STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195431	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Hill House	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46169 Based on observations, interviews, and record reviews, the facility failed to protect the resident's rights to be free from neglect by failing to ensure the availability of supplies in sufficient number the residents required necessary to provide care to residents as evidenced by: 1. Failing to provide appropriate sized incontinence briefs to 74 incontinent residents; and 2. Failing to provide a sufficient number of clean linens, when the facility was observed not having an adequate amount of clean towels and washcloths available. This had the potential to affect the census of 89. Findings: On 06/10/2024 at 9:30 a.m., an observation was made of S6CNA (Certified Nursing Assistant) assembling 4 incontinence briefs together. S6CNA stated the facility ran out of the size 2XL (extra-large) and 3XL incontinence briefs. S6CNA stated she was assembling the incontinence briefs together because she was told to get creative because the appropriate size briefs were not available. On 06/10/2024 between 1:00 p.m. and 1:25 p.m., an observation of the facility's supply closets for incontinence briefs revealed: Hall A - a partial pack of size XL (extra-large) and no size large, 2XL or 3XL available. Hall B - a partial pack of size large and no size XL, 2XL, or 3XL available. Hall C - no size large, XL, 2XL, or 3XL available. Hall D - a partial pack of size 2XL and no size large, XL, or 3XL available. Staff interviews were conducted at that time with S4LPN (Licensed Practical Nurse), S5LPN, S6CNA, and S7CNA. They verbalized there were not enough briefs in the appropriate sizes to provide incontinence care to the residents who required them. They stated last week, the facility weekly run out of the large, XL, 2XL, and 3XL which are the most frequently used sizes to fit the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/10/2024 at 12:19 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing) who stated most of the incontinent residents residing in the facility wore sizes large, XL, 2XL, or 3XL. She stated these sizes of incontinence briefs were the most frequently used for incontinent care, but each size was not available in central supply. On 06/10/2024 at 12:35 p.m., an interview was conducted with S2DON (Director of Nursing) who confirmed the facility had been out of the larger size briefs, including large, XL, 2XL, and 3XL since last week. On 06/10/2024 at 1:31 p.m., an interview was conducted with S12MR/CS (Medical Records/Central Supply). She confirmed she was responsible for completing the order supply lists for the facility including briefs. S12MR/CS stated the list of items for order are given to S1ADN (Administrator) for review. S1ADN reviews, approves, and submits orders himself to ensure the order is within the facility's budget. S12MR/MC further stated S1ADN would remove critically needed items from the order to fit the facility's budget, like gloves and briefs which puts the staff in a bind for supplies. She stated the facility would run out of incontinence briefs for the residents. On 06/10/2024 at 1:52 p.m., an interview was conducted with S1ADN who confirmed he submits the supply orders, including briefs, for the facility. On 06/10/2024 at 2:00 p.m., an observation and interview was conducted with S12MR/CS in the central supply. Observations of the central supply room revealed 20 packs of size large briefs and no size XL, 2XL, or 3XL briefs. S12MR/CS confirmed there were no briefs in XL, 2XL, or 3XL in the central supply room. S12MR/CS stated the facility ran out of incontinence briefs last week. Observations of the supply drop off area next to the locked central supply room revealed 3 boxes of size XL briefs, 2 boxes of size 2XL, and 5 boxes of size 3XL briefs. S12MR/CS stated these supplies had just arrived today on 06/10/2024. The facility failed to provide a policy for the provision of sufficient supplies including briefs. 41868 2. On 06/10/2024 between 12:50 p.m. and 1:10 p.m., an observation of the clean linen supply closets revealed: Hall A- no towels and no washcloths Hall B- 5 towels and 7 washcloths Hall C- 11 towels and no washcloths Hall D- 8 towels and no washcloths. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff interviews were conducted at that time with S4LPN (Licensed Practical Nurse), S5LPN, S6CNA (Certified Nursing Assistant), and S7CNA. They stated they use towels and washcloths to provide personal hygiene needs, including incontinent care for the residents. They stated they often run out of them in the clean linen supply closet and have to go to other hallways to get them or have to wait for laundry to distribute more. On 06/10/2024 at 1:15 p.m., an interview was conducted with S2DON. She confirmed that towels and washcloths were utilized for providing personal hygiene needs, including incontinence care for the residents. She further stated the facility did not utilize or have any disposable wipes. She confirmed that all clean linens available for usage are stored in the clean linen supply closets on the units. A review of the linen counts was conducted with S2DON. She confirmed that number currently available for usage was not an adequate number to care for all the resident's needs. She stated she would go to the laundry room to see what was available. An observation was made of the facility's laundry room with S2DON. A load of what appeared to be linens, including towels and washcloths, was in one of the two washers and another load was in one of the two dryers. S10HLS (Housekeeping/Laundry Staff) verbalized it takes about 30 minutes to wash, and another 30 minutes to dry. An observation of the clean linen table revealed 27 towels and 12 washcloths. S2DON confirmed the total available wash cloths and towels at this time for usage was 51 towels and 19 washcloths, which was not an adequate amount for the number of residents. S2DON then stated that S1ADN (Administrator) reported they should have an additional supply of linens in the storage supply closet and to put those in circulation. Upon observation of the storage supply closet with S2DON, there were no towels or washcloths available. During an interview with S1ADN on 06/10/2024 at 3:40 p.m., he stated he had spoken with the laundry staff and linens were delivered to the clean linen supply closets on each unit about an hour ago. He voiced he thought they had an additional supply of extra washcloths and towels available in the storage supply closet but was told there were none. On 06/10/2024 between 3:45 p.m. and 4:00 p.m. a second observation of the clean linen supply closets revealed: Hall A- 18 towels and 14 washcloths Hall B- 16 towels and 17 washcloths Hall C- 25 towels and 4 washcloths Hall D- 15 towels and 13 washcloths Staff interviews were conducted at that time with S8CNA who stated she has ran out of washcloths at times and have had to cut towels into pieces to make additional washcloths. S9CNA stated this was usually the last time any linens were delivered for the day and this supply would have to last until the following morning. On 06/10/2024 at 4:05 p.m. an interview was conducted with S11HLM (Housekeeping/Laundry Manager). He stated he was a contract employee and was not responsible for the purchase of linens, such as towels and washcloths, and voiced there was a shortage of linen supplies available. He stated that at this time, the last load of linen for today was in the dryer and would be distributed once completed, and it would be tomorrow morning before anymore would be restocked. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided no policy for the provision of linens, including towels and washcloths.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46169 Based on record review, observation, and interviews, the facility failed to follow the physician's orders for 1 (#3) resident out of 5 (#1, #2, #3, #4, #5) residents sampled, as evidence by failing to follow orders for obtaining an x-ray timely causing a delay in care for the resident. Findings: Review of Resident #3's Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE]. The resident had diagnoses which included, but were not limited to Fracture of Unspecified part of Neck of Right Femur, subsequent encounter for Closed Fracture with routine healing and Encounter for other Orthopedic Aftercare. Review of Resident #3's physician's orders revealed the following orders for x-rays: An order date of 05/24/2024 at 1:44 p.m. that read, X-ray left femur. An order date of 05/28/2024 at 7:55 a.m. that read, X-ray left leg. An order date of 05/28/2024 at 8:15 a.m. that read, X-ray left hip, femur, knee, tib (tibia), fib (fibula), ankle, foot. An order date of 05/31/2024 at 2:02 p.m. that read, X-ray pelvis and lumbar spine. Review of Resident #3's nurse's notes revealed on 05/24/2024 at 12:00 p.m., she had a witnessed fall. Resident #3 had no visible injuries and had no complaints of pain. On 05/24/2024 at 1:51 p.m., Resident #3 complained of pain in her left leg while ambulating per therapy. The nurse practitioner was notified and ordered an x-ray. Further review of Resident #3's nurse's notes revealed on 05/27/2024 at 2:09 p.m., the nurse called contracted radiology service three times to check on the x-ray of the left leg and there was no answer. A note on 05/28/2024 at 7:59 a.m. revealed an order for an x-ray was faxed to the contracted radiology service. A note on 06/01/2024 at 5:20 p.m. revealed new order to send resident to hospital for positive left femur fracture. A further review of Resident #3's EMR revealed no x-ray results for 05/24/2024. The radiology interpretation for x-rays completed on 05/28/2024 revealed the following impressions: the left foot x-ray was an unremarkable foot examination; the left ankle and the left tibia/fibula x-rays had no significant findings; the left knee x-ray revealed severe osteoarthritis; the left femur x-ray revealed no obvious displaced fracture identified with a note the femoral neck region is sub-optimally evaluated; and the left hip x-ray revealed limited exam, no obvious acute osseous abnormality noted. The radiology interpretation for the lumbar spine x-ray completed on 06/01/2024 revealed 1) possible left proximal femur fracture, recommend correlation with left hip radiographs. 2) Demineralization of the spine. The radiology interpretation for the pelvis x-ray completed on 06/01/2024 revealed acute left proximal femur fracture, recommend dedicated left hip views or CT. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/2024 at 10:48 a.m., an interview was conducted with S4LPN (Licensed Practical Nurse). She confirmed Resident #3 had a fall on 05/24/2024 at 12:00 p.m., then during physical therapy complained of pain to the left leg. S4LPN notified the nurse practitioner of Resident #3's complaint of pain and received an order for an x-ray to the left leg. S4LPN stated on 05/28/2024, the x-ray was not completed and was reordered. On 06/10/2024 at 12:19 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing). She confirmed Resident #3 had an order written on 05/24/2024 for an x-ray of the left leg. S3ADON confirmed the x-ray ordered on 05/24/2024 was not completed until 05/28/2024. S3ADON stated the x-ray should have been completed by 05/25/2024. On 06/10/2024 at 2:48 p.m., a telephone interview was conducted with the contracted radiology service who confirmed they had not received an order for Resident #3 for an x-ray of the left leg on 05/24/2024. She confirmed an order was received for Resident #3 on 05/28/2024 for an x-ray and was completed on 05/28/2024 and did not reveal a fracture of the left hip. She stated on 06/01/2024, they received an order for Resident #3 for an x-ray that was completed on the same day which revealed a left femur fracture.