STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676316	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High Hope Care Center of Brenham	401 East Blue Bell Road Brenham, TX 77833

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three of eight residents (Resident # 9, Resident #19, and Resident # 37) reviewed for ADL care.The facility failed to ensure Resident #9, Resident #19 and Resident #37's nails were cleaned on 03/24/2026.This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem.Findings included:Resident #9Record review of Resident #9's face sheet, dated 03/26/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: type 2 diabetes mellitus with unspecified complications (the body develops insulin resistance and cannot use insulin effectively, leading to high blood glucose (sugar) levels. The person did not reported specific complications or acute, severe symptoms at the time of examination), anxiety disorder (involve more than occasional worry or fear, does not go away, is felt in many situations, and can get worse over time), and unspecified dementia, unspecified severity, with other behavioral disturbance (when a person shows significant memory decline- affecting thinking and daily functioning. However, the specific cause and severity are not yet determined) and, major depressive disorder, single episode, unspecified (a low mood or loss of pleasure or interest in activities lasting at least two weeks), Record review of Resident #9's Quarterly MDS Assessment, dated 02/19/2026, reflected Resident #9 was rarely/never understood. Staff was unable to complete Brief Interview for Mental Status (BIMS). She had poor short- and long-term memory recall. Her decision-making abilities was severely impaired (she rarely /never made decisions) Resident #9 did not refuse care. Resident #9 was totally dependent on staff for the following ADLs: eating, oral hygiene, toileting hygiene, showers, lower and upper body dressing, personal hygiene, bed mobility, and transfers.Record review of Resident #9's Comprehensive Care Plan, revised on 03/04/2026, reflected Resident #9 was dependent on staff for ADLs at all times related to dementia. Intervention: Resident #9 was dependent on staff with the following:Grooming- dependent on staffPersonal hygiene- dependent on staffDressing- dependent on staffBed mobility- dependent on staffEating -dependent on staffToileting- dependent on staffOral hygiene- dependent on staff Observation and interview on 03/24/26 at 12:00 p.m. revealed Resident #9 was lying in bed in her room. She had a blackish/brownish substance underneath her middle, ring and fore fingernails on her right hand. Resident #9 was not interview able.Observation and interview on 03/25/2026 at 8:00 a.m. revealed Resident #9 was lying in bed in her room. She had a blackish/brownish substance underneath her middle, ring and fore fingernails on her right hand. Resident #9 was not interview able.Resident#19Record review of Resident #19's face sheet, dated 03/26/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #19 had diagnoses of major depressive disorder, single episode, severe without psychotic features (a low mood or loss of pleasure or interest in activities lasting at least two weeks), unspecified lack of coordination (a general inability to control or coordinate muscle movements that cannot be linked to a specific underlying diagnosis), and spastic hemiplegia affecting right dominant side (brain damage causing stiffness, muscle (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tightness, and diminished control of the right arm and leg).Record review of Resident #19's MDS assessment dated [DATE], reflected Resident #19 had a BIMS score of 15 which indicated his cognition was intact. Resident #19 did not refuse care. He was dependent on staff for the following ADLs: dressing, showers, and toileting hygiene. Resident #19 required substantial/ maximal assistance (helper does more than half the effort) with personal hygiene.Record review of Resident #19's revised care plan dated 03/03/2026, reflected Resident #19 had an ADL self-care performance deficit related to right side paresis (weakness on the right side of the body). Interventions: Resident #19 required assistance with dressing, grooming and personal hygiene.Record review of Resident #19's Skin Observation Tool Assessment, dated 03/18/2026 reflected Resident #19 did not refuse nail care.Record review of Resident #19's Skin Observation Tool Assessment, dated 03/25/2026 reflected Resident #19 did not refuse nail care.Observation and interview on 03/24/2026 at 12:50 p.m. revealed Resident #19 was sitting in his room sitting in his wheelchair. Resident #19's fingernails on his right hand underneath his middle and ring fingernails had a blackish/brownish substance. He had blackish/brownish substance underneath his middle and fore fingernails on his left hand. Resident #19 stated he did not like his nails to be dirty. He stated he asked someone Saturday (03/21/2026) to clean his nails and the person stated they would get someone to clean them sometime next week. Resident #19 stated he did not recall the staff name. He stated she worked with the nurses.Resident #37Record review of Resident #37's face sheet, dated 03/26/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #37 had diagnoses unspecified dementia, unspecified severity, with other behavioral disturbance (when a person shows significant memory decline- affecting thinking and daily functioning and with behaviors), unspecified lack of coordination (type 2 diabetes mellitus with other diabetic circulatory problems (occurs when chronic high blood sugar damages blood vessels, narrowing them and restricting blood flow throughout the body), unspecified lack of coordination (a general inability to control or coordinate muscle movements that cannot be linked to a specific underlying diagnosis), major depressive disorder, recurrent severe without psychotic features (a severe mental condition characterized by persistent low mood, loss of interest, and physical/cognitive symptoms lasting at least two weeks), unqualified visual loss in both eyes (vision impairment such as blindness or low vision, where the specific category of severity of the impairment. The exact visual deficit was not clearly classified), and hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side (a neurological deficit caused by bleeding in the brain (non-trauma) that damages the right hemisphere- controls left side of the body)Record review of Resident #37's MDS assessment dated [DATE], reflected Resident #37 had a BIMS score of 2 which indicated his cognition was severely impaired. Resident #37 was dependent on staff for the following:Eating- dependent on staffOral Hygiene- dependent on staffToileting Hygiene- dependent on staffShower/Bathe - dependent on staffUpper and lower body dressing- dependent on staffPersonal Hygiene - dependent on staffTransfers - dependent on staffBed mobility - dependent on staffRecord review of Resident #37's care plan was revised on 02/18/2026 reflected Resident #37 had an ADL self-care performance deficit due to dementia (memory loss that is severe enough to interfere with daily life) and visual impairment (a person's eyesight cannot be corrected to a normal level). Resident #37 required assistance with personal hygiene and bathing and report any refusals. Resident #37 was dependent on staff for eating, personal hygiene, showers, dressing, transfers, and bed mobility.Record review of Resident #37's skin observation tool assessment, dated 03/16/2026, reflected Resident #37 did not refuse nail care.Record review of Resident #37's skin observation tool assessment, dated 03/23/2026, reflected Resident #37 did not refuse nail care.Observation and interview on 03/24/2026 at 10:00 am revealed Resident #37 was lying in her bed located in her room. Resident #37's fingernails on her left hand underneath his middle and ring fingernails had a blackish/brownish substance. Resident #37 was not interview able.In an interview on 03/26/2026 at 8:14 am, LVN A stated the nurses were responsible for all residents' nail care such as trimming, cleaning, and filing. LVN A (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill, such as stomach problems nausea and vomiting. LVN A stated if a resident refuses showers, nail care or any type of care the nurses documents the refusal on weekly skin tool assessment. He stated there was one person who refused a lot of care and it was not Resident # 37 and Resident #9, or Resident #19. He stated he had been in-service on nail care, and all staff was to report any nail issues with the resident to the nurse.In an interview on 03/26/2026 at 9:35 am, CNA D stated the nurses was responsible for all nail care. She stated if a CNA observed any problems with a residents nails the CNA was to report it to the nurse supervisor. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as nausea and diarrhea. CNA D stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. CNA A stated anytime a resident refused any type of care she reported it to the charge nurse and the charge nurse would document it in the resident's medical record. She stated she was not aware of anyone on central hall (the hall where Resident #9 and Resident #19 resided) refused care.In an interview on 03/26/2026 at 9:50 am, LVN B stated the Nurses were responsible for cleaning, trimming, and filing all residents' nails. LVN B stated the residents' nails were usually cleaned when nurses completed weekly skin assessments or as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as infection in the stomach. LVN B stated the infection possibly may have symptoms such as vomiting. LVN B stated she was more familiar with Resident # 19, and she was not aware of him refusing care including nail care. She stated if a resident refused nail care the nurse would document it on the skin observation tool assessment.In an interview on 03/26/26 at 1:40 pm, the Administrator stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria, however it would be difficult to determine if the blackish/ brownish substance was bacteria. She stated it was a possibility a resident may become ill with stomach issues such as vomiting and nausea if they ingested the blackish/ brownish substance. She stated the Nurses were responsible for all residents' nails such as cleaning, trimming, and filing. The DON stated the ADON and DON was responsible for monitoring ADL care which included nail care. She stated anyone observe Residents needing any type of nail care was instructed to report to the nurse. She stated an in-service had been given to the staff on nail care and reporting any issues with nails when CNAs are giving residents a shower.Record review of the Facility's Activities of Daily Living (ADL), Supporting Policy, dated 2001, reflected Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:Hygiene (bathing, dressing, grooming, and oral care);

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an ongoing activity program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 (Residents #9, and #37) of 6 residents reviewed for activities. The facility failed to provide activities for Resident #9, and Resident #37to meet their psycho-social and mental well-being for the months of January, February and March 2026.This failure could place residents at risks of boredom, depression, behavior, diminished quality of life and decreased cognitive function. Findings includeResident #9Record review of Resident #9's face sheet, dated 03/26/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: anxiety disorder (involve more than occasional worry or fear, does not go away, is felt in many situations, and can get worse over time), and unspecified dementia, unspecified severity, with other behavioral disturbance (when a person shows significant memory decline- affecting thinking and daily functioning. However, the specific cause and severity are not yet determined) and, major depressive disorder, single episode, unspecified (a low mood or loss of pleasure or interest in activities lasting at least two weeks).Record review of Resident #9's Significant Change MDS Assessment, dated 11/20/2026, reflected Resident #9 was rarely/never understood. Staff was unable to completed Brief Interview for Mental Status (BIMS). She had poor short- and long-term memory recall. Her decision-making abilities was severely impaired (she rarely /never made decisions). Resident #9 Activity Preferences for Customary Routine and Activities section revealed the was no interest in the following :Choosing clothes to wearCaring for personal belongingsReceiving tub bathReceive showerReceive bed bathReceive sponge bathSnacks between mealsStaying up past 8:00 p.m.Family or significant other involvementUse of phone in privatePlace to lock personal belongingsReadingListen to musicBeing around animals such as petsKeep up with the newsDoing things with group of peopleParticipating in favorite activitiesSpending time away from the nursing homeSpending time outdoorsParticipating in religious activities or practices Record review of Resident #9's Quarterly MDS Assessment, dated 02/19/2026, reflected Resident #9 was rarely/never understood. Staff was unable to completed Brief Interview for Mental Status (BIMS). She had poor short- and long-term memory recall. Her decision-making abilities was severely impaired (she rarely /never made decisions) Resident #9 did not refuse care. She was totally dependent on staff for the following ADLs: eating, oral hygiene, toileting hygiene, showers, lower and upper body dressing, personal hygiene, bed mobility, and transfers.Record review of Resident #9's Comprehensive Care Plan, revised on 03/09/2026, reflected Resident #9 was dependent on staff for meeting emotional, intellectual, physical and social needs. Resident #9 will participate in 1-3 programs on unit as tolerated and sensory stimulation 3 times per week. Intervention: Encourage Resident #9's family involvement. Invite Resident #9's family to attend special events, activities, and meals. Invite Resident #9 to scheduled activities. Record Review of the activity participation records for the year 2026 reflected Resident #9 did not attend or receive sensory stimulation three times per week in the month of January 2026 and March 2026. Observation and interview on 03/24/2026 at 12:00 pm Resident #9 was lying in bed and the lights were off in the room. Resident #9 was staring toward wall in front of her and her eyes were moving. The television was not on in Resident #9's room.Observation and interview on 03/24/2026 at 2:00 pm Resident #9 was lying in bed and the lights were on in her room. The television was not on in Resident #9's room. Her eyes were opened and she was staring toward the ceiling. Resident was not interview able. Observation and interview on 03/25/2026 at 10:30 am Resident #9 was lying in bed and the lights was on in her room. The television was not on in Resident #9's room. Her eyes were open and she would move her eyes from side to side as she looked (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toward the ceiling. Resident was not interviewableObservation on 03/26/2026 at 11:00 am Resident #9 was lying in bed and the lights was off in her room. She was asleep.Resident #37Record review of Resident #37's face sheet, dated 03/26/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #37 had diagnoses unspecified dementia, unspecified severity, with other behavioral disturbance (when a person shows significant memory decline- affecting thinking and daily functioning and with behaviors), unspecified lack of coordination unspecified lack of coordination (a general inability to control or coordinate muscle movements that cannot be linked to a specific underlying diagnosis), major depressive disorder, recurrent severe without psychotic features (a severe mental condition characterized by persistent low mood, loss of interest, and physical/cognitive symptoms lasting at least two weeks), unqualified visual loss in both eyes (vision impairment such as blindness or low vision, where the specific category of severity of the impairment. The exact visual deficit was not clearly classified), and hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side (a neurological deficit caused by bleeding in the brain (non-trauma) that damages the right hemisphere- controls left side of the body).Record review of Resident #37's Annual MDS assessment dated [DATE], reflected Resident #37 had a BIMS score of 8 which indicated her cognition was moderately impaired. Resident #37 did not respond to the questions about her activity preferences.Record review of Resident #37's MDS assessment dated [DATE], reflected Resident #37 had a BIMS score of 2 which indicated her cognition was severely impaired. Resident #37's vision was severely impaired- no vision or sees only light, color or shapes; eye do not appear to follow objects.Record review of Resident #37's care plan was revised on 02/18/2026 reflected Resident #37 had visual impairments. She enjoyed socializing with the staff and visits with her family member. Resident #37 will participate in 1:1 (in room activities) 5 times per week. Interventions: Interview Resident #37 for her activity preferences and provide activities of known interest when possible. Invite Resident #37's family to attend activities with the resident in order to support participation. Offer to turn on television for resident to hear. Place monthly activities calendar in resident room, alert resident of activities due to visual impairments.Record review of Resident #37's Activity Assessment, dated 09/25/2025, reflected Resident #37's activity preferences was the following: 1:1 visits (in room activities), devotional readings, stop and chat (when she is in the hall people stop and talk to her), visits with family and likes to talk with staff with a good sense of humor. She loves to listen to music. Signed by Activity Director.Record review of Resident #37's activity participation record for the months of January , February and March of 2026 reflected Resident #37 did not receive 1:1 activities (in room activities) five times per week as assessed on her care plan. Observation and interview on 03/24/2026 at 10:00 am Resident #37 was lying in bed. She stated I can't see anything when introduced self to Resident #37. She stated she liked music and would listen to music. Resident #37 stated can you turn radio on so I can hear it. There was not a radio in her room. Resident #37's television was not turned on in her room. Resident #37 stated yes when asked if she wanted to listen to music on the television. She also stated yes when asked if she liked listening to news or have someone to read to her. She was in a quiet room. Observation and interview on 03/25/2026 at 8:15 am Resident #37 was lying in bed. She stated yes when asked if she liked listening to music, listening to news on television or have someone to read to her. She stated yes when asked if became lonely sometimes. She stated, I like to talk. The television in her room was not on at the time of visit. She was in a quiet room.Observation and interview on 03/26/2026 11:10 am Resident #37 was lying in bed in a quiet room She stated yes when asked if she liked listening to music and if she wanted to listen to music. She stated yes I do when asked if she became lonely sometimes during the day. Resident #37 did not answer any further questions. The television was not on in resident #37's room.Interview on 03/24/2026 at 11:05 a.m. the Activity Assistant stated the Activity Director was on leave and would be off for a few months. She stated she was trained by the Activity Director prior to her taking a leave of absence from work. She stated the Activity Director did explain to her about activities and in-room activity program. She (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she was trained on care plans and to follow the Residents activity care plan. The Activity Assistant stated stop and chat was an activity the activity staff would do when a resident was in hallway or in dining room and the activity staff would stop and speak to the resident. She stated they would ask how the resident was doing and if the resident was not interview able the activity staff would report the weather and the day of week. She stated the activity staff did not sit and do an actual activity with the residents and the activity staff would speak to the resident. She stated if a resident was not receiving activities there was a possibility a resident may become depressed, bored and become isolated in their room. The Activity Assistant stated she had been doing the job for a few weeks. She stated she was trained on how to document in the computer when she did any activity with a resident. The Activity Assistant reviewed the participation records with surveyor and stated Resident # 9 and Resident # 37 did not receive the activities they were expected to receive according to their care plan during the months of January, February and March of 2026. Interview on 01/08/2026 11:45 a.m. the Administrator stated she expected a variety of activities to be provided for all residents. She stated each resident's activity preference needed to be assessed, and each resident's activity was expected to be planned according to their activity preferences. She stated activities such as independent, in-room, and/or group activities were to be documented on participation records. The Administrator stated she expected all residents to be interviewed, and their activity preferences updated and all care plans to be revised to reflect each resident's activity preferences. She stated the activity department was already discussed and a Performance Improvement Project known as a PIP was in place to improve the activity program in the facility. She stated if a resident was not receiving activities there was a potential a resident would have a decline in their cognition, mental status, physical status and quality of life. She stated a resident with a history of depression may become depressed and isolate themselves in their rooms. The Administrator stated the Activity Director and Activity Assistant was responsible for the activity programming and documentation of all activities department including participation records. She stated she was the Activity Director supervisor. Record review of the Activity Director's Personnel revealed the Activity Director completed the 45 hours of study and testing for Activity Director and received her activity certification on 01/07/2026. Reviewed Activity Assistant training from the Activity Director.Record review of the Facility Activity Programs Policy, dated June 2018, reflected Activity programs are designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident. The activities program was provided to support the well-being of residents and to encourage both independence and community interaction. Activities offered are based on the preferences of each resident. Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure each resident was treated with respect, dignity and care for 1 of 4 residents (Resident #9) observed for resident rights. The facility failed to ensure Resident # 9's privacy curtain was used or the door to her room was closed when she her private area was exposed when lying in bed. This failure could place residents at risk of feeling embarrassed and diminish the resident's quality of life.Findings included Record review of Resident #9's face sheet, dated 03/26/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: unspecified dementia, unspecified severity, with other behavioral disturbance (when a person shows significant memory decline- affecting thinking and daily functioning. However, the specific cause and severity are not yet determined) and, major depressive disorder, single episode, unspecified(a low mood or loss of pleasure or interest in activities lasting at least two weeks), and anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily functioning). Record review of Resident #9's Quarterly MDS Assessment, dated 02/19/2026, reflected Resident #9 was rarely/never understood. Staff was unable to completed Brief Interview for Mental Status (BIMS). She had poor short- and long-term memory recall. Her decision-making abilities was severely impaired (she rarely /never made decisions) Resident #9 did not refuse care. Resident #9 was totally dependent on staff for the following ADLs: eating, oral hygiene, toileting hygiene, showers, lower and upper body dressing, personal hygiene, bed mobility, and transfers.Record review of Resident #9's Comprehensive Care Plan, revised on 03/04/2026, reflected Resident #9 was on an anti-anxiety medication related to anxiety. Intervention: Monitor Resident #9 for any mood or behavior indicators and notify physician as needed. Resident #9 was dependent on staff for ADLs at all times related to dementia. Intervention: Resident #9 was dependent on staff with the following:GroomingPersonal hygieneDressingBed mobilityEatingToiletingOral hygiene Observation and interview on 03/24/2026 at 12:00 pm Resident #9 was lying in her bed. The door to her room was opened and the privacy curtain was not used to provide privacy for Resident #9. She did not have a sheet over her and her brief was below the top of her vagina area. Anyone passing Resident #9's room was able to see top portion of her vagina area. Resident was not interviewable.Observation on 03/24/2026 at 12:05 pm staff passing Resident #9's room and was looking in her room and did not enter the room to cover Resident #9 or use the privacy curtain. Interview on 03/24/2026 at 12:09 pm the housekeeping supervisor stated she did enter Resident #9's room and she did not notice if Resident #9 was exposed. She stated she looked toward Resident #9 but did not notice she was exposed. She stated she went in to check things in the room and did not notice Resident #9. She stated she had been in serviced on resident rights and dignity. She did not recall the date of the in-service. The Housekeeping Supervisor states she could have covered Resident #9 with her blanket or asked nursing staff to check on Resident #9. She stated there was a possibility a person may become embarrassed if their private areas were exposed to other people. Interview on 03/26/2026 at 9:35 a.m., CNA D stated she had been trained on resident rights. She stated it was recently but did not recall the exact date. CNA D stated staff were responsible for providing privacy to the residents to ensure their private areas was not exposed where other people walking in the hall could see a resident private area. She stated she was not aware Resident #9 removed her sheets or bedspread when she was lying in bed. She stated if privacy was not provided a resident may feel ashamed or embarrassed. CNA D stated the charge nurse or the DON monitored to ensure staff were providing privacy. CNA D did not respond when asked if she was assigned to Resident #9 on 03/26/2026. Interview on 03/26/2026 at 9:50 a.m., LVN B stated she had been trained on resident rights. She stated she did not recall the last time she had in-service on resident rights. (continued on next page)

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	676316	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High Hope Care Center of Brenham	401 East Blue Bell Road Brenham, TX 77833

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated any staff observed a resident private area exposed to people walking in the hallway was responsible to cover resident with blanket, bedspread or use the privacy curtain. She said it could be a dignity issue if a resident private area was exposed for anyone to view when walking down the hall. She stated a resident could feel embarrassed or humiliated. LVN B stated this was against a resident rights to be exposed for visitors or other residents to see a person's private area while the person was lying in bed. LVN B stated he was the nurse assigned to the hall where Resident #9 resided.Interview with the Administrator on 03/26/2026 at 1:40 p.m., she stated in-services had been given to all staff regarding dignity and resident rights. She stated she did not recall the date of the last in-service. The Administrator stated it was a resident right to preserve the resident's dignity. She stated if the Housekeeping Supervisor went into Resident #9's room she was expected to notice the resident and if she had observed Resident #9 exposed, she could have asked for assistance used privacy curtain or pull the bedspread over the resident and report it to the nurse. The Administrator stated all staff was responsible to ensure Resident Rights are being followed including dignity. She stated if a resident was exposed there was a possibility the resident may become embarrassed, feel humiliated or can become upset by other people in the hall observing their private area.Record review of the Facility's Policy on Quality of Life- Dignity, dated 08/2009, reflected Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Resident shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 (Resident #37) reviewed for accidents hazards and supervision.The facility failed to ensure Resident # 37's fall mat was in place on 03/19/2026.This failure could place resident at risk for falls with the possibility of injury, including fractures. Findings included:Record review of Resident #37's face sheet, dated 03/26/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #37 had diagnoses unspecified dementia, unspecified severity, with other behavioral disturbance (when a person shows significant memory decline- affecting thinking and daily functioning and with behaviors), unspecified lack of coordination (a general inability to control or coordinate muscle movements that cannot be linked to a specific underlying diagnosis), unqualified visual loss in both eyes (vision impairment such as blindness or low vision, where the specific category of severity of the impairment. The exact visual deficit was not clearly classified), and hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side (a neurological deficit caused by bleeding in the brain (non-trauma) that damages the right hemisphere- controls left side of the body)Record review of Resident #37's MDS assessment dated [DATE], reflected Resident #37 had a BIMS score of 2 which indicated his cognition was severely impaired. Resident #37 was dependent on staff for the following:Toileting HygieneTransfersBed mobilityRecord review of Resident #37's care plan was revised on 02/18/2026 reflected Resident #37 was at risk for falls related to dementia. She was unaware of safety needs. Interventions: Resident #37 required fall mat beside bed. Assure call light within reach and encourage resident to call for assistance as needed. Resident #37's bed needed to be in low position when resident is in bed. Anticipate and meet Resident #37's needs.Record review of Resident #37's physician order, dated 3/18/2026, reflected Resident #37 had an order dated on 06/02/2025 -fall mat next to bed. Observation and interview on 03/24/2026 at 10:00 am Resident # 37 was lying in bed. The rolling bedside table was located beside Resident #37's bed. The fall mat was located at the foot of the bed. Resident #37 stated I am afraid of falling and I did not need to break a bone. Observation and interview on 03/26/2026 at 8:53 am Resident #37's bed was moved at an angle, and the head of bed was beside tall chest of drawers. Resident #37's fall mat was not beside her bed. Resident #37 stated I don't want to fall I am afraid of falling. Interview on 03/26/2026 at 9:05 am The Director of Nurses stated if a fall mat was on a resident care plan it was expected to be beside the resident's bed. She stated the fall mat was not to be at an angle and was to be placed directly beside from the head of the bed to the foot of the bed. She stated there was a possibility Resident #37 hit her head on chest of drawers or the floor. She stated the resident could possibly sustain an injury such as broken bone. The Director of Nurses stated anytime a resident has a fall precaution in place she expected all staff to ensure the fall precaution is in place at all times. Record Review of Fall Prevention, dated April 2012, reflected Review thoroughly at-risk individuals in team conference, formulate interdisciplinary goals addressing safety, identify specify strategies for fall prevention in the care plan, related to the resident's specific risk factors and condition, and communicate level of risk to staff caring for resident.

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	676316	A. Building B. Wing	03/26/2026

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain an Antibiotic Stewardship program for 1 of 1 facility's reviewed for Antibiotic Stewardship. The facility failed to provide the track and trending log to include Resident #45 and Resident #48, who were receiving UTI prophylactic antibiotics. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: Resident #45Record review of Resident #45's face sheet, dated 03/25/2026, revealed a seventy-two-year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Her admitting diagnosis was urinary tract infection (a bacterial infection in the urinary system (kidneys, ureters, bladder, or urethra), commonly causing burning pain when urinating, a frequent urge to pee, and cloudy or foul-smelling urine), dementia (a progressive syndrome causing cognitive decline-memory loss, thinking, and behavior changes-that interferes with daily life), and major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy). Record review of Resident #45's Quarterly MDS dated [DATE] revealed Section C - Cognitive Patterns indicated a BIMS score of 14 indicating no cognitive issues. Record review of Resident #45's care plan revealed a focus, undated, Resident #45 was on an antibiotic as prophylactic (intended to prevent disease) related to a UTI hospitalization from 02/15/2025 - 02/15/2025. Resident #45 had chronic UTI's with intervention, undated, administer medication as ordered, notifying MD and RP of any changes. Resident #48Record review of Resident #48's face sheet, dated 05/25/2026, revealed a ninety-five-year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Her admitting diagnoses included unspecified kidney failure (occurs when kidney function stops, but the underlying cause remains unknown, or when it is not immediately classified as acute or chronic), and personal history if UTIs (a documented record of recurring urinary tract infections. It is defined as having at least two infections within six months or three within a year). Record review of Resident #48's Quarterly MDS (clinical assessment to determine resident's strength and needs) dated 11/24/2025 revealed Section C - Cognitive Patterns revealed no BIMS score. Record review of Resident #45's care plan revealed a focus dated 02/28/2024 Resident #48 was on prophylaxis antibiotics due to history of UTI due to overactive bladder with intervention dated 06/11/2021 administer antibiotic as ordered observing effectiveness and for side effects and notify physician as needed. Record review of antibiotics and infection tracking revealed facility had not maintained tracking for Resident #45 and Resident #48. During an interview on 03/26/2026 at 9:49 AM the DON said she did not like prophylactic antibiotics for UTIs because it opened the residents to C.Diff (a bacterium causing severe, watery diarrhea, abdominal pain, and fever, often after antibiotic use disrupts normal gut flora) and helped contribute to building up a resistance to antibiotics. The DON said she had discussed Resident #45 and Resident #48s' antibiotic use with the MD, but she did not record this in the facility track and trending log. The DON said she was responsible for monitoring infection control for the facility, and the Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcome infection control facility policy was not followed. Record review of facility Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes dated 2001 reflected antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.