

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Holly Hill House		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Kingston Road Sulphur, LA 70663	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251</p> <p>Based on record review and interviews, the facility failed to provide quarterly statements of personal funds for 1 (Resident #7) of 1 resident investigated for personal funds. The deficient practice had the potential to affect a census of 80 residents.</p> <p>Findings:</p> <p>Review of Resident #7's electronic health record revealed that she was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, and Unspecified Diastolic Congestive Heart Failure.</p> <p>Review of Resident #7's MDS (Minimum Data Set) with an ARD (Assessment Review Date) of 01/16/2024 Section C (Cognitive Patterns) revealed she had a BIMS (Brief Interview for Mental Status) of 15, indicating she was cognitively intact.</p> <p>On 4/04/2024 at 3:23 p.m., an interview was conducted with Resident #7. She stated that the facility was in charge of her funds and that she had not been given a statement in over 2 years. She stated that she would like to know what was in her account.</p> <p>On 4/09/2024 at 10:00 a.m., an interview was conducted with S9BOM (Business Office Manager) in regards to Resident #7's personal funds statements. She stated that she had provided Resident #7 with her quarterly statement in January 2024 for the last quarter of the year 2023, but she did not have any documentation that she had done this. S9BOM confirmed that there was no documentation of Resident #7 receiving any quarterly statements for 2023 and there should be.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</p> <p>Based on observations, interviews, and record reviews; the facility failed to protect the resident's right to be free from abuse for 3 (#1, #2, #3) of 7 (#1, #2, #3, #4, #5, #6, #7) sampled residents. The facility failed to protect:</p> <ol style="list-style-type: none"> 1. Resident #1 from sexual abuse by Resident #2. 2. Resident #2 from physical abuse by Resident #5. 3. Resident #3 from physical abuse by Resident #4. <p>This deficient practice resulted in:</p> <ol style="list-style-type: none"> 1. psychosocial harm for Resident #1 on 03/02/2024 at 4:42 p.m., when Resident #2 grabbed her breasts. Resident #1 was observed startled by staff at the time of the incident. The resident's responsible party stated that she would have been panicked, very fearful, and not happy at all. 2. physical harm for Resident #2 on 03/14/2024 at 8:54 p.m., when Resident #5 struck Resident #2 on the top of his head with a cane resulting in a laceration that required sutures. 3. physical harm for Resident #3 on 03/09/2024 at 1:42 p.m., when Resident #4 hit Resident #3 in the eye that resulted in a contusion to the area with subsequent complaints of headaches and pain. <p>Findings:</p> <p>On 04/08/2024, a review of the facility's Abuse Neglect Policy dated 01/2024 read in part:</p> <p>Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff or other residents .The facility prohibits mistreatment, neglect, or abuse of residents .The resident must not be subjected to abuse by anyone.</p> <ol style="list-style-type: none"> 1. A record review of Resident #2's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses in part: Vascular Dementia, Aphasia, Mood Disorder, Sexual Dysfunction, Disorder of Adult Personality and Behavior. <p>A record review of Resident #2's quarterly MDS (Minimal Data Set) dated 03/08/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) that could not be completed due to the resident rarely understood. A staff assessment for mental status was conducted and indicated the resident's cognitive skills for daily decision making was severely impaired.</p> <p>A review of Resident #2's progress notes revealed the following:</p> <p>03/02/2024 4:42 p.m .observed in dining room physical inappropriately touched another resident's (Resident #1) breast.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #2's care plan, failed to identify the resident's diagnosis of Sexual Dysfunction. Review of Incident Report, dated 03/02/2024 at 16:24 (6:24 p.m.), revealed the section titled Incident Description read: Resident observed inappropriately touching a female resident (Resident #1) on the breast. Immediate Action Taken read: Redirected to another area away from female resident and supervisor, doctor, and family notified, one on one staff assigned to resident in his room, psych med increased until physician can assess resident for behavior. Further review of the incident report revealed a witness stated written by S8CNA (Certified Nursing Assistant) stating Resident #1 was startled and upset at first.</p> <p>On 04/04/2024 at 1:15 p.m., an observation was made of Resident #2 sitting in his wheelchair propelling self in and out of dining areas in the memory care unit, in view and observation of staff. An attempt for an interview was made at that time but was unsuccessful as he did not respond to any questions or conversation.</p> <p>On 04/04/2024 at 3:15 p.m., an interview was conducted with S1ADON (Assistant Director of Nursing). S1ADON confirmed the incident in which Resident #2 grabbed Resident #1 breasts. She stated that the doctor was immediately notified of the incident; a medication change was immediately put into place, and Resident #2 was immediately placed on 1 on 1 observation. The doctor also assessed Resident #2 the next morning. S1DON stated the medication change was effective and he has had no other incidents of sexually inappropriate behavior.</p> <p>04/08/2024 at 3:40 p.m. and on 04/09/2024 at 4:00 p.m., phone interview attempts with S8CNA were unsuccessful.</p> <p>On 04/08/2024 at 4:00 p.m., an interview was conducted with S3LPN (Licensed Practical Nurse). S3LPN confirmed she was the nurse on duty for 03/02/2024 when Resident #2 grabbed Resident #1's breast. She stated the incident was immediately reported to her by the S8CNA. S8CNA reported to her that Resident #2 reached and grabbed the female's breast from behind her. She stated they immediately separated the two residents, redirected Resident #2, and initiated 1-on-1 observation for Resident #2. She then notified the administrator; the police; the doctor; responsible parties for both involved residents; and completed an incident report.</p> <p>On 04/09/2024 at 2:20 p.m., a phone interview was conducted with the Resident #1's RP (Responsible Party). He stated that his grandmother would have panicked, would not have been happy at all and would have been very fearful if the incident with Resident #2 had occurred prior to her Dementia diagnosis.</p> <p>On 04/09/2024 at 4:00 p.m., an interview was conducted with S6ADM (Administrator). S6ADM acknowledged he was aware of the sexual abuse incident that occurred on 03/02/2024 perpetrated by Resident #2 onto Resident #1.</p> <p>44269</p> <p>2. Review of Resident #5's EHR revealed he was admitted to the facility on [DATE] with the following diagnoses, in part: Cerebral Infarction, Vascular Dementia-Unspecified Severity with Other Behavioral Disturbance, Sepsis, Metabolic Encephalopathy, and Acute Cystitis with Hematuria.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's 5- Day MDS Assessment with an ARD (Assessment Reference Date) of 03/07/24 revealed a BIMS score of 09 indicating moderate cognitive impairment.</p> <p>Review of Resident #5's nursing progress notes dated 03/14/2024 at 8:54 p.m. per S3LPN (Licensed Practical Nurse) revealed Resident #5 being sent to hospital for behavior, hit roommate (Resident #2) in the head with his walking stick because Resident #2 bumped in Resident #5's bed and woke him up.</p> <p>Review of a form titled Incident Report revealed the incident occurred and was discovered on 03/14/2024 at 8:30 p.m. and entered into the state's electronic reporting system on 03/14/2024 at 8:43 p.m. Resident #2 was identified as the victim with an injury sustained of a laceration that required evaluation in the ER (emergency room) and the accused was identified as Resident #5 for an allegation of physical abuse.</p> <p>Further review of the Incident Report dated 03/14/2024 revealed Resident #5 was laying in his bed when his roommate, Resident #2, was trying to get by and bumped into Resident #5's bed. Resident #5 then hit Resident #2. Resident #5 is being sent to the hospital for psychological evaluation and Resident #2 is being sent to ER. Police have been notified.</p> <p>Review of S3LPN's handwritten statement revealed: Resident #2 was hit in the head by Resident #5; his roommate. Reason - he bumped his bed and keeps going in/out of his room waking him up and stares at him all day at 8:35 p.m.</p> <p>Review of S8CNA's (Certified Nursing Assistant) typed statement read: I was in the dining room with other residents when the nurse informed me that Resident #5 stated he hit Resident #2 in the head with his cane. I went down to the residents' room and observed Resident #2 laying on the bed bleeding from his head. I put a towel on the wound while the nurse called for help.</p> <p>On 04/08/2024 at 3:40 p.m., 04/09/2024 at 8:20 a.m., and 4/09/2024 at 4:30 p.m., interview attempts with S8CNA were unsuccessful.</p> <p>On 04/08/2024 at 5:15 p.m., an interview was conducted with S3LPN. S3LPN confirmed she was working the night of 03/14/2024 when the incident occurred between roommates Resident #2 and Resident #5. She stated Resident #5 came up to her at the nursing station and casually informed her that he had hit Resident #2 in the head with his cane and there was a lot of blood in their room. S3LPN assessed Resident #2 and observed a laceration on top of his head that required ER visit for sutures. Resident #5 was no longer in the facility. He had been discharged to home with family after the incident occurred.</p> <p>3. Review of Resident #3's EHR revealed he was admitted to the facility on [DATE] with the following diagnoses in part: Acute Respiratory Failure, Muscle Wasting and Atrophy, Liver Cell Cancer, Anxiety Disorder, Atrial Fibrillation and Cerebral Vascular Accident.</p> <p>Review of Resident #3's Significant Change MDS assessment revealed a BIMS score of 15 indicating he was cognitively intact.</p> <p>Resident #3 was unable to be interviewed due to actively transitioning on hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #4's EHR revealed he was admitted to the facility on [DATE] with the following diagnoses in part: Unspecified Dementia- Unspecified Severity with Other Behavioral Disturbance, Major Depressive Disorder- Recurrent Severe with Psychotic Symptoms, Anxiety Disorder and Bipolar Disorder.</p> <p>Review of Resident #4 quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indicating his cognition was intact.</p> <p>Review of Resident #3's nursing progress notes revealed an entry dated 03/09/2024 at 1:42 p.m. per S4LPN: This Resident in dining room visiting with other residents when another resident started cursing and yelling. This resident told him to be quiet. Other resident did not stop cursing and this resident got up and went to his table and told him again to be quiet. Other resident then put fist up and said come on This resident states go ahead and hit me. Other resident then hit this resident in the eye. No other fighting noted. Very light pink area noted to this resident's outer eye. This resident is not complaining of pain. Family here and aware.</p> <p>Review of a form titled Incident Report revealed the incident occurred and was discovered on 03/09/2024 at 11:30 a.m. and entered into the state's electronic reporting system on 03/09/2024 at 12:52 p.m. Resident #3 was identified as the victim with an injury of redness to his eye. Resident #4 was identified as the accused for allegation of physical abuse.</p> <p>Further review of the Incident Report dated 03/09/2024 revealed Resident #4 and Resident #3 were playing bingo in the dining room. Resident #4 spoke ugly to another resident (Resident #6) so Resident #3 was defending her asking Resident #4 to stop speaking to her like that. Resident #4 then wheeled in his wheelchair to Resident #3 and hit Resident #3 in the eye. Resident #3's eye is red.</p> <p>Review of a handwritten statement per a family member of an unidentified resident/volunteer dated 03/09/2024 revealed, in part: I call 1 game of bingo and Resident #4 started after that game of Bingo was over and Resident #4 went off on Resident #6. Resident #4 told her to shut the f#@% up and that's when Resident #3 got up from his chair and Resident #4 was telling him to come on and Resident #3 went by Resident #4 and hit Resident #4 on the corner of his eye.</p> <p>Review of a handwritten statement per S10CNA dated 03/09/2024 revealed: Witnessed Resident #4 and Resident #3 getting into it. The 2 residents was passing licks (hitting/slapping) so she and the kitchen workers stopped them and Resident #4 was removed from the dining room .The kitchen staff told me that Resident #4 wanted to move Resident #6 and Resident #3 said get your hands off of her and Resident #4 said don't mess with me old man and Resident #3 then hit Resident #4.</p> <p>Review of S11NP's progress note (Nurse Practitioner) dated 03/15/2024 revealed Resident #3 was assessed for complaints of a headache and eye pain. S11NP's assessment revealed with recent contusion right eye, now with complaints of eye pain and headaches. Resident is currently alert, appropriate. Able to follow commands with normal eye movement, slight fading discoloration to eyelid; resident c/o (complaint of) pain to right eye periorbital and headache with pain level of 3/10. Skin inspection revealed redness to right periorbital area; Assessment and Plan= New Diagnoses: Headache and contusion right eye and plan to complete neuro (neurological) vital signs, prn (as needed) pain meds, may need further work up if any changes & continue hospice services.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>On 04/09/2024 at 10:10 a.m. an interview was conducted with Resident #4. The resident stated he felt safe living at the facility. The resident explained he recalled the incident last month when he was playing bingo in the dining room when Resident #3 started swinging at him so Resident #4 swung back striking Resident #3 in the eye.</p> <p>On 04/09/2024 at 11:35 a.m., an interview was conducted with S10CNA. S10CNA stated she recalled the incident between Resident #4 and Resident #3 on 03/09/2024 and confirmed she was working that day when the two were with other residents in the dining room playing bingo. She explained that the kitchen staff told her that Resident #4 wanted to move Resident #6 and Resident #3 said get your hands off of her and Resident #4 said don't mess with me old man and Resident #3 said hit me and then that's when the fight started. Resident #4 punched Resident #3 in the eye with his fist. S10CNA recalled Resident #3's eye was red.</p> <p>On 04/09/2024 at 1:00 p.m., an interview was conducted with S4LPN. S4LPN stated she was familiar with Resident #3 and Resident #4. She stated she was working on 03/09/2024 when she was informed Resident #4 hit Resident #3 in the eye during Bingo in the dining room. She stated that Resident #3 had redness noted to his eye and required in house monitoring only.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</p> <p>Based on observation, interviews, and record reviews, the facility failed to develop a resident centered comprehensive care plan for 3 (#2, #4, #7) out of a finalized sample of 7 residents as evidenced by:</p> <ol style="list-style-type: none"> 1. Failing to identify and plan for Resident #2's diagnosis of Sexual Dysfunction, 2. Failing to follow physician's orders to increase Resident #4's medication, 3. Failing to identify and plan for Resident #7's BIPAP (Bi-level Positive Airway Pressure) machine, 4. Failing to follow physician's orders to apply creams, change oxygen tubing, and clean oxygen concentrator filter for Resident #7. <p>This deficient practice had the potential to affect a total census of 80 residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident #2 <p>A record review of Resident #2's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with diagnoses in part: Vascular Dementia, Aphasia, Mood Disorder, Sexual Dysfunction, and Disorder of Adult Personality and Behavior.</p> <p>A review of Resident #2's care plan revealed the facility failed to identify the resident's Sexual Dysfunction diagnosis.</p> <p>A review of Resident #2's Nurse's Notes revealed documentation of the following behaviors:</p> <p>09/01/2023 6:41 a.m .Fondling himself at the table, counseled at this time.</p> <p>09/01/2023 7:56 a.m .fondling himself again.</p> <p>09/09/2023 4:35 p.m .resident motioning for female resident to follow him.</p> <p>09/10/2023 11:30 a.m .noted to be fondling self in dining room in front of female residents.</p> <p>09/15/2023 10:39 a.m .touching the aide inappropriate ways on her bottom .continued to touch aid on her bottom.</p> <p>09/16/2023 7:30 p.m .noted on two separate occasions, patted them on the bottom.</p> <p>09/30/2023 2:13 a.m .observed resident to be masturbating.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/23/2023 6:43 p.m .resident took off brief in dining area in front of other residents.</p> <p>03/02/2024 4:42 p.m .observed in dining room physical inappropriately touched another residents breast.</p> <p>03/02/2024 9:15 p.m .observed on 1:1 (continuous observation), rubbing his penis through clothing attempting to masturbate.</p> <p>On 04/04/2024 at 3:00 p.m., an interview was conducted with S2MDS (Minimum Data Set). S2MDS confirmed she is responsible for developing and updating all resident care plans. S2MDS confirmed that Resident #2 had a diagnosis of Sexual Dysfunction upon admission. She reviewed Resident #2's care plan and nurse's notes, and confirmed that neither the diagnosis for Sexual Dysfunction, nor any of his sexual behaviors were identified in his plan of care and should have been.</p> <p>On 04/09/2024 at 1:15 p.m., an interview was conducted with S1ADON (Assistant Director of Nursing). She confirmed Resident #2's admission diagnosis of Sexual Dysfunction as well as the documented incidents' of sexual behaviors. She viewed and confirmed that neither the resident's diagnosis for Sexual Dysfunction, nor his sexual behaviors were identified in his care plan and should have been.</p> <p>44269</p> <p>2. Resident #4</p> <p>Review of Resident #4's EHR revealed he was admitted to the facility on [DATE] with the following diagnoses in part: Unspecified Dementia- Unspecified Severity with Other Behavioral Disturbance, Major Depressive Disorder- Recurrent Severe with Psychotic Symptoms, Anxiety Disorder and Bipolar Disorder.</p> <p>Resident #4 was care planned for having a behavior problem r/t (related to) history of cursing staff, threatening staff, disorganized thinking. Dx (Diagnoses) of Bipolar D/o (Disorder), anxiety, depression with an intervention to administer medications as ordered.</p> <p>Review of Resident #4's active April 2024 physician's orders revealed an order with a start date of 09/10/2021 for Buspirone tablet- Give 5 mg (milligram) by mouth two times a day for anxiety.</p> <p>Review of Resident #4 EHR revealed he was hospitalized at an inpatient behavioral hospital from 03/10/2024 thru 03/22/2024. His admission treatment plan dated 03/10/2024 revealed an order to increase Buspirone (Buspar) 5 mg tablet to TID (three times daily).</p> <p>Review of Resident #4's discharge medication list dated 03/22/2024 revealed to continue taking Buspirone 5 mg oral tablet three times a day for anxiety.</p> <p>Review of Resident #4's March 2024 eMAR (electronic Medication Administration Record) revealed he was administered Buspirone 5 mg oral tablet two times a day from 03/22/2024 thru 03/31/2024.</p> <p>Review of Resident #4's April 2024 eMAR revealed he was administered Buspirone 5 mg oral tablet two times a day from 04/01/2024 thru 04/09/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/09/2024 at 10:26 a.m., an interview was conducted with S5LPN who verified she was the nurse for Resident #4. She stated he did have a diagnosis of anxiety and reviewed the resident's current eMAR. S5LPN confirmed Resident #4 received ordered Buspirone 5 mg oral tab two times a day.</p> <p>On 04/09/2024 at 1:51 p.m., an interview was conducted with S1ADON (Assistant Director of Nursing) who explained either herself or the DON (Director of Nursing) reviewed readmission paperwork, including hospital records, for residents who were readmitted to facility from a hospital. S1ADON confirmed Resident #4 was hospitalized at an inpatient behavioral hospital from 03/10/2024 thru 03/22/2024 and that the former DON reviewed his readmission paperwork. S1ADON confirmed Resident #4 was administered Buspirone 5 mg oral tablet twice a day from 03/22/2024 through 04/09/2024. S1ADON reviewed Resident #4's EHR and confirmed his Buspirone 5 mg oral tablet should have been increased to three times a day per the behavioral hospital's discharge medication list dated 03/22/2024 and was not increased.</p> <p>47251</p> <p>Resident #7</p> <p>Findings:</p> <p>Review of Resident #7's electronic health record revealed that she was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, and Unspecified Diastolic Congestive Heart Failure.</p> <p>Review of Resident #7's MDS (Minimum Data Set) with an ARD (Assessment Review Date) of 01/16/2024 Section C (Cognitive Patterns) revealed she had a BIMS (Brief Interview for Mental Status) of 15, indicating she was cognitively intact. Further review of this MDS Section O (Special Treatments, Procedures and Programs) revealed she was coded for Non-Invasive Mechanical Ventilator and receiving Oxygen Therapy.</p> <p>Review of Resident #7's active care plan revealed it did not include a plan of care for BiPAP.</p> <p>Review of active physician's orders for Resident #7 revealed the following orders:</p> <ol style="list-style-type: none"> 1. Apply antifungal powder and pillow case to bilateral breasts for redness BID (twice a day) and PRN (as needed) every day and evening shift for redness under breast. 2. Apply Barrier Cream to Coccyx Daily and PRN as preventative every shift for preventative. 3. BiPAP (Bi-level positive airway pressure) on for sleep at bedtime related to Chronic Obstructive Pulmonary Disease, Unspecified. 4. Oxygen - clean oxygen concentrator filter weekly every night shift every Thursday for maintenance. 5. Oxygen 2L(Liters)/NC(Nasal Cannula) continuously every shift for SOB (Shortness of Breath). 6. Oxygen Tubing- Change Weekly every night shift every Thursday. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Holly Hill House		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Kingston Road Sulphur, LA 70663	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Triamcinolone cream apply to outer right ear and left forearm bid (two times a day) please have padding to her glasses and oxygen tubing that goes over right ear two times a day.</p> <p>Review of the TAR (Treatment Administration Record) for January 2024 through April 2024 revealed the following: Oxygen tubing changing weekly on Thursdays had not been done for 3 Thursdays. Oxygen concentrator filter cleaning weekly on Thursdays had not been done for 3 Thursdays. The application of the antifungal powder had not been applied for a total of 11 doses. The application of the barrier cream to coccyx had not been applied for a total of 14 doses. The Triamcinolone cream to outer right ear had not been done for a total of 18 doses.</p> <p>On 04/04/2024 at 3:23 p.m., an interview was conducted with Resident #7. She stated that staff had not been applying her barrier cream to coccyx and antifungal powder underneath her breasts as they should have been.</p> <p>On 4/04/2024 at 4:18 p.m., an interview and record review with S2MDSN (Minimum Data Set Nurse) was conducted. S2MDSN confirmed that Resident #7 was not care planned for BiPAP and she should have been.</p> <p>On 4/08/2024 at 1:48 p.m., a record review and interview was conducted with S1ADON of Resident #7's TAR for January 2024 through April 2024. She confirmed that the oxygen tubing had not been changed weekly, oxygen concentrator filter had not been changed weekly and that the barrier cream, antifungal powder and triamcinolone cream all had multiple doses missing and that these should have been performed.</p>		

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NAME OF PROVIDER OR SUPPLIER Holly Hill House		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Kingston Road Sulphur, LA 70663	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47251</p> <p>Based on observations and interviews the facility failed to properly store respiratory equipment for 1 resident (#7) out of 1 resident (#7) investigated for respiratory care.</p> <p>Findings:</p> <p>Review of Resident #7's electronic health record revealed that she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, and Unspecified Diastolic Congestive Heart Failure.</p> <p>Review of Resident #7's MDS (Minimum Data Set) with an ARD (Assessment Review Date) of 01/16/2024 Section C (Cognitive Patterns) revealed she had a BIMS (Brief Interview for Mental Status) of 15, indicating she was cognitively intact. Further review of this MDS Section O, (Special Treatments, Procedures and Programs) revealed she was coded for Non-Invasive Mechanical Ventilator.</p> <p>Review of Resident #7's physician's orders revealed in part, BiPAP (Bi-level positive airway pressure) on for sleep at bedtime. Levalbuterol HCL (Hydrochloride) nebulization solution 1.25 mg (milligram)/3ml (milliliter) 1 vial, inhale orally via nebulizer every 8 hours as needed for SOB (shortness of breath).</p> <p>On 04/04/2024 at 3:23 p.m., an observation and interview was conducted with Resident #7. An observation was made of this resident lying in her bed. She is awake, alert and oriented to person, place, and time. It was observed that her BiPAP mask was lying on her bedside table not stored properly and there was nothing available for storage. There was also a nebulizer mask dated 03/22/2024 on the mask that was also lying on the bedside table. There was no storage observed for the nebulizer mask. Resident #7 stated that she wore her BiPAP every night and that the staff placed in on her. She also stated that she received a nebulizer treatment when she was short of breath provided by the staff. Resident #7 stated that her BiPAP mask and her nebulizer mask were always left on her bedside table.</p> <p>On 04/04/2024 at 3:47 p.m., an observation and interview with S7LPN (Licensed Practical Nurse) was conducted. She confirmed that Resident #7's BiPAP mask and nebulizer mask was on her bedside table and not properly stored. She also confirmed that the date of 03/22/2024 on her nebulizer mask was outdated. She stated that the BiPAP should have been bagged and the nebulizer mask should have been changed weekly and both had not been done.</p> <p>On 04/08/2024 at 2:13 p.m., an observation and interview with S1ADON (Assistant Director of Nursing) was conducted. Resident #7's BiPAP mask was lying on resident's bedside table, not stored properly. S1ADON confirmed that Resident #7's BiPAP mask was not stored properly and that it should have been stored in a bag. A policy for respiratory storage was requested from S1ADON and never received.</p> <p>On 04/09/2024 at 9:30 a.m., a policy on respiratory equipment storage was requested from S6ADM (Administrator). He stated that he would look for one. No policy was received.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Holly Hill House		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Kingston Road Sulphur, LA 70663	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/09/2024 at 1:25 p.m., a second request was made for a policy on respiratory equipment storage to S1ADON. She stated that she could not provide a policy and that respiratory equipment such as Resident #7's BiPAP and nebulizer should be stored in a bag and in addition the nebulizer mask should have been labeled.</p>		