

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2026
NAME OF PROVIDER OR SUPPLIER  Princeton Place-Ruston		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews and interviews, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible. The facility failed to ensure CNAs did not place two briefs on 3 (#2, #3, and #4) of 4 residents observed for incontinent care. Findings: Resident 2 Review of the medical record for Resident #2 revealed an admission date of 02/09/2026. Resident #2 had diagnoses that included lymphedema, muscle spasm, chronic pain, anxiety, depression, diabetes mellitus and dementia. Review of the admission MDS assessment dated [DATE] revealed Resident #2 had a BIMS of 15 which indicated intact cognition for daily decision making. Resident #2 was dependent on staff for toileting, partial to moderate assistance with personal hygiene, and was at risk for developing pressure ulcers. Review of the current care plan revealed Resident #2 was at risk for complications due to refusing care. Check and encourage resident to use commode and change brief every two hours and as needed. On 03/02/2026 at 8:20 p.m. observation of Resident #2 with S3LPN revealed she was wearing two briefs. Interview with S3LPN confirmed the CNA should not have placed two briefs on Resident #2. Interview with Resident #2 on 03/02/2026 at 8:25 p.m. revealed the CNAs sometimes put two briefs on her but she hasn't said anything to anyone. Further interview with Resident #2 revealed she did not tell the CNA to put two briefs on her. Interview with S4CNA on 03/02/2026 at 9:30 p.m. revealed she placed two briefs on Resident #2 because Resident #2 asked her to put two briefs on her because she didn't like her bed to get wet. S4CNA further revealed she was not supposed to place two briefs on Resident #2. Resident 3 Review of the medical record for Resident #3 revealed an admission of 12/21/2020. Resident #3 had diagnoses including hemiplegia and hemiparesis, urinary tract infection, and malignant neoplasm of prostate. Review of the quarterly MDS assessment dated [DATE] revealed Resident #3 had a BIMS score of 15 which indicated intact cognition for daily decision making. Resident #3 was dependent on staff for toileting, setup assistance with personal hygiene, and was at risk for developing pressure ulcers. Review of the current care plan revealed Resident #3 had urinary incontinence, wears adult briefs and staff were to provide pericare as needed. On 03/02/2026 at 8:15 p.m. observation of Resident #3 with S3LPN revealed he was wearing two briefs. Interview with S3LPN confirmed the CNA should not have placed two briefs on Resident #3. Interview with Resident #3 on 03/02/2026 at 8:50 p.m. revealed he did not ask the CNA to put two briefs on him. Interview with S4CNA on 03/02/2026 at 9:30 p.m. revealed she placed two briefs on Resident #3 because Resident #3 asked her to put two briefs on him because he didn't like his bed to get wet. S4CNA further revealed she was not supposed to place two briefs on Resident #3 Resident #4 Review of the medical record for Resident #4 revealed an admission date of 09/25/2018. Resident #4 had diagnoses including diabetes mellitus and vascular dementia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 7 which indicated severe cognitive impairment for daily decision making. Resident #4 was dependent on staff for toileting hygiene, set up assistance with personal hygiene, and was at risk for developing pressure ulcers. Review of the current care plan revealed Resident #4 had bowel and bladder incontinence (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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>related to dementia and used disposable briefs, and the resident needed to be changed every two hours and as needed. On 03/02/2026 at 8:15 p.m., observation of peri care performed by S5CNA and S6CNA for Resident #4 revealed the resident was wearing two briefs. Interview with S6CNA on 03/02/2026 at 9:10 p.m. revealed she placed two briefs on Resident #4 because she was a heavy wetter. S6CNA further stated she was not supposed to place two briefs on Resident #4. Interview with S7LPN on 03/02/2026 at 9:20 p.m. confirmed the CNAs should not place two briefs on the residents. On 03/02/2026 at 9:40 p.m. S1 Administrator was notified of the CNAs placing two briefs on Resident #2, #3 and #4. S1 Administrator confirmed the CNAs should not have used two briefs on the residents. Interview with S8CNA Supervisor on 03/03/2026 at 2:10 p.m. confirmed the CNAs should not have placed two briefs on the residents.</p>		