

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52271</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure residents received services for reasonable accommodation of needs by failing to provide set-up assistance with meals for 1 (#26) of 1 residents reviewed for positioning and mobility.</p> <p>Findings:</p> <p>Review of the record for resident #26 revealed an admitted [DATE]. Resident #26 had diagnoses that included flaccid hemiplegia affecting right dominant side, right hand contracture, sequelae of cerebrovascular disease, and hypertension.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 12 which indicated that resident #26 had moderate cognitive impairment. Additionally, the MDS documented that resident #26 had a one sided functional limitation in range of motion and required set-up or clean-up assistance with meals.</p> <p>Review of resident #26's current plan of care revealed an intervention dated 12/20/2024, per occupational therapy, staff is to assist with meal tray set-up.</p> <p>On 04/14/2025 at 12:15 p.m., resident #26's lunch tray was observed being delivered to his bedside table. It was observed that S9Certified Nursing Assistant (CNA) did not provide set-up assistance for resident #26 which included not opening seasoning packets or beverages. S9CNA then exited the room. Resident #26 turned his bedside table to reposition his tray in front of him. Interview at that time with resident #26 revealed staff do not assist him with opening items such as milk cartons or pepper packets. Resident #26 was observed opening a pepper packet with his teeth. Resident #26 confirmed that he does have difficulty chopping his meat and revealed that it would be helpful if staff would chop his meat.</p> <p>On 04/16/2025 at 8:07 a.m., resident #26 was observed in his room with his breakfast tray delivered and he had consumed approximately 50% of his meal. Further observation revealed that resident #26's milk carton had not been opened and additional fluids on the tray were still covered. S7LicensedPracticalNurse (LPN) was notified that resident #26's milk carton and fluids were not opened.</p> <p>On 04/16/2025 at 7:55 a.m., an interview was conducted with S7LPN regarding resident #26's requirement for assistance with meals. S7LPN confirmed that resident #26 was independent with feeding himself but staff open his drinks.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/16/2025 at 2:15 p.m., S1ExecutiveDirector was notified of the findings related to the facility's failure to provide reasonable accommodation of needs for resident #26 who required set-up assistance with meals.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17835</p> <p>Based on observation and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 1 (#29) of 9 (#6, #7, #19, #22, #29, #32, #33, #80, #133) residents reviewed for environment. The failed practice was evidenced by resident #29 not having bed linen on the bed.</p> <p>Findings:</p> <p>Review of the record for resident #29 revealed an admission of 01/16/2024 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. Resident #29 required two person physical assistance with bed mobility, transfers, and toilet use.</p> <p>On 04/14/2025 at 3:19 p.m., observation of resident #29's bed revealed there was no linen on the bed and the resident was observed lying on a draw sheet. Interview with resident #29 at that time revealed this was a frequent problem with staff failing to put linen on the bed. Resident #29 stated she had reported not having linen to the nurses and nothing had changed.</p> <p>Interview with S9Certified Nursing Assistant on 04/14/2025 at 4:40 p.m. confirmed that no bed linen was currently on the bed for resident #29. She revealed that this frequently occurs with residents who have a bariatric bed.</p> <p>On 04/16/2025 at 2:15 p.m. S1Executive Director was notified resident #29 did not have linens on her bed and she was in the bed lying on a draw sheet.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52271</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a resident was free from physical restraints imposed for the purpose of discipline or convenience for 1 (#31) of 3 (#31, #53, and #96) residents reviewed for restraints. The facility failed to ensure that resident #31 was able to self-release his wheelchair seatbelt upon request which resulted in the failure to identify the seatbelt as a restraint.</p> <p>Findings:</p> <p>Review of the facility's Restraint Evaluation and Restraint Reduction Policy dated 08/2013 revealed: Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected. The policy states that individuals responsible for restraints include all members of the interdisciplinary team (as appropriate to individual resident needs) and the Director of Nursing (DON) monitors restraints.</p> <p>Seatbelts that are front-fastened and can be easily unfastened by the alert and somewhat oriented resident are not included if the resident can demonstrate self-release upon request.</p> <p>Review of the medical record for resident #31 revealed an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, history of falling, age related osteoporosis, and nicotine dependence.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 9 which indicated moderate impaired cognition.</p> <p>Review of the Physician's Orders dated 01/04/2025 specified resident #31's seatbelt as: self-releasing alarming seatbelt (non-restraint) due to unawareness of physical limitations with a diagnosis of schizoaffective disorder.</p> <p>Review of resident #31's current plan of care revealed the self-releasing alarming seatbelt to wheelchair was a fall intervention.</p> <p>On 04/14/2025 at 3:47 p.m., resident #31 was observed in his wheelchair and it was noted that the wheelchair seatbelt was secured.</p> <p>On 04/16/2025 at 10:57 a.m., an observation of resident #31 with S3Director of Nursing Services (DNS) was conducted. Resident #31 was seated in his wheelchair with his seatbelt in place. S3DNS asked resident #31 to unbuckle his seatbelt. Resident #31 did attempt to release the seatbelt but was unable to complete the act. Resident #31 stated to S3DNS that he could not complete the task.</p> <p>On 04/16/2025 at 11:15 a.m., an interview with S3DNS revealed there was no supporting documentation regarding restraint reduction attempts or reassessments for resident #31.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/16/2025 at 2:15 p.m., S1ExecutiveDirector was notified of the findings related to the facility's failure to identify that resident #31's wheelchair seatbelt was a restraint.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52271</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure a care plan had been revised for 1 (#31) of 3 (#31, #53, and #96) residents reviewed for restraints.</p> <p>Findings:</p> <p>Review of the facility's Restraint Evaluation and Restraint Reduction Policy dated 08/2013 revealed: Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected. The policy states that individuals responsible for restraints include all members of the interdisciplinary team (as appropriate to individual resident needs) and the Director of Nursing (DON) monitors restraints.</p> <p>The policy procedure states that all residents using a restraint are to be evaluated and re-evaluated approximately every quarter.</p> <p>The policy procedure states that care plan updates are to occur approximately every quarter and/or as a goal or approach direction changes.</p> <p>Review of the medical record for resident #31 revealed an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, history of falling, age related osteoporosis, and nicotine dependence.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 9 which indicated moderate impaired cognition. The MDS indicated a chair alarm in use daily, however, there was no documentation that indicated a wheelchair seatbelt was in place.</p> <p>Review of the Physician's Orders dated 01/04/2025 specified resident #31's seatbelt as: self-releasing alarming seatbelt (non-restraint) due to unawareness of physical limitations with a diagnosis of schizoaffective disorder.</p> <p>Review of resident #31's current plan of care revealed the self-releasing alarming seatbelt to wheelchair was a fall intervention. The current plan of care did not address the use of a restraint.</p> <p>On 04/16/2025 at 11:15 a.m., S3Director of Nursing Services confirmed that there was no supporting documentation available regarding reassessing resident #31 for restraints.</p>		

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52271</b></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>		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575</b></p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to monitor for any active bleeding or bruising for a resident who received an anticoagulant for 1 (#104) of 5 (#20, #33, #60, #96, and #104) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Review of the medical record for resident #104 revealed an admitted [DATE] with diagnoses including chronic kidney disease, chronic diastolic congestive heart failure, and atrial fibrillation.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #104's Brief Interview for Mental Status (BIMS) score was 14 which indicated intact cognition for daily decision making. Resident #104 was independent or required set up help only with activities of daily living.</p> <p>Review of the current care plan revealed resident #104 was at risk for abnormal bleeding and/or bruising related to the use of an anticoagulant. The interventions were to monitor for active bleeding/bruising or for symptoms of internal bleeding and if noted to notify the resident's physician.</p> <p>Review of the April 2025 physician's orders revealed an order dated 08/29/2025 for Apixaban (Eliquis, anticoagulant) 5 milligrams, give 1 tablet orally twice daily related to atrial fibrillation. Further review revealed an order dated 08/29/2025 to monitor for active bleeding or for symptoms of internal bleeding such as: abnormal bruising, black tarry stools, or bright red vomit and to notify the resident's physician if any of the above is noted.</p> <p>Review of the record for resident #104 revealed no documented evidence of monitoring for active bleeding/bruising or for any sign or symptoms of internal bleeding.</p> <p>On 04/16/2025 at 1:25 p.m., an interview with S5Clinical Operations/Regional Support confirmed there was no documentation regarding monitoring for active bleeding or for any symptoms of internal bleeding for resident #104.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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>

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 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>		