STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High Hope Care Center	475 High Hope 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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews the facility failed to provide quarterly statements for resident personal funds accounts for 1 (#17) resident out of 5 residents reviewed for personal funds. Findings: Review of Resident #17's EMR (electronic medical record) revealed an admit date of 08/10/2023 with diagnoses that included major depressive disorder, panic disorder and sleep apnea. Further review revealed she was her own Responsible Party (RP). Review of Resident #17 EMR revealed an MDS (Minimum Data Set) assessment dated [DATE] that revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact. On 03/16/2026 at 10:34 a.m., during an interview with Resident #17. She stated she had personal funds in an account at the facility. Resident #17 further reported she had never received a quarterly statement since being at the facility. On 03/17/2026 at 11:15 a.m., an interview was conducted with S2AC, she reported she was responsible for ensuring the resident quarterly statements were sent out for the resident or RP with funds entrusted to the facility. S2AC stated if a resident was their own RP, they would receive their quarterly statement, and it was hand delivered to the resident. S2AC confirmed Resident #17 was her own responsible party and received a hand delivered statement quarterly. S2AC could not confirm if Resident #17 received a quarterly statement. There was no evidence presented prior to exit of the survey that the resident had received quarterly statements.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interviews, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment related to PASARR (Preadmission Screening and Resident Review) Level II determinations for 2 (#7, #58) out 3 resident reviewed for PASARR. Findings: Resident #7 A review of Resident #7's EMR (electronic medical record) revealed an admission date of 05/04/2024 with diagnoses that included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, recurrent severe without psychotic features, and generalized anxiety disorder. Further review of Resident #7's EMR revealed a PASRR Level II Evaluation Summary and Determination with an issue date of 09/30/2024. Review of Residents #7's comprehensive MDS assessment with an Assessment Reference Date (ARD) of 05/15/2025 revealed the PASARR Level II status was coded as not indicated. On 03/18/2026 at 10:30 a.m., an interview was conducted with S7MDS who was responsible for resident MDS assessments. S7MDS stated that she was unaware of Resident #7's Level II PASARR status. S7MDS confirmed the last comprehensive MDS assessment was on 05/15/2025 was coded incorrectly. Resident #58 A review of Resident #58's EMR revealed an admission date of 02/18/2026 with diagnoses that included, but were not limited to, anxiety disorder due to known physiological condition, schizophrenia, and unspecified intellectual disabilities. Further review of the EMR revealed a PASRR Level II Evaluation Summary and Determination effective 02/13/2026 through 08/14/2026. Review of Residents #58's comprehensive MDS assessment with an ARD of 02/24/2026 revealed the PASARR Level II status was coded as not indicated. On 03/17/2026 at 1:47 p.m., a concurrent record review and interview was conducted with S7MDS. S7MDS reviewed Resident #58's PASRR documentation and confirmed Resident #58 had a Level II determination effective 02/13/2026. S7MDS stated she had not previously used this documentation to verify PASARR status and confirmed the MDS assessment was coded inaccurately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure all drugs and biologicals remained locked in stored compartments of 1 medication cart when unattended during medication pass.Findings:On 03/18/2026, review of the facility's Medication Storage policy and procedure indicated Date Reviewed/Revised: 2026. The policy read, in part, All drugs and biologicals will be stored in locked compartments (i.e., medication carts. and During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.On 03/17/2026 at 2:51 p.m., when approaching the Hall W nurses' station, Med Cart A was observed midway down the hallway. There was no nurse in sight. Approaching the cart, it was observed that the back of the cart was near the wall of the hallway, with the front face of the cart facing the center of the hallway and providing access to the drawers of the cart. No nurse attended the cart or was within line of sight of the cart. The locking mechanism for the drawers was protruding from the front center of the cart, indicating it was unlocked. Drawers were successfully pulled open confirming the cart was unlocked. Drawers contained resident's medications and associated biologicals. At this time, S8LPN appeared from a nearby resident's room. S8LPN confirmed the medication cart was unlocked and unable to be seen and accessed when she stepped away from the cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of the facility's policy and procedures, the facility failed to store food in accordance with professional standards for food service, and ensure sanitary conditions were maintained in the kitchen as evidenced by: bulk items, juice, and snacks stored without the used by/expiration date, and without the date the items were delivered and/or opened; andbuildup of grime and water stains on bottom shelf of a food preparation table and dish covers storage rack. This deficient practice had a potential to affect 90 residents who consumed food from the kitchen. Findings: 1. On 03/16/2026, a review of the facility's policy titled, Storage of Food and Non-Food Items with last reviewed date of 02/27/2026, read in part, Policy: All food or non-food items are stored in a safe and sanitary manner .Procedure: 1. Dry Storage .E. Food items are marked with the date of delivery as they are stored. Boxes, cans and bags are marked individually.On 03/16/2026 at 8:56 a.m., a tour of the dry food storage area and an interview was conducted with S2DS who stated she was in charge of the kitchen. The following items were observed: Three large plastic bulk storage containers with individual labels of flour, fish fry, and rice without the dates to indicate when they were delivered, opened and placed in the containers, or the used-by date for the items. S2DS stated the containers were supposed to be dated with the date they were placed in the container and the use-by date from the original container the items were removed. She stated she did not have the original boxes anymore therefore did not know the date. Further observation of the dry storage area revealed 7 containers with 710 ounces each of liquid that were not labeled with the use-by date, expiration date, or delivery date: 3 concentrated orange juice, 1 concentrated apple juice, and 3 concentrated cranberry juice. S2DS stated the juices were removed from a box with dates that should have been placed on the containers at the time they were removed from the original box. Continued observations revealed a drawer with crackers and snack packs that were not labeled with the use-by date: 72 wheat crackers snack packs, 82 cheese crackers, and 87 [NAME] snack packs. S2DS stated the items came in boxes with use by dates and the dates should have been saved with the items, but were not. 2. On 03/16/2026 a review of the facility's policy titled Cleaning Schedule with a last reviewed date of 02/27/2026 read in part, Policy: A cleaning schedule is established by the dietary manager for the daily, weekly and monthly cleaning procedures in the dietary department. Proper cleaning procedures are followed for each piece of equipment. Procedure: 1. All equipment and work areas are cleaned after each use or on a routine basis. 2. A cleaning schedule is established by the dietary manager. The cleaning schedule lists the cleaning tasks to be performed, the person or position responsible for each task and the time frame for cleaning 3. The cleaning schedule is posted in the dietary department . On 03/16/2026 at 9:15 a.m., an observation was made of a two shelves metal rack that was used to store the hard plastic meal covers. The rack was observed with brown grime around the legs and white water stains on the bottom shelf of the cart. S2DS confirmed the findings. She stated that the white water statins were hard to come off, but there should be no grime on the rack. S2DS stated staff should have cleaned the rack before storing the meal covers. Further observation revealed the bottom shelf of the metal food preparation table had a buildup of grime around the legs. There were hamburger buns stored in a plastic bag which were in a hard plastic container on the shelf. S2DS confirmed the findings. She stated the prep table should not be like that, there was a cleaning schedule for staff to clean the kitchen equipment. On 03/16/2026 at 10:39 a.m., an interview was conducted with S1ADM who was responsible for the day to day functions of the facility. He stated that he was made aware of the findings in the kitchen by S2DS and confirmed the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an effective infection control program by failing to ensure laundry staff wore appropriate personal protective equipment (PPE) while sorting soiled laundry to prevent the spread of infection.Findings:A review of the facility's policy titled Laundry and Bedding, Soiled, last reviewed 01/27/2026, read as follows; Onsite Laundry Processing 1. Hand hygiene products, as well as appropriate PPE (i.e., gloves and gowns) are available and used while sorting and handling contaminated linens.During a tour of the facility's laundry room on 03/17/2026 at 2:05 p.m., S4LS, a laundry staff member, was observed sorting visibly soiled laundry. At that time, S4LS was not wearing a disposable gown. He confirmed that the laundry was from residents and was soiled. S4LS further acknowledged that a disposable gown should have been worn while sorting soiled resident laundry but was not.On 03/17/2026 at 2:07 p.m., an interview was conducted with the housekeeping and laundry supervisor identified as S5HS, who affirmed that S4LS was handling contaminated resident laundry and should have been wearing a disposable gown as a part of his PPE.On 03/18/2026 at 2:35 p.m., an interview was conducted with S6IP who is a certified infection preventionist and is responsible for the facility's infection control program. S6IP validated that facility protocol required staff to wear PPE that included disposable gowns when sorting resident soiled laundry.