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	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Hill House	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect the resident's right to be free from physical abuse by other residents for 1 (#2) out of 4 (#1, #2, #3 and #4) sampled residents. The facility failed to protect Resident #2 from physical abuse when Resident #3 slapped Resident #2 in the face on 08/09/2025. The deficient practice had the potential to effect a census of 79.Findings: Review of the facility's abuse, prevention and prohibition policy revealed in part .Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.Review of the facility's Incident Report for the past 90 days revealed one incident of resident to resident physical aggression for Resident #2 dated 08/09/2025 at 3:20 p.m. Resident #2Review of Resident #2's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, unspecified dementia, unspecified severity, with psychotic disturbance, anxiety disorder, and conductive hearing loss, bilateral.Review of Resident #2's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score that was unscored, indicating the resident could not participate in the interview. Resident #3 Review of Resident #3's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, bipolar disorder, current episode depressed, moderate; vascular dementia, severe, with psychotic disturbance, vascular dementia, severe, with agitation; major depressive disorder, recurrent, mild and anxiety disorder, unspecified.Review of Resident #3's most recent Quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 99, indicating her cognitive status could not be assessed.Review of the facility's Incident Report dated 08/09/2025 at 3:20 p.m., revealed the following in part: Incident Location: Common area/day roomPerson Preparing report: S4LPN (Licensed Practical Nurse)Incident Description: Today (08/09/2025) at 3:20 p.m., Resident #2 was involved in an incident where he was the victim of resident-to-resident physical aggression. Resident #2 was sitting at the dining room table and because he was blind, he feels his surroundings and was rubbing the table. S6CNA (Certified Nursing Assistant) stated Resident #2 touched a package of gram crackers that were on the table. S6CNA stated due to Resident #3 getting upset, S6CNA stated she removed the Resident #2 from the table. As she was pushing Resident #2 while in his wheelchair, Resident #3 went around S6CNA, stood in front of the Resident #2, and began to yell at the resident. Resident #3 slapped Resident #2 with her right hand on the left side of Resident #2's face. S4LPN (Licensed Practical Nurse) immediately went in front of the Resident #3 to allow S6CNA to take Resident #2 out of the sight of Resident #3.S4LPN noted a red area to the residents left upper cheek area. Level of Pain: 4.On 08/25/2025 at 11:30 a.m., an interview was conducted with S6CNA, she reported she was present when the resident to resident altercation occurred with Resident #2 (victim) and Resident #3 (accused). She stated she was standing in the hallway, at the dining room door, as she was conducting one on one care with another resident when she observed Resident #2 feeling on the table to put his cup of coffee down. S6CNA stated as Resident #2 passed his hand over a pack of graham crackers, Resident #3 was walking from the table to the door. S6CNA stated Resident #3 turned around and saw Resident #2 touch the crackers then Resident #3 began yelling at Resident #2. Resident #3 turned around moving toward Resident #2. S6CNA stated she went to Resident #2 and got between him and Resident #3 to stop Resident #3 from hitting on Resident #2. She stated she turned him away from Resident #3 and Resident #3 came around her and began slapping Resident #2 on the side of the face, yelling at the resident. She stated the nurse then came in and got between Resident #2 and #3 to stop resident #3 from hitting on Resident #2. On 08/25/2025 at 12:35 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing). She confirmed she was aware of the incident of the resident to resident altercation with Resident #2 and Resident #3. S3ADON confirmed Resident #2 was not protected from abuse. On 08/27/2025 at 10:00 a.m., an interview was conducted with S4LPN. She confirmed she was working when Resident #3 slapped Resident #2. She confirmed Resident #3 willfully intended to hit Resident #2 because the resident yelled and went toward Resident #2 to hit him, yelling as she hit him.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews, the facility failed to ensure allegations of injury of known origin were reported immediately to the Administrator or his/her designated representation, and reported to the state agency not later than 2 hours after the allegation was identified for 1 (#4) out of 4 (#1, #2, #3 and #4) residents reviewed for timely reporting of critical incidents.Findings:Review of the facility's abuse, prevention and prohibition policy revealed in part .Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.Reporting/Response: 1. The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility Administrator or his/her designated representative in the Administrator's absence.Resident #4Review of Resident #4's critical incident report related to injury of unknown origin with bruising to the right side of head revealed the event occurred on 08/03/2025 at 6:00 p.m. The date the incident was discovered was documented as 08/03/2025 at 6:00 p.m. The date the report was entered was documented as 08/03/2025 at 7:53 p.m., with a report due date of 08/08/2025. Review of Resident #4's progress notes revealed in part, on 08/03/2025 at 10:16 a.m., the resident experienced a change in condition noted as a Hematoma to right side head above temple. S7CNA (Certified Nursing Assistant) reported to S5LPN that Resident #4 had hematoma on the right upper temporal area. Upon assessment, purplish raised bruising noted. Light blue bruising noted below area. Resident #4 unable to let S5LPN know how/when accident occurred.On 08/26/25 at 9:00 a.m., an interview was conducted with S5LPN. She stated she was notified by S7CNA of a bruise to the right side of the face on Resident #4, on the morning of 08/03/2025, before breakfast. She stated the bruise was found the morning of 08/03/2025, and she did not report it to the administrative staff until later in the day, sometime after lunch. She stated she did not know how the bruise occurred. S5LPN confirmed she did not immediately report the injury of unknown origin and should have.On 08/26/2025 at 10:40 a.m., an interview was conducted with S3ADON (Assistant Director of Nursing) who stated the facility Administrator was responsible for reporting alleged violations to the state agency. She confirmed the facility's administrative staff were made aware of Resident #4's injury: S11RN (Registered Nurse) notified S3ADON on 08/03/2025 at 6:43 p. m. S3ADON notified S2DON (Director of Nursing) on 08/03/2025 at 6:47 p.m. and S2DON notified S1ADM on 08/03/2025 at 6:51 p.m. She confirmed Resident #4 had an injury of unknown origin that S5LPN failed to report immediately and that the incident was not reported to the state agency within 2 hours as required.On 08/27/2025 at 10: 15 a.m., an interview was conducted with S1ADM (Administrator). He reported he was responsible for submitting the critical incidents. He stated when a reportable occurs the administrative team discuss the incident, if it is reportable within 2 hours the clinical team will gather with S1ADM to discuss and review the policy for steps to take. He stated S2DON and S3ADON were responsible for gathering the information and investigate and interview the staff and obtain written statements. He stated when he was ready to submit the completed investigation he asked if there was any other witness statements or investigations before submitting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure an investigation of an allegation of abuse was thoroughly investigated for 1 (#4) of 3 (#2, #3, #4) sampled residents reviewed for abuse. Findings:Review of the facility's abuse, prevention and prohibition policy, with an approved date of 12/2024, revealed in part .Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers staff of other agencies serving the resident, family members or legal guardians, friends or other individuals . Investigation: Resident abuse must be reported immediately to the administrator. The facility administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. 2. Initiate investigation including initial reporting to all required agencies.5. Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, resident or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. 6. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on.Review of Resident #4's medical record revealed a re-entry admission date of 04/02/2025, with diagnoses that included in part Parkinson's disease without dyskinesia, without mention of fluctuations; unspecified dementia, unspecified severity, with other behavioral disturbance and delusional disorders.Review of Resident #4's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/08/2025 revealed a BIMS score of 00, which indicated severely cognitively impaired. Review of a facility's critical incident report revealed events occurred on 08/03/2025 at 6:00 p.m. and discovered on 08/03/2025 at 6:00 p.m. and was entered on 08/03/2025 at 7:43 p.m. Incident Investigation: completed by S1ADM (Administrator) on 08/07/2025 at 5:53 p.m. revealed the following in part, S1ADM wrote investigation findings: Resident #4 with a BIMS 99, did sustain a hematoma to the right side of head above the temple. The resident is unable to state or recall the origin of injury. The resident did not complain of pain. Resident was assessed with no further injuries noted. Resident was treated for injury. The injury was first noticed by hall CNA (Certified Nursing Assistant) and was reported to the nurse who examined and treated. Recognition of the injury was early afternoon. Nurse initiated all required protocol for the injury, including contacting physician and family. Charge nurse became aware of the injury approximately 6:00 p.m., and informed the regional nurse and Administrator of the injury. Administrator initiated the investigation and critical incident report.There is no video surveillance to view. There is no roommate to interview.There is no evidence to the origin of injury. Abuse cannot be substantiated. Included in the attachment is face sheet, statement, diagnosis of resident, summary of event, police case, nurses' notes, progress notes, skin assessment, SBAR (Situation, Background, Assessment and Recommendation), and in-service. Review of the SBAR communication form and progress note dated 08/03/2025 revealed in part, hematoma to right side of head above temple. Before getting resident up, CNA reported to this nurse that resident had a hematoma on right upper temporal area. Upon assessment, purplish raised bruising noted. Light blue bruising noted below area. Resident unable to let this nurse know how/when accident occurred.Resident family notified on 08/03/2025 at 10:55 a.m. and NP (Nurse Practitioner) notified on 08/03/2025 at 11:00 a.m.On 08/25/25 at 4:15 p.m., an interview was conducted with S8CNA, she reported she worked 11:00 p.m. - 7:00 a.m. on 08/02/2025. S8CNA stated she made her 1st round on Resident #4 with S9CNA. She stated when they entered the room she noticed a bruise to Resident #4's face and asked S9CNA what happened. S9CNA stated she did not know. S8CNA stated the resident did not complain of pain and could not tell them what had happened to her. S8CNA stated S9CNA reported it to nurse. She stated she did not know how Resident #4 had gotten the bruise. On 08/25/2025 at 4:30 p.m., during an interview with S9CNA, she stated she worked with S8CNA, on the night of 08/02/2025. S9CNA stated when they walked into Resident #4's room, S8CNA asked her what had happened to Resident #4's face. S9CNA, told her she did not know saying that was the first time she had seen it. S9CNA stated she reported to the nurse, S12LPN Licensed Practical Nurse), who was covering the unit at the time. S9CNA stated S12LPN's response was yeah ok. And nothing more was asked of her after that time from anyone at the facility.On 08/25/2025 at 6:33 p.m., 08/26/2025 at 9:14 a.m. and 11:44 a.m., attempts were made to contact S12LPN for phone interview, no answer, and unable to leave a message.On 08/26/2025 at 9:00 a.m., an interview was conducted with S5LPN who stated she was notified by S7CNA, of a bruise to the right side of Resident #4's face on the morning of 08/03/2025, before breakfast. She stated she did not report it to the

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the State Long Term care Ombudsman of a facility-initiated transfer for 1 (#1) out of 4 (#1, #2, #3 and #4) residents sampled. Findings: A review of Resident #1's admission record revealed an initial admission date of 07/17/2025 and a discharged with return anticipated date of 07/27/2025 with diagnoses that included but were not limited to, depression, Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of Resident #1's nurse's notes revealed on 07/27/2025 at 9:30 a.m., Resident #1 transferred out of the facility to the hospital with transportation service via stretcher. A review of the emergency transfer log noting the Ombudsman notifications from July 2025 revealed Resident #1's transfer to the hospital on [DATE] was not identified on the list. On 08/25/2025 at 12:35 p.m., an interview and record review was conducted with S3ADON (Assistant Director of Nursing). S3ADON confirmed Resident #1 was transferred out of facility via a stretcher to the hospital on [DATE]. A review of the Emergency Transfer Log noting Ombudsman notification for July 2025 was conducted. S1ADON confirmed that the State Long-Term Care Ombudsman was not notified of Resident #1's facility-initiated transfer, and should have been.

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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** Based on record review and interviews, the facility failed to implement a comprehensive person-centered plan of care that identified the resident's need for 1:1 (one on one) supervision to manage behaviors for 2 (#1, #3) out of 4 (#1, #2, #3 and #4) sampled residents.Findings:Resident #1Review of Resident #1's EMR (electronic medical record) revealed the resident was readmitted to the facility on [DATE] with a diagnoses not limited to depression, unspecified Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.Review of Resident #1's EMR, progress notes revealed a progress note dated 07/26/2025 at 4:28 p.m.,. Resident #1 stated I'm going to go in my room and hang myself. At 4:30 p.m., S13LPN (Licensed Practical Nurse) notified S10NP (Nurse Practitioner) who gave an n/o (new order) for 1:1 r/t (related to) suicidal ideation. Resident #1 was placed immediately on 1:1 with S13LPN at nurses' station.Further review of the EMR progress notes revealed no evidence of 1:1 supervision of the resident from 07/26/2025 at 9:56 p. m. through 07/27/2025 at 9:30 a.m. Resident #1 was transferred out facility with transportation service to the behavioral hospital on [DATE] at 9:30 a.m. for behaviors.Resident #3Review of Resident #3's EMR revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, bipolar disorder, current episode depressed, moderate; vascular dementia, severe, with psychotic disturbance, vascular dementia, severe, with agitation; major depressive disorder, recurrent, mild and anxiety disorder, unspecified.Review of Resident #3's EMR progress note's revealed on 08/09/2025 at 3:43 p.m., S10NP documented: Spoke with S4LPN on memory care unit. S10NP was advised that Resident #3 had become aggressive with Resident #2 and began striking Resident #2 in the face multiple times. Residents #1 and #3 were separated for safety. S10NP advised S4LPN to place Resident #3 on 1:1 and consult inpatient psych. Further review of Resident #3 EMR progress notes revealed no evidence of 1:1 supervision of the resident from 08/09/2025 at 3:20 p.m. until Resident #3 transferred out facility with transportation service to the behavioral hospital on [DATE] at 11:15 p.m.On 08/25/2025 at 12:35 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing). She confirmed she was aware of the incident of suicidal ideation of Resident #1 and the resident to resident altercation with Resident #2 and Resident #3. S3ADON reviewed Resident #1's EMR and confirmed the nursing documentation for Resident #1's 1:1 supervision was not documented in the EMR from 07/26/2025 at 9:56 p.m. through 07/27/2025 at 9:30 a.m., before Resident #1 was transferred out of the facility to the behavioral hospital. S3ADON also reviewed Resident #3's EMR and confirmed there was documentation in the progress note from S10NP for 1:1 supervision, but there was no documentation one to one supervision had been implemented for Resident #3 after the incident on 08/09/2025 at 3:20 p.m. until Resident #3 was transferred out of facility.On 08/26/2025 at 9:42 a.m., an interview was conducted with S10NP, she confirmed she was notified by the facility of the suicidal ideation for Resident #1 on 07/26/25 and gave a telephone order to initiate 1:1 supervision and consult inpatient psych. She also confirmed she had given a telephone order on 08/09/2025 to S7LPN for 1:1supervision after the resident to resident altercation for Resident #3 with a consult for inpatient psych care.