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	02/25/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure sanitation and housekeeping services were sufficient to maintain a clean and sanitary interior environment, including areas under resident's beds, for 4 of 11 resident rooms observed, (room [ROOM NUMBER] A & B, room [ROOM NUMBER] A & B, room [ROOM NUMBER] A & B, and room [ROOM NUMBER] A & B), observed for sanitary conditions. The facility failed to ensure and maintain a clean and sanitary interior environment, as evidenced by trash not empty, dust accumulation, debris, and lack of routine or incomplete daily housekeeping in resident's rooms and under-bed cleaning. These failures could result in inadequate sanitation, increased risk of respiratory irritation, infection, or pest attraction.Findings include: room [ROOM NUMBER]On 02/23/2026 at 9:30 AM, during an observation of room [ROOM NUMBER] A & B, revealed visible dust and lint accumulation, plastic spoons under the resident's bed, and scattered paper debris accumulated on the floor. The bedside trash container was full of trash and PPE gowns. During an observation and interview on 02/24/2026 at 10:37 AM, Resident #65, room [ROOM NUMBER]A, stated housekeeping typically cleaned the room daily, over the past couple of days during the weekend, the room was not cleaned, and trash was not emptied. The trash container was full of PPE gowns, and other trash. Resident #64, room [ROOM NUMBER]B, the floor was observed with paper debris, and dust and lint build-up were noted under the bed. room [ROOM NUMBER]On 02/23/2026 at 9:35 AM, an observation of room [ROOM NUMBER] A & B revealed visible dust, and lint, accumulated under the resident's beds (A & B). The bedside trash container was full of trash and PPE gowns. During an observation and interview on 02/24/2026 at 10:45 AM, Resident #127, room [ROOM NUMBER]A, reported that the trash container was full over the weekend and that her family member had to empty the trash herself. The resident further stated that the floor had not been cleaned since the previous week. There was paper debris on the floor, and dust accumulated under the bed. During an observation and interview on 02/24/2026 at 10:50 AM, a visitor of Resident #131, room [ROOM NUMBER]B, stated that housekeeping did not clean or mop the floor over the weekend. The bathroom trash container with PPE gowns was not empty, paper debris on the floor, dust and debris under bed. room [ROOM NUMBER]On 02/23/2026 at 9:40 AM, an observation of Room#107 revealed visible dust build-up, lint, candy wrapper, plastic spoon, and debris accumulated under the resident's beds, and on floor in (room [ROOM NUMBER] A). Additional observations noted that trash container was full. During an interview and observation on 02/24/2026 at 11:15 AM Resident # 90, room [ROOM NUMBER]B stated housekeeping cleaned the room, but could not state if cleaning under the bed was performed. Observation noted debris under the bed, including paper wrappers, a plastic spoon, and dust accumulation under the bed remained present after a housekeeping cleaning request made on 02/23/2026 related to a water spill. room [ROOM NUMBER]On 02/23/2026 at 9:45 AM, an observation of room [ROOM NUMBER] revealed visible dust build-up, lint, and debris accumulated under the resident's beds (A & B). During an observation and interview on 2/24/2026 at 10:55 AM, Resident # 35, 110A, stated housekeeping came to room daily, mop and empty the trash containers, but do not mop under the bed. The floor during interview had (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper debris and dust accumulated under the bed. During an interview on 2/24/2026 at 11:00 AM, Resident #86, room [ROOM NUMBER]B, stated that housekeeping cleaned the room daily, including mopping and emptying trash in the room and bathroom. There was paper debris and dust accumulation under the bed. During an interview and observation on 02/25/2026 at 2:30 PM, the Housekeeper/Laundry Supervisor stated that resident rooms receive daily cleaning. She stated housekeepers are trained to clean resident rooms daily, including under beds by moving the bed when debris was visible by using a five- step and seven-step cleaning process. The Housekeeping/Laundry Supervisor stated that four housekeeping staff are scheduled daily, with one staff member assigned to each hallway, to provide routine facility cleaning. She stated that after housekeeping staff leave for the day, laundry staff provide housekeeping coverage until 7:00 PM. Coverage after 7:00p.m. was provided by nursing staff, including CNAs, and cleaning supplies are available to address spills or debris on the floor. Housekeeping/Laundry Supervisor observed rooms 101,103, and 107 visible debris under resident beds, indicating the routine cleaning did not consistently include under-bed area, despite under-bed cleaning being identified as a part of the five-step and seven step cleaning process. During an interview on 02/25/2026 at 2:45 PM housekeeper stated she previously served as a lead housekeeper and trainer and reported that staff are trained to use a five-step and seven-cleaning process, which includes moving beds when debris is visibly noted. She stated she frequently covers shifts when staff are absent due to call-ins. She further states that housekeeping training and in-services are provided by a contracted company. During an interview on 02/25/2026 at 02:50 PM, the Housekeeper company district manager stated that housekeeping staff are trained to clean resident rooms daily, including under beds, by moving the bed when debris is visible noted. She states housekeeping staff are trained to use a five- step and seven-step cleaning process in which copies of steps are posted inside supply closet door. She stated she expected housekeeping staff to follow the guidelines using the using the five- step and seven-step cleaning process. During an interview on 02/25/2026 at 3:00 PM CNA E stated after 7:00 PM. Nursing staff, including CNAs, provide housekeeping coverage and cleaning supplies are available in the supply area to address spills and debris on the floor. During an interview on 02/25/2026 at 3:15 PM CNA F stated after 7:00 PM, nursing staff provide housekeeping coverage and that cleaning supplies are in the supply area to address spills, accidents, and debris on the floor. During an interview on 02/24/2026 at 3:30 PM the DON stated that staff are informed that after housekeeping staff leave for the day, laundry staff provide housekeeping coverage until 7:00p.m. She stated that after 7:00 PM nursing staff, including CNAs, provide housekeeping coverage and that cleaning supplies are available to address spills, incidents, or debris on floors and in resident rooms. During an interview on 02/24/2026 at approximately 4:00 PM, the Administrator stated that housekeeping services are provided by a contracted company. He reported that housekeeping staff are trained to clean resident rooms daily, including cleaning them under beds by moving them when visible debris was present. He further stated that staff are trained in a five-step and seven-step cleaning process, with procedures posted on the inside of the housekeeping supply closet. The Administrator stated that the housekeeping manager/supervisor oversees daily operations. He also introduces the contracted company's district housekeeping manager and stated that he expected housekeeping staff to adherer to established company protocols and guidelines. A review of the February 2026 staffing schedule showed twice-daily deep-clean/focus room checks for rooms 101, 107, 213, 314, 402, and 407. Housekeeping shifts were scheduled from 8:00 a.m. to 2:00 p.m., 8:00 a.m. to 3:30 p.m., and 9:00 a.m. to 4:00 p.m., with laundry staff covering housekeeping duties from 4:00 p.m. to 7:00 p.m. A review of the contracted company's five-step daily patient/resident room cleaning procedure (dated 1/1/2000), showed that housekeeping staff are trained to empty trash, clean hard surfaces, spot clean walls, dustmop and damp mop. The procedure requires moving furniture as needed to clean the entire floor, including behind beds and dressers, and alone baseboards. A review of the contracted company's seven-step daily washroom cleaning procedure (dated 1/1/2000), indicated that housekeeping staff (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are instructed to check supplies, empty trash, clean and sanitize sinks, tubs, and commodes, spot clean walls or partitions, and dust mop and damp mop floors using an approved germicide solution to disinfect surfaces. A review of the Residents Room Cleaning Policy No. 008 (dated and last reviewed 2/1/2025) indicated staff must follow infection control precautions when cleaning. Floors are to be dust mopped, damp mopped, per infection control standards. Rooms are regularly cleaned and disinfected, with emphasis on high-touch surfaces such as light switches, bed rails doorknobs, and call lights.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews. the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and the residents goals and preferences for 2 of 3 residents (Resident #18, Resident #63) reviewed for oxygen therapy. The facility failed to ensure Resident #18 received oxygen at the rate ordered by the physician. Resident #18's oxygen was set at 3.5 LPM on 2 consecutive days and at 4.0 LPM on the third day instead of 2 LPM as ordered by the physician.The facility failed to ensure Resident #63's nasal cannula (a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) was stored in a bag when not in use. These failures could place residents who receive oxygen therapy at risk for respiratory distress and infection.The findings included: 1.Record review of a face sheet dated 02/24/2026 indicated Resident #18 was a [AGE] year-old female who re-admitted to the facility on [DATE]. She had diagnoses which included COPD (chronic obstructive pulmonary disease - a progressive, irreversible lung disease causing obstruction, inflammation, and chronic airflow blockage) and dementia. Record review of an annual MDS dated [DATE] indicated Resident #18 had a BIMS score of 3 indicating her cognition was severely impaired. The MDS also indicated Resident #18 received oxygen therapy. Record review of a care plan dated 01/13/2025 noted Resident #18 had a concern for shortness of breath with interventions to address it which included the administration of oxygen as ordered by the physician. Record review of Resident #18's physician's orders dated 02/24/2026 indicated an order dated 01/30/2025 for her to receive oxygen via nasal canula at a flow rate of 2 LPM (liters per minute) continuously. During an observation and interview on 02/23/2026 at 10:28 AM, Resident #18 was receiving oxygen at flow rate of 3.5 LPM via nasal cannula. Resident #18 said she did not know anything about the oxygen except that she could not breathe without it. She said she was comfortable and respirations were noted to be even and unlabored. During an observation on 02/24/2026 at 02:00 PM, Resident #18 was noted receiving oxygen at a flow rate of 3.5 LPM via nasal cannula. During an observation on 02/25/2026 at 08:10 AM, Resident #18 was noted receiving oxygen at a flow rate of4.0 LPM via nasal cannula. During an interview on 02/25/2026 at 08:15 AM, LVN D checked Resident #18's physician's orders and said Resident #18 was to receive oxygen via nasal cannula at a flow rate of 2.0 LPM. She said she did not know why the oxygen setting was incorrect. She said the nurses were responsible for monitoring the oxygen delivery flow rates. LVN D said incorrect oxygen flow rates could compromise a person's respiratory status. During an interview on 02/25/2026 at 08:30 AM, the DON said the nurses were responsible for monitoring oxygen administration and ensuring the oxygen flow rates were set at the rate ordered by the physician. The DON said oxygen rates set higher than those ordered by the physician could place residents at risk for respiratory distress. She said over oxygenating could cause a resident to decrease their respirations and become oxygen deprived. The DON said she and the ADONs were responsible for ensuring the nurses followed the physicians' orders and the facility's policies regarding oxygen administration. Record review of the facility's Oxygen Administration Policy dated 03/14/2019 indicated the following: Compliance guidelines: A resident receives oxygen therapy when there is an order by a physician.Procedure:3. Obtain physician orders for oxygen administration. Orders should include the following:c. flow rate delivery. 2.Record review of Resident #63's undated face sheet indicated Resident # was a [AGE] year-old male admitted [DATE] with diagnoses including Other Specified Chronic Obstructive Pulmonary Disease (a respiratory illness that involves chronic obstruction of lung airflow) and Acute Respiratory Failure, Unspecified (a respiratory illness that occurs when the lungs fail to adequately exchange oxygen and carbon dioxide). Record review of Resident #63's most recent Quarterly MDS dated [DATE] indicated Resident #63 utilized a wheelchair and was fully dependent on staff for transfer between bed and wheelchair. The MDS indicated he had (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a BIMS score of 4, indicating severe cognitive impairment. The MDS indicated he had difficulty focusing attention and exhibited disorganized thinking. The MDS indicated Resident #63 had oxygen therapy while a resident and within the last 14 days. Record review of Resident #63's comprehensive care plan dated 06/18/2024, last updated 12/23/2025, indicated Resident #63 was at risk for shortness of breath and utilized oxygen therapy related to respiratory disease. Interventions included oxygen as ordered/recommended by physician. Record review of Resident #63's orders indicated:*Change O2 and/or nebulizer tubing Q Week, start date 10/27/2024, revision date 03/28/2025. *Oxygen at 2-3 Liters per nasal cannula for signs and symptoms of shortness of breath/comfort continuous, start date 10/27/2024, revision date 11/20/2025. *May use oxygen at 2-3 liters for comfort when in room resting and when out of room/bed as tolerated and intermittently for comfort, start date not indicated, revision date 10/22/2024. During an observation on 02/23/2026 at 10:09 AM, Resident #63's nasal cannula was on the floor beside the oxygen concentrator, not stored in a bag, in his room. During an interview on 02/25/2026 at 10:48, LVN J indicated that the oxygen concentrator in the shared bedroom was Resident #63's. LVN J indicated that this was her first day to work this week and she was unaware that Resident #63's nasal cannula had been improperly stored. LVN J indicated the risk of Resident #63's nasal cannula being on the floor instead of in a bag would be the potential for infection. During an interview on 02/25/2026 at 11:15 AM, ADON K indicated that she was responsible for ensuring that nursing staff are completing appropriate tasks. ADON K indicated that she was unaware of why Resident #63's nasal cannula would be found on the floor. ADON K indicated that the risk to Resident #63 of his nasal cannula being placed on the floor would be the potential for infection. During an interview on 02/25/2026 at 2:22 PM, the DON indicated that the nasal cannula was properly stored when it was in a bag. The DON indicated that the nurse was responsible for ensuring this was completed properly and that she was responsible for ensuring the nurse complete their appropriate tasks. The DON indicated that the risk to Resident #63 of his nasal cannula being placed on the floor is that debris could enter the cannula and cause infection. Record review of facility's Oxygen - Respiratory Tubing/Equipment Management policy dated 02/12/2018, revised January 2022, indicated the following: Compliance guidelines:To maintain properly functioning equipment and decrease the potential for the spread of infection by maintaining clean equipment and tubing bottles and masks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed food service safety , in that: *Steam tables were dirty with food spatter on glass on all 4 Satellite Kitchens *12 Dirty cookie sheets containing carbon build-up on rack *2 Dirty muffins pans containing carbon build up were stacked against each other *Dishwasher test log, had been filled in and completed for the entire day These failures could place residents who ate food from the kitchen at risk of foodborne illness Findings included: During observations and interviews on 02/23/2026, the following was noted in the kitchen and satellite kitchens: *At 8:45 AM there were carbon built up on 2 muffin pans stacked against each other, 12 large dirty cooking sheets with carbon build up on a rack in the main kitchen and the DM said that was a build up over years and would have to check on replacing them. *At 9:45 AM Hall 200 steam table glass had spatter on the glass and dirty bottom shelf. *At 11:06 an interview with DA A identified the dishwashing/pot sink temperature sheet and stated he did pre-sign by initialing for the remainder of the day noon and night, he said he knew he was not sign until it was actually completed according to the Food Preparation and Service Policy, dated revised October 1, 2018. He said, this could cause food to be served in a manner that my not be safe and unclean. *At 11:07 AM on Hall 300 steam table glass had spatter on the glass and dirty bottom shelf. During an interview with DA B she said it was her responsibility as the server to clean the steam table and she has neglected to clean per policy. *At 11:12 AM on Hall 400 steam table glass had spatter on the glass and dirty bottom shelf. *At 11:55 AM on Hall 100 steam table glass had spatter on the glass and dirty bottom shelf. During a follow up visit to the kitchen on 02/24/2026 an interview with DM and the Clinical Director of Operations at 11:00 AM, the DM said she was trained and able to handle the current situation of the kitchen, temps recorded, and steam table cleaned, by making sue the kitchen staff who are assigned to the satellite kitchens clean their steam tables, and DA record temps as they obtain the temps. She had her food managers certification. During an interview on 02/24/2026 at 9:42 AM the DM said she did not have any documentation that staff have been in-serviced on kitchen sanitation. She said she could do it today. A review of documentation provided by the Clinical Director of Operations indicated on 02/24/2026 the kitchen staff was in-serviced on required to clean their steam tables, obtaining temperature and recording right date and time. Review of facility policy for Food Preparation and Service dated revised October 1, 2018. Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure MDS data accurately reflected the resident's status for 1 of 6 residents (Resident #76) reviewed for MDS accuracy. This facility failed to indicate Resident #76's current nutritional approach was by feeding tube in MDS dated [DATE]. This failure could put residents at risk for an inaccurate comprehensive assessment record. The findings included: Record review of Resident #76's undated face sheet indicated Resident #76 was an [AGE] year-old male admitted [DATE] with diagnoses including Dysphagia, Unspecified (difficulty swallowing), Gastrostomy Status (indicating a person has undergone a procedure resulting in a permanent opening in the stomach for nutritional support), and Gastro-Esophageal Reflux Disease without Esophagitis (a condition in which stomach acid frequently flows back into the esophagus). Record review of Resident #76's admission MDS dated [DATE] indicated Resident #76 had unclear speech, was rarely/never understood, and usually had the ability to understand others. The MDS indicated Resident #76 had a BIMS score of 14, indicating normal thinking and memory. The MDS indicated Resident #76 utilized a wheelchair and was dependent on staff for all functional abilities. Section K0520 of the MDS indicated the Resident #76 had received Parenteral/IV feeding and a feeding tube while not a resident and. Section K0520 of the MDS did not indicate that Resident #76 received Parenteral/IV feeding and a feeding tube while a resident. Record review of Resident #76's comprehensive care plan dated 12/22/2025 indicated Resident #76 was at risk for nutritional deficits and/or dehydration. Interventions included nurse to provide enteral feedings and flushes as recommended by physician. Record review of Resident #76's orders indicated:*Enteral Feed, dated 12/09/2025*Every shift, flush G-Tube with 50cc of water before and after medication pass and feeding administration, dated 12/4/2025. *Every shift, confirm G-Tube placement per auscultation and aspiration before any feeding/medication/flush administered, dated 12/04/2025. *Formula: Jevity 1.5 at 55 cc/hr for 24 hours, dated 12/04/2025 Record review of Resident #76's hospital records dated 12/04/2025 indicated that an interventional radiology guided percutaneous endoscopic gastrostomy tube placement (a procedure used to insert a feeding tube directly into the stomach for people who cannot eat orally) was performed on 11/25/2025. During an observation on 02/23/2026 at 10:25 AM, Resident #76 was observed lying in bed. A Jevity formula bag and water bag was observed hanging beside the bed and Resident #76 nodded his head when asked if he received tube feeding. During an interview on 02/25/2026 at 10:35 AM, with both MDS LVN L and corporate MDS support nurse indicated MDS LVN L and MDS LVN M were responsible for completing the MDS. MDS LVN L indicated that MDS LVN M completed Resident #76's MDS, but was not present at the facility at the time of interview. The corporate MDS support nurse indicated she was responsible for overseeing the MDS process and ensuring accurate assessment. The corporate MDS support nurse indicated that MDS assessments were conducted by utilizing information from residents' charts, resident interview, and family interview. MDS LVN L indicated that it is likely that Resident #76's nutritional status was selected in error and indicated that completing the assessments can be tedious and that they have difficulty completing the assessments due to performing other responsibilities, including working as direct care staff. The corporate MDS support nurse indicated that it was important to have an accurate MDS assessment in order to provide proper care and transfer of information. The corporate MDS support nurse indicated that there was not a facility policy on accurate MDS assessments and that they utilized the RAI manual. During an interview on 02/26/2026 at 1:20 PM, the ADM indicated the MDS nurses were responsible for completing MDS assessments and that he was responsible for ensuring these are done correctly. The ADM indicated that the corporate MDS support nurse completed reimbursement follow ups. The ADM indicated that the MDS was completed through record review and interviews. The ADM was unable to provide a potential risk to residents for the MDS assessment not being accurately completed. The ADM indicated that there was no facility policy on accurate MDS assessments and that the facility utilized the RAI manual.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to meet professional standards of care for 1 of 6 residents (Resident #3) reviewed for professional standards when diagnosing a mental health disorder. The facility did not ensure Resident #3 had sufficient clinical documentation to support a new diagnosis of schizophrenia. This failure could place residents at an increased risk of inappropriate care planning, psychosocial stigma, and future treatment decisions based on incorrect clinical information. The findings included: Record review of Resident #3's undated face sheet indicated Resident #3 was an [AGE] year-old female originally admitted to the facility on [DATE] and most recently admitted on [DATE] and had the diagnoses of Alzheimer's Disease with Late Onset (a form of dementia that typically begins after the age of 65 characterized by memory and cognitive issues); Schizophrenia, Unspecified (a psychiatric diagnosis used when a person exhibits hallucinations, delusions, disorganized thinking, or abnormal behavior); Manic Episode, Severe with Psychotic Symptoms (characterized by a period of elevated mood, energy, and increased activity often accompanied by a break from reality); and Insomnia due to Medical Condition (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early and not being able to return to sleep). Record review of Resident #3's most recent Quarterly MDS, dated [DATE], indicated Resident #3 had clear speech, was usually understood, and usually understands others. The MDS indicated Resident #3 had a BIMS of 3, indicating severe problems with thinking or memory. The MDS indicated that Resident #3 had no evidence of an acute change in mental status from the baseline and did not exhibit inattention, disorganized thinking, or altered levels of consciousness. Record review of Resident #3's comprehensive care plan, revised 12/04/2026, indicated Resident #3 required anti-psychotic medication. Interventions included monitoring, documenting, and reporting to the MD signs and symptoms of psychotropic drug complications. Record review on 02/24/2026 at 10:20 AM of Resident #3's diagnosis report indicated that the diagnosis of Schizophrenia, Unspecified was created on 01/05/2026. Record review of Resident #3's medication orders indicated an order dated 03/28/2025 and revised 01/07/2026 for Olanzapine Tablet 5 MG (an antipsychotic medication used to treat mental health conditions such as Schizophrenia) 1 tablet by mouth at bedtime for Mania/Schizophrenia. A record review of Resident #3's inpatient psychiatric hospitalization records dated 01/25/2022 through 02/11/2022 indicated within the initial psychiatric evaluation dated 01/25/2022 indicated a current diagnosis of dementia with behavioral disturbance. The discharge summary within these records dated 02/11/2022 indicated a discharge diagnosis of dementia with behavioral disturbance. The inpatient psychiatric hospitalizations records did not indicate a diagnosis of Schizophrenia. Record review of Resident #3's referral documentation from hospice received by the facility on 03/05/2025 indicated the diagnoses of Alzheimer's Disease with Late Onset, Other Specified Depressive Episodes, Other Specified Anxiety Disorders, and Insomnia due to Medical Condition. The medication report on this documentation dated 03/05/2025 indicated Resident #3 was prescribed Olanzapine 5 MG 1 tablet orally at bedtime for sleep and anxiety dated 12/20/2024. A visit note report on this documentation dated 02/27/2025 indicated Resident #3 was not assessed for psychiatric symptoms. Record review of a progress note dated 01/05/2026 at 4:57 PM by MDS LVN M indicated the MD clarified Olanzapine diagnosis to Mania/Schizophrenia. The progress note indicated Resident #3's family was present and indicated to the doctor that Resident #3 used to speak to invisible people in her room or when alone and that Resident #3 was placed on Olanzapine during an inpatient psychiatric stay. Record review on 02/25/2026 at 3:18 PM of an undated medication consent indicated Resident #3 had the psychiatric condition of Mania/Schizophrenia and was prescribed Olanzapine 5 MG 1 tablet at bedtime. Record review on 02/25/2026 at 3:19 PM of a medication consent signed by Resident #3's representative on 4/23/2025 indicated Olanzapine 5 MG use for the diagnosis of psychotic disorder. During a telephone interview on 02/25/2026 at 2:38 PM, Resident (continued on next page)

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	02/25/2026

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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3's representative indicated he was unaware of the clinical indication for Resident #3 to receive an anti-psychotic medication. Resident #3's representative indicated that the facility provided her anti-psychotic medication like she's supposed to take it. During a telephone interview on 02/25/2026 at 2:54 PM, the MD indicated that the diagnosis of Schizophrenia was based on clinical findings. The MD indicated that Resident #3 had been prescribed Olanzapine by hospice prior to her admission to the facility and he continued this medication. The MD indicated that he had not reviewed any documentation from the local mental health agency and that Resident #3's representative indicated that Resident #3 had been hospitalized at an inpatient psychiatric hospital and obtained the diagnosis of Schizophrenia. The MD indicated he was not a psychiatrist, that he thought he had reviewed the documentation from the inpatient psychiatric hospital, and that he believed he was following the diagnosis that a previous psychiatrist had provided Resident #3. During an interview on 02/25/2026 at 3:40 PM, with LVN MDS M, the DON, and the VP of Clinical Operations, LVN MDS M indicated she had attended a care plan meeting with Resident #3's representative who indicated that Resident #3 had an inpatient psychiatric hospitalization and requested she continued to be prescribed Olanzapine. The VP of Clinical Operations and the DON indicated that they did not have documentation of Resident #3's previous inpatient psychiatric hospitalized but were obtaining it. During an interview on 02/25/2026 at 3:57 PM, the ADM indicated that he was unaware of Resident #3 obtaining the new diagnosis of Schizophrenia. The ADM indicated that the DON was responsible for obtaining clinical documentation to support this diagnosis and that they had discussions daily regarding this. The ADM was unable to identify a risk to residents for obtaining a new diagnosis of Schizophrenia without sufficient clinical documentation. The ADM was asked for a policy regarding new psychiatric diagnoses and did not provide this prior to exit. During an interview on 02/25/2026 at 4:15 PM, the ADM was asked for a policy regarding new psychiatric diagnoses and did not provide this prior to exit. During an interview on 02/25/2026 at 4:29 PM, the VP of Clinical Operations and the DON provided Resident #3's previous inpatient psychiatric hospitalization. The VP of Clinical Operations indicated that these records were not available for review by the physician prior to making the diagnosis of Schizophrenia.

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(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** Based on observations, interviews, and record reviews, 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 4 residents (Resident #16) reviewed for pharmacy services. LVN C failed to flush Resident #16's enteral tube with water during medication administration as ordered by the physician. This failure could place residents who receive medications via a gastric tube (also called an enteral tube) at risk for tube occlusion (clogging), medication-nutrient interactions, reduced drug efficacy, and potential toxicity. Findings included: Record review of a face sheet dated 02/24/2026 indicated Resident #16 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included spastic diplegic cerebral palsy (permanent, non-progressive neurological disorder appearing in infancy and caused by abnormal brain development), aphasia (unable to speak), adult failure to thrive, dysphagia (difficulty with swallowing), gastrostomy status (having a gastric tube), developmental disorder, and constipation. Record review of a quarterly MDS dated [DATE] indicated Resident #16 was rarely understood, dependent on staff for all activities of daily living, and received liquid nutrition via a gastrostomy tube. Record review of a care plan dated 10/08/2025 indicated Resident #16 was at risk for nutritional deficits and/or dehydration risks and included an intervention to provide fluids as ordered. Record review of the physician's orders dated 02/24/2026 indicated an order dated 11/16/2023 to flush the gastric tube with 30ml water before and after medication administration and flush with 5-10ml water between each medication. During an observation and interview on 02/24/2026 at 08:43 AM, LVN-C was noted to prepare Resident #16's medications and administer them to him via an enteral tube (a tube placed through the abdominal wall into the stomach). LVN-C prepared 6 crushed tablets, 1 powdered medication, and 1 packet of granules medication for a total of 8 individual cups of medications diluted and/or dissolved in water and took them to Resident #16's bedside table. LVN-C halted the infusion of liquid nutrition and disconnected the feeding pump tubing from Resident #16's gastric tube (enteral tube). LVN-C proceeded to administer the 8 medications, one after the other. After LVN-C administered the third medication, she turned toward the surveyor and said she did not give any water between the medications because Resident #16 did not tolerate it. She said Resident #16 got fussy if it took very long to give his medicines. LVN-C then continued to administer the remaining medications. LVN-C did not flush the gastric tube with water prior to administering the first medication. LVN-C did not flush the gastric tube between each of the 8 medications. LVN-C did not flush the gastric tube after administering the last medication. LVN-C then reconnected the feeding pump tubing to the gastric tube and restarted the flow of liquid nutrition. LVN-C discarded the empty medication cups, washed her hands, and returned to the cart. LVN-C said she had not spoken to the physician about Resident #16's orders for water flushes with his medication administration. LVN-C said she did not know if the water ordered for flushing the tube during medication administration was included in the calculation of Resident #16's water needs. LVN-C said the water flushes were to help prevent the gastric tube from getting clogged. During an interview on 02/24/2026 at 11:21 AM, the DON said she expected the nurses to follow the physicians' orders for gastric tube water flushes. She said the water flushes help minimize the risk of the tubes getting clogged, provide the resident with water for hydration purposes, and assist with absorption of the medications into the blood stream. The DON said she was responsible for ensuring the nurses followed the physicians' orders for administration of medications via the gastric tube route. Record review of the facility's policy entitled Medication Administration via Enteral Tube indicated the following: Compliance Guidelines: To administer medications through an enteral tube in an accurate, safe, timely and sanitary manner.