

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676368	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Treviso Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1154 East Hawkins Parkway 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</b></p> <p>Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or others for 1 of 6 residents (Resident #1) reviewed for reasonable accommodations of needs .</p> <p>The facility failed to ensure Resident #1 had a functioning call light.</p> <p>This failure could place residents at risk of possible falls, major injuries, hospitalization , and unmet needs.</p> <p>Findings include:</p> <p>Record review of Resident #1's, undated, face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Cerebral Infarction (a serious condition that occurs when blood flow to the brain is blocked, causing an area of dead brain tissue), Urinary Tract Infection (a bacterial infection that affects the urinary tract, which includes the bladder, ureters, kidneys, and urethra), and Repeated Falls.</p> <p>Record review of Resident #1's significant change in status MDS, dated [DATE], reflected Resident #1 was understood and understood others. Resident #1's BIMs score was an 11, which indicated moderate impaired cognition. Resident #1 required substantial or maximal assistance with all ADLs.</p> <p>Record review of Resident #1's, undated, care plan reflected Resident #1 was at risk for falls related to history of falling, anti-anxiety medication use, and use of hypnotic therapy. The interventions included to ensure the call light was within reach and encourage her to use it to call for assistance as needed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/15/24 at 10:30 a.m., the Family Member said Resident #1 had a fall this morning. He said he was informed by Resident #2 who called him at about 6:46 a.m. He said he also had a camera in the room that showed Resident #1 sitting on the floor in his room. He said Resident #2 was hollering for help and no one went to help him after Resident #2 pushed the call light button. He said he lived nearby and drove to the facility. He said the nurses were all at the nurse's station not helping Resident #1. He said he asked them why they were not helping, and they said they did not know Resident #1 pushed their call light button . He said the nurses said room [ROOM NUMBER] Resident's #1 and #2 are in did not fully work . He said they told him the light at the door would turn on but the indicator at the nurse's station would not make an audible noise. He said Resident #1 was not hurt but he was upset that no one answered the call light in a timely manner. He said he did not know the names of the nurses he spoke to.</p> <p>During an observation on 11/15/2024 at 10:43 a.m. of an undated (no time stamp approximately 5 seconds long) camera footage provided by Family Member it was observed that Resident #1 was sitting on the floor of his room. Resident #2 was interacting with the resident. Resident #2 yelled, help twice. Resident #1's bed was in the low position and a fall matt was on the floor with Resident #1 pushing it away from himself.</p> <p>During an observation on 11/15/2024 at 10:56 a.m. revealed Resident #1 and Resident #2's call light was pressed in room [ROOM NUMBER] . A light was observed above the door of the room. Upon going to the nurse's station and with a staff present the call light did not make an audible noise or light to indicate the call light in the room had been activated .</p> <p>During an interview on 11/15/24 at 11:07 a.m. with LVN A, she said she worked the 6:00 a.m. to 6:00 p.m. shifts. She said she worked the morning on 11/15/24 when Resident #1 slipped out of bed. She said she knew Resident #1 slid out of bed because she was informed by the Family Member of Resident #1 and #2. She said she was the nurse on duty assigned to the 600-hall which included room [ROOM NUMBER] . She said at about 6:46 she was at the nurse's station at the medication cart getting ready to pass medications. She said there were two CNAs working with her. She said she was standing in front of the nurse's station and could not see room [ROOM NUMBER] light was on neither from the doorway or the screen at the nurse's station that lit up. She said normally there was an audible noise when a call light was pushed but room [ROOM NUMBER] light was not working at the nurse's station screen nor the audible noise it made so she was unaware Resident #1 or #2 had pushed their button. She said she could not hear Resident #2 calling for help either. She said she did not know where CNA B or C was. She said she would answer call lights as well as the CNA's. She said after she was notified of the fall by Resident #1 and Resident #2's family member she checked the resident who was sitting on his bottom, on his fall matt, with the bed in a low position. She said she would never let a call light go off for that long, but she did not know it had been activated.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/15/24 at 11:20 a.m., CNA B said she worked with Residents #1 and #2 today as she was assigned to their hall. She said she was informed Resident #1 slipped out of his bed by Resident #1's family member. She said she did not know Resident #1 had pushed their call button as she was not within eyesight of the door light of the room nor could she hear the audible call light noise that was made when the call light was activated . She said the last time she worked previous to 11/15/24 was on 11/12/24 and she believed the call light made an audible noise that day. She said when she came to work at 6:00 a.m. on 11/15/24 the morning shift did not report anything or note for the 600 hall. She said along with herself two others were working the 600 hall. She said there were a total of 12 residents on this hall. She said there were plenty of staff to work the 600 hall. She said when they went to see the resident after their family member said he slipped they found Resident #1 sitting on the fall mat and his bed was in the low position.</p> <p>During an interview on 11/15/2024 at 11:50 a.m., with Resident #1 he said he slipped onto the floor this morning. He said he was not hurt. He said he slipped down to his fall mat then pushed his fall mat away from him but could not get back up. He said he did not know how long he was on the floor, but it was more than 30 minutes . He said it seemed like hours. He said his Family Member came into the room and helped him up.</p> <p>During an interview on 11/15/2024 at 11:53 a.m., with Resident #2 she said she noticed Resident #1 was on the floor around 6:00 a.m. to 6:20 a.m. She said she pushed her help button, but no one came. She said she started to panic, so she called her Family Member. He wasn't hurt but he couldn't get back into bed. She said her Family Member came and nurses came to help Resident #1 into bed.</p> <p>During an interview on 11/15/24 at 12:07 p.m. with the Administrator, he said he was notified Resident #1 slipped from his bed at 9:00 a.m. today. He said the Maintenance Director said the audible notification the call light made when the button was pushed was not working. He said the company that serviced their system was notified and staff were in serviced this morning on call light systems to notify him of a malfunction and to give residents a bell to ring.</p> <p>During an interview on 11/15/2024 at 2:10 p.m., CNA C said she worked on 11/15/24 on the night shift. She said she worked with Resident #1. She said she knew Resident #1's room, had a malfunctioning call light system. She said last night (11/15/24) Resident #1 had pushed his call light a few times and she entered the room but the audible noise it made when the call light was pushed was not working. She said she could see his light turned on at his room door. She said his call light had not worked since last Sunday, 11/10/24, that she knew of. She said she was not sure the exact date it has been malfunctioning, but she knew it hadn't worked since last Sunday . She said she placed in the digital charting an order to Maintenance and told LVN D that it was not working .</p> <p>During an interview on 11/15/24 at 2:18 p.m., LVN D said she worked last night, 11/15/24, on the night shift with Resident #1. She said she knew his call light was coming on because she could see his light turn on in the hallway above his door. She said she did not know the audible noise that was made when a call light was pushed was not working for Residents #1's room. She said CNA C reported to her several days prior the call light was not working right but she saw the call light was coming on above the door so she disregarded what CNA C told her since she saw it was working. She said she did not know the audible noise was malfunctioning. To her knowledge Resident #1 had not fallen last night on her shift. She said no one reported to her that Resident #1 had fallen on her shift.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/15/2024 at 2:40 p.m., the Maintenance Director said in room [ROOM NUMBER] he fixed the call light system last Monday 11/11/24. He said he replaced the shower box to the call light system. He said he fixed it in response to a staff that reported the call light system not functioning the day prior. He said the light was showing up outside the door, but the call light was not making an audible noise. He said someone had pulled the shower box wiring out of the wall. He said he replaced the entire unit last Monday in the bathroom. He said last Monday once he fixed the shower box it was making an audible noise and a visual light when he tested the call light from the shower box. He said he did not replace the call box in the bedroom just the call box in the bathroom. He said he was new to the online system for reporting maintenance issues, so he doesn't know how to bring up work orders he has completed. He said he can see current work orders but work orders that are finished he cannot pull up. He said since he put the new shower box in last Monday he had been going back in every other day checking the call light system and it had worked fine.</p> <p>During an interview on 11/15/24 at 3:45 p.m., the Administrator said he expected the call light system worked in the facility. He said the Maintenance Director replaced the shower box for the call light system this past Monday. He said he believed the call light system just stopped working this morning. He said he understood his staff could not provide a timeline of when the call light system was and was not working but he believed it stopped working just today only. He said the work order that was placed last week by CNA C fixed the call light system even though just the bathroom box was replaced, and the bed box was not replaced.</p> <p>During an interview on 11/15/2024 at 3:50 p.m., the Director of Nurses said she expected the call light system functioned properly. She said residents could be placed at risk of falls if the system was not functioning properly.</p> <p>Record review of the facility's policy and procedure, revised October 2010, titled, Answering the Call Light reflected The purpose of the procedure is to respond to the resident's requests and needs . Answer the call light as soon as possible .Some residents may not be able to use their call light. Be sure you check these residents frequently.</p>		