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	06/10/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman of the transfer or discharge and the reasons for the transfer or discharge in writing at least 30 days before the resident is transferred or discharged or as soon as practicable before transfer or discharge 1 of 2 resident (Residents #1) reviewed for transfer and discharge. The facility failed to provide notice to the Office of the State Long-Term Care Ombudsman of the transfer of Resident #1 on 05/11/2026 with a written discharge/transfer notice. This failure could place residents at risk of improper discharge planning and diminished quality of life.Findings included: Record review of Resident #1's face sheet dated 06/11/2026 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of chronic obstructive pulmonary disease (difficulty breathing), congestive heart failure (the heart does not pump efficiently), chronic kidney disease, lack of coordination. Record review of Resident #1's Discharge MDS assessment dated [DATE] indicated Resident #1 was always understood by others, was able to understand others, had a BIMS of 12 which indicated Resident #1 was moderately cognitively impaired. The MDS also indicated Resident #1 required extensive assistance for dressing and personal hygiene, bed mobility and physical help to transfer with bathing. Record review of Resident #1's electronic medical record indicated a Discharge summary dated [DATE] had been completed. Record review of Resident #1's order summary report dated as of 06/11/2026 indicated she had an order to discharge from the facility on 05/11/2026. Record review of Resident #1's nursing progress note dated 05/11/2026 indicated she was transferred to another long-term facility with Resident #1's medication given to family. During an interview on 06/10/2026 at 11:38 AM, the Ombudsman said the facility had not contacted her that Resident #1 had transferred to another facility. The Ombudsman said she still had not received any type of written or verbal communication from the facility regarding Resident #1's discharge. The Ombudsman said she learned Resident #1 had been discharged from the facility after she had seen Resident #1 at another facility while visiting. The Ombudsman said she was not aware of why Resident #1 was discharged but assumed it was regarding her behaviors. The Ombudsman said it was important for her to be notified in a timely manner of any transfer/discharges in case she needed to be an advocate for the resident, assist the resident with any information and help them navigate through the discharge/transfer process. During an interview on 06/10/2026 at 12:01 PM, Resident 1's Representative stated they had received a call from the DON at the facility approximately a month ago to schedule a meeting for Resident #1. Resident #1's Representative said the meeting was a very intense discussion regarding Resident #1's rude behaviors to staff and her expectations from staff. The Resident's Representative said after the heated and intense discussion Resident #1 finally said she needed a fresh start. The Resident's Representative stated they had all agreed upon the decision to look at other facilities for Resident #1 to transfer into. Resident #1's Representative stated they were able to relocate Resident #1 prior to the 30-day notice period that the facility had given them. Resident #1's Representative was unable to provide a copy or the exact date of the facility 30 day notice she had received from the facility. An attempted telephone interview (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 06/10/2026 at 12:20 PM with Resident #1. Left a message and requested a call back. During an interview on 06/10/2026 at 01:06 PM, the DON said on 04/04/2026 a meeting was held with Resident #1 and her representatives to check-in and see how things were going with Resident #1. The DON said during the meeting Resident #1 stated she needed a fresh start. The DON said since Resident #1 initiated the transfer/discharge plan a 30-day discharge notice was not required and therefore one was not issued. The DON said she had attempted to contact the Ombudsman on 04/06/2026 via phone to notify her of Resident #1's plan to discharge but was unsuccessful. The DON said she did not leave the Ombudsman a message and did not receive a call back. The DON said the Ombudsman was in and out of the facility often and she might have mentioned Resident #1's transfer/discharge in passing. The DON said it was important to keep the Ombudsman informed regarding discharges/transfers to allow the resident and resident representative to be fully informed of their rights and to assist and or support with any resident needs. During an interview on 06/10/2026 at 01:30 PM, the Social Worker said she had attended the meeting with Resident #1 and Resident #1's representatives on 4/4/2026. The Social Worker said that during the meeting, Resident #1 had verbalized she wanted to make a fresh start at another facility. The Social Worker said a discharge notice was not completed to her knowledge. The Social Worker said she was responsible for notifying the Ombudsman of discharges and transfers. The Social Worker said she would send a list of discharges/transfers to the Ombudsman office via fax at the end of each month when a 30-day notice was not required. The Social Worker stated she could not provide any proof of notifying the Ombudsman office from January of 2026 through 06/10/2026. The Social Worker stated that she had reached out at a conference to figure out how to notify the Ombudsman of discharges and transfers that did not require the 30-day notice but had never received any feedback and did not know the correct procedure to follow. The Social Worker said she was responsible for discharge planning and the assisting the Business Office Manager with the 30-day discharge notices. The Social Worker stated Resident #1 would not have required a discharge notice to the Ombudsman because Resident #1 was self-initiated to leave the facility. The Social Worker stated it was important to include the Ombudsman with resident discharges and transfers to ensure the residents' needs and rights were met. During an interview on 06/10/2026, at 02:45 PM, the Administrator said the Business Office Manager and himself were responsible for 30-day discharge notices. The Administrator said the Social Worker was responsible for notification to the Ombudsman for discharges and transfers. The Administrator said Resident #1 had initiated the transfer at her own will during a meeting therefore a 30-day written notice was not required to be given to the Ombudsman. The Administrator said he was not familiar with the proper procedure on notification to the Ombudsman but felt what the facility was currently doing was too lackadaisical and he had made a call to the Ombudsman's office to find out the requirement. The Administrator said he had the Social Worker send via fax to the Ombudsman office all the discharges/transfers for the last 6 months since there was no documentation showing any written notifications of transfers/discharges had been completed since January 2026. The Administrator said it was important for the Ombudsman to be notified timely and in writing of all transfers/discharges. Record review of facility's Transfer or Discharge Policy dated 03/2027 indicated, Our facility shall provide a resident and or the resident's representative with a 30-day written notice of an impending transfer or discharge or when insurance provides notice of non-coverage. 2. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: .4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.