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: 676262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #1) reviewed for pharmacy services. MA B failed to hold Resident #1's metoprolol (a medication used to treat high blood pressure and elevated heart rate) when Resident #1's pulse was outside of the physician ordered parameters on 9/18/24 as well as 9/30/24. These failures could place residents at risk of receiving unnecessary medication and significant adverse effects from medication error. Findings included: Record review of Resident #1's face sheet dated 10/4/24 indicated she was [AGE] years old readmitted to the facility on [DATE] with diagnoses including history of stroke, Type II diabetes, COPD (chronic obstructive pulmonary disease-group of lung diseases that block airflow and make it difficult to breathe) A-Fib (Atrial fibrillation is an abnormal heartbeat caused by extremely fast and irregular beats from the upper chambers of the heart) and high blood pressure. Record review of the MDS dated [DATE] indicated Resident #1 had unclear speech, usually others and usually made herself understood. The MDS indicated she had moderate cognitive impairment (BIMS of 10). The MDS indicated Resident #1 had no behavior of rejecting care. The MDS indicated Resident #1 was dependent on staff for; oral hygiene; toileting hygiene; showering/bathing; dressing the upper body; dressing the lower body; and putting on/taking off footwear. The MDS indicated Resident #1 required supervision or touching assistance with eating. Record review of the care plan dated 9/12/24 indicated Resident #1 had chronic health conditions, the care plan interventions included; administer medications as recommended by the physician; and monitor my vital signs as indicated. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the physician order summary dated 10/4/24 indicated Resident #1 had an active order for metoprolol Tartrate 50 mg, 1 tablet two times a day related to high blood pressure. The order indicated the medication should be held for a SBP less than 110 mmHg or ;a DBP less than 60 mmHg or; a pulse less than 60bpm. Record review of Resident #1's MAR (medication administration record) for September 2024 indicated she had been administered her metoprolol Tartrate 50 mg, 1 tablet with a pulse outside of the order parameters on the following dates; *9/14/24, heart rate 55 bpm administered by MA C; *9/18/24, heart rate 58 bpm administered by MA B; and *9/30/24, heart rate 56 bpm administered by MA B. Record review of Resident #1's MAR for October 2024 indicated she had been administered her metoprolol Tartrate 50 mg, 1 tablet with a pulse outside of the order parameters on 10/1/24. Her rate was 56 bpm, and the medication was administered by MA B. During an interview on 10/4/24 at 9:30 a.m. Resident #1 responded yes when asked if the facility had been administering her medications. Resident #1 was not able to identify her medications or if any medications had been held. During an interview on 10/4/24 at 1:55 p.m., MA C said she worked at the facility in a prn (as needed) compacity. MA C said the hall Resident #1 resided on was not her usual hall. MA C said she would not have administered the metoprolol to Resident #1 with a heart rate less than 60 bpm. MA C said the medication works to lower blood pressure and heart rate and could cause Resident #1's heart rate to drop below a normal rate if it was administered with a heart rate below 60 bpm. MA C said the MAR requires the entrance of a heart rate with the administration of the medication and she would have entered the rate of 55 bpm. MA C said she had either documented the incorrect heart rate by mistake or documented the administration by mistake. During an interview on 10/4/24 at 2:00 p.m., RN A said she was one of the 2 facility ADONs. RN A said MA B should not have administered Resident #1's metoprolol when her pulse was outside of the physician ordered parameters. RN A said metoprolol was a medication used to treat high blood pressure and lower heart rate. RN A said the medication being administered outside the parameters set by the physician could cause Resident #1's heart rate to drop to low. RN A said currently herself and RN D were working together with corporate to fulfill the duties of the DON role. RN A explained the facility had hired a new DON who would start in a few weeks. RN A said currently there was a system in place to identify when medications where held (not administered) to Resident but there was not a system in place to identify when a Resident had been administered medication outside ordered medication parameters. RN A explained in the EMR system if a MA documented a medication was not administered, they were required to enter a numerical code that indicated why the medication was held. RN A said she (RN A) could then run a report that would reflect why medications were held. RN A said there was no report she currently could run in the EMR system that would allow/ enable her to see when Residents were administered medications, despite documented vital signs outside of physician ordered parameters. RN A said she would speak to corporate office to see if EMR system could be worked to enable her to run such a report. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/24 at 2:07 p.m., RN D said she was one of the 2 facility ADONs. RN D said MA B should not have administered Resident #1's metoprolol when her pulse was outside of the physician ordered parameters. RN D said the medication being administered outside the parameters set by the physician could cause Resident #1's heart rate or blood pressure to drop to low. RN D said she was not aware of any report that could be ran to see if Residents were being administered medication outside of physician ordered parameters. RN D said it was important for Residents to be administered medications as ordered by the physician. During an interview on 10/4/24 at 2:20 p.m., MA B if she had documented she administered the metoprolol to Resident #1 on 9/18/24 and 9/30/24 she probably had administered it. MA B said she would like to think that she incorrectly documented either the pulse or the administration itself but could not say for sure. MA B said it was important to ensure residents were administered medications as ordered and in the case of Resident #1 and her metoprolol it was important because her heart rate could drop to low. During an interview on 10/4/24 at 3:02 p.m. the Administrator said it was important for residents to be administered medications as ordered by the physician/within physician ordered parameters for the health and safety of the residents. The Administrator said she planned to reach out to corporate to see if something could be changed in the EMR to allow better monitoring and compliance with physician ordered parameters. Record review of the facility policy and procedure titled Medication Administration, revised January 2024 stated . Resident medications are administered in an accurate, safe, timely, and sanitary manner . If applicable and/or prescribed, take vital signs or tests prior to administration of the dose . Administer medications as ordered by the physician.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 2 of 3 residents (Resident #1 and Resident #2) reviewed for accurate medical records. MA C failed to correctly document in the EMR with regards to Resident #1's metoprolol Tartrate 50 mg, on 9/14/24. MA E failed to correctly document in the EMR with regards to Resident #2's entresto 24/46 mg adminstration on 9/29/24. These failures could place resident's at risk of unnecessary treatment, adverse drug reactions, or inadequate treatment. Findings included: Record review of Resident #1's face sheet dated 10/4/24 indicated she was [AGE] years old readmitted to the facility on [DATE] with diagnoses including history of stroke, Type II diabetes, COPD (chronic obstructive pulmonary disease-group of lung diseases that block airflow and make it difficult to breathe) A-Fib (Atrial fibrillation is an abnormal heartbeat caused by extremely fast and irregular beats from the upper chambers of the heart) and high blood pressure. Record review of the MDS dated [DATE] indicated Resident #1 had unclear speech, usually others and usually made herself understood. The MDS indicated she had moderate cognitive impairment (BIMS of 10). The MDS indicated Resident #1 had no behavior of rejecting care. The MDS indicated Resident #1 was dependent on staff for; oral hygiene; toileting hygiene; showering/bathing; dressing the upper body; dressing the lower body; and putting on/taking off footwear. The MDS indicated Resident #1 required supervision or touching assistance with eating. Record review of the care plan dated 9/12/24 indicated Resident #1 had chronic health conditions, the care plan interventions included; administer medications as recommended by the physician; and monitor my vital signs as indicated. Record review of the physician order summary dated 10/4/24 indicated Resident #1 had an active order for metoprolol Tartrate 50 mg, 1 tablet two times a day related to high blood pressure. The order indicated the medication should be held for a SBP less than 110 mmHg or ;a DBP less than 60 mmHg or; a pulse less than 60bpm. Record review of Resident #1's MAR for September 2024 indicated she had been administered her metoprolol Tartrate 50 mg, 1 tablet with a pulse outside of the order parameters on the following dates; *9/14/24, heart rate 55 bpm administered by MA C; *9/18/24, heart rate 58 bpm administered by MA B; and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*9/30/24, heart rate 56 bpm administered by MA B. During an interview on 10/4/24 at 1:55 p.m., MA C said she worked at the facility in a prn compacity. MA C said the hall Resident #1 resided on was not her usual hall. MA C said she would not have administered the metoprolol to Resident #1 with a heart rate less than 60 bpm. MA C said the medication works to lower blood pressure and heart rate and could cause Resident #1's heart rate to drop below a normal rate if it was administered with a heart rate below 60 bpm. MA C said the MAR requires the entrance of a heart rate with the administration of the medication and she would have entered the rate of 55 bpm. MA C said she had either documented the incorrect heart rate by mistake or documented the administration by mistake. 2. Record review of Resident #2's face sheet dated 10/4/24 indicated he was [AGE] years old admitted to the facility on [DATE] with diagnoses which included degenerative disease of the basal ganglia (a degenerative condition that occurs when the basal ganglia, a set of brain structures that control speech, movement and posture) are damaged or fail to function, hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following stroke, aphasia (affects a person's ability to express and understand written and spoken language) and high blood pressure. Record review of Resident #2's MDS dated [DATE] indicated he had unclear speech. The MDS indicated Resident #2 usually made himself understood and usually understood others. The MDS indicated Resident #2 had severe cognitive impairment (BIMS of 5). The MDS indicated he had no behavior of rejecting care. The MDS indicated Resident #2 was dependent on staff for toileting and putting on/taking off footwear. The MDS indicated Resident #2 required maximal assistance with showering/bathing and dressing the lower body. The MDS indicated he required partial assistance with oral hygiene, dressing the upper body, and personal hygiene. The MDS indicated he required set up/clean up assistance with eating. Record review of Resident #2's care plan dated indicated he had heart disease and was at risk for cardiac complications. The care plan interventions included; administer medications as ordered by my physician and monitor vital signs as indicated. Record review of the physician order summary dated 10/4/24 indicated Resident #1 had an active order for entresto 24/46 mg, 1 tab by mouth once a day for high blood pressure. The order indicated the medication should be held for a SBP less than 120 mmHg or ;a DBP less than 55 mmHg or; a pulse less than 55bpm. Record review of Resident #2's MAR (medication administration record) for September 2024 indicated he had been administered his entresto 24/46 mg, 1 tab with a pulse outside of the order parameters on 9/29/24. His heart rate was 53 bpm and the medication was administered by MA E. During an interview on 10/4/24 at 2:00 p.m., RN A said MAs should ensure they document vital signs and medication administration correctly. RN A said it was important that medical records are complete and accurate. RN A said incorrect documentation could negatively affect residents as nurse practitioners and physicians make treatment decisions in part based on the information in medical record. During an interview on 10/4/24 at 2:07 p.m., RN D said MAs should ensure they document vital signs and medication administration correctly. RN D said inaccurate documentation of vital signs and medication administration is incorrect information that may be used in treatment decisions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/4/24 at 2:48 p.m., MA E said worked for a staffing agency and had worked regularly at the facility in the past (in 2023) but recently (September 2024) started working at the facility again. MA E said she had been a MA for [AGE] years and would not have Resident #2's entresto medication with a heart rate of 53 bpm even if there were not written parameters without checking with the nurse. MA E said she probably entered Resident #2's heart rate incorrectly if the administration was documented. MA E said the '5' and the '6' are right beside each other on the keyboard and she hit the wrong key. MA E said there was no doubt in her mind she had charted incorrectly. During an interview on 10/4/24 at 3:02 p.m., the Administrator said it was important for medical records to be accurate and expected staff to ensure they accurately documented vital signs and medication administration. Record review of the facility policy and procedure titled Medical Records revised January 2023 reflected, . Compliance Guidelines: A medical record is maintained for every person admitted to a community in accordance with accepted professional standards and practices . The medical record consists of but not limited to the following: . a record of the resident's assessments; the plan of care and services provided . The facility policy and procedure did not further elaborate on the importance of accurate vitals signs and medication as part of the medical record.