| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Treviso Transitional Care | 1154 East Hawkins Parkway<br>Longview, TX 75605 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 22 residents (Resident #9 and Resident #25) reviewed for resident rights.1. The facility failed to ensure Resident #9's urinary catheter bag was covered with the privacy cover flap. 2. The facility failed to ensure CNA D and CNA G knocked on Resident #25's door before entering on 8/25/25.3. The facility failed to ensure CNA D and CNA G closed Resident #25's privacy curtain during catheter care on 8/25/25.4. The facility failed to ensure CNA D and CNA G properly covered Resident #25 during catheter care on 8/25/25. These failures could place residents at risk of humiliation, diminished quality of life, loss of dignity and self-worth.<br><br>Findings included:<br><br>1. Record review of Resident #9's face sheet dated 8/26/25 indicated he was [AGE] years old and was admitted to the facility on [DATE]. Resident #9 had diagnoses which included urinary tract infection, heart failure, chronic kidney disease, extended spectrum beta lactamase (ESBL) resistance (infection that has resistance to many common antibiotics), weakness and lack of coordination.<br><br>Record review of Resident #9's admission MDS assessment dated [DATE] indicated Resident #9 had a BIMS score of 9, which indicated he had moderate cognitive impairment. Resident #9 required a wheelchair or walker for mobility. Resident #9 was dependent on staff for most ADL's, including toileting and transfers. Resident #9 had an indwelling urinary catheter (tube inserted into the bladder to drain urine out of the body).<br><br>Record review of Resident #9's Care Plan indicated he had an indwelling catheter for urine retention. Resident #9 was on Enhanced Barrier Precautions (an infection control strategy that uses gloves/gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms) and at risk for infection related to indwelling medical device.<br><br>During an observation and interview on 8/24/2025 at 11:29 AM, Resident #9 was sitting in his wheelchair in his room and said he had just returned from a group activity. Resident #9 had a urinary catheter, and the privacy cover flap was bunched up under the hanging hook under his wheelchair and was not covering the urine in his drainage bag.<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 8/24/2025 at 2:56 PM, Resident #9 was sitting in his wheelchair in the lobby area in front of the nurses' station. Resident #9's privacy cover of his urinary catheter bag continued to be bunched up under the hanging hook under the wheelchair and was not covering the urine in the urinary drainage bag.<br><br>During an interview on 8/26/2025 at 2:17 PM, Resident #9 said he did not know his urinary catheter bag was not covered Sunday because the staff hung it under his wheelchair. Resident #9 said he would not want his urine in his bag to be seen by everyone when he was out in the hallways, and he did not like it. Resident #9 said even at his home, he kept his urinary catheter bag in a cloth bag to cover it.<br><br>During an interview on 8/26/25 at 2:22 PM, LVN K said the urinary catheter drainage bag privacy cover flap was for the resident's privacy, it covered the resident's urine, so it was not exposed to everyone. LVN K said if the urinary catheter drainage bag was not covered, it could be embarrassing for some residents. LVN K said if the privacy flap was not covering the urinary catheter drainage bag, the resident could be embarrassed, have low self-esteem, and not want to have to answer questions to other residents. LVN K said all staff would be responsible for ensuring the urinary catheter drainage bag was covered and stored properly. LVN K said all staff could pull the privacy flap on the urinary catheter drainage bag down and reposition it.<br><br>During an interview on 8/26/2025 at 2:38 PM, CNA A said she had worked at the facility since November of 2024. CNA A said she was assigned to the 400 hall, but she helped wherever needed. CNA A said the nurse or aide on duty would be responsible for ensuring the urinary catheter bag was covered. CNA A said most residents would not like letting everyone see their urine in the bag. CNA A said the cover for the urinary catheter bag was to provide privacy for the resident. CNA A said staff should make sure the urinary catheter bag cover flap was down and covering the urinary catheter bag when attaching it to the resident's wheelchair. CNA A said the nursing staff and aides would be responsible for ensuring the urinary catheter cover was covering the urine in the bag for the privacy of the resident.<br><br>During an interview on 8/26/2025 at 3:17 PM, CNA D said the cover on the urinary catheter bag was for the privacy of the resident. CNA D said if the urine in the urinary catheter was not covered, it could cause the resident to be embarrassed. CNA D said the nurse and the aides would be responsible for ensuring the cover was covering the urinary catheter bag.<br><br>During an interview on 8/26/2025 at 3:50 PM, the ADON said the cover on the urinary catheter bags was to cover the urine in the bag for the resident's privacy. The ADON said if the urinary catheter bag was not covered it could be embarrassing for the resident.<br><br>During an interview on 8/26/2025 at 4:27 PM, the DON said the cover flap of the urinary catheter bag was for privacy. The DON said the CNAs and nursing staff would be responsible for ensuring the privacy cover was covering the urine in the bag. The DON said people could see the urine in the bag and cause the resident to not feel good about it.<br><br>During an interview on 8/26/2025 at 4:52 PM, the ADM said he would expect the urinary catheter bag cover to cover the urine in the catheter bag for the privacy and dignity of the resident. The ADM said if the urinary catheter bag was not covered it could affect the resident's dignity.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review of Resident #25's face sheet dated 8/26/25 indicated Resident #25 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted [DATE]. Resident #25 had diagnoses including heart failure (is a condition where the heart muscle is weakened or stiffened, making it unable to pump blood effectively), neuromuscular dysfunction of bladder (a person does not have bladder control because of brain, spinal cord, or nerve problems), dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and generalized anxiety disorder (is a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry about various everyday events or situations).<br><br>Record review of Resident #25's annual MDS assessment dated [DATE] indicated Resident #25 was usually understood and usually had the ability to understand others. Resident #25's BIMS score was 5 which indicated severe cognitive impairment. Resident #25 required substantial/maximal assistance for toileting hygiene. Resident #25 had an indwelling catheter.<br><br>Record review of Resident #25's care plan dated 10/30/22 indicated Resident #25 had an ADL self-care deficit related to dementia. Intervention included required staff participant times 1 to use toilet.<br><br>Record review of Resident #25's care plan dated 7/7/25 indicated Resident #25 had an indwelling catheter related to atonal bladder (is a condition where the bladder muscles are weak and do not contract properly, leading to difficulty or inability to urinate). Intervention included change catheter as indicated.<br><br>During an observation on 8/25/25 at 4:00 p.m., CNA D and CNA G entered Resident #25's room without knocking. CNA D and CNA G washed their hands and donned gowns. CNA D lowered Resident #25's covers to his ankles. Resident #25 had a t-shirt and brief on. Resident #25 complained about being cold. CNA D unattached Resident #25's brief and exposed his perineal area. The surveyor remained at the foot of Resident #25's bed until catheter care started. The surveyor moved next to CNA D to closely observe catheter care being provided. Resident #25's privacy curtains were left open. Resident #25's roommate was in the room.<br><br>During an interview on 8/26/25 at 2:18 p.m., the surveyor attempted to interview Resident #25 about catheter care performed on 8/25/25. Resident #25 had disorganized thinking and started talking about luggage in his room. Unable to interview Resident #25.<br><br>During an interview on 8/26/25 at 2:20 p.m., CNA D said she knocked and introduced herself to Resident #25. She said she did not pull the privacy curtain because the surveyor was in the way. She said Resident #25's blankets should have been at his knees. She said it was important to knock before entering a residents' room, pull the privacy curtain, and cover the residents to provide them privacy. She said not providing the residents privacy could make them feel embarrassed or uncomfortable.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/26/25 at 2:31 p.m., LVN F said she expected the CNAs to knock on the residents' doors before entering. She said it provided privacy to the resident. She said she expected the CNAs to pull the privacy curtains during cares. She said if the CNAs felt like the surveyor was in the way of closing the privacy curtain, they should ask the surveyor to step in to close the curtain. She said it was important to close the privacy curtains during cares to provide privacy and dignity. She said during catheter care, the residents' body should be covered as much as possible. She said this provided comfort, dignity, and privacy. She said Resident #25 liked to be covered because he was always cold. She said the residents could feel like their rights were taken away and dignity not being honored.<br><br>During an interview on 8/26/25 at 3:00 p.m., ADON N said she expected the nursing staff to knock before entering a residents' room, close privacy curtains and cover the resident during cares. She said it was the resident's right and dignity. She said if those things were not done, the resident could be embarrassed. She said nursing management did competency check offs upon hire and skill check offs to ensure staff did those things.<br><br>During an interview on 8/26/25 at 5:44 p.m., the ADM said he expected the nursing staff to knock on the residents' doors before entering, cover the resident as much as possible and close privacy curtains during catheter care. He said it was important to do those things for dignity and privacy. He said when those things were not done, the resident could feel undignified. He said the facility ensured the nursing staff knew to do those things by doing competency check offs.<br><br>During an interview on 8/26/25 at 6:13 p.m., the DON said she expected the nursing staff to knock on the residents' doors before entering, cover the resident as much as possible and close privacy curtains during catheter care. She said those things should be done for dignity. She said when those things were not done, it could have a negative effect on the resident. She said the nursing staff should be monitored to ensure those things were being done. She said the nursing staff was educated through training on resident rights.<br><br>Record review of CNA D's, “C.N.A Proficiency Evaluation” dated 3/21/25 indicated, “…daily catheter care… explain procedure to the resident…provide privacy… met expectation…Director of Talent and Learning Q…”<br><br>Record review of CNA G's, “C.N.A Proficiency Evaluation” dated 3/21/25 indicated, “…daily catheter care… explain procedure to the resident…provide privacy… met expectation…Director of Talent and Learning Q…”<br><br>Record review of the facility's policy titled “Resident Rights” dated revised December 2016, indicated . employees shall treat all residents with kindness, respect, and dignity … federal and state laws guarantee certain basic rights to all residents of this facility … these rights include the resident's right to … a dignified existence … be treated with respect, kindness, and dignity …”.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's policy titled “Quality of Life - Dignity” dated revised August 2009, indicated . each resident shall be cared for in a manner that promoted and enhanced quality of life, dignity, respect and individually … residents shall be treated with dignity and respect at all times … residents' privacy space and property shall be respected at all times … staff will knock and request permission before entering residents' rooms … staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures … staff shall promote dignity and assist residents as needed by … a. helping the resident to keep urinary catheter bags covered …“.<br><br>Record review of a facility's, “Perineal Care” policy revised 10/2010 indicated, “…The purposes of this procedure arc to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition… 4. Fold the bedspread or blanket toward the foot of the bed… 5. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet… Avoid unnecessary exposure of the resident's body…”. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consult with the resident's physician and representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 22 residents (Resident #61) reviewed for notification of change.The facility failed to notify the NP/MD of Resident #61's complaint of left foot pain on 8/21/25.This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition.Findings included: Record review of Resident #61's face sheet dated 8/26/25 indicated he was [AGE] years old and was admitted to the facility on [DATE]. Resident #61 had diagnoses which included cerebral infarction (stroke-disruption of blood flow to the brain causing tissue damage), hemiplegia and hemiparesis (paralysis (unable to move) and/or muscle weakness on one side of the body) of left side, chronic embolism and thrombosis (blood clot) of deep veins of right lower extremity, chronic pain syndrome, weakness and lack of coordination.Record review of Resident #61's quarterly MDS assessment dated [DATE] indicated Resident #61 had a BIMS score of 13, which indicated he was cognitively intact. Resident #61 was dependent on staff for bathing, toileting, and dressing and required moderate staff assistance for most other ADL's. Resident #61 received pain medications as needed. Resident #61's pain rarely or not at all affected his sleep, therapy activities, or day-to-day activities. Resident #61 received opioid medication (prescription pain medication used to treat moderate to severe pain).Record review of Resident #61's Care Plan dated and last reviewed on 8/11/25 indicated he had osteoarthritis and was at risk for pain, decline in ADLs and mobility with interventions including: five analgesics as ordered by the physician, observe/document/report to physician as needed, signs and symptoms or complications related to osteoarthritis, such as joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in self-care ability, pain after exercise or weight bearing and report to nurse any change in level of activity or ability to perform ADLs. Resident #61 had recurrent deep vein thrombosis to right lower extremity. Resident #61 had limited physical mobility. Resident #61 had potential for pain with interventions including: acknowledge presence of pain and discomfort, listen to the resident's concerns, administer pain medications per physician orders, and report complaints and non-verbal signs of pain. Record review of Resident #61's nurses' notes ranging from 8/01/25 to 8/26/25 did not reveal any documentation from 8/18/25 to 8/26/25, until after surveyor intervention on 8/26/25. There was no mention of Resident #61 reporting left foot pain. After surveyor intervention, LVN H documented on 8/26/25, the resident stated pain to his left foot that was more on the inside of the bottom of his foot. LVN H noted the physician, obtained an order for an x-ray, and administered as needed pain medication.Record review of Resident #61's Physical Therapy Treatment Encounter Note dated 8/21/25 indicated PTA Y reported resident's foot pain to nursing and she was going to consult physician in regards to possibly getting an x-ray.Record review of Resident #61's NP follow-up visit note dated 8/21/25 indicated he continued to get stronger, participated in therapy sessions with improvements. Resident #61's review of systems indicated he was positive for activity change, arthralgias (joint pain) and gait problem. Resident #61 had acute left knee pain. The NP note indicated Resident #61 was sitting in wheelchair in his room. There was no mention of Resident #61 complaining of left foot pain in the NP note.Record review of Resident #61's physician note dated 8/26/25 indicated the reason for visit was left foot pain and Resident #61 stated the pain began approximately six days prior after being treated in therapy with a foot vibrator and he found it difficult to walk on the foot because of the pain. The note indicated Resident #61 had acute left foot pain, suspected to be arthritic, and would check an x-ray as a precaution. The note indicated the plan was to obtain left foot films, Tylenol for pain, and other medications as before. Record review of Resident #61's pain log indicated he had no pain 8/21/25 through 8/25/25, but he had pain at a level 6 on a 1-10 scale with 10 being the worse pain on 8/26/25.During an observation and interview on 8/24/25 at 10:13 AM, Resident #61 said his left foot hurt so bad and he could not stand on it, so he could not do therapy. Resident #61 said the nurses were aware and he was waiting on an x-ray of his left foot, but did not know when it would be scheduled. Resident #61 said his only concern was needing his left foot checked out.During an observation and interview on 8/26/25 at 8:25 AM, LVN H was on 400 hall passing medications. LVN H said Resident #61 had not reported having left foot pain to her and he normally only report left knee pain. LVN H said she would go talk to him.During an observation and interview on 8/26/25 beginning at 8:30 AM, LVN H entered Resident #61's room and asked |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment and clean bed linens for 4 of 6 residents (Resident #'s 12, 30, 34, and 39) reviewed for a homelike environment. The facility failed to ensure Resident #12's floor was free of debris, dust, shreds of papers, and five thick white hardened puddles of a substance on the floor beside and under the bed.The facility failed to ensure Resident # 30, Resident #34, and Resident #39 's bed linens were changed. These failures could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life.Findings included:1. Record review of a face sheet dated 08/27/2025 indicated, Resident #12 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included dysphagia following other (difficulty swallowing) cerebrovascular disease (affects the blood vessels of the brain and circulation) hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), neuromuscular (the nerves and muscles that control bladder are impaired) dysfunction of the bladder, gastrostomy (surgical opening in the abdominal wall for food intake) and dementia (a group of thinking and social symptoms that interferes with daily functioning).Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #12 was usually understood by others and usually understood others. The MDS indicated Resident #12 had a BIMS of 00 and was severely cognitively impaired. The MDS indicated Resident #12 was dependent on staff for toileting, dressing, and bathing. Record review of the care plan revised on 6/19/2025 indicated Resident #12 required assistance with ADL self-care due to a deficit related to dementia with the following interventions: required assistance of two staff for toilet use, transfers, and bed mobility. During an observation on 08/24/2025 at 12:30 PM, Resident #12 was lying in his bed asleep. Resident #12's floor around and under the dresser, chair and bedside table was covered in a layer of dust and dirt, giving a grimy appearance. Resident #12's floor beside and underneath the bed had a total of five thick white hardened puddles of a substance. There was visible debris such as white paper scattered across the floors and the floor mat surface. During an observation on 08/25/2025 at 08:00 AM, Resident #12 was lying in his bed but unable to interview due to his cognitive status. Resident #12's floor around and under the dresser, chair and bedside table were covered in a layer of dust and dirt, giving a grimy appearance. Resident #12's floor beside and underneath the bed had five thick white hardened puddles of a substance. There was visible debris such as white paper scattered across the floors and the floor mat surface. During an interview on 08/25/2025 at 02:00 PM, Housekeeper W said she had already cleaned Resident #12's room and had noticed there was some dust behind and under the furniture earlier. Housekeeper W said she was not always assigned to Resident #12's room but she cleaned her room assignments once a day and started from the floors, dusting all the surfaces and wiping down the bathrooms. Housekeeper W stated she does a walk through later during the day before her shift ended just to pick up the floors and bathrooms. Housekeeper W stated she had attempted to clean the white substance off the floor, but it was real sticky, and she had not been successful. Housekeeper W said she had reported the white sticky stains to her supervisor today. Housekeeper W said it was important for the residents' rooms to be clean and fresh because it was their home. Housekeeper W said her supervisor was able to remove the sticky substance once it had been sprayed down.During an interview on 08/26/2025 at 09:15 AM, the Environmental Services Supervisor stated the housekeepers have a 5 step cleaning process that is followed daily which included to empty and remove the trash, wipe receptacle, replace liner, high dust wipe flat surfaces with cloth and disinfectant, spot clean walls, wipe with cloth and disinfectant, dust mop gather debris with mop and pickup with dust pan, damp mop, mop floor with disinfectant from the back corner to the door. The Environmental Services Supervisor said the importance of a clean room was to decrease the chances of spreading germs that caused infections and to create a homey space for the residents. The Environmental Services Supervisor stated she was able to remove the sticky, white, hardened substance easily from Resident #12's floor once she was notified of the situation. The Environmental Services Supervisor stated she expected the rooms to be cleaned properly daily. During an interview on 08/26/2025 at 11:30 AM., the DON said the residents' rooms should be repaired and cleanly maintained to decrease infection. The DON said residents' rooms were theirs, and they should be nice and homelike.During an interview on 08/26/2025 at 4:45 PM., the Administrator said he expected the residents' rooms to remain clean to prevent the spread of infection and create a home like environment. The Administrator said the residents' rooms were monitored daily during rounds. The Administrator said they |

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| Treviso Transitional Care | 1154 East Hawkins Parkway<br>Longview, TX 75605 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promptly resolve grievances for 1 of 6 residents (Resident #54) reviewed for grievances.The facility did not ensure Residents #54 grievances related to meals being served late was resolved.The facility did not ensure the grievance received during Resident Council related to meals being served late on 03/07/2025, 04/04/2025, 06/02/2025, and 07/03/2025 were resolved.These failures could place residents at risk for grievances not being addressed and resolved promptly, hunger, frustration and low blood sugars. Findings included: Record review of a face sheet dated 08/27/2025 revealed Resident #54 was [AGE] year-old male admitted on [DATE] with diagnoses including type 2 diabetes (adult onset of too much sugar in the blood), personal history of a trauma fracture, pain, unsteadiness on feet, and an elevated white blood count. Record review of the quarterly MDS dated [DATE] revealed Resident #54 was understood and understood others. The MDS revealed Resident #54 had highly impaired hearing, clear speech, and adequate vision with corrective lenses. The MDS revealed Resident #54 had a BIMS of 06 which indicated severe cognitive impairment and required extensive assistance for bed mobility, dressing, toilet use, personal hygiene, transfer and bathing. Record review of Resident #54's care plan with revised date of 07/17/2025 revealed the potential for hypo/hyperglycemia (blood sugar levels) related to diabetes mellitus with the intervention of Accu-Chek (blood sugar check by pricking the skin) with sliding scale per orders. Record review of grievance log dated 03/07/2025 revealed the resident council had expressed concerns with food not served timely. The grievance log stated residents reported that dinner was served at 7PM. The grievance log stated the resolution was in-service training for all dietary staff on the topic of meals are to be served at a timely manner to maintain a structured daily routine for residents.Record review of grievance log dated 04/04/2025 revealed the resident council had expressed concerns with food not served timely. The grievance log stated residents reported that dinner was served at 9PM 0n 04/03/2025. The grievance log stated the resolution was in-service training for all dietary staff on the topic of meals are to be served at a timely manner and there was an issue with the tray system and missing meal tickets. Record review of grievance log dated 06/02/2025 revealed the resident council expressed concerns with food not served timely. The grievance log stated residents reported that dinner was served late and cold. The grievance log stated the residents had concerns due to potential low blood sugars. The grievance log stated the resolution was in-service training for all dietary staff on the topic of meals are to be served at a timely manner to maintain a structured daily routine for residents.Record review of grievance log dated 07/03/2025, revealed the resident council expressed concerns with food not served timely. The grievance log stated residents reported that dinner was served at late. The grievance log stated the resolution was in-service training for all dietary staff on the topic of meals are to be served at a timely manner to maintain a structured daily routine for residents. Dietary staff were to notify the nursing staff if meals were late so the residents would be informed. During an interview on 08/24/2025 at 11:32 AM, Resident #54's family member stated the meals were always late when Resident #54 was eating in his room on hall 400. Resident #54's family member stated it would be after 2:00 PM when trays were served. Resident #54's family member stated she was concerned for Resident #54 during those late mealtimes because of a potential for a low blood sugar. Resident #54's family member stated she was glad Resident #54 was moved to the 100 hall and the DON had suggested Resident #54 eat in the dining hall to ensure his meals were served on time. Resident #54's family member stated she was concerned for other residents who could not advocate for themselves and was receiving the late meals. During an observation on 08/24/2025 at 12:48 PM, the lunch trays arrived on hall 400 to be served. The sign on hall 400 indicated lunch served at 12:00 PM.During an observation on 08/24/2025 at 1:14 PM, the lunch trays arrived on hall 500 to be served. The sign on hall 500 indicated lunch served at 12:00 PM. During an interview on 08/26/2025 at 04:10 PM, the DON said dietary services had been an ongoing complaint/grievance for lateness of meals. The DON said it was better than it had been in the past. The DON said mealtimes were important for a variety of reasons such as health needs like preventing weight loss, dignity, maintain appropriate blood sugar levels. The DON stated dietary services continued to be educated on routine scheduled mealtime deliver.During an interview on 08/26/2025 at 04:45 PM, the Administrator said he was primarily responsible for keeping up with the grievance log, following up and resolving grievances. The Administrator said when a resident filed a grievance a resolution was developed and completed within 2-3 days at the very longest. He said if a resolution could not be completed |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to be free from any physical restraints imposed for purposes of convenience and not required to treat medical symptoms for 1 of 1 resident reviewed for restraint use (Resident #8).The facility failed to ensure Resident #8 was free from physical restraints in the form of seatbelt located on the wheelchair that Resident #8 was unable to remove independently. This failure could place residents at risk for a decreased quality of life, a decline in physical functioning and injury. Findings included:Record review of a face sheet printed on 8/24/2025 indicated Resident #8 was an [AGE] year-old, female and was readmitted on [DATE] with diagnoses including Chronic pain syndrome (a long-term condition characterized by persistent pain that last for months or years, significantly affecting daily life), hemiplegia affecting left nondominant side (partial or total paralysis on one side of the body), hypertension (occurs when the pressure in your blood vessels is consistently too high), age-related osteoporosis (occurs when the body loses bone mass) and neuromuscular dysfunction of bladder (occurs when there is a problem with the brain, nerves, or spinal cord that affects bladder control). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #8 was understood and understood others. The MDS indicated Resident #8 had a BIMS score of 14 which indicated she was cognitively intact. The MDS indicated Resident #8 had no functional impairment in her upper extremities and was impaired to both lower extremities requiring the use of mobile device of wheelchair in the last 7 days of the assessment period. The MDS indicated Resident #8 required substantial assistance with personal care such as toileting, showering/bathing, and dressing upper/lower body. The MDS indicated physical restraints were not used for Resident #8. Record review of a care plan last revised on 6/20/2025, indicated Resident #8 was at moderate risk for falls related to gait and balance problems. The care plan interventions included to anticipate and meet the resident's needs, keep call light within reach and encourage resident to use it for assistance as needed, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. The care plan inventions did not include a seatbelt or restraint. During an observation and interview on 8/25/2025 at 8:47 Am, Resident #8 was observed sitting up in her power wheelchair in the main area near the nurse's station. Resident #8 was observed to have a black safety belt securing her in the powerchair. Resident #8 observed to have limited grasp in her upper extremities, and she said she was unable to remove the seatbelt independently. Resident #8 said she wanted the safety belt on because she slides out of her wheelchair. During an observation and interview on 8/25/2025 at 1:21 PM, Resident #8 sitting in her wheelchair with the safety belt across her chest just below her breast. Resident said she wanted the safety belt on to help keep her in her seat. During an interview on 8/26/2025 at 9:35 AM, CNA R said Resident #8 was unable to transfer herself. She said Resident #8 could navigate the environment in her motorized wheelchair. CNA R said resident was contracted in her upper hands and sometimes had difficulty turning on her powerchair. CNA R said technically, she had restraints because she had a seatbelt on her wheelchair, so she does not flip out. CNA R said Resident #8 had the seatbelt on since she had worked at the facility which was 3 months. CNA R said the LVN or RN maybe responsible for the assessment of residents with restraints. CNA R said it maybe care planned. CNA R said she did not have access to the care plans. CNA R said when Resident #8 returns to bed, she would unlock the seatbelt. CNA R said the seatbelt was like a baby seatbelt. CNA R said she makes sure the seatbelt is not suffocating her. CNA R said Resident #8 could not unlock her own seatbelt. CNA R said she would consider the seatbelt a restraint. CNA R said she could not think of how the restraint could negatively impact Resident #8. She said Resident #8 was in her right mind and would come to staff for assistance or if something hurt her. During an interview on 8/26/2025 at 10:30 AM, LVN U said a restraint was anything that was preventing a Resident from moving freely. LVN U said there were no residents on Hall 200 that currently had restraints. She said if a resident had restraints, the Nurse Practitioner would have to put in an order for seatbelt or a restraint. LVN U said she considered a seatbelt on a wheelchair a restraint. LVN U said Resident #8 did not have a restraint on her wheelchair. LVN U said the nurses were responsible to assessing a resident with a restraint. LVN U said she did not know Resident #8 used the strap on her wheelchair and said it could be the mechanical lift sling strap. LVN U said Resident #8 would not be able to unlock a seatbelt. LVN U said Resident #8 could have respiratory issues from the strap or if the strap was too tight, it could cause sores. LVN U said Resident #8 did not have any issues. She said the policy for the nursing home would be the guide to determine if a resident required a |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 22 residents (Resident #3) reviewed for MDS assessment accuracy. The facility did not ensure Resident #3's quarterly MDS identified a diagnosis of Diabetes and use of insulin. These failures could place residents at risk for not receiving care and services to meet their needs.Findings included:Record review of the face sheet dated 8/25/2025 indicated Resident #3 was [AGE] year-old female who was readmitted [DATE] with diagnoses including fracture of lower end of left tibia (a break in the shinbone which is the larger bone in the lower leg), neuromuscular dysfunction of bladder (refers to a condition where the bladder's ability to store and release urine is impaired due to problems with nervous system), malignant neoplasm of uterus (a cancerous tumors that develop when cells in the lining of the uterus) and Diabetes (a group of diseases that affect how the body uses blood sugar). Record review of the most recent MDS dated [DATE] indicated Resident #3 was understood and understood others. Resident #3 had a BIMS score of 14 indicating she was cognitively intact. The MDS did not indicate Resident #3 was a Diabetic. In section N0350 of the MDS indicated Resident #3 was receiving Insulin injections in the last 7 days and was not marked to receiving hypoglycemic (including insulin) in section N0415.Record review of Resident #3's care plan revised on 7/15/2025 did not indicate Resident #3 was a Diabetic. Record review of Resident #3's MAR dated 8/1/2025-8/31/2025 indicated Resident #3 was administered Insulin Glargine (a long-acting modified form of medical insulin used to manage Type I and Type II Diabetes) subcutaneously (under the skin) at bedtime and Lispro per sliding scale (a treatment approach that adjust insulin doses based on current blood sugar reading) before meals for diabetes. Record review of Resident #3's order summary report dated 8/25/2025 indicated she was ordered Insulin Glargine (a long-acting modified form of medical insulin used to manage Type I and Type II Diabetes) subcutaneously (under the skin) at bedtime and Lispro per sliding scale (a treatment approach that adjust insulin doses based on current blood sugar reading) before meals for diabetes. During an interview on 8/26/2025 at 10:30 AM, LVN U said the MDS nurse was responsible for updating the diagnosis on the computer. LVN U said she completes a head-to-toe assessment on the residents when they are admitted . She said the MDS nurse reviews the assessments, hospital records to enter in the MDS in the computer. She said the care plan was developed by the MDS nurse and the DON. She said a diagnosis of diabetes would need to be care planned as well as the insulin. She said it was important because the resident could have medical issues, and the nurse would not know to check for signs and symptoms. She said a resident could have signs and symptoms that may not get treated and a resident could go into a diabetic coma. LVN U said the aides do not have access to the care plans. LVN U said Resident #3 does have a diagnosis of diabetes. LVN U said she looked at the orders and not the care plan. LVN U said the care plans were for the patient, department heads, MDS and the families. LVN U said she does not have access to the care plans. LVN U said Resident #3 has an order for insulin for her diabetes and gets blood glucose checks three times daily. During an interview on 8/26/2025 at 11:53 AM, MDS Coordinator B said the last quarterly MDS assessment did not indicate Resident #3 had Diabetes. She said insulin was checked on the MDS. MDS Coordinator B said there was not a care plan indicating a Resident #3 was a diabetic. MDS Coordinator B said anyone on staff can access the care plan. MDS Coordinator B said it would be important for Diabetes to be on the care plan to ensure the residents' needs were being met. MDS nurse said there would need to be interventions for her Diabetes on the care plan. MDS Coordinator B said the resident was on insulin and Resident #3 had orders for insulin. MDS Coordinator B said it was not on her Diagnosis list. During an interview on 8/26/2025at 12:52 PM, ADON N said I am not the MDS nurse, but I would think the diagnosis would need to be on the MDS and care plan. She said she would expect the MDS nurse to document and code the MDS with accuracy. ADON B said the MDS drives the care plan. During an interview on 08/26/2025 at 3:53 PM, the DON said she expected the nurse to code the Diabetes. She said she expected the Diabetes to be on the care plan. The DON said the facility updated the care plan when there was a change in condition, quarterly, annually and as needed in team meetings. The DON said the MDS Coordinator and herself were responsible for updating the care plan. There could be a negative outcome. During an interview on 8/26/2025 at 4:12 PM, the ADM said the MDS nurse was responsible for ensuring the diagnosis of diabetes was coded on MDS for Resident #3. The ADM said the MDS was completed upon admission, quarterly and annually. He said he expected the diagnosis to be care planned |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the resident and their representative with a summary of the baseline care plan for 2 of 6 residents (Resident #60 and Resident #114) reviewed for baseline care plans. The facility failed to provide Resident #60 and Resident #114, a copy of the summary of their baseline care plans. This failure could place residents at risk of not knowing their care and needs provided by the facility. Findings included:1. Record review of Resident #60's face sheet dated 8/26/25 indicated Resident #60 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #60 had diagnoses including pneumonia (is an infection that inflames the air sacs in one or both lungs), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and chronic obstructive pulmonary disease (is a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction). Resident #60 was his own responsible party. Record review of the MDS indicated Resident #60 was admitted to the facility less than 21 days ago. No MDS for Resident #60 was completed prior to exit.Record review of Resident #60's 48 Hour Care Plan dated 8/18/25, signed by MDS Coordinator C, did not reflect a copy of the summary of the baseline care plan was provided to Resident #60. Record review of Resident #60's medical records on 8/26/25 at 9:00 a.m., did not reflect a copy of the summary of the baseline care plan was provided to Resident #60.During an observation and interview on 8/24/25 at 11:38 a.m., a family member of Resident #60 was at the bedside with Resident #60. Resident #60 was hard of hearing. The family member of Resident #60 helped communicate with Resident #60. The family member of Resident #60 said he was with Resident #60 when he was admitted . The family of Resident #60 said he did not recall Resident #60 receiving a baseline care plan. The family member of Resident #60 asked Resident #60 about a baseline care plan. Resident #60 appeared confused and shook his head. 2. Record review of Resident #114's face sheet dated 8/25/25 indicated Resident #114 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #114 had diagnoses including calculus of gallbladder with acute cholecystitis (is a condition where gallstones (calculi) in the gallbladder lead to inflammation of the gallbladder (cholecystitis)), type 2 diabetes is a chronic condition that happens when you have persistently high blood sugar levels), and heart failure (occurs when the heart muscle doesn't pump blood as well as it should). Resident #114's face sheet did not reflect a responsible party. Record review of the MDS indicated Resident #114 was admitted to the facility less than 21 days ago. No MDS for Resident #114 was completed prior to exit.Record review of Resident #114's care plan report dated 8/19/25 indicated Resident #114 was at moderate risk for falls related to gait/balance problems and had a code status of full code. Resident #114's care plan report did not reflect a copy of the summary of the baseline care plan was provided to Resident #114.Record review of Resident #114's admission Care Conference Summary dated 8/21/25, signed the ADON N, did not reflect a copy of the summary of the baseline care plan was provided to Resident #114. Record review of Resident #114's medical records on 8/26/25 at 9:10 a.m., did not reflect a copy of the summary of the baseline care plan was provided to Resident #114.During an interview on 8/25/25 at 3:31 p.m., Resident #114 said he did not get a copy of anything. During an interview on 8/26/25 at 9:20 a.m., the MDS Coordinator C said the bedside nurses were responsible for the baseline care plans. During an interview on 8/26/25 at 12:10 p.m., LVN H said she did not know about baseline or 48-hour Care Plans. During an interview on 8/26/25 at 3:00 p.m., the ADON N said a nurse or ADON saw the newly admitted resident within 24 hours to orient to the facility. The 48-hour care plan was then started. She said the MDS Coordinators then wrapped up the 48-hour care plan. She said there was a section on the 48-hour care plan that indicated the proof of a copy was given to the resident. During an interview on 8/26/25 at 5:16 p.m., the ADM said the IDT was responsible for the baseline care plan. He said the MDS Coordinators and Social Service should ensure the resident or responsible party received a copy of the summary of the baseline care plan. He said the staff should document in the residents' progress note or on the 48-hour care plan to indicate a copy was given to the resident or responsible party. He said it was important to give a copy of the summary, of the baseline care plan, for acknowledgement of provision of care. During an observation and interview on 8/26/25 at 6:13 p.m., the DON said the IDT was responsible for ensuring the resident or responsible party received a copy of the summary, of the baseline care plan. She said a copy of the summary was given to the resident or responsible party after the care conference meeting. She said on the 48-hour care plan there was an area that indicated the proof of a copy was given to the resident. The DON |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 5 of 22 residents reviewed for care plans (Resident #3, Resident # 5, Resident # 8, Resident # 75, Resident #97)The facility failed to ensure Resident #3's diagnosis of diabetes was coded on the quarterly MDS on 6/5/2025 and care planned. The facility failed to ensure Resident #5's bathing type/preference was care planned on 5/22/2025. The facility failed to ensure Resident #8's seatbelt restraint on wheelchair was care planned with interventions on how to monitor. The facility failed to ensure Resident #75's swallowing difficulties, coded on his 8/9/25 admission MDS assessment was care planned.The facility failed to ensure Resident #75's active discharge planning was care planned. The facility failed to ensure Resident #97's swallowing difficulties, coded on his 8/7/25 admission MDS assessment was care planned.The facility failed to ensure Resident #97's active discharge planning was care planned.The facility failed to ensure Resident #97's care plan intervention of no water pitcher at the bedside was implemented on 8/25/25. These failures could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed/implemented to address their needs.<br><br>Findings included:<br><br>1. Record review of the face sheet dated 04/16/24 indicated Resident #3 was [AGE] year-old female who was readmitted [DATE] with diagnoses including fracture of lower end of left tibia (a break in the shinbone which is the larger bone in the lower leg), neuromuscular dysfunction of bladder (refers to a condition where the bladder's ability to store and release urine is impaired due to problems with nervous system), malignant neoplasm of uterus (a cancerous tumors that develop when cells in the lining of the uterus) and Diabetes (a group of diseases that affect how the body uses blood sugar).<br><br>Record review of the most recent MDS dated [DATE] indicated Resident #3 was understood and understood others. Resident #3 had a BIMS score of 14 indicating she was cognitively intact. The MDS did not indicate Resident #3 was a Diabetic. In section N0350 of the MDS indicated Resident #3 was receiving Insulin injections in the last 7 days and was not marked to receiving hypoglycemic (including insulin) in section N0415.<br><br>Record review of Resident #3's care plan revised on 7/15/2025 did not indicate Resident #3 was a Diabetic.<br><br>Record review of Resident #3's MAR dated 8/1/2025-8/31/2025 indicated Resident #3 was administered Insulin Glargine (a long-acting modified form of medical insulin used to manage Type I and Type II Diabetes) subcutaneously (under the skin) at bedtime and Lispro per sliding scale (a treatment approach that adjust insulin doses based on current blood sugar reading) before meals for diabetes.<br><br>Record review of Resident #3's order summary report dated 8/25/2025 indicated was ordered Insulin Glargine (a long-acting modified form of medical insulin used to manage Type I and Type II Diabetes) subcutaneously (under the skin) at bedtime and Lispro per sliding scale (a treatment approach that adjust insulin doses based on current blood sugar reading) before meals for diabetes.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/2025 at 11:06 AM, LVN U said the nurse was responsible updating the diagnosis into the computer. LVN U said she completes a head-to-toe assessment and the MDS nurse reviews the nursing assessments, hospital records to enter the MDS in the computer. LVN U said the care plan was identified through the MDS and the DON. LVN U said Diabetes and insulin should be care planned. She said if a resident had medical issues the nurse knows to check and look for signs and symptoms. LVN U said a resident could have signs and symptoms, potentially not be treated or go into a diabetic coma. LVN U said she looks at the orders and does not have access to the care plan. LVN U said the care plan was for the resident, the department heads, MDS and the families. LVN U said Resident # 3 did have an order for insulin for her diabetes and Resident #3's blood glucose was checked 3 times daily.<br><br>During an interview on 8/26/2025 at 11:53AM, MDS Coordinator B said the last quarterly MDS does not indicate Resident #3 had Diabetes. She said the MDS indicated Resident #3 was checked to be on insulin. MDS Coordinator B said there was not a care plan indicating Resident #3 was a diabetic. She said anyone on staff can access the care plan. MDS Coordinator B said it would be important for Diabetes to be on the care plan. She said there would need to be interventions for her Diabetes on the care plan. MDS Coordinator B said the resident was on insulin and had orders for insulin. MDS Coordinator B said it was not on her diagnosis list. MDS Coordinator B said if Diabetes was not on the care plan, it would not be ensuring all the needs resident's needs were being met.<br><br>During an interview on 8/26/2025 at 12:52 PM, ADON N said she was not the MDS nurse, but she thought diabetes would need to be on the care plan. ADON N she has done care plans. She said the facility would care plan infection and behaviors on the care plan. ADON N said she expected the MDS nurses to document and code the MDS with accuracy. She said the MDS drives the care plan. ADON N said MDS was a minimal data assessment that go off the orders. ADON N said diabetes should be on the care plan.<br><br>During an interview on 8/26/2025 at 3:43 PM, the DON said she expected the nurse to code diabetes and expected it to be on the care plan. The DON said the facility updated the care plan when there was a change in condition, quarterly, annually, and as needed in team meeting. The DON said the MDS Coordinator and herself were responsible for updating the care plan. The DON said it could cause a negative outcome but did not elaborate.<br><br>During an interview on 8/26/2025 at 4:12 PM, the ADM said the MDS nurse was responsible for ensuring the diagnoses were coded on MDS. He said the care plan and MDS were completed upon admission, quarterly and annually. He said he expected the diagnoses to be care planned and was important for the provision of care. The ADM said it could negatively result in improper care of the resident.<br><br>2. Record review of a face sheet printed on 8/24/2025 indicated Resident #5 was a [AGE] year-old, male and was readmitted on [DATE] with diagnoses including acute osteomyelitis, heart failure (occurs when the heart muscle is unable to pump blood effectively, which can result from various conditions that damage the heart) , hypertension (occurs when the pressure in your blood vessels is consistently too high) and peripheral vascular disease (a slow and progressive disorder of the blood vessels causing narrowing, blockage, or spasms in a blood vessels).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of a quarterly MDS assessment dated [DATE] indicated Resident #5 was understood and understood others. The MDS indicated Resident #5 had a BIMS score of 7 which indicated he was severely cognitively impaired. The MDS indicated Resident #5 had no functional impairment in his upper extremities and was impaired to both lower extremities requiring the use of mobile device of wheelchair in the last 7 days of the assessment period. The MDS indicated Resident #5 required substantial assistance with personal care such as showering/bathing and dressing upper/lower body.<br><br>Record review of a care plan last revised on 7/25/2025, indicated Resident #5 had self-care deficits related to disease process with interventions for assistance of 1 staff to participate with bathing and 2 persons to assist with transfers.<br><br>During an interview on 8/24/2025 at 10:05 AM, Resident #5 said he was not receiving showers and there was not enough staff to get him up out of bed. Resident #5 said hospice could not get him up.<br><br>During an interview on 8/25/2025 at 8:40 AM, Resident #5 said he only received bed baths 5 days a week. He said hospice does not get him up because they cannot use the mechanical lift with one person. He said he feels sticky after a bed bath and wishes he could take a shower.<br><br>During an interview and observation on 8/25/2025 at 3:15 PM, Resident #5 said he asked the charge nurse about 2 weeks ago for a shower, but he could not recall the nurse's name. He said she told him that he would get a shower, but he did not want to take away from his roommate's shower time. He said he never received a shower. Resident #5 said getting a bed bath and washing his hair with dry shampoo was drying out his scalp. Resident #5 was observed to have large white patch to right side of head.<br><br>During an interview on 8/26/2025 at 9:35 AM, CNA R said Resident #5 was on hospice and they provided him with a bed bath. CNA R said Resident #5 occasionally received a shower and said she had given him a shower. CNA R said she thought he should be able to get a shower if he wanted one. CNA R said she would fit him in to get a shower. She said he had voiced he did not feel clean, and she said he had dryness on his scalp. CNA R said if a resident were not getting his preference in bathing, it could upset him, and he may feel dirty. CNA R said she was not sure if the nurses were aware of his dry scalp, and she said she would have to let the nurse staff know. CNA R said she would check with the nursing staff to see if they were aware of his dry scalp.<br><br>During an interview on 8/26/2025 at 10:30 AM, LVN U said Resident #5 was on hospice and the Hospice aides were responsible for bathing him. She said he received a bed bath from hospice, but she had just received a request for showers. She said he had hypotensive episodes and gets dizzy. She said she had informed the unit manager Resident #5 was wanting showers today. LVN U said she was not aware prior to today that he wanted a shower. She said he had not made a request before.<br><br>During an interview on 8/26/2025 at 11:53AM, the MDS Coordinator B said the staff would write down the preferences and communicate to other staff. MDS Coordinator B said she the facility had morning meetings, and they do discuss acute care plans.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/25 at 12:30 PM, the Activity Director said the facility completes an assessment upon admission and annually we ask what they like to do. She said she would read it out and input the information in the system. The Activity Director said dietary puts in their assessment. She said she does ask questions about bathing. She said the nurses were the ones who identify which type of bath was ordered.<br><br>During an interview on 8/26/2025 at 12:52 PM, ADON N said the facility staff discuss in the clinical meetings in the morning and discuss resident's preferences. ADON N said anyone could update the care plan. She said she was there when Resident # 5 received his bed bath last week and he did not mention he wanted a shower. ADON N said Resident #5 had dandruff since he had been at the facility. ADON N said the hospice aides soaps him up like he was in a bathtub. ADON N said she expects the aides to clean and rinse him well, so he does not feel sticky.<br><br>During an interview on 8/26/2025 at 3:43 PM, the DON said she thought the communication should be between hospice and the facility staff to make it happen. The DON said when Resident #5 got to the facility, he was weak, and it was not safe for him to shower. She said he had mentioned wanting a shower in the past, but he was not strong enough. The DON said Resident #5 was in his right mind and did speak his mind. The DON said she was not aware of the white patches on the right side of his scalp. The DON said she wants to get him what he asks for so that he is comfortable.<br><br>During an interview on 8/26/2025 at 4:12 PM, the ADM said he would expect Resident #5's shower/bath preferences to be care planned. He said he would expect the nurses or staff to update or report any new preferences. The ADM said not receiving the proper bath could cause skin breakdown. The ADM said the charge nurse was responsible for ensuring Resident #5 received his bath or choice.<br><br>3. Record review of a face sheet printed on 8/24/2025 indicated Resident #8 was an [AGE] year-old, female and was readmitted on [DATE] with diagnoses including Chronic pain syndrome (a long-term condition characterized by persistent pain that last for months or years, significantly affecting daily life), hemiplegia affecting left nondominant side (partial or total paralysis on one side of the body), hypertension (occurs when the pressure in your blood vessels is consistently too high), age-related osteoporosis (occurs when the body loses bone mass) and neuromuscular dysfunction of bladder (occurs when there is a problem with the brain, nerves, or spinal cord that affects bladder control).<br><br>Record review of a quarterly MDS assessment dated [DATE] indicated Resident #8 was understood and understood others. The MDS indicated Resident #8 had a BIMS score of 14 which indicated she was cognitively intact. The MDS indicated Resident #8 had no functional impairment in her upper extremities and was impaired to both lower extremities requiring the use of mobile device of wheelchair in the last 7 days of the assessment period. The MDS indicated Resident #8 required substantial assistance with personal care such as toileting, showering/bathing, and dressing upper/lower body. The MDS indicated physical restraints were not used for Resident #8.<br><br>Record review of a care plan last revised on 6/20/2025, indicated Resident #8 was at moderate risk for falls related to gait and balance problems. The care plan interventions included to anticipate and meet the resident's needs, keep call light within reach and encourage resident to use it for assistance as needed, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 8/25/2025 at 8:47 Am, Resident #8 was observed sitting up in her power wheelchair in the main area near the nurse's station. Resident #8 was observed to have a black safety belt securing her in the powerchair. Resident #8 observed to have limited grasp in her upper extremities, and she said she was unable to remove independently. Resident #8 said she wanted the safety belt on because she slides out of her wheelchair.<br><br>During an observation and interview on 8/25/2025 at 1:21 PM, Resident #8 sitting in her wheelchair with the safety belt across her chest just below her breast. Resident said she wanted the safety belt on to help keep her in her seat.<br><br>During an interview on 8/26/2025 at 9:35 AM, CNA R said Resident #8 was unable to transfer herself. She said Resident #8 could navigate the environment in her motorized wheelchair. CNA R said resident was contracted in her upper hands and sometimes had difficulty turning on her powerchair. CNA R said technically, she had restraints because she had a seatbelt on her wheelchair, so she does not flip out. CNA R said Resident #8 had the seatbelt on since she had worked at the facility which was 3 months. CNA R said the LVN or RN maybe responsible for the assessment of residents with restraints. CNA R said it maybe care planned. CNA R said when Resident #8 returns to bed, she would unlock the seatbelt. CNA R said the seatbelt was like a baby seatbelt. CNA R said she makes sure the seatbelt is not suffocating her. CNA R said Resident #8 could not unlock her own seatbelt. CNA R said she would consider the seatbelt a restraint. CNA R said she could not think of how the restraint could negatively impact Resident #8. She said Resident #8 was in her right mind and would come to staff for assistance or if something hurt her.<br><br>During an interview on 8/26/2025 at 10:30 AM, LVN U said a restraint was anything that was preventing a Resident from moving freely. LVN U said there was no residents on Hall 200 that currently had restraints. She said if a resident had restraints, the Nurse Practitioner would have to put in an order for seatbelt or a restraint. LVN U said she considered a seatbelt on a wheelchair a restraint. LVN U said Resident #8 did not have a restraint on her wheelchair. LVN U said the nurses were responsible to assessing a resident with a restraint. LVN U said she did not know Resident #8 used the strap on her wheelchair and said it could be the mechanical lift sling strap. LVN U said Resident #8 would not be able to unlock a seatbelt. LVN U said Resident #8 could have respiratory issues from the strap or if the strap were too tight, it could cause sores. LVN U said Resident #8 did not have any issues. She said the policy for the nursing home would be the guide to determine if a resident required a restraint. LVN U said there would be an order and care planned. LVN U said the DON and MDS nurse were responsible for updating the care plan.<br><br>During an interview and observation on 8/26/2025 at 11:06 AM, observed Resident #8 in her wheelchair. LVN U was present and said there was a seatbelt, and she was unaware. LVN U said the seatbelt was part of the wheelchair and not the mechanical lift sling.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/2025 at 11:53 AM, MDS Coordinator B said Resident #8 did not have a care plan for restraints. MDS Coordinator B said the nurse would be responsible for putting in the care plan for restraints. MDS Coordinator B said she was unsure if Resident #8 could unlock the seatbelt by herself. She said the nurses would be responsible for ensuring a resident was able to unlock themselves from a seatbelt. MDS Coordinator B said it could cause harm due to discomfort. MDS Coordinator B said Resident #8 had an evaluation in her chart for physical restraints, but the documentation had “NA” (Not applicable) for restraints. MDS Coordinator B said the care plans were updated quarterly, and the staff have morning meetings where they discuss things that need to be updated. MDS Coordinator B said both MDS nurses were responsible for updating quarterly care plans.<br><br>During an interview on 8/26/2025 a 12:40 PM, the Director of Therapy T said wheelchairs normally come with seatbelts. She said the therapist must reposition Resident #8 frequently and position her every day. Director of Therapy T said she did not think Resident #8 could unlock the seatbelt. She said the therapist had worked with her on gripping a spoon and fork. Director of Therapy T said the facility was a “restraint free” facility and she was not aware of the seatbelt. She said she did not know who was putting the seatbelt on Resident #8. She said she was shocked to see it on her. Director of Therapy T was told by Resident #8 after hearing about the seatbelt that she felt safer with it on. Director of Therapy T said another therapist was trying to figure out a way to keep her safe in her wheelchair and the foam cushion instead of the pillow.<br><br>During an interview on 8/26/2025 at 12:52 PM, the ADON said the facility does not use restraints. The ADON said a seatbelt is not considered a restraint if the resident could unhook it. The ADON said she had not observed Resident #8 with a seatbelt on. The ADON said it was possible that Resident #8 could unlock the seatbelt. The ADON said typically, the facility staff work with therapy to determine if Resident #8 was able to unlock her seatbelt if in use. The ADON said it would need to be care planned and a restraint assessment would need to be completed by the nurses. The ADON said a resident could get a skin injury or cut themselves. The ADON said she had never seen a seatbelt on Resident #8.<br><br>During an interview on 8/26/2025 at 3:31 PM, the DON said she had a conversation with Resident #8 and was told by Resident #8 she had told the aide she wanted to use the seatbelt. The DON said she spoke with CNA R, and she told her she did not ask the nurse whether Resident #8 was supposed to wear the seatbelt. The DON said CNA R was going by what Resident #8 wanted and felt comfortable. She said the CNA did not know to go to the nurse. The DON said therapy had not seen a seatbelt on Resident #8. The DON said she educated CNA R to go to the nurse and educated on restraints, orders, assessment, and care plans. The DON said therapy was getting involved to work with Resident #8. The DON said CNA R was new CNA and had gone through the classes and orientation. The DON said she expected the CNA to go to the nurse to ask before placing a seatbelt on any resident. The DON said she expected the residents to be assessed for restraints and expected there to be an order. The DON said the nurses were responsible for ensuring the residents are restraint free. The DON said a restraint could have a negative outcome if not addressed. She said it could cause skin injury.<br><br>During an interview on 8/26/2025 at 4:12 PM, the ADM said he considered a seatbelt a restraint if the resident was unable to unlock the seatbelt without assistance. He said he expected the staff and CNA to ask nurses about orders, assessments prior to using a restraint. He said using a restraint could affect the resident's dignity and psychologically. The ADM said he expected an order in place with return demonstration. The ADM said the nurses were responsible for ensuring orders, assessments were in place with the use of any restraints. The ADM said it would also need to be care planned.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Record review of Resident #75's face sheet dated 8/25/25 indicated Resident #75 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #75 had diagnoses including congestive heart failure (is a condition where the heart muscle is weakened and cannot pump blood effectively), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and hemiplegia (is paralysis that affects only one side of your body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction affecting left non-dominant side(occurs when blood flow to the brain is interrupted, leading to tissue damage).<br><br>Record review of Resident #75's admission MDS assessment dated [DATE] indicated Resident #75 was understood and had the ability to understand others. Resident #75's BIMS score was 12 which indicated moderate cognitive impairment. Resident #75 required setup for eating. Resident #75 had signs and symptoms of possible swallowing disorder due to holding food in mouth/cheeks or residual food in mouth after meals. Resident #75 had a mechanically altered and therapeutic diet. Resident #75 overall goal was discharge to the community. The source of discharge goal was the family. Resident #75's MDS assessment indicated there was an active discharge plan occurring for the resident to return to the community. Resident #75's MDS Assessment, Care Area Assessment Summary, indicated nutritional status care area was triggered.<br><br>Record review of Resident #75's care plan dated 8/24/25 indicated Resident #75 had an ADL self-care performance deficit related to hemiplegia and impaired balance. Intervention included Resident #75 required times one staff participation to eat. Resident #75's care plan did not reflect swallowing difficulties and active discharge planning.<br><br>During an observation and interview on 8/24/25 at 10:51 a.m., Resident #75 was lying in bed watching television. Resident #75 was hard of hearing. Resident #75 said he did therapy every day. He said his family member worked out of the country and their spouse worked full time. He said he was getting stronger to go live with his family members.<br><br>5. Record review of Resident #97's face sheet dated 8/25/25 indicated Resident #97 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #97 had diagnoses including myocardial infarction (occurs when blood flow decreases or stops in one of the coronary arteries of the heart), congestive heart failure (is a condition where the heart muscle is weakened and cannot pump blood effectively), chronic obstructive pulmonary disease (is a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction), and acute and chronic respiratory failure (is a condition where there's not enough oxygen or too much carbon dioxide in your body).<br><br>Record review of Resident #97's admission MDS assessment dated [DATE] indicated Resident #97 was understood and had the ability to understand others. Resident #97 had a BIMS score of 15 which indicated an intact cognition. Resident #97 required setup for eating. Resident #97 had signs and symptoms of possible swallowing disorder due to holding food in mouth/cheeks or residual food in mouth after meals. Resident #97 overall goal was discharge to the community. The source of discharge goal was the family. Resident #97's MDS assessment indicated there was an active discharge plan occurring for the resident to return to the community. Resident #97's MDS Assessment, Care Area Assessment Summary, indicated nutritional status care area was triggered.<br><br>Record review of Resident #97's care plan dated 8/15/25 indicated Resident #97 had a diagnosis of history of fluid overload secondary to congestive heart failure. Resident #97 is on a 1500 milliliters fluid restriction per day. Intervention included no water pitchers at bedside.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #97's care plan dated 8/17/25 indicated Resident #97 had an ADL self-care performance deficit related to impaired balance. Intervention included Resident #97 required times one staff participation to eat. Resident #97's care plan did not reflect swallowing difficulties and active discharge planning.<br><br>During an observation on 8/25/25 at 9:47 a.m., Resident #97 was out of the facility. On Resident #97's bedside table was a water pitcher with clear liquid in it.<br><br>During an interview and observation on 8/25/25 at 3:04 p.m., LVN K and the surveyor walked into Resident #97's room together. On Resident #97's bedside table was a water pitcher. LVN K said the nurses were responsible for ensuring Resident #97 did not have a water pitcher at the bedside. She said she knew Resident #97 was not supposed to have a water pitcher at the bedside. She said she was not sure why Resident #97 was on a fluid restriction. She said Resident #97 could have the order for no water pitcher at the bedside because of a heart issue or fluid retention.<br><br>During an interview on 8/25/25 at 3:23 p.m., CNA E said she did not normally work the hall Resident #97 resided on. She said she asked the nurses about each resident before the start of her shifts. She said that was how she knew which residents were on fluid restrictions. She said she did not give Resident #97 a water pitcher this morning. She said she only made Resident #97's bed after he left the facility. She said it was important to follow the fluid restriction because you did not want the residents to excessively drink due to kidney issues, fluid retention, or deficiency issues. She said the excessive fluid could cause congestive heart failure or kidney failure.<br><br>During an interview on 8/26/25 at 9:20 a.m., the MDS Coordinator C, with MDS Coordinator B present, said the DON started the comprehensive care plan. The MDS Coordinator C said it had to be opened by a RN. The MDS Coordinator C said the comprehensive care plan was completed by the Coordinators. The MDS Coordinator C said she used a worksheet that included the residents' diagnoses, medications, physician orders, and care area assessment summary to determine what was included on the residents' care plan. The MDS Coordinator C said she normally added the residents' swallowing difficulties to the care plan only if they had a diagnosis or documentation. The MDS Coordinator C acknowledged the swallowing difficulties could only be added to the MDS assessment, if there had been documentation in the residents' chart of swallowing difficulties. The MDS Coordinator C said if the care area assessment summary triggered for discharge planning and there were issues, like uncertain placement, then the social service was responsible for care planning. The MDS Coordinator C said discharge planning normally was not care planned unless there were issues. The MDS Coordinator C said Resident #75 and Resident #97 were rehabilitation residents with plans to discharge back to the community. The MDS Coordinator B said care areas triggered on the MDS assessment and discharge planning needed to be care planned to make sure to meet the residents' needs and know their wishes. The MDS Coordinator C said it was important to care plan those things to make sure the staff knew the residents' needs and wishes. The MDS Coordinator C said comprehensive care plan were overseen by the IDT. The MDS Coordinator C said the comprehensive care plans were reviewed in morning meetings.<br><br>(continued on next page) |

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| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/25 at 11:03 a.m., CNA A said she worked last weekend. She said she gave Resident #97 a water pitcher because he requested it over the weekend. She said Resident #97 was on fluid restriction. She said the nurses did make the CNAs aware of who was on fluid restrictions. She said she did not know there was an order and on his care plan for no water pitcher at the bedside. She said Resident #97 threw fits when he did not get what he wanted. She said sometimes the nurses were aware his was requesting more fluids. She said it was important to follow the care plan intervention because the body could get fluid overloaded. She said the resident could then need hospitalization.<br><br>During an interview on 8/26/25 at 12:10 p.m., LVN H said the IDT was responsible for all the information on the comprehensive care plan. She said the MDS Coordinators were responsible for care area triggered from the MDS. She said she would want the residents' swallowing difficulties or disorder on the care plan. She said she would want it for safety, to know the specific issue and if speech therapy was involved. She said a residents' swallowing difficulties affected their eating and medication administration. She said she would also want the residents' discharge planning on the care plan. She said it was important to know who the resident was going home with and the plan on how they were getting discharged . She said it was also important so everyone was on the same page. She said Resident #97 was fluid restricted. She said everyone was responsible but especially the nursing and dietary staff, for ensuring Resident #97 fluid restriction was followed. She said everybody was responsible for ensuring Resident #97 did not have a water pitcher at his bedside. She said she could not recall if Resident #97 had a water pitcher at his bedside on 8/24/25. She said if the care plan intervention was not followed, the resident could be hospitalized for fluid overload. She said Resident #97 was alert and oriented to person, place, time, and event. She said Resident #97 could do want he wanted. She said if the resident was non-complaint with no water pitcher being at the bedside or fluid restriction, then education and documentation needed to be done.<br><br>During an interview on 8/26/25 at 3:00 p.m., ADON N said everyone was responsible for ensuring Resident #97 did not have a water pitcher at the bedside. She said Resident #97 was not a “guzzler” of fluids. She said if a resident requested a water pitcher, they needed to be educated and encouraged to adhere to the recommendation. She said if a resident was non-complaint, then the nurse should document and notify the nursing management and physician. She said if the care plan intervention was not followed then it could affect the resident's lab values and general health. She said the MDS Coordinators were responsible for care planning care areas triggered on the MDS. She said the nursing management care planned acute changes of condition. She said she would expect the residents' discharge planning to be care planned. She said the IDT was responsible for care planning the residents' discharge plan. She said the IDT met on Wednesdays to discuss discharge plans. She said the residents with discharge plans were discussed every day in the skilled meeting.<br><br>During an interview on 8/26/26 at |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 17 residents reviewed for ADLs (Residents #59.) The facility did not clean or trim Resident #59's fingernails.This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health.The findings were:Review of Resident #59's electronic face sheet dated 10/18/2024 revealed he was admitted to the facility on [DATE] with diagnoses of Dysphagia (difficulty swallowing), Parkinson's Disease (a progressive, chronic neurological disorder characterized by symptoms such as tremors, muscle stiffness, slow movement (bradykinesia), and impaired balance), Lack of Coordination (a neurological symptom characterized by awkward, clumsy movements affecting the whole body, limbs, or eyes, resulting from impaired muscle control and a disruption in how the brain controls voluntary movements).Record review of Resident #59's annual MDS dated [DATE] revealed a BIMS with a score of 15, which indicated resident #59 is cognitively intact. The MDS also revealed, Resident #59, required supervision and touching assistance with personal hygiene.During an observation and interview on 08/24/25 at 10:03 a.m., Resident #59 was observed with long and dirty fingernails. He said that he did not know where his nail clippers were or if staff clip his nails. His hands were shaking. During an observation on 08/25/25 at 11:30 a.m. Resident #59 he was observed with long and dirty fingernails.During an observation on 08/26/25 at 9:15 a.m. Resident #59 he was observed with long and dirty fingernails.During an interview on 08/26/25 at 1:57 p.m., CNA X said that it was the responsibility of CNAs to ensure that residents that were dependent for ADL care received the care they need. She said that included resident's fingernails.During an interview on 08/26/25 at 4:19 p.m., the Director of Nurses said CNAs were responsible to ensure that residents dependent for care had their nails trimmed and cleaned for them. She said that residents could be at risk of infections if their nails are consistently dirty. During an interview on 08/26/25 at 4:36 p.m., the Administrator said that CNAs were responsible to clean and trim the nails of residents that cannot do for themselves. He said there could be a risk of infection if their nails were not kept trimmed and cleaned. Record review of a facility's Quality of Life-Dignity policy revised on 08/2009, indicated . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.) . |

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|---|---|---|---|
| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #3) reviewed for accidents and supervision. The facility failed to ensure CNA G performed a safe mechanical lift transfer for Resident #3. This failure could place residents at risk of injury.Findings include:Record review of Resident #3's face sheet dated 8/26/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #3 had diagnoses which included history of left tibia (lower leg bone), diabetes (high blood sugar), history of falls, rheumatoid arthritis (chronic inflammation disorder usually affecting small joints in the hands and feet), hypertension (high blood pressure), and heart failure.Record review of Resident #3's quarterly MDS dated [DATE] indicated had a BIMS score of 14, which indicated she was cognitively intact. Resident #3 used a wheelchair for mobility. Resident #3 required moderate assistance with most ADLs.Record review of Resident #3's Care Plan dated and last reviewed on 7/15/25 indicated she had an ADL self-care performance deficit related to disease process and required two staff participation with transfers. Resident #3 was at risk for falls.During an observation on 8/26/2025 beginning at 9:32 AM, CNA G and CNA D placed a lift pad under Resident #3. CNA G positioned the mechanical lift over Resident #3 in bed, then CNA G and CNA D attached to the mechanical lift pad to the lift. CNA G then lifted Resident #3 up off bed with the mechanical lift legs straight (not in wide position) and did not lock the lift wheels during lifting, CNA G then pulled Resident #3 back away from over the bed with the mechanical lift legs not in wide position and turned the mechanical lift to the right and then pushed Resident #3 toward the wheelchair. CNA G then opened the mechanical lift legs to the wide position and pushed Resident #3 over the wheelchair and then lowered her into the wheelchair and did not lock the mechanical lift wheels while being guided by CNA D. During an interview on 8/26/2025 at 3:17 PM, CNA D said she had worked at the facility for two years. CNA D said CNA G worked Resident #3's hall and she was just helping CNA G during the mechanical lift transfer. CNA D said the mechanical lift wheels should be locked when raising or lowering the resident during the mechanical lift transfer. CNA D said the mechanical lift legs should be in the wide position when going around the wheelchair. CNA D said the mechanical lift legs should be in the wide position during moving of the mechanical lift to balance the lift. CNA D said the mechanical lift could tilt over and the resident could get hurt if the mechanical lift legs were not in the wide position during the transfer. CNA D said she just assisted CNA G during the mechanical lift transfer and guided Resident #3 and positioned her in the chair while CNA G lowered Resident #3 into the wheelchair. During an interview on 8/26/2025 at 3:32 PM, CNA G said the wheels of the mechanical lift should be locked when lifting a resident, but not during lowering to allow for the mechanical lift to move to adjust for the resident's feet and comfort. CNA G said the legs of the mechanical lift should be in the wide position during lifting the resident and not in the wide position during moving the resident across the room to be able to safely maneuver the mechanical lift. CNA G said the legs of the mechanical lift should be in wide position when lifting the resident for stability of the lift and to go around the wheelchair. CNA G said during moving/transferring the resident, the legs of the mechanical lift would not be opened to wide position. CNA G said the wheels of the mechanical lift should be locked when lifting the resident to ensure the lift did not move, for the safety of the resident.During an interview on 8/26/2025 at 3:50 PM, the ADON said the wheels of the mechanical lift should be locked during raising and lowering the resident for safety and stabilization of the lift. The ADON said the mechanical lift legs should be in the wide position when the lift was bearing the weight of the patient. The ADON said the mechanical lift legs should be opened to wide position during moving of the resident. The ADON said the mechanical lift legs should be in the wide position for stability of the lift. The ADON said the resident could tip over if the mechanical lift legs were not in the wide position during transfers and the wheels were not locked. The ADON said the resident could get hurt. During an interview on 8/26/2025 at 4:27 PM, the DON said the base of the mechanical lift should be in the wide position when lifting and moving the resident and the wheels of the mechanical lift should be locked during lifting and lowering of the resident. The DON said the mechanical lift could tilt and cause an injury to the resident if the base was not in the wide position during lifting, lowering and moving the resident and the wheels were not locked when lifting and lowering the resident. During an interview on 8/26/2025 at 4:52 PM, the ADM said he would expect staff to perform safe mechanical lifts. The ADM said |

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|---|---|---|---|
| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 2 residents (Residents #25) reviewed for urinary catheters. The facility failed to ensure Resident #25 had an indwelling (foley) catheter securement device on 8/25/25.The facility failed to ensure on 8/25/25, CNA D provided catheter care per the facility's policy and procedure on Resident #25.These failures could place residents at risk for indwelling urinary catheter dislodgement, urethral (empties urine from the bladder and out of the body) damage, pain, and urinary tract infections.Findings included:Record review of Resident #25's face sheet dated 8/26/25 indicated Resident #25 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #25 had diagnoses including neuromuscular dysfunction of bladder (a person does not have bladder control because of brain, spinal cord, or nerve problems), dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), extended spectrum beta lactamase (ESBL) resistance (occurs when bacteria produce enzymes (ESBLs) that break down beta-lactam antibiotics), and chronic kidney disease (is a condition where the kidneys gradually lose their ability to filter waste products from the blood), stage 4.Record review of Resident #25's annual MDS assessment dated [DATE] indicated Resident #25 was usually understood and usually had the ability to understand others. Resident #25's BIMS score was 5 which indicated severe cognitive impairment. Resident #25 required substantial/maximal assistance for toileting hygiene. Resident #25 had an indwelling catheter.Record review of Resident #25's care plan dated 7/7/25 indicated Resident #25 had an indwelling catheter related to atonal bladder (is a condition where the bladder muscles are weak and do not contract properly, leading to difficulty or inability to urinate) and urinary retention due to neuromuscular dysfunction (9/25/24). Resident #25's responsible party requested he only wear a leg bag and not a drainage bag due to Resident #25 forgetting that the bag is attached to the bed. Foley has been pulled out multiple times. Education was provided on the risk of wearing the leg bag. On 6/2/25, Resident #25's responsible party was ok with only using a foley drainage bag instead of the leg bag. Intervention included change catheter as indicated. Record review of Resident #25's order summary dated 8/26/25 indicated:*Foley catheter 18 French 30 cubic centimeter bulb to drainage bag. Diagnosis: Urinary retention due to neuromuscular dysfunction of bladder, two times a day for monitor. Start date 1/8/25. *Foley catheter care every shift and as needed, every shift for monitor. Start date 2/5/24. During an observation on 8/25/25 at 4:00 p.m., CNA D lowered Resident #25's covers to his ankles. Resident #25 had a t-shirt and brief on. Resident #25 complained about being cold. CNA D unattached Resident #25's brief and exposed his perineal area. The surveyor remained at the foot of Resident #25's bed until catheter care started. The surveyor moved next to CNA D to closely observe catheter care being provided. Resident #25's privacy curtain was open. Resident #25 did not have a catheter securement device. CNA D started catheter care by cleaning Resident #25's lower abdomen, groin creases, underside of penis then moved towards the urethra and junction of indwelling catheter tubing. During the catheter care, Resident #25's catheter tubing was not secured and pulled. During an interview on 8/26/25 at 2:18 p.m., the surveyor attempted to interview Resident #25 about catheter care performed on 8/25/25. Resident #25 had disorganized thinking and started talking about luggage in his room. Unable to interview Resident #25. During an interview on 8/26/25 at 2:20 p.m., CNA D said during catheter care, the cleaning was supposed to start at the groin creases. She said Resident #25 did not have on a catheter securement device. She said after catheter care, she did not let the nurse know Resident #25 did not have a securement device. She said a catheter securement device was important so the catheter tubing did not pull. She said she did not feel like Resident #25's catheter tubing was pulling during catheter care. She said pulling could cause swelling. She said not cleaning the catheter right could cause an infection. During an interview on 8/26/25 at 2:31 p.m., LVN F said it was the nurse's responsibility to ensure a resident with an indwelling catheter had a securement device. She said Resident #25 pulled the securement devices off. She said she did not know if Resident #25's behavior was care planned. She said the securement device prevented pulling, dislodgement, and trauma. She said during catheter care, cleaning should start at the urethra then wash downwards. She said it was important to clean away from the urethra to prevent contamination. She said the catheter tubing should be held during catheter care, so it did not move around to prevent pulling |

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| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practices for 4 of 17 residents (Resident #40, Resident #13, Resident #41, Resident #97) reviewed for respiratory care.1. The facility failed to ensure Resident #40's oxygen was placed on 2 liters per minute via nasal cannula as ordered by the physician.2. The facility failed to ensure Resident #13 had a physician order for her tracheostomy (is a medical device inserted into the trachea (windpipe) to establish an airway for breathing) type, size, configuration, and inflated or deflated. On 8/24/25, Resident #13 had a Shiley (type of tracheostomy tube) 6. 0 XLT (Extended-Length), deflated cuffed tracheostomy. 3. The facility failed to ensure Resident #41's oxygen was administered at the correct setting of 4 liters per minute on 8/24/25 and 8/25/25 as ordered by the physician.The facility failed to ensure on 8/25/25, Resident #41 was not on an oxygen cylinder tank (medical devices that store supplemental oxygen) that read refill which indicated the oxygen cylinder was empty. 4. The facility failed to ensure Resident #97's oxygen was administered at the correct setting of 2 liters per minute on 8/24/25 as ordered by the physician. The facility failed to ensure on 8/24/25, Resident #97's nebulizer mask (is a device used with a nebulizer machine to deliver medication as a fine mist directly into the lungs) was stored in a bag when not in use.These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.Findings included:<br><br>1. Record review of Resident #40's face sheet, dated 6/18/25 revealed a [AGE] year old male admitted on [DATE] with diagnoses that included Emphysema (lung disease where the air sacs (alveoli) in the lungs are damaged and destroyed, leading to shortness of breath, coughing, and wheezing), Chronic Obtrusive Pulmonary Disease (lung disease that involves a group of lung conditions, including emphysema and chronic bronchitis, that block airflow and make breathing difficult), and Malignant Neoplasm of Prostate (a type of cancer that begins with abnormal cells in the prostate gland).<br><br>Record review of Resident #40's significant change MDS assessment, dated 05/29/25, revealed Resident #40 had a BIMS of 13, which indicated he was cognitively intact. Order for oxygen was after the latest MDS.<br><br>Record review of Resident #40's care plan dated 7/6/2025 indicated that Resident #40 had a problem related to his diagnoses of emphysema and chronic obtrusive pulmonary disease. Resident #40 was to be given oxygen therapy per physician's orders.Record review of an order for Resident #40, dated 8/1/2025, “O2: O2 at 2 l/m via nasal cannula PRN SOB ”<br><br>During an observation and interview on 8/25/25 at 9:07 a.m., Resident #40's oxygen concentrator was set to 1 liter per minute. He said that he wore his nasal cannula most of the day, so he doesn't lose his breath. He said he didn't know what the concentrator should have been set at.<br><br>During an observation on 8/25/25 at 2:00 p.m., Resident #40's oxygen concentrator was set to 1 liter per minute .<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/25 at 1:59 p.m. LVN U said nursing staff was responsible to ensure that residents who used an oxygen concentrator for supplemental oxygen were set to the required volume. She said that if a resident required 2 liters a minute it should not be greater or less then the ordered amount. She said that residents could be placed at risk for respiratory problems, become short of breath, and have lowered oxygen saturation.<br><br>During an interview on 8/26/25 at 4:19 p.m., the Director of Nurses said that resident's oxygen should be set at the level ordered by their physician. She said the volume of air could be found in the resident's orders. She said that residents could be placed at risk of having shortness of breath and lowered oxygen saturation if their orders were not followed. She said that nurses were responsible for ensuring this type of order was followed.<br><br>During an interview on 8/26/25 at 4:36 p.m., the Administrator said that it was the responsibility of nursing staff to ensure that residents orders were followed which includes the rate at which they were receiving oxygen. He said that residents could be placed at risk of shortness of breath and lowered oxygen saturation levels.<br><br>2. Record review of Resident #13's face sheet, dated 8/24/25, indicated Resident #13 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13 had diagnoses including chronic respiratory failure (is a condition where the lungs are unable to provide enough oxygen to the body over a prolonged period, leading to low oxygen levels in the blood (hypoxemia)), asthma (is a chronic respiratory condition that causes inflammation and narrowing of the airways, leading to recurring episodes of wheezing, shortness of breath, chest tightness, and coughing), stenosis of larynx (is a narrowing of the larynx (voice box) that impedes airflow, leading to symptoms like hoarseness, wheezing, and shortness of breath), and tracheostomy status.<br><br>Record review of Resident #13's quarterly MDS assessment dated [DATE] indicated Resident #13 was understood and had the ability to understand others. Resident #13 had a BIMS score of 15 which indicated intact cognition. Resident #13 had oxygen therapy, tracheostomy care, and non-invasive mechanical ventilator (the delivery of oxygen into the lungs via positive pressure without the need for endotracheal intubation (is a flexible tube that is placed in the trachea (windpipe) through the mouth or nose)).<br><br>Record review of Resident #13's care plan dated 7/9/24 indicated Resident #13 had tracheostomy related to chronic respiratory failure, respiratory illness, and stenosis of larynx. Intervention included trach size: Portex Bivonatis (type of tracheostomy)6, deflated bulb outer diameter, 100 liters. Date initiated 6/6/24.<br><br>Record review of Resident #13's order summary dated 8/24/25 indicated:<br><br>*Tracheostomy: Change humidifier container weekly and date, every shift, every Sunday. Start date 10/9/23.<br><br>*Tracheostomy: Change Tracheostomy tubing and collar weekly and as needed, every day, every Sunday. Start date 10/9/23.<br><br>*Tracheostomy: Cleanse site with normal saline, pat dry and apply dry dressing daily and as needed. Start date 5/21/25.<br><br>(continued on next page) |

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| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

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| Treviso Transitional Care | 1154 East Hawkins Parkway<br>Longview, TX 75605 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *Tracheostomy: Tracheostomy: Cleanse site with normal saline, pat dry and apply dry dressing daily and as needed, every day shift. Start date 5/21/25.<br><br>*Tracheostomy: Oxygen via Tracheostomy collar at 5 liters per minute at night and as needed for shortness of breath, as needed. Start date 8/1/25.<br><br>*Tracheostomy: Oxygen via Tracheostomy collar at 5 liters per minute at night and as needed for shortness of breath, at bedtime for shortness of breath. Start date 8/1/25.<br><br>*Tracheostomy: Suction as needed. Start date 10/9/23.<br><br>*Tracheostomy: Trachea Collar day time, every shift. Start date 1/2/24.<br><br>Resident #13's order summary did not reflect a physician order for a tracheostomy type, size, configuration, and inflated or deflated.<br><br>Record review of Resident #13's Administration Record Report dated 8/1/25-8/31/25 indicated:<br><br>*Tracheostomy: change disposable inner cannula (is a removable, disposable or reusable tube that fits inside the main tracheostomy tube) #6 daily and as needed every day shift related to tracheostomy status. Start date 6/5/25. The Medication Administration Record indicated treatment on 8/24/25.<br><br>*Tracheostomy: change every 3 months with ENT, every day shift, every 15 months, starting on the 15th for 1 day. Start date 9/15/24. The Administration Record Report indicated Resident #13's tracheostomy change was not due in August 2025.<br><br>Resident #13's Administration Record Report did not reflect a physician order for a tracheostomy type, size, configuration, and inflated or deflated.<br><br>During an observation and interview on 8/24/25 at 2:27 p.m., Resident #13 was sitting on her bed. Resident #13 spoke very softly and occasionally the surveyor had to read her lips. Resident #13 said she had a 6.0 tracheostomy in. Resident #13 raised her chin for the surveyor to observe the tracheostomy tube outer cannula (the main body of the tube that remains in the trachea). Resident #13's tracheostomy tube had markings that stated, “Shiley XLT 6.0.” Resident #13 pilot [NAME] (a small balloon attached to the cuff that indicates when the cuff is inflated) was flat or deflated. Resident #13 said she was hoping to get her tracheostomy taken out soon.<br><br>During an interview on 8/26/25 at 12:10 p.m., LVN H said whoever got the order for Resident #13's tracheostomy should have ensured it was in the resident's medical records. She said it was important to have the tracheostomy order to know exactly what the resident had. She said it would be disastrous if the wrong tracheostomy size was put in the resident.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Record review of Resident #41's face sheet dated 9/2/25 indicated Resident #41 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #41 had diagnoses including chronic obstructive pulmonary disease (is a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction), chronic respiratory failure (is a condition where the lungs are unable to provide enough oxygen to the body over a prolonged period, leading to low oxygen levels in the blood (hypoxemia)), and heart failure (is a condition where the heart muscle is weakened or stiffened, making it unable to pump blood effectively).<br><br>Record review of Resident #41's quarterly MDS assessment dated [DATE] indicated Resident #41 was understood and had the ability to understand others. Resident #41 had a BIMS score of 4 which indicated severely impaired cognition. Resident #41 received oxygen therapy.<br><br>Record review of Resident #41's care plan dated 6/5/25 indicated:<br><br>*Resident #41 had altered respiratory status/difficult breathing related to chronic respiratory failure. Intervention included provide oxygen as ordered.<br><br>* Resident #41 had oxygen therapy related to chronic respiratory failure. Intervention included oxygen settings: oxygen via nasal cannula/mask at 4 liters continuously.<br><br>Record review of Resident #41's physician order dated 5/23/25 at 2:46 p.m., indicated Oxygen at 4 liters per minute via nasal cannula continuously, every shift, every day, 6am-6pm/6pm-6am.<br><br>Record review of Resident #41's Administration Record Report dated 8/1/25-8/31/25 indicated Oxygen at 4 liters per minute via nasal cannula continuously, every shift. Start date 5/23/25. The MAR indicated LVN H administered the physician order on 8/24/25 (6am-6pm) and LVN K on 8/25/25 (6am-6pm).<br><br>During an observation and interview on 8/24/25 at 11:57 a.m., Resident #41 was lying in the bed. Resident #41's nasal cannula prongs (is a device that gives you additional oxygen (supplemental oxygen or oxygen therapy) through your nose) were not in her nose. Resident #41 placed the prongs in her nose when questioned about oxygen use. Resident #41's nasal cannula tubing was connected to a flowmeter (is a medical device used for oxygen flow measurement) on the wall. Resident #41's flowmeter was on 2.5 liter per minute.<br><br>During an observation on 8/25/25 at 9:44 a.m., Resident #41 was in her room sitting in a wheelchair. Resident #41's nasal cannula was connected to an oxygen cylinder with a regulator (is a device that reduces and controls the high pressure of oxygen from a tank or cylinder to a safe, low, and usable pressure for delivery to a patient). The regulator indicated Resident #41 was on 4 liters per minute. The oxygen cylinder meter was near the “refill” mark.<br><br>During an observation on 8/25/25 at 11:32 a.m., Resident #41 was in her room sitting in a wheelchair. Resident #41's nasal cannula was connected to the flowmeter on the wall. The flowmeter indicated Resident #41 was on 3.5 liters per minute.<br><br>During an observation on 8/25/25 at 3:29 p.m., Resident #41 was sitting in the common area, in a wheelchair. Resident #41's nasal cannula was connected to an oxygen cylinder with a regulator. The regulator indicated Resident #41 was on 3 liters per minute. The oxygen cylinder meter was on the red colored “refill” mark. Resident #41 did not appear in any respiratory distress.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/25/25 at 3:41 p.m., LVN K said she was assigned to Resident #41. The surveyor showed LVN K Resident #41's oxygen cylinder with a regulator. She said Resident #41 was supposed to be on 4 liters according to the doctor's order. She said she knew the amount of oxygen the resident was supposed to be on by reviewing the physician orders and MAR/TAR. She said if the resident was on the wrong liters, they could not be getting the proper amount of oxygen for the ordered saturation range. She said the nurse was responsible for the oxygen tanks. She said the nurses should ensure the residents' oxygen tank did not run out while in use. She said if the resident was using a tank that was on refill they could not be getting the proper oxygenation. She said not getting enough oxygen could cause altered level of consciousness and brain function.<br><br>4. Record review of Resident #97's face sheet, dated 8/25/25, indicated Resident #97 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #97 had diagnoses including myocardial infarction (occurs when blood flow decreases or stops in one of the coronary arteries of the heart), congestive heart failure (is a condition where the heart muscle is weakened and cannot pump blood effectively), chronic obstructive pulmonary disease (is a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction), and acute and chronic respiratory failure (is a condition where there's not enough oxygen or too much carbon dioxide in your body).<br><br>Record review of Resident #97's admission MDS assessment dated [DATE] indicated Resident #97 was understood and had the ability to understand others. Resident #97 had a BIMS score of 15 which indicated an intact cognition. Resident #97 had shortness of breath with exertion and when lying flat. Resident #97 had continuous oxygen therapy.<br><br>Record review of Resident #97's care plan dated 8/17/25 indicated:<br><br>*Resident #97 had oxygen therapy related to acute respiratory failure, chronic obstructive pulmonary disease, and congestive heart failure. Intervention included oxygen settings: oxygen via nasal cannula/mask at 2 liters continuously.<br><br>*Resident #97 had altered respiratory status and difficulty breathing related to acute respiratory failure. Intervention included administer medication/puffers as ordered.<br><br>Record review of Resident #97's physician order dated 8/3/25 at 2:39 p.m., indicated oxygen at 2 liters per minute via nasal cannula every shift related to acute and chronic respiratory failure.<br><br>Record review of Resident #97's order summary dated 8/25/25 indicated:<br><br>*Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally every 4 hours as needed for wheezing related to chronic obstructive pulmonary disease. Start date 8/20/25.<br><br>Record review of Resident #97's Administration Record Report dated 8/1/25-8/31/25 indicated:<br><br>*Oxygen at 2 liters per minute via nasal cannula every shift related to acute and chronic respiratory failure. Start date 8/4/25. The MAR indicated LVN H administered the physician order on 8/24/25.<br><br>*Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally every 4 hours as needed for wheezing related to chronic obstructive pulmonary disease. Start date 8/20/25. The MAR indicated RN O administered the physician order on 8/25/25 at 4:16 a.m.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 8/24/25 at 11:16 a.m., Resident #97 was sitting in a recliner. Resident #97's nasal cannula was connected to the flowmeter on the wall. The flowmeter indicated Resident #97 was on 3 liters per minute. Resident #97 said he had received a nebulizer treatment earlier and it had really helped his breathing. Resident #97's nebulizer mask was on the nightstand not stored in a bag.<br><br>During an interview on 8/25/25 at 3:04 p.m., LVN K said the residents' nebulizer mask was supposed to be stored in bag when it was not in use. She said the nurses were supposed to make sure the mask was stored in a bag. She said the CNAs could also notify the nurses if they noticed the mask not in the bag. She said she was not sure why the nebulizer mask had to be in bag. She said it was probably because of bacteria.<br><br>During an interview on 8/25/25 at 3:23 p.m., CNA E said the nurses were responsible for storing the nebulizer mask when it was not in use. She said it was important to store it in a bag to keep it away from germs and cross contamination.<br><br>During an interview on 8/26/25 at 3:00 p.m., the ADON N said nursing was responsible for the residents' respiratory equipment. She said she expected the nurses to follow the physician orders related to the ordered liters. She said she expected the nurses to always check the oxygen cylinder tanks to make sure they were not empty. She said if the resident was not on the ordered number of liters or using an empty oxygen tank, they could not have an adequate supply of oxygen. She said decrease oxygen levels could cause shortness of breath and anxiety. She said the nebulizer mask should be stored in a bag when it was not in use. She said it was stored in bag to prevent the spread of infections. She said Resident #13 should have a tracheostomy order. She said the staff would not know the correct size if something happened. She said nursing management oversaw the nursing staff. She said the nursing management oversaw this process by checking orders and making rounds.<br><br>During an interview on 8/26/25 at 5:44 p.m., the ADM said the charge nurses were responsible for the residents' respiratory equipment. He said the nursing administration should oversee the nurses. He said the residents should be on the ordered number of liters and a filled oxygen tank to provide adequate need of oxygen and for proper oxygen levels. He said this prevented shortness of breath. He said the nebulizer mask should be stored in bag when not in use. He said it was important to do this for infection control and dust. He said not storing the mask properly placed the resident at risk of an infection. He said Resident #13 should have a tracheostomy order. He said it was important for proper ordered care and tracheostomy care. He said without a tracheostomy order it placed the resident at risk for infection and harm. He said the DON oversaw the nursing staff. He said the process should be overseen by monitoring orders daily and rounding with assessments.<br><br>During an interview on 8/26/25 at 6:13 p.m., the DON said the nurses were responsible for oxygen therapy and equipment. She said the residents should be on the ordered number of liters and a filled oxygen tank to maintain comfort. She said not doing those things placed the residents at risk for a negative outcome. She said the nursing management should oversee this process by monitoring and education. She said the nurses were responsible for obtain a physician order for Resident #13's tracheostomy. She said a physician order was important for care and knowledge. She said it also ensured accurate medical records. She said the clinical team oversaw the nurses.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of facility policy titled, “Oxygen Administration” dated October 2010 revealed that, “The purpose of this procedure is to provide guidelines for safe oxygen administration…. Record review of facility policy titled, “Oxygen Administration” dated October 2010 revealed that, “The purpose of this procedure is to provide guidelines for safe oxygen administration…. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. The nasal catheter is a piece of tubing inserted through the resident's nostrils into the back of his/her mouth. It is held in place by a piece of skin tape attached to the resident's forehead and/or cheek. After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record the date and time that the procedure was performed. The name and title of the individual who performed the procedure. The rate of oxygen flow, route, and rationale. The frequency and duration of the treatment. The reason for as needed administration. All assessment data obtained before, during, and after the procedure. How the resident tolerated the procedure.<br><br>Record review of facility policy titled, “Tracheostomy Care” dated August 2013 revealed that, “…The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas… Preparation and Assessment… Check physician order…” |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide or obtain dental services for each resident.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine dental care for 3 of 3 (Resident's #35, #100, and #37) residents reviewed for dental services. The facility failed to ensure adequate follow-ups were completed on dental referrals for Residents #35, #100, and #37. This failure could affect residents by placing them at risk for oral complications and diminished quality of life. Findings included: Record review of a face sheet dated 08/27/2025 indicated Resident #35 was a [AGE] year-old female re-admitted to the facility on [DATE] with diagnoses including acute kidney failure, heart failure, hypertension (high blood pressure), and altered mental status. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #35 understood others and was understood by others. The MDS indicated Resident #35 had a BIMS of 12 and was moderately cognitively impaired. The MDS indicated Resident #35 did not have any mouth or facial pain, discomfort, or difficulty swallowing. The MDS indicated Resident #35 had natural teeth. Record review of Resident #35's electronic data record indicated no dental referral had been made. During an observation and interview on 08/24/2025 at 10:26 AM, Resident #35 stated her implants broke. Resident #35 was observed with only anchorage implant wires present in her mouth. Resident #35 voiced concerns regarding a referral for dental services to be provided by the facility. Resident #35 stated no one at the facility had ever visited with her regarding the need for her implants to be repaired. Resident #35 stated she had difficulty eating most of the time unless food was soft. Resident #35 stated she would like to have her implants so that she could have a better variety of food to eat. Record review of the face sheet dated 08/27/2025 indicated, Resident #100 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included congestive heart failure, hypertension (high blood pressure), cerebrovascular disease (affects the blood vessels of the brain and circulation), hyperlipidemia (high levels of fat particles in the blood). Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #100 was understood by others and understood others. The MDS indicated Resident #100 had a BIMS of 13 and was cognitively intact. The MDS indicated Resident #100 required maximum assistance with toileting, dressing, and bathing. The MDS indicated Resident #100 did not have any mouth or facial pain, discomfort, or difficulty chewing. Record review of Resident #100's electronic data record indicated no dental referral had been made. During an interview on 08/24/2025 at 10:35 AM, Resident #100 stated she had pain in her teeth. Resident #100 stated it had been a very long time since anyone in the facility had followed up with her regarding her dental needs. Resident #100 stated she was able to eat but suffered from throbbing tooth pain at times that would eventually go away. Record review of the face sheet dated 08/27/2025 indicated, Resident #37 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included cerebral infarction (occurs when blood flow to brain is interrupted resulting in tissue damage), chronic obstructive pulmonary disease (breathing difficulties), hypertension (high blood pressure), cerebrovascular disease (affects the blood vessels of the brain and circulation), hyperlipidemia (high levels of fat particles in the blood). Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #37 was usually understood by others and usually understood others. The MDS indicated Resident #37 had a BIMS of 0 and could not complete the interview. The MDS indicated Resident #37 required maximum assistance with toileting, dressing, and bathing. The MDS indicated Resident #37 did not have any mouth or facial pain, discomfort, or difficulty chewing. Record review of Resident #37's electronic data record indicated no dental referral had been made. During an interview and observation on August 2408/24/2025 at 11:02 AM, Resident #37 stated he did not have any teeth and wanted dentures. Resident #37 said the facility was supposed to be letting him know something but never had. During an interview on 08/24/2025 at 12:13 PM., the Social Worker said she was responsible for dental referrals and the follow -ups. The Social Worker said the facility had made dental referrals and most every resident in the facility had been referred in May. The Social Worker was not able to provide any documentation of communication following the referral for Resident #35's dental implants, Resident #100's post dental visit status, or Resident # 37's financial update from Medicaid regarding dental services for his dentures. The Social Worker said it was important to make dental referrals and to follow-up on the referrals appropriately and timely to prevent weight loss and ensure the residents' needs were met. During an interview on 08/26/2025 at 4:00 PM, the DON said she was not aware of Resident #35's dental implant issues. The DON said she expected the Social Worker to ensure and handle those types of dental referrals appropriately and timely, so the residents do not have any type of |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure each resident receives and the facility provides food that accommodates residents' food preferences for 4 of 22 residents (Resident#13, Resident #41, Resident #75, and Resident #97) reviewed for the accommodation of resident's meal choices.The facility failed to ensure Resident#13, Resident #41, Resident #75, and Resident #97 meal choices were honored.This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: 1. Record review of Resident #13's face sheet, dated 8/24/25, indicated Resident #13 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13 had diagnoses including Type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels) and chronic respiratory failure (is a condition where the lungs are unable to provide enough oxygen to the body over a prolonged period, leading to low oxygen levels in the blood (hypoxemia)). Record review of Resident #13's quarterly MDS assessment dated [DATE] indicated Resident #13 was understood and had the ability to understand others. Resident #13 had a BIMS score of 15 which indicated intact cognition. Resident #13 required supervision for eating. Resident #13 was on a therapeutic diet. Record review of Resident #13's care plan dated 6/16/23 indicated Resident #13 was at risk for weight fluctuations due to obesity, changes in appetite, difficulty adjusting to new environment, and recent hospitalization. Intervention included provide prescribed diet and observe closely during mealtimes. During an observation and interview on 8/24/25 at 2:27 p.m., Resident #13 was sitting on the bed. Resident #13 had an uneaten salad on her bedside table. Resident #13 said she had not received what she had asked for. She said she eventually settled on a salad. 2. Record review of Resident #41's face sheet dated 9/2/25 indicated Resident #41 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #41 had diagnoses including chronic obstructive pulmonary disease (is a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction), chronic respiratory failure (is a condition where the lungs are unable to provide enough oxygen to the body over a prolonged period, leading to low oxygen levels in the blood (hypoxemia)), heart failure (is a condition where the heart muscle is weakened or stiffened, making it unable to pump blood effectively), and nutritional anemia (is a lack of healthy red blood cells caused by lower than usual amounts of vitamin B-12 and folate). Record review of Resident #41's quarterly MDS assessment dated [DATE] indicated Resident #41 was understood and had the ability to understand others. Resident #41 had a BIMS score of 4 which indicated severely impaired cognition. Resident #4 required supervision for eating. Resident #41 was on a therapeutic diet. Record review of Resident #41's care plan dated 9/29/24 indicated Resident #41 had an ADL self-care performance deficit related to disease process. Intervention included eating: Resident #41 required times 1 staff participation to eat. During an interview on 8/24/25 at 11:57 a.m., Resident #41 said she received the food she ordered 50% of time. She said the food was what you would expect in a nursing home. 3. Record review of Resident #75's face sheet dated 8/25/25 indicated Resident #75 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #75 had diagnoses including congestive heart failure (is a condition where the heart muscle is weakened and cannot pump blood effectively), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and hemiplegia (is paralysis that affects only one side of your body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction affecting left non-dominant side(occurs when blood flow to the brain is interrupted, leading to tissue damage). Record review of Resident #75's admission MDS assessment dated [DATE] indicated Resident #75 was understood and had the ability to understand others. Resident #75's BIMS score was 12 which indicated moderate cognitive impairment. Resident #75 required setup for eating. Resident #75 had signs and symptoms of possible swallowing disorder due to holding food in mouth/cheeks or residual food in mouth after meals. Resident #75 had a mechanically altered and therapeutic diet.Record review of Resident #75's care plan dated 8/24/25 indicated Resident #75 had an ADL self-care performance deficit related to hemiplegia and impaired balance. Intervention included Resident #75 required times one staff participation to eat.During an observation and interview on 8/24/25 at 10:51 a.m., Resident #75 was lying in bed watching television. Resident #75 was hard of hearing. He said it did no good filling out the lunch form. He said he would fill the lunch form out but would not get what he ordered. 4. Record review of Resident #97's face sheet dated 8/25/25 indicated Resident #97 was a [AGE] year-old male admitted to the facility on [DATE] |

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|---|---|---|---|
| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Treviso Transitional Care | 1154 East Hawkins Parkway<br>Longview, TX 75605 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 of 22 residents (Residents #9), 1 of 1 laundry rooms, and 1 of 6 halls (Hall 100) reviewed for infection control practices. 1. The facility failed to ensure Resident #9's urinary catheter bag was not touching the floor on 8/26/25. 2. The facility failed to ensure the Housekeeping/Laundry Supervisor L did not let clean blankets touch the floor during the folding process on 8/26/25. 3. The facility failed to ensure proper infection control measures when CNA D served ice from the ice chest cooler located on Hall 100 on 08/24/2025.These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection.<br><br>Findings included:<br><br>1. Record review of Resident #9's face sheet dated 8/26/25 indicated he was [AGE] years old and was admitted to the facility on [DATE]. Resident #9 had diagnoses which included urinary tract infection, heart failure, chronic kidney disease, extended spectrum beta lactamase (ESBL) resistance (infection that has resistance to many common antibiotics), weakness and lack of coordination.<br><br>Record review of Resident #9's admission MDS assessment dated [DATE] indicated Resident #9 had a BIMS score of 9, which indicated he had moderate cognitive impairment. Resident #9 required a wheelchair or walker for mobility. Resident #9 was dependent on staff for most ADL's, including toileting and transfers. Resident #9 had an indwelling urinary catheter (tube inserted into the bladder to drain urine out of the body).<br><br>Record review of Resident #9's Care Plan indicated he had an indwelling catheter for urine retention. Resident #9 was on Enhanced Barrier Precautions (an infection control strategy that uses gloves/gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms) and at risk for infection related to indwelling medical device.<br><br>During an 8/26/2025 at 8:16 AM, Resident #9 was lying in bed asleep with his bed in the low position. Resident #9's urinary catheter drainage bag was attached to the side of his bed and was sitting on the floor.<br><br>During an observation and interview on 8/26/2025 at 2:17 PM, Resident #9 said staff hang his urinary catheter drainage bag under his wheelchair, Resident #9's urinary catheter drainage bag was dragging the floor under his wheelchair in his room. Resident #9's RP was in the room visiting.<br><br>During an interview on 8/26/25 at 2:22 PM, LVN K said the urinary catheter drainage bag should be stored on a non-moveable part of the bed or wheelchair and below the resident's bladder. LVN K said everyone would be responsible for ensuring the urinary catheter drainage bag was covered and stored properly. LVN K said the urinary catheter drainage bag should not be dragging the floor. LVN K said if the urinary catheter drainage bag drug the floor, it could pull the urinary catheter out of the resident. LVN K said it would be an infection control and could increase the resident's risk of infection.<br><br>(continued on next page) |

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| | 676368 | A. Building<br>B. Wing | 08/26/2025 |

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| Treviso Transitional Care | 1154 East Hawkins Parkway<br>Longview, TX 75605 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/2025 at 2:38 PM, CNA A said she had worked at the facility since November of 2024. CNA A said she was assigned to the 400 hall, but she helped wherever needed. CNA A said the nurse or aide on duty would be responsible for ensuring the urinary catheter bag was covered and not dragging the floor. CNA A said if the urinary catheter drainage bag drug the floor, it could possibly get poked and cause leakage. CNA A said the urinary catheter bag should not be dragging the floor because it could cause a rip and leak, and it would contaminate the bag. CNA A said it would be an infection control issue. CNA A said if the urinary catheter bag drug the floor, it could cause an infection for the resident.<br><br>During an interview on 8/26/2025 at 3:17 PM, CNA D said the urinary catheter bag should not touch the floor because it could get dirty and germs. CNA D said the urinary catheter bag would need to be replaced because it would be contaminated. CNA D said the nurse and the aides would be responsible for ensuring the urinary catheter bag was not touching the floor.<br><br>During an interview on 8/26/2025 at 3:50 PM, the ADON said the urinary catheter bag should not be allowed to touch the floor because it increased the risk of infection for both the resident and other people. The ADON said it would be an infection control issue.<br><br>During an interview on 8/26/2025 at 4:27 PM, the DON said the cover flap of the urinary catheter bag was for privacy. The DON said the urinary catheter bag should be hung below the resident's bladder and “definitely not” touching the floor, because of contamination. The DON said the urinary catheter bag dragging/touching the floor, could cause injury or infection to the resident.<br><br>The DON said the CNAs and nursing staff would be responsible for ensuring the urinary catheter bag was not dragging/touching the floor.<br><br>During an interview on 8/26/2025 at 4:52 PM, the ADM said he would expect the urinary catheter bag to be stored off the floor and not allowed to drag under a resident's wheelchair due to risk of infection. The ADM said allowing the urinary catheter bag to drag/touch the floor was an infection control issue and placed the resident at risk for infection.<br><br>2. During an interview and observation on 8/26/25 at 1:28 p.m., the HSK/Laundry Supervisor L said she had been employed at the facility for 6 years. During the interview process, HSK/Laundry Supervisor L took a clean, facility provided blanket out of a wire hamper and proceeded to fold the blanket. She allowed the corners of four facility provided blankets to touch the floor. She folded the four blankets and set them on the counter near other laundry items. HSK/Laundry Supervisor L became upset when questioned about the four blankets. She snatched the blankets off the counter and said, “we don't have big enough tables for them not to touch the floor!” She took the blankets to the dirty side of the laundry room. She said the blankets could not touch the floor because the floor was contaminated.<br><br>During an interview on 8/26/25 at 3:00 p.m., the ADON N said the clean laundry should not touch the floor. She said the laundry personnel was responsible for ensuring the laundry did not get contaminated. She said but anyone who saw the laundry touching the floor was responsible. She said it was an infection control issue. She said it placed the residents at risk for getting an infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/26/25 at 5:44 p.m., the ADM said if clean laundry touched the floor, he expected it to be discarded. He said laundry could not touch the floor because of infection control. He said it placed the resident at risk for potentially getting an infection. He said the Laundry Supervisor should ensure infection control was followed but, the Supervisor was the one observed letting the laundry touch the floor. He said he oversaw the HSK/Laundry Supervisor L. He said the laundry department was contractual workers.<br><br>During an interview on 8/26/25 at 6:13 p.m., the DON said she expected the laundry to be discarded if it touched the floor. She said laundry could not touch the floor because of infection control. She said it placed the resident at risk for cross-contamination.<br><br>3. During an observation on 08/24/2025 at 10:55 AM, CNA D filled a resident's water cup with ice directly over the ice cooler. The water overflowed, spilling into the cooler and running down CNA D's hand into the ice supply. CNA D continued to serve ice to the residents on Hall 100.<br><br>During an interview on 08/25/2025 at 2:35 PM, CNA D stated she did not fill the cup over the ice cooler. CNA D stated the water did not overflow from the cup into the cooler. CNA D stated those practices could cause cross contamination and could make a resident sick.<br><br>During an interview on 08/26/2025 at 4:00 PM, the DON stated the residents' cups should not be filled over the ice cooler containing ice for the rest of the residents. The DON said the risk of cross contamination was high in that scenario. The DON said all staff were responsible to ensure cross contamination was prevented by following infection control protocols daily. The DON said it was important to follow infection control protocols to keep the residents free of sickness and infections.<br><br>During an interview on 08/26/2025 at 4:45 PM, the Administrator stated he expected infection control policies to be followed by all the staff and all staff was responsible to ensure cross contamination was not occurring in the facility. The Administrator said the staff were responsible to ensure fresh ice and water were served to the residents daily per the infection control policy.<br><br>Record review of the facility's policy titled Catheter Care, Urinary dated revised September 2014 indicated . the purpose of the procedure was to prevent catheter-associated urinary tract infections … Infection Control … b. be sure the catheter tubing and drainage bag were kept off the floor …”.<br><br>Record review of the facility's policy titled Infection Prevention and Control Program dated revised August 2016 indicated . The infection prevention and control program were a facility-wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance program … Prevention of Infection … a. important facets of infection prevention include … identifying possible infections or potential complications of existing infections … educating staff and ensuring that they adhere to proper techniques and procedures …”. |