

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 10/15/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540</p> <p>Based on record review, interviews, and facility's policy and procedure review, the facility failed to ensure S4LPN (Licensed Practical Nurse) notified the physician and/or charge nurse when a resident had a significant change in condition for 1 (#3) resident out of 7 (#1, #2, #3, #4, #5, #6, and #7) sampled residents.</p> <p>Findings:</p> <p>On 10/15/2024, a review of the facility's policy titled, Catheter Care, Urinary with a last reviewed date of 07/2024, read in part, . Input/Output: 1. Observe the resident's urine output for noticeable increased or decreases. If the output decreases significantly . report it to the medical practitioner or charge nurse .</p> <p>Review of Resident #3's record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Retention of Urine, Benign Prostatic Hyperplasia, and Parkinsonism.</p> <p>Review of Resident #3's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 7, indicating his cognition was severely impaired. Further review of Resident #3's Significant Change MDS dated [DATE], read in part, Section H: Bladder and Bowel selected yes for indwelling catheter.</p> <p>Review of Resident #3's May 2024 electronic MAR/TAR (Medication Administration Record/Treatment Administration Record), read in part, foley catheter output every shift .</p> <p>05/12/2024: day output = 800 cc (cubic centimeters), evening output = 1200 cc, night output = 500 cc;</p> <p>05/13/2024: day output = 700 cc, evening output 800 cc, night output = 500 cc;</p> <p>05/14/2024: day output = 350 cc, evening output 425 cc, night output = 600 cc;</p> <p>05/15/2024: day output = 350 cc, evening output 800 cc, night output = 100 cc .</p> <p>Review of Resident #3's progress notes revealed a note dated 05/16/2024 by S4LPN that read in part, foley catheter output every shift less than 100 cc .</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/14/2024 at 11:52 a.m., an interview was conducted with S4LPN. S4LPN stated she did work the night shift on 05/15/2024 from 11:00 p.m. - 7:00 a.m. a total of 8 hours. She stated she noticed the urinary output was very low at 6:00 a.m. She confirmed that she did not notify Resident #3's physician and/or the on call charge nurse of this significant change related to the resident's decreased urinary output.</p> <p>On 10/15/2024 at 9:12 a.m., a joint interview was conducted with S1DON (Director of Nursing) and S2ADON (Assistant Director of Nursing). A review of Resident #3's foley catheter urinary output on May 2024 MAR was conducted with S1DON and S2ADON. On 05/15/2024, the night shift revealed Resident #3 had a urinary output of 100 cc in 8 hours. S1DON stated per documentation Resident #3 usually has a urinary output of 350 cc - 800 cc or more per shift. S1DON confirmed that Resident #3's urinary output of 100 cc in 8 hours was a significant change in the resident's condition, and the nurse should have notified the on call charge nurse and Resident #3's physician.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for 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 record review and interview, the facility failed to protect the resident's right to be free from physical abuse for 1 (#2) out of 4 (#2, #4, #6, #7) residents investigated for abuse. The facility failed to protect Resident #2 from physical abuse by Resident #7. The deficient practice had to potential to affect a total census of 78.</p> <p>Findings:</p> <p>On 10/15/2024, a review of the facility's policy titled Abuse and Neglect-Clinical Protocol, with a review date of 01/2024, defined abuse as; resident to resident abuse includes the term 'willful'. The word willful means that the individual's action was deliberate (not inadvertent or accidental).</p> <p>Resident #2</p> <p>Review of the Clinical Record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses, which included Alzheimer's disease, Major Depressive Disorder, and Mood Affective Disorder.</p> <p>Review of the Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 08/22/2024 revealed Resident #2 had a BIMS (Brief Interview of Mental Status) score of 9, which indicated she was mildly cognitively impaired.</p> <p>Review of the facility's Progress Notes revealed the following, in part: On 09/21/2024 at 10:36 a.m., S6LPN (Licensed Practical Nurse) documented in part: Resident (Resident #2) was walking from dining room area and other resident (Resident #7) asked her a question. She answered and the other resident (Resident #7) accused her (Resident #2) of being a gossip and then proceeded to punch her (Resident #2) in her right hip.</p> <p>Resident #7</p> <p>Review of the Clinical Record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses, which included Bipolar Disorder, Hallucinations, and Dementia.</p> <p>Review of the Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 08/29/2024 revealed Resident #7 had a BIMS (Brief Interview of Mental Status) score of 9, which indicated she was mildly cognitively impaired.</p> <p>Review of the facility's Progress Notes for Resident #7 revealed the following, in part: On 09/21/2024 at 10:14 a.m., S6LPN documented in part: Patient (Resident #7) left out of the dining room and went up to another resident (Resident #2) and stated that she (Resident #2) was a gossip and then initiated to argue with the other resident (Resident #2) and then punched the resident (Resident #2) on right hip and stated are ya'll going to send me out of this unit now? Resident (Resident #7) was removed away from other resident (Resident #2).</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/14/2024 at 9:30 a.m., it was confirmed that Resident #7 was hospitalized and was unavailable for interview.</p> <p>On 10/15/2024 at 9:45 a.m., an interview was conducted with Resident #2. She was unable to recall the incident in which she was struck by Resident #7.</p> <p>On 10/14/2024 at 1:15 p.m., an interview was conducted with S6LPN. S6LPN confirmed she witnessed Resident #7 hit Resident #2 with a closed fist. She stated she was standing next to Resident #7 when she starting making accusations against Resident #2 as Resident #2 unknowingly approached Resident #7. She stated, at that time Resident #7 reached out and willfully struck Resident #2 with a closed fist on Resident #2's right hip then stated ya'll going to send me out of this unit now?</p> <p>On 10/15/2024 at 10:00 a.m., an interview was conducted with S1DON (Director of Nursing). S1DON confirmed Resident #7 had struck Resident #2 on the hip with a closed fist, and he believed the intention of Resident #7 was a willful and intentional act of physical abuse.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 47540</p> <p>Based on record reviews and interviews, the facility failed to ensure that services were provided as outlined in the comprehensive plan of care for 1 (#3) out of 7 (#1, #2, #3, #4, #5, #6, and #7) sampled resident as evidence by failing to:</p> <ol style="list-style-type: none"> foley catheter urinary output was monitored and recorded every shift, and side effects of anticoagulants were monitored and recorded. <p>Findings:</p> <p>On 10/15/2024, a review of the facility's policy titled, Catheter Care, Urinary with a last reviewed date of 07/2024, read in part, . Input/Output: . 2. Maintain an accurate record of the resident's daily output every shift .</p> <p>Review of Resident #3's record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Retention of Urine, Benign Prostatic Hyperplasia, and Heart Failure.</p> <p>Review of Resident #3's most recent Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was 7, indicating his cognition was severely impaired. Section N: Medications selected yes for receiving anticoagulants. Further review of Resident #3's Significant Change MDS dated [DATE], read in part, Section H: Bladder and Bowel selected yes for indwelling catheter.</p> <p>Review of Resident #3's comprehensive plan of care, read in part, The resident is on Anticoagulant therapy (Apixaban) with interventions . Dated 09/29/2022: Monitor/document/report to Nurse/Dr. anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB (Shortness of Breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs). Further review of the care plan revealed, The resident has Catheter with interventions . Dated: 04/16/2024: Monitor and document . output as per facility policy.</p> <p>Review of Resident #3's April 2024 electronic MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed that Resident #2 received Eliquis (Apixaban) Tablet 5 mg (milligram) 1 tablet by mouth two times a day for anticoagulant. Further review of the MAR failed to reveal foley catheter urinary output monitoring and side effects of anticoagulant monitoring from 04/25/2024 - 04/30/2024.</p> <p>Review of Resident #3's May 2024 MAR/TAR revealed that Resident #2 received Eliquis (Apixaban) Tablet 5 mg (milligram) 1 tablet by mouth two times a day for anticoagulant. Further review of the MAR failed to reveal foley catheter urinary output monitoring on 05/01/2024, 05/02/2024, and day and evening shift on 05/03/2024, and failed to reveal side effects of anticoagulant monitoring from 05/01/2024 - 05/15/2024.</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 - Few</p>	<p>On 10/14/2024 at 1:09 p.m., and interview was conducted with S5LPN (Licensed Practical Nurse). She stated that Resident #3 was on an anticoagulant, there was no side effects of anticoagulant monitoring that was documented anywhere.</p> <p>On 10/15/2024 8:30 a.m. a policy and procedure regarding anticoagulant monitoring was requested from S2ADON (Assistant Director of Nursing). On 10/15/2024 at 8:45 a.m. S2ADON stated the facility does not have any policies regarding anticoagulant monitoring.</p> <p>On 10/15/2024 at 9:12 a.m. a joint interview was conducted with S1DON (Director of Nursing) and S2ADON (Assistant Director of Nursing). S2ADON stated residents that have a foley catheter staff should be documenting their output on resident's MAR every shift. Review of Resident #3's comprehensive care plan with S2ADON and confirmed that Resident #3 had an order to monitor and document the foley catheter urinary output and monitor and document side effects of anticoagulant. Review of Resident #3's April and May 2024 MAR with S2ADON confirmed that there was no documentation of Resident #3's foley catheter urinary output from 04/25/2025 - 04/30/2024, 05/01/2024 - 05/02/2024, and day and evening shift on 05/03/2024. S2ADON confirmed side effects of anticoagulant monitoring was supposed to be done every shift, after review of April 2024 and May 2024 MAR with S2ADON. She confirmed the Resident #3 was on Eliquis (Apixaban) and there was no side effects of anticoagulant monitoring that was documented from 04/25/2024 - 05/15/2024.</p>		