

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2026
NAME OF PROVIDER OR SUPPLIER The Heights on Valley Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections to meet the needs of 2 of 5 residents (Resident #1 and Resident #2) reviewed for infection control. The facility failed to enter Resident #1's contact isolation orders in her electronic medical record and failed to initiate contact precautions for Resident #1 who was positive for c.difficile (a bacterium that causes an infection of the colon) for 2 days. The facility failed to separate Resident #2 from Resident #1, who had a confirmed c. difficile infection, in a timely manner. This failure could place residents at risk of spread of infection. The findings included: Record review of Resident #1's admission record dated 7/18/26 revealed an [AGE] year-old female who readmitted on [DATE]. Her diagnoses included acute respiratory failure (when your lungs cannot deliver enough oxygen or remove enough carbon dioxide from your blood), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), legal blindness, anxiety, and type 2 diabetes. Record review of Resident #1's discharge, return anticipated MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were modified independence. She required partial/moderate assistance from staff with toileting hygiene. Record review of Resident #1's care plan report completed 6/5/26 revealed she was at risk for infection or recurrent/chronic infection related to compromised medical condition. Interventions were to report changes in condition to the MD as clinically indicated. Record review of Resident #1's nursing note dated 6/10/26 at 12:32 p.m. written by LVN W revealed in part, .Resident reports having nausea, vomiting, diarrhea last couple of days on/off. Notified. NP ok for stat cbc/cmp/collect stool for c-diff/ Zofran 4 mg po TID prn nausea and vomiting x 7 days. (A cbc evaluates blood cells, while a cmp assess organ function and metabolic balance. A stool tests for C. diff detects the presence of toxin-producing bacteria in individuals with diarrhea). Record review of Resident #1's undated Lab Results Report for her C-Difficile stool sample revealed the lab reported the results to the facility on 6/11/26 at 9:47 p.m. The facility reviewed the results on 6/12/26 at 2:50 p.m. The result of the stool test was detected which indicated the specimen contained toxigenic (producing a toxin) C difficile strain with pathogen locus (refers to a specific location in the genome of a pathogenic microorganism that contains genes or genetic elements directly involved in causing disease). Record review of Resident #1's nursing note dated 6/12/26 at 2:50 p.m. written by LVN D revealed in part, .Results for C-Diff showing detected. Notified NP of results. Awaiting orders at this time. Monitoring. Record review of Resident #1's nursing note dated 6/12/26 at 3:11 p.m. written by LVN D revealed in part, .New order for Vancomycin 125 mg. use contact precautions. Record review of Resident #1's Order Summary Report revealed an order for isolation: contact isolation precautions: ensure infection site is contained prior to leaving room. If not able to contain infection source, then (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident/patient should remain in room for all care/services, every shift, order date 6/14/26. There were no isolation orders entered prior to 6/14/26. Record review of Resident #1's nursing note dated 6/13/26 at 9:32 a.m. by LVN L revealed in part, .resident currently taking Vancomycin x 10 days for C-diff, resident assisted to bathroom, no loose stool noted at this time, fluids encouraged. Record review of Resident #1's nursing note dated 6/14/26 at 1:35 p.m. by LVN L revealed in part, .remains on Vanco q 6 x 10 days for C-diff, resident in room with contact isolation precautions in place. Family aware of C-diff precautions. Record review of Resident #1's census revealed she was in a semiprivate room [ROOM NUMBER]-A from 12/11/25 - current. Record review of Resident #1's nursing note dated 6/15/26 at 7:10 p.m. by LVN E revealed in part, .911 called to transport resident to hospital d/t lethargic. Resident #2 Record review of Resident #2's admission record dated 7/18/26 revealed [AGE] year-old female who readmitted on [DATE]. Her diagnoses included metabolic encephalopathy (a change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), dementia, and muscle weakness. Record review of Resident #2's significant change in status MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired. She was dependent on staff for all ADL care except eating which she needed supervision or touching assistance. Record review of Resident #2's care plan reviewed on 6/17/26 revealed she was at risk for significant infections and/or recurrent infections related to compromised medical condition, revised on 6/21/25. Record review of Resident #2's nursing note dated 6/14/26 at 1:15 p.m. revealed in part, .Spoke with. RP for resident and notified that we would be moving. (Resident #2) to 309-B, due to isolation precaution, stated, it was ok;. Record review of Resident #2's census revealed she was roommates with Resident #1 in room [ROOM NUMBER] until 6/14/26 when she was moved to 309-B. In an interview on 7/18/26 at 12:50 p.m. CNA O said Resident #1's stool was very loose approximately 3-4 weeks ago, and she was having diarrhea in the restroom which was reported to the nurse. She said a couple of days later the resident was unable to get out of bed and her stool was still very loose. Her stool smelled like c. diff but the facility did not confirm that she had something (an infection). She said the facility moved the Resident #2 out of the room before they put the precautions out. She said contact precautions for Resident #1 including the PPE cart were set up the day before the resident was sent out to the hospital. She said she did not gown up when caring for the resident prior to them putting the precautions in place and was changing the resident without gowns. She said she had not received an in-service on infection control since she had been at the facility. In an interview on 7/18/26 at 1:11 p.m. Resident #1's family member said the resident had diarrhea and vomiting, she was in bed and could barely make it to the restroom. He said the first weekend of June (6/6/26 - 6/7/26) he reported it and the nurse gave her some medication, but she was not getting better. He said the resident was confused and did not remember right now. In an interview on 7/18/26 at 1:20 p.m. Resident #1 said before going to the hospital she had diarrhea, vomiting, and had a stomach virus/ colon infection. In an interview on 7/18/26 at 1:31 p.m. LVN D who worked the day shift on 6/12/26 said she barely remembered that day and was working prn at the time. She said she did not recall setting up isolation for Resident #1 but she wanted to say she probably initiated it. She said the facility might have been isolating both Resident #1 and Resident #2 because they shared a room. She said sometimes there was no place to move the roommate to. In an interview on 7/18/26 at 1:48 p.m. the DON said Resident #1's c. diff results returned to facility on 6/11/26 at 9:47 p.m. In an interview on 7/18/26 at 2:34 p.m. the DON said the facility normally placed a resident on isolation when positive for c. difficile. She said Resident #1 was put on isolation which was put into place on 6/14/26 if going by the order in the system. She said a positive c.difficile result did not require a single room because the infection was in the stool. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said she would have to investigate if her staff were using PPE with Resident #1 (between the day they found out she was positive for c. diff [6/12/26] and when the order was put in [6/14/26]) because she did not know. In an interview on 7/18/26 at 2:44 p.m. the Administrator said as soon as the facility was made aware of the positive c.diff result she expected staff to follow protocol, alert the staff, and re-educate staff so they know what to do. She said entering the contact precaution order was part of the facility protocol and the purpose was for notification reasons and to ensure everyone followed the order. In an interview on 7/18/26 at 3:08 p.m. LVN L said Resident #1 was being treated for c.diff and was on contact precautions. She said when the MD saw the resident on Saturday (6/13/26) she could not remember if the resident was on contact precautions and did not remember the exact date she was placed on contact precautions. She said she did not recall when her roommate (Resident #2) was moved. She said she did not know the facility tested her for c. diff but when she was informed she was positive she always gownned up and followed the signage in place. In an interview on 7/18/26 at 4:46 p.m. the DON said Resident #1 was the only resident to have c.difficile before and after her hospitalization (on 6/15/26). In an interview on 7/18/26 at 4:36 p.m. the DON said the facility did not have a policy on MD orders. In an interview on 7/18/26 at 5:44 p.m. the DON said all nurses were responsible for entering orders timely. She said there was no risk to Resident #2 due to the residents not sharing any areas, past 3 feet from each other and Resident #2 could not walk. She said the contact precaution orders were put in late but said the isolation bins were there and staff would have had isolation gear on. She said floor staff were responsible for setting up isolation. Record review of the facility's Infection Prevention and Control policy revised April 2024 revealed in part, .The elements of the infection prevention and control program consist of coordination/oversight, guidance/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety.9. Prevention of infection a. important facets of infection prevention include: . 9. Implementing appropriate isolation precautions when necessary. In addition to Standard Precautions, Contact Precautions may be implemented for a resident known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient-care items in the resident's environment. A. examples of infections requiring Contact Precautions include, but are not limited to: . clostridium difficile. b. resident placement: place the resident in a private room. When a private room is not available, a resident with the same infection with the same microorganism, but with no other infection, may be co-horted. d. Gown: .wear a gown (clean, non-sterile) when entering the room if you anticipate that your clothing will have substantial contact with the resident or contaminated surfaces.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 of 5 residents (Resident #1) reviewed for physician notification of laboratory services. The facility failed to review Resident #1's stool test results for c. difficile (a bacterium that causes an infection of the colon) and notify the MD/NP in a timely manner. The results were reviewed and NP was notified approximately 17 hours after the results were sent to the facility. This failure could place residents at risk of delayed treatment and spread of infection. The findings included: Record review of Resident #1's admission record dated 7/18/26 revealed an [AGE] year-old female who readmitted on [DATE]. Her diagnoses included acute respiratory failure (when your lungs cannot deliver enough oxygen or remove enough carbon dioxide from your blood), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), legal blindness, anxiety, and type 2 diabetes. Record review of Resident #1's discharge, return anticipated MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were modified independence. She required partial/moderate assistance from staff with toileting hygiene. Record review of Resident #1's care plan report completed 6/5/26 revealed she was at risk for infection or recurrent/chronic infection related to compromised medical condition. Interventions were to report changes in condition to the MD as clinically indicated. Record review of Resident #1's Order Summary Report revealed an order for stat (immediately or without delay) cbc/cmp/collect stool for c-diff one time only for lab monitoring for 4 days, order date 6/10/26. (A cbc evaluates blood cells, while a cmp assess organ function and metabolic balance. A stool tests for C. diff detects the presence of toxin-producing bacteria in individuals with diarrhea). Record review of Resident #1's nursing note dated 6/10/26 at 12:32 p.m. written by LVN W revealed in part, .Resident reports having nausea, vomiting, diarrhea last couple of days on/off. Notified. NP ok for stat cbc/cmp/collect stool for c-diff/ Zofran 4 mg po TID prn nausea and vomiting x 7 days. Record review of Resident #1's nursing note dated 6/10/26 at 3:00 p.m. written by LVN W revealed in part, .Collect small amount of brownish-green soft bowel movement noted placed specimen in cup labeled and placed in cooler. Record review of Resident #1's NP visit note dated 6/11/26 at 11:30 a.m. written by the MD revealed in part, .(Resident #1).is seen today. she is awake and alert with no acute distress. She reports feeling tired today and has been having diarrhea since yesterday. Care Coordination: Stool collected and sent to lab to rule out C. difficile; results pending. Started on Rocephin 1 g IM daily x 3 days for leukocytosis (high white blood cell count). with diarrhea. Follow-up. monitor for C. difficile stool test results. Record review of Resident #1's nursing note dated 6/11/26 at 12:14 p.m. written by LVN W revealed in part, .Notified [NP] regarding resident still having loose stools. Lab reviewed. Stool culture still pending at this time. Record review of Resident #1's undated Lab Results Report revealed her C-Difficile stool sample was collected by the facility on 6/10/26 at 5:12 p.m. The lab received the sample on 6/11/26 at 7:35 p.m. The lab reported the results to the facility on 6/11/26 at 9:47 p.m. The facility reviewed the results on 6/12/26 at 2:50 p.m. The result of the stool test was detected which indicated the specimen contained toxigenic (producing a toxin) C difficile strain with pathogen locus (refers to a specific location in the genome of a pathogenic microorganism that contains genes or genetic elements directly involved in causing disease). Record review of Resident #1's nursing note (continued on next page)		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 6/12/26 at 2:50 p.m. written by LVN D revealed in part, .Results for C-Diff showing detected. Notified NP of results. Awaiting orders at this time. Monitoring.Record review of Resident #1's nursing note dated 6/12/26 at 3:11 p.m. written by LVN D revealed in part, .New order for Vancomycin 125 mg. use contact precautions.In an interview on 7/18/26 at 1:11 p.m. Resident #1's family member said the resident had diarrhea and vomiting, she was in bed and could barely make it to the restroom. He said the first weekend of June (6/6/26 - 6/7/26) he reported it and the nurse gave her some medication, but she was not getting better. He said the resident was confused and did not remember right now.In an interview on 7/18/26 at 1:20 p.m. Resident #1 said before going to the hospital she had diarrhea, vomiting, and had a stomach virus/ colon infection. In an interview on 7/18/26 at 1:31 p.m. LVN D who worked the day shift on 6/12/26 said she barely remembered that day and was working prn at the time. She said she always had a list of labs that were pending results, and as the day progressed, she would check the electronic medical record for laboratory or diagnostic results and sometimes did not get results until 4 p.m. She said if laboratory results were an emergency or had a critical value, the lab would call the facility. She said the facility would like to have the results as soon as available and someone may not have checked Resident #1's results prior to her shift. In an interview on 7/18/26 at 1:48 p.m. the DON said nursing staff should check the electronic medical record for laboratory results every shift and results were also reviewed in morning meeting by the IDT. She said lab orders should be reviewed and the NP/MD notified with results. She said Resident #1's c. diff results returned to facility on 6/11/26 at 9:47 p.m. and the Vancomycin was started on 6/12/26. In an interview on 7/18/26 at 2:31 p.m. the Administrator said during morning meeting on 6/10/26 the IDT discussed Resident #1's nausea/vomiting concerns. She said there was no documentation regarding Resident #1 at the 6/11/26 meeting and on 6/12/26 the IDT discussed her cbc labs but did not have documentation about a positive c-diff test.In an interview on 7/18/26 at 2:34 p.m. the DON said she always told her staff to review lab/diagnostic results every shift and to look when first coming on shift, try to look in the middle of the shift, and look when they were closing out the shift. She said it was important to monitor for lab results so nursing staff could report any abnormal labs to the MD/NP. In an interview on 7/18/26 at 5:32 p.m. the DON said all nurses were responsible to ensure lab results were read in a timely manner. She said there was no risk to Resident #1 because staff were aware something was going and she was already on an antibiotic.In an interview on 7/18/26 at 5:33 p.m. LVN E said she tried to check the laboratory results every night and day shift would report if there were pending results. She said if the results were not available upon starting the shift, she would check again after her first round. She said she might have been busy that night (6/11/26) and sometimes the other residents needed her and pulled her away and could not see the results in a timely manner. She said she did not recall seeing Resident #1's results and did not remember being notified that a stool test was collected on Resident #1.Record review of the facility's Critical Laboratory Value Reporting staff education dated 4/22/26 read in part, .Purpose: to ensure timely reporting, communication, documentation, and follow-up of critical laboratory values to promote resident safety and meet regulatory standards. Definition: a critical laboratory value is a test result that falls outside of normal limits and may indicate a life-threatening or emergent condition requiring immediate clinical intervention. Expectation: all critical laboratory values must be received by a licensed nurse, verified with read-back, reported immediately to the provider, documented completely, and acted upon without delay. Critical labs may not be held for routine review, shift change, or rounds. Roles and responsibilities: Licensed nurse: receives and verifies results, assesses resident, notifies provider, implements orders, and documents actions.		