STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676476	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights on Valley Ranch	23200 Valley Ranch Parkway Porter, TX 77365

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on interviews and record review, the facility failed to promote and facilitate resident self- determination through support of resident choice for 1 of 4 residents (Resident #1) reviewed for resident rights. The facility failed to promote Resident #1's self-determination by not allowing her to eat in the dining room during meal time. This failure could place residents at risk of a decreased self-worth due to their preferences not being met. The findings include: Record Review of Resident #1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Cerebral Palsy (affects the movement and posture) and hypertension (high blood pressure) and major depressive disorder (mood disorder that causes feelings of sadness). Record Review of Resident #1's MDS dated [DATE] revealed a BIMS score of 12. Resident #1 used a wheelchair or walker as a mobility device; Resident #1 used suitable utensils to eat on her own; however, set up assistance was needed. Record Review of Resident #1's care plan dated 3/26/2024 revealed Resident #1's goals were to improve her ability to care for herself and require less physical dependence on others with ADL's. In an interview with FM A on 10/9/2024 at 2:50pm she stated Resident#1 called her a week in a half ago, which was the end of September 2024 (unsure of actual day) and told her the nursing staff was refusing to allow her to eat her meal in the dining area. She stated Resident #1 stated she was told to eat at the nursing station or in her room because staff had called in sick and there was a shortage of staff. FM A stated she telephoned the facility and spoke with an unidentified nurse who confirmed the shortage and indicated for safety reasons all residents were to either eat in their room or at the table next to the nursing station. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA A at 4:23pm she stated she worked with Resident #1 for 4 days out of the week. She stated when there is staff shortage residents have to eat in their rooms or by the nursing station. She stated, Resident #1 had Covid in August 2024 (unsure of date) and was quarantined. She stated that being confined to her room with the door closed was difficult for Resident #1. During the quarantine, Resident #1 would have outbursts and began screaming, hollering, and yelling because Resident #1 was feeling like she was boxed in a small space. CNA A further stated that the boxed in feeling may have contributed to Resident #1 outburst regarding not being able to eat in the dining room. In an interview with Resident #1 on 10/9/2024 at 5:57pm she stated she wanted to eat in the dining room and not in her room. She stated she didn't like being in her room. She stated she liked being out in the area with other residents. She stated about two weeks ago a CNA pushed her in her wheelchair to the dining room where she got her tray of food. She stated the nurse came in the dining room and told her that they were short of staff, and she had to eat by the nurse's station or in her room. Resident #1 stated she didn't want to eat in her room, and she was okay where she was at. She stated she didn't have an issue eating or swallowing and she didn't want to sit at or near the nursing station to eat nor was she going in her room to eat. Resident #1 stated LVN A picked up her tray and tried to take it, but she held on to it. She stated during the struggle with the tray (both pulling on tray), the food dropped on the floor. She stated the nurse got mad and told her she had to go to her room. She stated the nurse pushed her to her room and had a CNA sat there with her. She stated another tray was brought to her room and she didn't want it. She stated a lot of times staff were not in the dining room, but they wanted to apply the rules that day. She stated every time a staff member called in sick the residents are required to eat in their rooms which is not fair. In an interview with LVN A on 10/9/2024 at 6:54pm revealed she worked with Resident #1 and has recently documented on her behavior issue. LVN A stated Resident#1 is a problem. She stated she spoke with the [NAME] employees who informed her that Resident #1 has a diminished mental capacity of a 5-year-old. LVN A stated about two weeks ago there was a CNA who called in sick and would not be in to work. She stated the call in made the shift short of staff and as a result nurses must be on the floor doing observation and were not available to be in the dining room for observation. During this time, resident are to eat either in their rooms or at the table located next to the nursing station. LVN A stated Resident#1 wanted to go to the dining room during that time and she told her she could choose to eat in her room or next to the nursing station. She stated Resident #1 was adamant about eating in the dining room. She stated Resident #1 convinced another CNA to bring her to dining room. LVN A stated a nursing staff must be in the dining room while residents are there. There was no one monitoring residents in the dining room. LVN A stated she went to grab the tray and Resident#1 knocked all the food items off the tray onto the floor. LVN A stated she told resident she could eat in her room, but she refused. LVN A stated if Resident #1 wanted to eat in her room, there were aides in the hall that could look in her room and monitor her, but they would not be by her bedside. LVN A stated CNA B was asked to sit with Resident #1 after she took her to her room. LVN A knew the resident was upset. In an interview with the Admin on 10/9/2024 at 7:11pm he stated if an employee called in sick for their work shift, then facility policy was to call a worker in to cover that shift PRN (as needed). He stated all residents have a right to eat in the dining area and being denied because of a staff shortage was unacceptable. He stated he was unaware of that process and did not know that Resident #1 was denied the right to eat in the dining room. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with PCM on 10/10/2024 at 10:30am revealed she visited 10/8/2024, with Resident #1 and during that visit, Resident #1 was crying. She stated Resident #1 told her she was manhandled (forced back to her room by a LVN pushing her in the wheelchair) back to her room from the dining area after she refused to eat in her room because the facility was short of staff. PCM stated Resident #1 does not like to eat in her room. Resident #1 likes to eat in the dining room with other residents. In an interview with CNA B on 10/10/2024 at 2:31pm revealed about two weeks ago (couldn't remember exact date), earlier during lunch time she was caring for some residents in their rooms, and she heard Resident #1 screaming, then what appeared to be a crash. She was informed by LVN A, that Resident #1 didn't want to eat in her room and got upset and knocked the food and tray on the floor. She stated LVN A wheeled Resident#1 to her room so that she could decompress and calm down because she was screaming and disturbing the other residents. CNA B stated she has been informed and trained that when staff is not available or there is a shortage of staff, the dining room is closed, and residents are to eat in their rooms because there are no staff to observe the resident in case of an emergency. CNA B stated she brought Resident #1 a food tray from the dining room, and Resident#1 told her she wasn't going to eat what was in the tray because it wasn't what she ordered or had while in the dining room. CNA B stated Resident#1 continually stated to her that she needed to eat because she was losing a lot of weight. She stated she took the tray back, told LVN A Resident #1 didn't want to eat what was on the tray. CNA B stated LVN A didn't say anything about the tray, so she returned the tray to the dining area and there wasn't another tray given to resident after her refusal. In an interview with an anonymous resident on 10/11/2024 at 12:22pm stated if there was a staff shortage, residents are required to eat in their rooms or at the supervisor's desk area. She stated this was not an issue for her since she liked to eat in her room anyway. However, she stated she knew Resident #1 does not like to eat in her room. In an interview with Resident #3 on 10/11/2024 at 12:42pm she stated, when there is a shortage of staff because staff member calls in and stated they would not be in for their work shift, residents are required to eat in their room or in the area where the nurse station is located. She stated the residents have no other choice. She stated she didn't mine eating in her room but knows Resident #1 does not like it because she liked eating in the dining area. In an interview with CNA C on 10/11/2024 at 3:45pm revealed when the facility is short staffed sometimes residents must eat in their rooms or in the area of the nursing station so if there is an issue with choking or something then the nurses can address it immediately. She stated this is only an issue with Resident #1 because she always wants her way. Record review of the facility's Resident Rights Policy dated 2/2017 and revised 10/2022 revealed, the community should educate, encourage, and honor the rights of those we serve. The Community will promote the exercise rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. Record Review of the facility's Quality of Life policy dated 0/2017 and revised 1/2023 revealed: Dignity - Community will promote care of residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his individuality. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Self-determination and participation. Resident has a right to: C. Make choices about aspect of life in the community that are significant to them.