

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER The Heights of Tyler		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42190</p> <p>Based on interview, and record review, the facility failed to ensure resident who were transported by the facility were free from abuse for 1 of 1 resident (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure Resident # 1 was protected from abuse.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 09/22/2023 and ended on 09/27/2023. The facility had corrected the noncompliance before the survey began.</p> <p>This failure had the potential to affect all residents who depend on the facility for transportation to medical appointments or other social outings.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 09/18/24, indicated the resident #1 was readmitted to the facility on [DATE], with diagnosis to include, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, unspecified severe protein-calorie malnutrition, other disorders of phosphorus metabolism (the body's phosphate levels are abnormal, either too high or too low), interstitial emphysema (when to air leaks into the lung's connective tissue, damaging lung structure) and cachexia (significant loss of muscle and fat mass). Resident #1 has a BIMS (Brief Interview for Mental Status) score of 05.</p> <p>Review of the facility's provider investigation report, dated 9/22/2023, indicated Resident #1 informed an un-named nurse manager, that Driver - A called her a stupid bitch, on 09/22/2023, while driving her to a medical appointment.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676262
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/17/24 at 1:44PM, Driver - A, said she was the van driver who transported Resident #1 to a medical appointment on 09/22/2023. She said she transported Resident # 1 to the address of the medical facility, she was given, but when she arrived, the medical facility informed her, they need to be somewhere else. She said when she loaded Resident #1 back up, Resident #1 was crying and yelling, saying she's suppose to have surgery that day and she wanted to get this thing off her foot. She said she told Resident #1, that was where they were going, and when she started driving, Resident #1 continued to cry, and got louder. She said she turned the radio up, thinking it would calm her down, but she got even louder. She said she reiterated to Resident #1 that was where they were going, that she was going to have surgery that day, that they were just sent to the wrong location. She said after getting to the next location, she went inside to double check that Resident #1 was having surgery at that location. She said the facility informed her that Resident #1 was not on the schedule for surgery. She said she call Medical Records - B, and informed her that she was bring Resident #1 back to the facility because she was not scheduled for surgery. She said she let Resident #1 know, she was not scheduled for surgery today, there was some kind of mix-up. She said Resident #1 kept crying and screaming, telling her she is supposed to have surgery that day and she wanted this thing off her foot. She said the radio was still on, she turned it up a little, Resident #1 got louder over the music, and she eventually said, god damn it, I'm doing the best I can, what the hell you want me to do. She said she brought Resident #1 back to the facility and put her at the nurse station where she continued to yell about having surgery. When asked, Driver- A said she had taken abuse and neglect training and she did not believe her use of god damn it or hell was verbal abuse. When asked to define verbal abuse, Driver - A said, making a resident feel uncomfortable or insulting them about their diagnosis. When asked if she received any disciplinary action, Driver - A said she was suspended for 2-3 days and had to go through abuse and neglect training again. Driver - A denied calling Resident #1 a stupid bitch.</p> <p>During interview on 09/17/2024 at 1:55PM, Medical Records - B said she noticed Resident #1 was fussing, yelling out a lot, when she was brought back to the facility, so she decided to ride with Driver - A, when she took Resident #1 back to her medical appointment. Medical Records B said she and Driver -A, did not have any conversation about Resident #1 behavior, during the drive to the appointment or returning from the appointment. Medical Records B said she was not aware of any name calling Driver - A, may have used towards Resident #1.</p> <p>During interview on 09/17/2024 at 2:35PM, the Administrator said she was not with the facility at the time of the incident. She said the former Administrator and the former DON are no longer with the facility. She said she was not aware of who the un-named nurse manager was, but she does not believe that person is with the facility. The Administrator said she is not aware of any performance issues with Driver - A, since she became the Administrator.</p> <p>Review of Driver - A's personnel file, on 09/18/2024, indicated an investigation of the allegation of abuse, was conducted and Driver - A did receive a suspension. The review also revealed Driver - A also completed abuse and neglect training on 09/27/2023. Since the time of the incident, there were no documented issues with the Van Driver.</p> <p>Review of a facility policy titled: Abuse Guidance: Preventing, Identifying and Reporting, with a revision date of 10/2022, revealed: Verbal abuse is the oral written or gesture language that willfully include the use of disparaging and derogatory term to residents or their family or within hearing distance, regardless of their age, ability to comprehend, or disability .</p> <p>(continued on next page)</p>		

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