STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676262	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Tyler	2650 Elkton Trail Tyler, TX 75703

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observations, interviews, 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 for 3 of 10 residents (Resident #1, Resident #2, and Resident #3) reviewed for infection control practices. 1. The facility failed to ensure a wound vacuum cannister with red - brown liquid was not left in Resident #1's and Resident #2's room on 08/28/24. 2. The facility failed to ensure a brown substance was not present on the handrail in Resident #3's bathroom on 08/28/24. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1. Record review of Resident #1's face sheet, dated 08/28/24, indicated she was admitted to the facility on [DATE]. Her diagnoses included iron deficiency anemia secondary to blood loss (a deficiency of iron in the body related to a loss of blood), and chronic kidney disease (a disease where the kidneys do not function as well as they should). Record review of Resident #1's quarterly MDS assessment, dated 07/25/24, indicated she had a BIMS score of 1, which indicated severe cognitive impairment. Record review of Resident #1's progress note, dated 08/18/24, indicated her wound vacuum was removed and she was sent to the hospital on 08/18/24. During an observation on 08/28/24 at 11:00AM, Resident #1 was not in the room at this time. There was a facility wound vacuum at the bedside. It was half full of a brown - red substance. The tube was still connected to the canister, and it was dangling off the bedside table to the floor. During an interview on 08/28/24 at 11:02AM, the Administrator said Resident #1 was still in the hospital. (continued on next page)

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 - Few	During an observation on 08/28/24 at 1:51PM, the wound vacuum was still at bedside, half full of a brown-red substance, with the tube still dangling off the side of the bedside table to the floor. During an observation on 08/28/24 at 3:03PM, the wound vacuum was still at bedside, half full of a brown-red substance, with the tube still dangling off the side of the bedside table to the floor. Record review of Resident #2's face sheet, dated 08/28/24, indicated she was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), and cellulitis (a bacterial infection that affects the skin's deeper layers and the tissue underneath). Record review of Resident #2's Admission MDS assessment, dated 08/14/24, indicated she had a BIMS score of 15, which indicated intact cognition. She was usually understood and usually able to understand others. During an observation on 08/28/24 at 11:18AM, Resident #2 was in her wheelchair, in her and Resident #1's shared room, the wound vacuum was still present on Resident #1's side of the room, half full of a brown-red substance, with the tube still dangling off the side of the bedside table to the floor. During an interview on 08/28/24 at 3:05PM, Resident #2 was in bed, in her and Resident #1's shared room. She said she saw the wound vacuum on Resident #1's side of the room. She said it was gross and she thought the staff would have cleaned it up by now. 2. Record review of the face sheet dated 3/27/24 indicated Resident #3 was [AGE] years old female admitted on [DATE] with diagnoses including Amputation of Right Hand, Gangrene (a serious condition that occurs when tissue dies due to a lack of blood supply), Tachycardia (a heart rate that's faster than 100 beats per minute while at rest). Record review of the Quarterly MDS dated [DATE] indicated Resident #3 was understood and understood others. The MDS indicated a BIMS score of 06 which indicated Resident #3 was significantly cognitively impaired. The MDS indicated Resident #3 was dependent for toileting. During an observation and interview on 8/28/24 at 1:20 p.m. inside Resident #3's bathroom had an unknown brown substance on the toilet handrail. Resident #3 said that the feces had been there for two weeks. She said that she has not asked anyone to clean it up. During an observation on 8/28/24 at 3:40 p.m. inside Resident #3's bathroom a brown substance was observed smeared on the handrail for the toilet. During an interview on 08/28/24 at 3:42PM, ADON A said she did not expect the wound vacuum to be left at the bedside. She said she expected the staff to dispose of the canister and tubing into a biohazard bag once it was disconnected from the resident. She said that it was an infection control issue. She said the brown substance on the railing should have been cleaned by the aides. She said housekeeping was expected to clean everything but bodily fluids. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24 at 3:53PM, Corporate Nurse B said her expectation was for the staff to properly discard of the biohazard material. She said housekeeping and nursing staff were responsible for cleanliness of the bathroom and ensuring there was not a brown substance on the handrails in the bathroom. She said the risk to the residents was possible infection. During an interview on 08/28/24 at 4:00PM, the Administrator said she expected the staff to clean up the biohazard material and to dispose of the wound vac canister and tubing. The risk to the residents would be infection. Nursing was responsible for cleaning up the canister and any staff were responsible for cleaning up the brown material. Record review of the facility's Infection and Prevention Control policy, last revised April 2024, stated: .The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program . 9. Prevention of Infection a. Important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infections; (2) instituting measures to avoid complications or dissemination; (3) educating staff and ensuring that they adhere to proper techniques and procedures; . .(5) educating staff and ensuring that they adhere to reporting exposures to potentially infectious materials; (6) educating staff and ensuring that they adhere to proper infection prevention and control practices when performing resident care activities as it pertains to his/her role responsibilities and situation . .(8) immunizing residents and staff to try to prevent illness; . .(10) disinfecting multi-patient use equipment or supplies after each use and stored appropriately; i.e., foot care equipment/supplies, including but not limited to nail clippers, scalers, files, and burr tools should be stored separated from clean, un-used foot care equipment or supplies. Reusable equipment or devices (e.g., scalers, electronic nail file, and surgical instruments) that are used on one resident should be cleaned and disinfection or sterilization prior to use according to manufacturer's instructions. If the manufacturer does not provide multi-patient use instructions, the device should not be used for multi-patient use .