STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676368	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treviso Transitional Care	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility has failed to ensure that the resident environment remains as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 5 residents reviewed for accidents. (Resident #1)The facility failed to notify nursing staff when CNA B and CNA C found Resident #1 on the floor after an unwitnessed fall.The facility failed to complete an assessment on Resident #1's unreported fall.This failure could place residents at risk for injury or delayed treatment.Findings included:Record review of Resident #1's face sheet dated 03/24/26 indicated Resident #1 was an [AGE] year old female and was admitted on [DATE] with diagnoses including Unsteadiness on Feet (caused by malfunctioning sensory signals from the eyes, ears, or body, leading to a wobbly or lightheaded sensation), Malaise (faintness), Lack of Coordination (poor muscle control that causes clumsy, jerky, or uncoordinated movements, often resulting from damage to the cerebellum in the brain). Record review of the MDS dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated a BIMS score of 13 indicating Resident #1 was cognitively intact. The MDS revealed that Resident #1 was not able to transfer from the toilet due to medical condition or safety concern. Resident #1 required partial or moderate assistance for transfers. Resident #1 was coded as frequently incontinent of bowel and bladder.Record review of a care plan revised on 04/17/26 indicated Resident #1 had an actual fall on 4/17/2026 related to transferring from toilet to wheelchair without assist and wheelchair not locked. Stated she missed the seat related to unsteady gait. Diagnosis of acute/subacute Lumbar 1 compression fracture (compressed spine) with mild anterior predominant height loss. Chronic appearing compression deformity of Lumbar 3, and multilevel degenerative changes. Care plan further indicated that Resident #1 required a one person assist for transfers and to use the toilet. Care plan indicated that Resident #1 was at moderate risk for falls due to debility and generalized weakness. Staff were to anticipate resident's needs. Resident #1's care plan indicated that Resident #1 had an activities of daily living self care performance deficit related to impaired balance and pain.Record review of hospital records for Resident #1 dated 4/17/2026. Shows that Resident #1 presented to the hospital with mild pain to the left lower quadrant. Acute/subacute compression fracture of L 1 with mild anterior predominant height loss. New since previous scan. Chronic appearing anterior compression deformity of L3.During an interview on 5/12/26 at 8:30 a.m. with Resident #1's Family Member she said that on 4/14/26 at around 6:00 p.m. Resident #1 had a fall from her wheelchair in the bathroom. She said that she did not actually witness the incident, but Resident #1 told her on 4/17/26 after she said she was starting to feel some pain. She said that Resident #1 told her that CNA C took her to the toilet and left her there for about 5 minutes. She said that Resident #1 told her that when she finished using the restroom she transferred herself from the toilet to her wheelchair whose wheels were not locked. She said that Resident #1 told her that she fell on the floor and a few minutes later CNA C came into the room to help her get up into her chair. She said that Resident #1 told her that CNA C and CNA B helped Resident #1 into her chair and then into bed. She said that Resident #1 told her that she did not report it because she was afraid that (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676368	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treviso Transitional Care	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	everyone would be mad at her for falling and she didn't want anyone to get into trouble.During an interview on 5/12/26 at 9:41 a.m. with the Director of Nurses she said that she was made aware of the incident with Resident #1 when the Family Member of Resident #1 told her what happened. She said that she questioned CNA B and CNA C. She said that CNA C admitted that she was the CNA that first found Resident #1 on the floor and she did not report it to anyone what had occurred. She said that CNA B also admitted that she helped CNA C to move Resident #1 to her wheelchair and bed. She said that the nurse on duty had no idea that the incident occurred. She said that she spoke to Resident #1 and she told her that she transferred herself to the bathroom and neither CNA B or CNA C helped her to transfer to the toilet. She said that Resident #1 said she did not want her to know she tried to transfer herself and was afraid she would get into trouble and that was why she did not tell anyone. She said that CNA B and CNA C should have reported to a nurse that Resident #1 had a suspected fall so Resident #1 could be assessed. She said that Resident #1 was placed at risk for further injury by not allowing a nurse to properly assess her after she fell. She said that it was facility policy that a resident was assessed after a fall and by not reporting the fall it prevented a nurse from completing an assessment. Resident #1 has had a history of falling per her family at home prior to admission. She said that per her family Resident #1 also has had back injuries.During an interview on 5/12/26 at 10:16 a.m. LVN A said that she was working on 4/14/26 the day Resident #1 fell. She said that she was not made aware of the fall that occurred because CNA B and CNA C did not report to her. She said that CNAs should report falls as she would need to assess the resident for injury. She said that Resident #1 has tried to transfer herself without asking for help. She said that she has tried going to the bathroom herself without asking for help.During an interview on 5/12/26 at 10:37 a.m. with Family Member of Resident #1 he said Resident #1 told him on 4/17/26 that she fell while trying to get back into her wheelchair. He said that Resident #1 told him CNA C placed her onto the toilet and left for about 5 minutes. He said that the Director of Nurses said that she questioned CNA B and CNA C and they both said they never transferred Resident #1. He said that Resident #1 did not appear in any pain on 417/26 when she told him what happened. He said that getting accurate information from Resident #1 was difficult. He said that previously to admitting to the facility Resident #1 fractured her back at home from multiple different falls.During an interview on 5/12/26 at 10:55 a.m. CNA B said that she was working on 4/14/26 during the time that Resident #1 fell. She said that Resident #1 took herself to the bathroom without any assistance. She said that she had told Resident #1 many times to ask for help before going to the bathroom. She said that it was CNA C that found Resident #1 on the floor and CNA C called her for help. She said that when she entered the bathroom Resident #1 was sitting on the floor. She said that her and CNA C helped Resident #1 into her chair and then put her into her bed. She said that Resident #1 did not complain about pain and was not grimacing. She said that neither her or CNA C notified a nurse about what happened. She said that when a resident has an unwitnessed fall like this she was trained to notify a nurse. She said that she was so busy that day she forgot to notify the nurse what happened.During an interview on 5/12/26 at 11:00 a.m. CNA C said that she was working the day Resident #1 slid from her chair in the bathroom. She said that she was not assigned to Resident #1 but she walked by and saw her call light on so she entered and that was when she saw Resident #1 on the floor. She said that Resident #1 told her she slid onto the floor and she did not fall. She said she called for CNA B and they helped her into her chair and then back into her bed. She said that they did not report the incident because they did not know it qualified as a fall and she wasn't showing any pain. She said that she was trained on the facility fall policy, but she made a mistake in determining whether a fall happened or not. She said that Resident #1 has a history of transferring herself without asking for help. She said that Resident #1 was told many times that not to transfer by herself.During an interview on 5/12/26 at 12:50 p.m. with Resident #1 she said that she remembers the incident where she fell at the other facility she lived at. She said she cannot remember the exact day but recently she slipped out of her wheelchair and hit her butt on the floor. She said that CNA C helped her to get onto the toilet, left her on the toilet alone, and then when she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676368	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treviso Transitional Care	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	finished using the restroom she got herself up and sat down into her wheelchair. She said she was sitting on the toilet for about 5 minutes. She said that she decided to get up without assistance because she was ready to go back to bed. She said that when she turned around to sit down she slipped out of her chair and slid down to her butt on the floor. She said that a few minutes later CNA C came back into the room and saw her on the floor and CNA B also came and they helped her back up and into bed. She said she did not report that she hurt her back because she was afraid her would get mad at her. She said it wasn't until her came that she told him about what happened.During an interview on 5/12/26 at 1:26 p.m. with the Administrator he said that it was the policy of the facility that if a resident had a fall or was suspected to have fallen the resident would be assessed by a nurse. He said that CNAs were required to report to a nurse if a resident had a fall or if the CNA suspected that a fall occurred. He said that a resident could be placed at further risk of injury if a CNA failed to report a fall that occurred.Record review of a facility policy titled, Falls - Clinical Protocol revised September 2012 revealed that, As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling.Staff will ask the resident and the caregiver or family about a history of falling.The staff and physician should document in the medical record a history of one or more recent falls (for example, within 90 days).While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause.In addition, the nurse shall assess and document/report the following:Vital signs;Recent injury, especially fracture or head injury;Musculoskeletal function, observing for change in normal range of motion, weight bearingChange in cognition or level of consciousness;Neurological status;Pain;Frequency and number of falls since last physician visit;Precipitating factors, details on how fall occurred;All current medications, especially those associated with dizziness or lethargy; andAll active diagnose.The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events.