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 03/24/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet residents highest practicable physical, mental, and psychosocial needs for 1 of 4 residents reviewed for care plans, (Resident #1). Resident #1 was not care planned for making allegations of a consensual relationship with a staff member (CNA B), including that the staff member would no longer provide care for her. This failure could place residents at risk of not having their individualized needs met, and a decline in their quality of care and life. Findings included: Record review of the undated face sheet indicated Resident #1 was a [AGE] year-old female that admitted [DATE]. Record review of the physician's orders dated 3/24/26 indicated Resident #1 had diagnoses that included: Generalized Anxiety Disorder (persistent, excessive, and uncontrollable worry about every day, routine matters for at least 6 months), chronic atrial fibrillation (rapid irregular electrical signals causing the upper heart chambers to quiver instead of contracting properly), osteoarthritis (degenerative joint disease where protective cartilage on bone ends breaks down), and Dementia without behaviors (decline in mental ability such as memory loss, confusion, and behavioral changes-severe enough to interfere with daily life). Record review of the quarterly MDS dated [DATE] indicated Resident #1 had adequate hearing, clear speech, understood others and was understood by others. She had a BIMS score of 15 indicating she was cognitively intact. The MDS indicated Resident #1 was dependent for chair to bed transfer and rolling left and right in bed. Record review of the care plan dated 6/20/25 indicated for her self-care deficit, Resident #1 had osteoarthritis of both shoulders and hips. She required a 2-person assist for bed mobility and turning and repositioning. One of the interventions for ADL's was I prefer female staff only. This intervention was initiated 3/24/26. The care plan indicated she had impaired cognitive function/dementia or impaired thought processes. The care plan also indicated she took antianxiety medication. Record review of the PIR dated 3/7/26 indicated Resident #1 alleged that she had consensual relations with a care giver. Resident was requested to go to local hospital for evaluation. Resident refused. Internal resident assessment by licensed nurse revealed no trauma, no injury and no emotional effect. Licensed nurse noted noticeable increased confusion to baseline. Resident physician also evaluated in person.For the provider response: Alleged perpetrator put on suspension pending investigation. Resident interviewed by community administrator. Resident presented high level of confusion to baseline. Resident reports of the event varied in time of day and date several times. Resident also stated ?Never mind I'm just a crazy old lady.'. The PIR also indicated, Most interviews supported that this resident has been fixated on the accused - always requesting that he perform her care.The PIR indicated the facility determined the alleged abuse did not occur. During an interview on 3/24/26 at 10:06 AM, LVN A said Resident #1 was confused at times. She would tell stories about things that did not happen when she was confused. She said sometimes she got reality mixed up with the music she listened to. She said Resident #1 was recently telling her a story about her grandson. She knew Resident #1 was confused and the story could not have been true. She said Resident #1 was very (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fond of CNA B. She said she was obsessed with him. During an observation and interview on 3/24/26 at 10:21 AM, Resident #1 was in her w/c sitting on a mechanical lift pad (specialized fabric support used with a mechanical lift to safely transfer individuals with limited mobility from chair to bed). She was a larger woman with glasses on, and her hair done. Resident #1 said she and CNA B were in love and had consensual sex. She said she had sex with CNA B this month. She said she did not remember the day, but it was around 7:00 PM and her roommate was in the room. Then, she said her roommate was not in the room. She said it was alright and she wanted him to do that, it was consensual. She said she felt safe at the facility and was not afraid of anyone. She asked if it was March now. This surveyor said yes. She said maybe it was not this month, that it must have been in February it happened. She had not talked to CNA B since then. He was not her aide anymore. She said she saw CNA B at the nurse's desk when she was in therapy this morning. They did not speak. She said he was always nice to her and had always been nice. She said CNA B was the nicest person here. She said the ADM told her a staff could not have a relationship with a resident. She said if they were in love, it should be okay. She said CNA B did not say anything about being in love with her. She just knew it in her heart. Resident #1 said she does not plan on having sex with CNA B again because she does not want either of them to get into trouble. She hopes CNA B does not get into trouble, he is a nice kid and has a child he is raising. During an interview on 3/24/26 at 10:39 AM, CNA B said he was [AGE] years old. He said he had definitely never had any sort of a romantic or sexual relationship with Resident #1 and would not have. He said he believed she was obsessed with him. Staff were telling him she asked about him. He said this was the first he had heard about he and Resident #1 being in love. He worked 7:00 AM to 7:00 PM most days. He said Resident #1's roommate was usually in the room when he and staff provided care for Resident #1, but in the past he had probably cared for her with only himself in the room. He did not remember. He said to transfer her with the mechanical lift there had to be 2 staff. He said the ADM called him at home on Saturday 3/7/26 to suspend him, and he had not provided care for her since then. He was rarely assigned to her (prior to 3/7/26) and usually worked on the back section or the front section of that hall. Resident #1 was in the middle section, but he did help when short staffed. CNA B said most people did not know his actual name. He had a nickname {nickname}. He said she started calling him his nickname and adding her last name to it. (ie: {nickname} her last name). He asked Resident #1 to call him by his {nickname} or his first name. At first she was calling him her son, then it went to {nickname} and her last name. Everyone called him {nickname} and Resident #1 did not know his actual name until he told her. He said he had been suspended during the investigation and was back at work once the investigation concluded. During an interview on 3/24/26 at 1:08 PM, MDS C said she did not care plan Resident #1's allegation with CNA B. She said that would have been the responsibility of MDS E, the other MDS nurse. She said MDS E should have care planned it because the care plan tells the story of the resident. She said nurses or CNA's would need to know about the alleged incident because it could have been considered a behavior and they would better know how to handle the situation. During an interview on 3/24/26 at 1:25 PM, LVN D looked through Resident #1's care plan and said she did not see that Resident #1 was care planned for the accusation and incident with CNA B. She said that should have been on the care plan. During an interview and record review on 3/24/26 at 1:30 PM, the DON said Resident #1 was obsessed with CNA B. She said she knew that nothing had happened between Resident #1 and CNA B. She said CNA B would not ever work with or provide care for Resident #1 again. She said he does not even work on that hall anymore. She said they had never had issues or concerns about CNA B. She looked at Resident #1's care plan and said under ADL's the care plan indicated I prefer female staff. This surveyor asked her when that was put in the care plan and she clicked on it. She showed this surveyor, the date was 3/24/26. She said Today. She said the care plan saying she preferred female staff did not make sense because Resident #1 had no problems with males and preferred CNA B. She looked through the rest of the care plan and there was nothing there addressing Resident #1 alleging she had a consensual sexual relationship with a staff. She said there (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been something put in the care plan that she had claimed this so that the nurses knew about it. She said it was first the responsibility of MDS E, then after that it was her responsibility. She said everyone knew this had happened and she could not figure out how it was missed, and that the care plan did not address it. She said the care plan should have been updated immediately and should have been updated on the day it was called in to the State, 3/7/26. She said MDS E did not work on Tuesdays (today). She said she would have to make sure they went over care plans in their morning meetings to make sure they were getting everything on the care plans that should be there. During an interview on 3/24/26 at 2:18 PM, ADON F said Resident #1 was very confused at times and other times seemed very with it. She said at the time Resident #1 made the allegation about CNA B she had a UTI. She said Resident #1 should have been care planned for claiming a consensual relationship with a staff because if she was stating that was happening and was having moments of confusion it should be in the care plan. If that particular staff had been moved to a different hall, that should have also been care planned. She said the care plans being accurate was important so that other staff would know what was going on. The MDS nurses were responsible for updating a care plan. ADON F said she did not update care plans unless directed by the DON to do so. But, she said any nurse could update a care plan at any time if they wanted to. During an interview on 3/24/26 at 2:49 PM, the ADM said Resident #1 liked several men that were staff, but nothing ever came up like this. He said, Maybe it should have been care planned that Resident #1 made that allegation. But, they had done a good job to make sure all staff knew what was going on so they could protect the residents and staff. The ADM said he would keep CNA B off of Resident #1's hall and CNA B would not provide care for her in order to protect them both. He said the MDS nurses were primarily responsible for making sure the care plans were accurate. He said any nurse could work on a care plan. Ultimately the DON was responsible for care plans being updated and accurate. During a telephone interview on 3/24/26 at 4:26 PM, MDS E returned my call. She said she had been an MDS nurse for approximately 1.5 years. She said she was responsible for Resident #1's care planning. She said she should have care planned Resident #1 for the allegation of a consensual sexual relationship with staff. She said she did not really know how to word it. When asked by this surveyor why she did not update the care plan, MDS E said she did not know how to answer the question. She said it was important to care plan everything about a resident and everything had to be care planned for a resident so that staff knew what was going on. She said care planning Resident #1 for her allegation would have helped to protect her and staff. She said the allegation was a major issue. She said it was her job to make sure it was in the care plan. She said she did not know if anyone oversaw her care plans to make sure she had care planned everything necessary. Record review of a care plan policy with a revised date of January 2023 indicated: Guidelines:Care Plans The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan should be initiated upon admission, continued to be developed during the initial 48-72 hours., throughout the completion of the admission comprehensive assessment. The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in conditions as defined in the RAI manual. Additional updates to the care plan may be done as indicated. The care plan should be prepared, reviewed and updated in accordance with the RAI guidance on a routine cadence (admission, quarterly, annually and with significant change). Additionally, the care plan should be modified as appropriate and on an as needed basis as per the RAI instructions.