

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 03/24/2026
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 0656</p> <p>Level of Harm - 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** Based on record review, observations, and interviews, the facility failed to ensure staff implemented a resident's established, individualized plan of care for 1 (Resident #1) of 3 sampled residents who required two person assistance with bed mobility. This deficient practice resulted in an actual harm for Resident #1 on 03/11/2026 at 1:45 p.m., when S4CNA failed to follow the resident's plan of care for using two person staff assistance. S4CNA provided bed mobility during ADL (activities of daily living) care for Resident #1 without assistance from another staff member resulting in the resident falling from her bed onto the floor sustaining an injury to her right lower extremity requiring hospitalization. Resident #1 was diagnosed as having a right periprosthetic fracture of the proximal tibia, a displaced fracture of the proximal right fibula, and a hematoma in the medial aspect of the proximal medial aspect of the lower leg measuring approximately 9cm (centimeters) x 2cm x 5 cm. The facility implemented a corrective action plan on 03/11/2026 which was completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings: A review of the facility's Activities of Daily Living policy with an approval date of 09/24/2025, revealed the following, in part: This facility provides each resident with care, treatment, and services according to the resident's individualized care plan. Review of the medical records for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, acquired absence of left leg above knee, cerebrovascular disease, and unspecified dementia. Review of Resident #1's quarterly MDS (Minimum Data Set) resident assessment with an ARD of 02/23/2026, revealed the following, in part: BIMS (Brief Interview for Mental Status) of 8 which indicated the resident was mildly cognitively impaired. Bed mobility (rolling left to right) defined as the ability to roll from a supine position to the left and right sides and return to supine in bed-Resident was assessed as requiring substantial to maximum assistance. This level of assistance indicated that the helper performs more than half of the effort, including lifting or supporting the trunk and/or limbs. Toileting hygiene -Dependent. This level of assistance indicated that the helper does all of the effort. Review of Resident #1's current Care Plan revealed the following, in part: Date Initiated: 01/04/2022 Focus: The resident has an ADL self care performance deficit: left AKA (above knee amputation), impaired mobility. Intervention: Bed Mobility: The resident requires 2 or more staff participation to reposition and turn in bed. Review of Resident #1's Nursing Notes revealed the following, in part: 3/11/2026 13:45 (1:45 p.m.) Note Text: This nurse heard resident yelling, upon entering room noted resident was sitting on the floor leaning on her L (left) side. Noted that R (right) leg was hyper extended while on floor. Instant bruising noted to R (right) ankle/top foot area. Skin tear to L (left) abdomen x's (times) 2 and R (right) center chest area. Resident lifted from floor using Hoyer lift x's 3. Successfully placed back in bed. O2 (oxygen) in place per NC (nasal cannula) . Resident c/o (complains of) pain. ambulance called for transport for post fall evaluation. Review of the resident's hospital records dated 03/11/2026 at 11:22 p.m. revealed Resident #1 sustained the following: 1. Acute mildly displaced and angulated comminuted periprosthetic fracture of the proximal tibia with the fracture line extending to the distal tip of the tibial prosthesis. 2. Acute mildly displaced (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 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>fracture of the proximal fibula. 3. Hematoma in the medial aspect of the proximal medial aspect of the lower leg measuring approximately 9cm (centimeters) x 2cm x 5 cm. Review of the facility's Investigative Report revealed the following, in part: On 03/11/2026 at approximately 1:45 p.m., Resident #1 was being provided peri care by a CNA (Certified Nursing Assistant) turned to left side while in bed and continued to roll off the bed and had a fall that resulted in a tibia fracture. On 03/23/2026 at 11:30 a.m., Resident #1 was observed in bed with a leg immobilizer in place to her right leg. The resident was not interviewable to answer questions regarding the incident involving the fall with fracture. On 03/23/2026 at 12:50 p.m., an interview was conducted with S4CNA who confirmed that on 03/11/2026, she provided bed mobility and ADL care to Resident #1 without a second staff member present for assistance when the resident fell from her bed. She explained that when turning Resident #1 to change her brief, the resident grabbed onto the mobility rail to assist with the turning. The resident turned all the way out of the bed falling to the floor. S4CNA stated she had not referenced the residents Kardex (electronic record containing the resident's care plan) prior to providing care and bed mobility and was unaware that resident information regarding care requirements was available on the Kardex. On 03/23/2026 at 2:15 p.m., an interview was conducted with S3LPN. S3LPN affirmed both she and S4CNA were caring for Resident #1 on 03/11/2026. She stated she heard Resident #1 yell out and seconds later S4CNA called for help. S3LPN entered the Resident #1's room and saw the resident lying on her left side, on the floor, on the left side of her bed with only one staff member present in the room to which she identified as S4CNA. She observed dark bruising already developing to the resident's right ankle/top of foot area and her right leg/ankle was in an unnatural position indicating a probable injury. S3LPN stated she immediately called for S2DON's assistance. She explained they assessed the resident and returned her back to her bed and she initiated the emergency hospital transfer protocol. On 03/24/2026 at 8:34 a.m., a phone interview was conducted with S2DON who was responsible for nursing services provided at the facility. S2DON confirmed S3LPN called him to the resident's room after Resident #1's fall. S2DON explained that when he entered the resident's room, Resident #1 was on the floor on the left side of her bed. S2DON affirmed that Resident #1 already had visible bruising to her right lower leg. He stated that, with assistance from three staff members, they lifted the resident back into the bed using a mechanical lift and S3LPN called EMS (emergency medical services). S2DON explained that all staff were trained upon hire and PRN (as needed) on accessing and following resident plans of care/Kardex including to review care requirements before providing care. He stated that Resident #1 had been assessed as a 2 person staff assist with transfers and bed mobility since her admission in 2022. He further confirmed that during his investigation, S4CNA verbalized to him that she was performing this task without a second staff member present because she had been caring for this resident for so long that she thought she could just do it herself. S2DON stated the root cause of the resident's fall and injury was due to S4CNA failing to properly follow the resident's plan of care and requirement for two staff while providing ADL care and bed mobility. The facility implemented corrective actions immediately with reeducation for S4CNA and clinical staff on the current shift and again for the oncoming shift on 03/11/2026. He also stated that this reeducation included a return demonstration from staff on how to access the resident care plan/Kardex. S2DON stated the facility had no further incidents regarding ADL care and bed mobility since 03/11/2026. On 03/24/2026 at 1:25 p.m., an interview was conducted with S1ADM who was responsible for the overall management of the facility. S1ADM provided documentation of the facility's investigation regarding Resident #1's fall. She stated that on 03/12/2026, a 100% audit of all residents' plans of care was completed to identify all residents that required two person assistance. It was at that time S2DON stated residents were no longer at risk. She further explained that on 03/13/2026, staff monitoring was initiated by the interdisciplinary team for residents requiring two person assistance to validate safety and compliance. This monitoring will be done on randomly selected residents that require the use of two person assistance 3 times a week for the following 90 days. She further explained that all staff were trained during their orientation (continued on next page)</p>		

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F 0656 Level of Harm - Actual harm Residents Affected - Few	<p>upon hire and as needed, regarding the resident plan of care and resident care requirements. A request was made for documentation that S4CNA had received this training. On 03/24/2026 at 1:50 p.m., S1ADM and S5HR, who provided S4CNA's personnel file. A hire date of 05/31/2022 was noted. S5HR provided the form that S4CNA signed on the date of her orientation as evidence that she had received the orientation handbook. S1ADM explained that education for resident plans of care and the Kardex was included in this orientation handbook. A copy of this handbook was provided at this time as well. It read as follows: Follow the Kardex and resident care plan for specific interventions - encourage and assist with repositioning, refer to Kardex and care plan for specifics. Point of Care Documentation - the resident's Kardex or plan of care with specific instructions on caring for the resident is also maintained in POC (plan of care) and are available for you to view at any time. A copy was S4CNA's transcript for continuing education was provided. It was noted that S4CNA completed a course titled, Repositioning in Bed on October 15, 2025 and again on November 14, 2025. The information provided in this continuing education course was also provided. In regards to positioning, it read as follows: For some people, it may need to be often, so it is important to refer to the individual's care plan for specific instructions. On 03/24/2026 at 3:06 p.m., S1ADM, provided documentation of a facility wide in-service that had been conducted on 10/15/2025. Procedures reviewed were two person transfers.task: check Kardex/service plan for appropriate transfer technique. S4CNA signature was observed on the sign in sheet as verification for having received this education. The skills demonstration checklist with this specifically stated task was dated 10/16/2025 and signed by S4CNA verifying she received the education. On 03/24/2026 at 3:40 p.m., a final phone interview was conducted with S4CNA. The signed education and in-services from hire, trainings from October 2025 and November 2025 that referenced following a residents plan of care, as well as the facility conducted in service were all reviewed and discussed. She confirmed to having received each one of these in-services/education agreeing that she remembered them. She now stated she looked at resident care plans, but just had not looked at hers (referring to Resident #1) in a long time. She further confirmed that she should have reviewed the resident's plan of care prior to administering care, but did not. Multiple Nurses and CNAs were interviewed from 03/23/2026 through 03/24/2026 on when and how to access a residents plan or care/Kardex. All staff interviewed were knowledgeable about the facility's policy and confirmed having received re-education with a return demonstration. Three random residents, who required assistance from two staff members for ADL care and bed mobility, were observed having two or more staff members enter the residents' room and provide ADL care from 03/23/2026 to 03/24/2026. No identified concerns were noted. During an interview on 03/23/2026 at 12:50 p.m., S4CNA confirmed that she received training after the incident on how and where to access this information, what information the kardex contained, and when to access it. On 03/24/2026 at 9:44 a.m., a follow up interview was conducted with S4CNA who correctly demonstrated how to access the resident's Kardex/care plan. The facility implemented the following actions to correct the deficient practice: I. Resident #1 assessed and sent for emergency evaluation and treatment. Investigation opened immediately on 03/11/2026. II. On 03/11/2026, S2DON and S6AIT initiated education and in-service for S4CNA and all clinical staff on the current shift and again for the oncoming shift. S4CNA was also retrained on following the resident's care plan and the facility's abuse policy and protocol. On 03/12/2026, a 100% audit of all residents plan of care completed to identify all residents that require two person assistance. It was at that time S2DON stated residents were no longer at risk. III. On 03/11/2026 initiated education of clinical staff that included a return demonstration had begun for all clinical staff and was completed on 03/12/2026. IV. On 03/13/2026, initiated staff monitoring by the interdisciplinary team on residents requiring two person assistance to validate safety and compliance. Monitoring will be done on randomly selected residents that require the use of two person assistance will be done 3 times a week for the following 90 days. The interdisciplinary team included S1ADM, S2DON, S6AIT, the assistant director of nursing, the two data collection nurses (MDS nurse), the nurse practitioner, and the staffing educator. Monitoring is ongoing. V. Facility's compliance date 3/13/2026.</p>		