observations, and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident for 1 (#1) of 3 sampled residents reviewed for care plans. Findings: Review of the record revealed an admission date of 05/23/2025 with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere mild with mood disturbance, repeated falls, hypothyroidism, and hyperlipidemia. Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 indicating severe cognitive impairment. Further review of the MDS revealed resident required substantial/maximal assistance with shower/bathing and personal hygiene. Review of the Resident #1's current care plan revealed the resident had an actual fall with minor injury related to poor balance with an intervention updated on 11/05/2025 for meals to be eaten in dining room for lunch and supper. Review of Resident #1's current ADL care plan revealed resident required total care with all ADLs including bathing and interventions included a bed bath on Monday, Wednesday, and Friday and as needed and shave resident on bath days. Observations of Resident #1 on 12/30/2025 at 12:30 p.m., 01/05/2026 at 12:50 p.m. and 01/06/2026 at 12:25 p.m. revealed the resident was in bed eating his lunch meal and long facial hair was noted. An interview on 01/06/2026 at 12:30 p.m. with S8LPN revealed Resident #1 had a whirlpool bath on 01/05/2026. Observation of Resident #1 with S8LPN confirmed the resident had long facial hair and it needed to be trimmed. An interview on 01/06/2026 at 3:00 p.m. with S2DON confirmed during an observation of Resident #1 with the surveyor that the resident had long facial hair that needed to be trimmed. S2DON confirmed during review of resident's current care plans that Resident #1 received a whirlpool bath three times per week, shaved by staff on bath days, and should be eating his lunch meal in the dining room. S2DON confirmed that the facility failed to implement interventions listed in Resident #1's current care plan.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195510
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