STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195520	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Place-Ruston	1405 White Street 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835 Based on record review and interviews, the facility failed to ensure an alleged violation involving physical abuse witnessed by staff was reported immediately to the Administrator of the facility for 1 (#2) of 7 (#1, #2, #3, #4, #5, #6, #7) sampled residents. Findings: Review of the Abuse Reporting Policy dated 01/05/2024 revealed the following: Policy: All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of unknown origin and misappropriation of resident property. Policy interpretation and implementation: 2. Any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property, must be reported to the Administrator and Director of Nurses. Physical Abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. 6. The person observing an incident of resident abuse, or suspecting resident abuse, must immediately report such incident(s) to their supervisor. The following information should be reported to the supervisor: The name of the resident(s) involved. The date and time that the incident occurred. Where the incident took place. The name(s) of the person(s) committing the alleged abuse, if known. Review of the record for resident #2 revealed an admitted [DATE] with following diagnoses: Alzheimer's disease, unspecified dementia, anxiety disorder and depression. (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
	195520	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Place-Ruston	1405 White Street 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment for resident #2 dated 06/21/2024 revealed resident #2 had severely impaired cognitive skills for daily decision making. During an interview with resident #2 on 07/29/2024 at 3:30 p.m., resident #2 was confused and was unable to recall any incident of possible abuse. Observation at this time revealed the resident did not have any bruising. Review of the record for resident #7 revealed an admitted [DATE] with following diagnoses: major neurocognitive disorder due to probable vascular disease, unspecified, with mood disturbance. Review of the MDS assessment for resident #7 dated 07/17/2024 revealed resident #7 had severely impaired cognitive skills for daily decision making. During an interview with resident #7 on 07/30/2024 at 3:00 p.m., resident #7 was confused and was unable to recall any incident with another resident. Review of the care plan for resident #7 revealed problem of unease in dealing with others with onset on 11/01/2023. Further review revealed the following approaches: approach resident warmly and positively, convey acceptance of resident, provide consistent caregivers on all shifts, provide opportunity for resident to express fears/concerns related to socialization with others, listen in non-judgmental manner, monitor resident socialization behavior and document at least daily, and allow resident to select seating at planned activities and in dining room. Interview on 07/30/2024 at 8:29 a.m. with S7 Certified Nursing Assistant (CNA) revealed that she witnessed resident #7 slap resident #2 hard on the left side of her face on 07/13/2024 at approximately 2:00 p.m. S7CNA stated that resident #7 was agitated prior to the incident and was difficult to redirect. S7CNA further revealed she was approximately 40 yards from the residents; therefore, she was unaware of what precipitated resident #7 slapping resident #2. S7CNA stated she did not tell the nurse on duty that resident #7 hit resident #2. S7CNA reported that she has been trained on abuse and neglect reporting but confirmed she failed to report to nurse and/or administrator that she witnessed physical abuse. Interview on 07/30/2024 at 10:00 a.m. with S9Licensed Practical Nurse (LPN) revealed she worked on 07/13/2024 from 7:00 a.m. to 3:00 p.m. S9LPN stated that she was not made aware of any incident involving resident #2 and resident #7. Interview on 07/30/2024 at 11:00 a.m. with S1Adminsitrator revealed she was unaware of any incident involving resident #2 and resident #7. S1Administrator confirmed S7CNA should have reported the alleged abuse regarding resident #2 and resident #7 immediately.