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	07/10/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 44596 Based on interview, and record review, the facility failed to consider the views of a resident group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life and failed to demonstrate their response and rationale for such response in a timely manner 3 (February, March, and April 2024) of 6 months reviewed for resident group response, in that: The documentation of the facility's effort to resolve resident grievances of medicine being left at bedside, not having their beds made, bedding not being changed on shower days, no snacks being provided, and the facility running out of toilet paper collected at Resident Council meetings on 02/01/2024, 03/21/2024, and 04/04/2024 were not made until between 05/07/2024 and 05/18/2024. This failure placed residents at risk of not having grievances addressed or provided a rational for facility decisions for issues identified in a timely manner. Findings included: Record review of Resident Council Meeting Forms dated 02/01/2024, 03/21/2024, and 04/04/2024 indicated the group council voiced their beds were not being made, their linens were not being changed, they were not receiving snacks, and the facility was running out of toilet paper frequently. The AD signed the Resident Council meeting form on 02/21/2024. The DON responded to the resident council grievance on 05/07/2024 about the beds being made with the response. Ambassadors will make rounds. The dietary manager responded to the resident council grievance about snacks on 05/16/2024 with the response, things are very chaotic right now and we are doing the best we can. The housekeeping supervisor responded to the grievance about the toilet paper shortage on 05/08/2024 with the response, manager will in service staff on leaving a larger supply out to ensure toilet paper does not run out. During an interview on initial tour on 07/08/2024 between 6:20 a.m. - 4:00 p.m., 2 confidential residents voiced their bed was not made and they were not receiving snacks. These confidential residents stated they made these concerns known during resident council meetings in February, March, April, May, and June of 2024. During a confidential group interview on 07/09/2024 at 10:00 a.m., 7 of 7 confidential residents said they had experienced not having their beds made and linens changed, not getting snacks, and running out of toilet paper over the last 6 months. 7 of 7 residents said they were concerned they were not receiving prompt responses to the grievances they were making during resident council. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 9:10 a.m., the Housekeeping Supervisor stated the facility discussed the issues voiced in the resident council in the morning meetings and resolutions were made verbally during those meetings. The Housekeeping Supervisor stated she thought AD K was going to relay the resolution to the residents, because that is who asked for the resolution in the morning meeting. The Housekeeping Supervisor stated she did an in service with her staff around mid-May to leave out extra toilet paper. She stated the in service was done verbally. During an interview on 07/10/2024 at 12:10 p.m., the Dietary Manager stated she was new and had only been in the facility for a couple weeks. She stated she met with the residents and introduced herself and asked about problems they were having with their food. She stated one of their concerns was snacks being available and she promptly addressed that by speaking with her staff and setting up snack times for 10 a.m., 2 p.m., and bedtime. The dietary staff was preparing trays of snacks and leaving them at the nurses' station for the nursing staff to distribute. She said this began around the 1st of July. Attempted to contact DM J (previous dietary manager) on 07/08/2024 at 11:20 a.m., 07/09/2024 at 2:15 p.m. and 07/10/2024 at 8:15 a.m., with no call back. During an interview on 07/10/2024 at 12:30 p.m., the DON stated she knew the policy for responding to grievances was 5 days. The DON stated she had been employed at the facility for about 3 weeks. The DON stated she was unsure why the previous DON had not responded to the resident council grievances for over 3 months. She stated not responding could make the resident's feel disrespected and could cause depression. Attempted to contact previous DON on 07/08/2024 at 10:20 a.m., 07/09/2024 at 4:15 a.m., and 07/10/2024 12:40 p.m. There was no response and no call back. During an interview on 07/10/2024 at 1:15 p.m., the AD stated she typed up the resident council minutes after each resident council meeting and presented a copy to each department head in the next morning meeting. She stated the DON, housekeeping supervisor and dietary manger were all present, along with the Administrator at these meetings. She stated she reminded the department heads that responses were needed to the resident council grievances daily during the morning meeting. She stated she did not receive responses for nearly 4 months on council meetings held at the first part of the year. She stated all at once the department heads handed in the same response to attach to multiple months resident council grievances. She stated the resident council was becoming frustrated because they felt they were being ignored. During an interview on 07/10/2024 at 2:09 p.m., the ADM stated he expected the grievances to be resolved in its entirety. The ADM said the grievance officer was the social worker, but each department would address the grievance in their area. The ADM stated he expected beds to be made, snacks to be served, toilet paper to be available to residents and staff, and the grievances be resolved within 5 business days. He stated he was not the ADM when the lack of attention occurred, but he would ensure they resident council did not feel ignored again. The ADM stated not responding to the resident council could leave the residents feeling like their voice does not matter in the facility, when their voice matters most. Record review of the Grievance Policy dated 2001, revealed the following: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The Administrator has assigned the responsibility of investigating grievances and complaints to the Social Service Director. 2. Upon receiving a grievance and complaint report, the Social Service Director will begin an investigation into the allegations. The department director of an involved employee will be notified of the nature of the complaint and that an investigation is underway. The investigation and report will include, as applicable: a. The date and time of the alleged incident; b. The circumstances surrounding the alleged incident; c. The location of the alleged incident; d. The names of any witnesses and their accounts of the alleged incident; e. The resident's account of the alleged incident; f. The employee's account of the alleged incident; g. Accounts of any other individuals involved (i.e., employee's supervisor, etc.); and h. Recommendations for corrective action. 3. The Resident Grievance/Complaint Investigation Report Form must be filed with the Administrator within five (5) working days of the incident. 4. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 5 working days of the filing of the grievance or complaint. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review, the facility failed to complete a resident assessment within the required time frame for 3 of 15 residents (Resident 24, Resident 16, Resident #5) reviewed for quarterly assessments. Resident #24's Quarterly MDS dated [DATE], was not completed until 7/8/24. Resident #16's quarterly MDS dated [DATE], was not completed until 7/5/24. Resident #5's quarterly MDS dated [DATE], was not completed until 7/5/24. This failure placed residents at risk of not having their assessments completed timely which could result in not having their individually assessed needs met. Findings included: 1. Record review of Resident #24's face sheet dated 01/27/24 indicated she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #24 had diagnoses including Acute Kidney Failure (A condition in which the kidneys suddenly can't filter waste from the blood), Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors), and Anemia (A problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). Record review of Resident # 24's quarterly MDS assessment dated [DATE] indicated Resident #24 had a BIMS score of 00, which indicated severe cognitive impairment. Resident #24 was dependent on staff for assistance with ADLs. Record review of Resident #24's electronic medical record accessed on 07/08/24 at 9:20 a.m. revealed that Resident #24 did not have a quarterly MDS submitted as of 7/8/24. Resident #24's quarterly MDS dated [DATE] was submitted and therefore made available for review on 7/9/24 after the facility was made aware. 2.Record review of Resident #16's face sheet dated 07/09/24 indicated Resident #16 was an [AGE] year-old female, admitted to the facility on [DATE]. Resident #16 had diagnoses including stroke, aphasia (a disorder that affects how one communicates usually occurring after a stroke), and heart failure. Record review of Resident #16's quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS of 08, indicating moderately impaired cognition. Resident #16 required maximum assistance with ADLs. The MDS sections A-Q were signed as completed on 07/05/2024 by LVN E. The MDS was signed reviewed and complete by RN L on 05/20/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the CMS transmittal report dated 07/08/2024, indicated Resident #16's quarterly assessment that was due to be completed and transmitted no later than 06/04/2024, was not completed until 07/05/2024 and not transmitted until 07/08/2024. The MDS was accepted with the CMS Warning Record, submitted late. This submission date is more than 14 days after the Z0500B (date the RN signed the assessment is completed 05/20/2024) on this new assessment. 3. Record review of Resident #5's face sheet dated 07/09/24 indicated Resident #5 was a [AGE] year-old female, admitted to the facility on [DATE]. Resident #5 had diagnoses including metabolic encephalopathy (brain function is disrupted due to different disease and toxins in the body), type II diabetes (a metabolic disorder in which the body has high glucose levels for prolonged periods of time), and dementia (a group of symptoms that affect memory, thinking, and daily life). Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 08, indicating moderately impaired cognition. Resident #5 required moderate assistance with ADLs. The MDS sections A-Q were signed completed on 07/05/2024 by LVN E. The MDS was signed reviewed and complete by RN L on 05/18/2024. Record review of the CMS transmittal report dated 07/08/2024, indicated Resident #5's quarterly assessment that was due to be completed and transmitted no later than 06/01/2024, was not completed until 07/05/2024 and was not transmitted until 07/08/2024. The MDS was accepted with the CMS Warning Record, submitted late. This submission date is more than 14 days after the Z0500B (date the RN signed the assessment is completed 05/18/2024) on this new assessment. During an interview on 07/09/2024 at 11:10 a.m., LVN E stated she was aware there were several MDS assessments that were late being finished and transmitted to CMS. LVN E stated she was the corporate regional support for the MDS Coordinator at the facility and she was attempting to help her get caught up. She stated it can be a challenge for one person to keep up with the number of MDSs and care plans that are due monthly in a facility like this facility. She stated they had a plan in place now to ensure the MDS assessments stayed up to date and were transmitted timely. LVN E stated not completing the MDS timely affected revenue for the facility and how the plan of care was updated to reflect resident's individualized care. During an interview on 07/10/2024 at 11:15 a.m., the MDS Coordinator stated she was the sole MDS nurse and her job duties included: reviewing clinical records for admission, prioritizing diagnoses on new admissions, entering Preadmission Screening and Resident Review information into the LTC portal, completing all LTCMI's (form that proves medical necessity for Medicaid services in a NF), baseline care plans, comprehensive care plans, updating care plans with new MDS information, completing all entry, discharge, admission, quarterly, significant change, state optional and Medicare MDSs. She stated she also gathered and reported all clinical and therapy information to insurances companies for continued skilled services for the residents at the facility for skilled nursing and several meetings each day with other members of the IDT and family members. The MDS Coordinator stated she knew there were MDSs that were behind and her regional support nurse (LVN E) had come up with a plan to get the facility caught up. She stated MDSs should be completed timely to ensure the staff was aware of the current level of care needed for each resident. The MDS Coordinator stated the facility followed RAI guidelines and CMS guidelines. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 1:00 p.m., the DON stated she was not aware of the late MDS assessments, but she had only been at the facility for about 3 weeks. The DON stated the MDS nurse had many responsibilities and she was more than competent to complete the required work. The DON stated she recently started allowing a nurse to come assist the MDS Coordinator with care plans 2 days per week. During an interview on 07/10/2024 at 1:15 p.m., the ADM stated he was aware of the late MDS assessments because he had been informed of them by LVN E. He stated the facility had a nurse now that would come help with care plans 1-2 days per week in an attempt to provide support to the MDS Coordinator. The ADM stated it was his expectation that all MDS assessments be completed and submitted timely. The ADM stated it could affect revenue and resident care if they MDS assessment was not finished and transmitted timely. Review of the RAI guidelines accessed on 07/10/2024 at 11:58 a.m., https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS20rai1202ch2.pdf revealed: The quarterly assessment is to be completed within 92 days of the Z0500 date of the admission assessment. The OBRA schedule would continue with another quarterly assessment to be completed within 92 days of the Z0500 of the previous quarterly. A third quarterly is completed within 92 days of the completion (Z0500) of the previous quarterly. 45643

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on interviews and record review, the facility failed to ensure each Minimum Data Set (MDS) was electronically completed and transmitted to the CMS System within 14 days after completion for 4 of 32 residents (Resident #149, Resident #24, Resident #16, and Resident #5) reviewed for MDS transmittal. The facility did not ensure Resident # 149's quarterly MDS assessment dated [DATE] was completed and successfully electronically transmitted within 14 days The facility did not ensure Resident # 24's quarterly MDS assessment dated [DATE] was completed and successfully electronically transmitted within 14 days . The facility did not ensure Resident # 16's quarterly MDS assessment dated [DATE] was completed and successfully electronically transmitted within 14 days . The facility did not ensure Resident # 5's quarterly MDS assessment dated [DATE] was completed and successfully electronically transmitted within 14 days This deficient practice could place residents at risk of not having their assessments transmitted and accepted in a timely manner and causing a delay in payments for the facility. The findings included: 1. Record review of Resident #149's face sheet dated 07/09/24 indicated Resident #149 was an [AGE] year-old female, admitted to the facility on [DATE]. Resident #149 had diagnoses including stroke, hemiplegia and hemiparesis affecting right dominant side (paralysis to one side of the body), and heart failure. Record review of Resident #149's admission MDS dated [DATE] indicated Resident #149 had a BIMS of 13, indicating intact cognition. Resident #149 required maximum assistance with ADLs. The MDS was signed by the MDS Nurse on 07/05/24. Record review of Resident #149's electronic medical record accessed 07/08/24 -07/10/24 indicated the MDS dated [DATE] was transmitted on 07/08/24. 2. Record review of Resident #24's face sheet dated 01/27/24 indicated she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #24 had diagnoses including Acute Kidney Failure (A condition in which the kidneys suddenly can't filter waste from the blood), Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors), and Anemia (A problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 24's quarterly MDS assessment dated [DATE] indicated Resident #24 had a BIMS score of 00, which indicated severe cognitive impairment. Resident #24 was dependent on staff for assistance with ADLs. Record review of Resident #24's electronic health records on 7/8/24 at 9:20 a.m. indicated the MDS dated [DATE] was transmitted on 07/08/24. 3.Record review of Resident #16's face sheet dated 07/09/24 indicated Resident #16 was an [AGE] year-old female, admitted to the facility on [DATE]. Resident #16 had diagnoses including stroke, aphasia (a disorder that affects how one communicates usually occurring after a stroke, and heart failure. Record review of Resident #16's quarterly MDS assessment dated [DATE] indicated Resident #16 had a BIMS of 08, indicating moderately impaired cognition. Resident #16 required maximum assistance with ADLs. The MDS sections A-Q were signed completed on 07/05/2024 by LVN E. The MDS was signed reviewed and complete by RN L on 05/20/2024. Record review of the CMS transmittal report dated 07/08/2024, indicated Resident #16's quarterly assessment that was due to be completed and transmitted no later than 06/04/2024, was not completed until 07/05/2024 and not transmitted until 07/08/2024. The MDS was accepted with the CMS Warning Record, submitted late. This submission date is more than 14 days after the Z0500B (date the RN signed the assessment is completed 05/20/2024) on this new assessment. 4. Record review of Resident #5's face sheet dated 07/09/24 indicated Resident #5 was a [AGE] year-old female, admitted to the facility on [DATE]. Resident #5 had diagnoses including metabolic encephalopathy (brain function is disrupted due to different disease and toxins in the body), type II diabetes (a metabolic disorder in which the body has high glucose levels for prolonged periods of time), and dementia (a group of symptoms that affect memory, thinking, and daily life). Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated Resident #5 had a BIMS of 08, indicating moderately impaired cognition. Resident #5 required moderate assistance with ADLs. The MDS sections A-Q were signed completed on 07/05/2024 by LVN E. The MDS was signed reviewed and complete by RN L on 05/18/2024. Record review of the CMS transmittal report dated 07/08/2024, indicated Resident #5's quarterly assessment that was due to be completed and transmitted no later than 06/01/2024, was not completed until 07/05/2024 and was not transmitted until 07/08/2024. The MDS was accepted with the CMS Warning Record, submitted late. This submission date is more than 14 days after the Z0500B (date the RN signed the assessment is completed 05/18/2024) on this new assessment. During an interview on 07/09/2024 at 11:10 a.m., LVN E stated she was aware there were several MDS assessments that were late being finished and transmitted to CMS. LVN E stated she was the corporate regional support for the MDS Coordinator at the facility and she was attempting to help her get caught up. She stated it can be a challenge for one person to keep up with the number of MDSs and care plans that are due monthly in a facility like this facility She stated they had a plan in place now to ensure the MDS assessments stayed up to date and were transmitted timely . LVN E stated not completing the MDS timely affected revenue for the facility and how the plan of care was updated to reflect resident's individualized care. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 11:15 a.m., the MDS Coordinator stated she was the sole MDS nurse and her job duties included: reviewing clinical records for admission, prioritizing diagnoses on new admissions, entering PASRR information into the LTC portal, completing all LTCMI's (form that proves medical necessity for Medicaid services in a NF), baseline care plans, comprehensive care plans, updating care plans with new MDS information, completing all entry, discharge, admission, quarterly, significant change, state optional and Medicare MDSs. She stated she also gathered and reported all clinical and therapy information to insurances companies for continued skilled services for the residents at the facility for skilled nursing and several meetings each day with other members of the IDT and family members. The MDS Coordinator stated she knew there were MDSs that were behind and her regional support nurse (LVN E) had come up with a plan to get the facility caught up. She stated MDSs should be completed timely to ensure the staff was aware of the current level of care needed for each resident. The MDS Coordinator stated the facility followed RAI guidelines and CMS guidelines. During an interview on 07/10/2024 at 1:00 p.m., the DON stated she was not aware of the late MDS assessments, but she had only been at the facility for about 3 weeks. The DON stated the MDS nurse had many responsibilities and she was more than competent to complete the required work. The DON stated she recently started allowing a nurse to come assist the MDS Coordinator with care plans 2 days per week. During an interview on 07/10/2024 at 1:15 p.m., the ADM stated he was aware of the late MDS assessments because he had been informed of them by LVN E. He stated the facility had a nurse now that would come help with care plans 1-2 days per week in an attempt to provide support to the MDS Coordinator. The ADM stated it was his expectation that all MDS assessments be completed and submitted timely. The ADM stated it could affect revenue and resident care if they MDS assessment was not finished and transmitted timely. Review of the facility policy titled MDS Submission Timeframes, dated 2001, indicated the admission MDS assessment for a resident should be transmitted no later than 31 days after the admission assessment was completed. The policy indicated a quarterly MDS assessment should be transmitted no later than 31 days following the R2b(completion) date. The Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted to the State MDS database in accordance with current federal and stated guidelines. 44596 45643

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to ensure that resident assessments accurately reflected the resident's status for 1 (Resident #13) of 12 residents reviewed for accuracy of resident assessments. The facility failed to ensure that Resident #13's MDS 05/05/2024 quarterly assessment accurately reflected the resident's history of falls. This failure put residents at increased risk of staff not being aware of resident needs due to inaccurate assessments. Findings included: Record review of Resident #13's face sheet dated 07/09/2024 revealed she was and 82-years-old female, admitted to the facility on [DATE]. She had diagnoses of Parkinson's Disease (chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), dysphagia (difficulty swallowing), and depression. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #13 had a BIMS of 08, which indicated moderate cognitive impairment. The MDS also revealed Resident #13 required moderate assistance with ADLs and was on a mechanically altered diet. The MDS revealed no falls had occurred since the last quarterly assessment, 03/21/2024. Record review of Resident #13's Fall assessment dated [DATE] completed by LVN D, revealed she had a fall while in her room attempting to take herself to the restroom. Resident #13 was noted to be sitting on the floor at the foot of her bed with a small bump above her right ear. Record review of Resident #13's comprehensive care plan dated 06/13/2024, revealed Resident #13 had a fall related to cognitive impairment and poor balance with an intervention from 04/06/2024 to offer the resident assistance to the bathroom at the begin of each round. During an interview on 07/09/2024 at 12:06 p.m., the MDS Coordinator revealed it looked like they missed the fall referring to not including Resident #13's history of falls in the quarterly MDS. She stated any fall the resident had since the last assessment should have been coded on the MDS. She said the MDS was developed based on hospital documents, history and physicals, orders, and by looking at the first seven day after admission. The MDS Nurse said if a fall was documented in the hospital records or History and Physical it should be on the MDS. She said if the MDS was not accurate the care plan may not be accurate. The MDS Coordinator stated the information about Resident #13's falls was missed. She said missing the resident's risk of falls on the MDS could increase the risk of falls because it might not get onto the resident's care plan. During an interview on 07/10/2024, at 1:43 p.m., the DON revealed that to construct the MDS assessment they look at everything such as resident's diagnoses, medications from the hospital, and discussions with the resident. She said the MDS triggers things on the CAA that need to go on the care plan so if something is missed on the MDS it could be missed on the care plan. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 1:55 p.m., the ADM revealed he expected all MDS assessments to be accurately coded and show a clear picture of the individual resident. He stated not having accurate assessments will cost the facility money and the resident's autonomy may be affected. Record review of the facility policy, Resident Assessment Instrument dated 2023 revealed that an accurate assessment was one where the health professional correctly documented the resident's problems and strengths to maintain or improve their medical status, functional abilities using the Resident Assessment Instrument (RAI). Information provided by the initial comprehensive assessment establishes baseline date for the ongoing assessment of resident progress.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the resident's practicable physical, mental, and psychosocial well-being for 2 (Resident #13 and Resident #44) of 10 residents reviewed for care plans. 1.The care plan for Resident #13 did not address the diagnosis and treatment for Parkinson's Disease. 2.The care plan for Resident #44 did not address a significant weight loss of greater than 10% in 180 days. These failures could place residents at risk of not having their individualized needs met, falls, weight loss and a decline in their quality of care and life. Findings include: 1.Record review of Resident #13's face sheet dated 07/09/2024 revealed she was and 82-years-old female, admitted to the facility on [DATE]. She had diagnoses of Parkinson's Disease (chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), dysphagia (difficulty swallowing), and depression. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #13 had a BIMS of 08, which indicated moderate cognitive impairment. The MDS also revealed Resident #13 required moderate assistance with ADLs and was on a mechanically altered diet. The MDS assessment indicated Resident #13 had a diagnosis of Parkinson's Disease. Record review of the consolidated orders for July 2024 for Resident #13 had an order for carbidopa-levodopa 25-250mg three times a day. Record review of the resident's no care plan was found for Resident #13's Parkinson Disease diagnosis and treatment. 2.Record review of Resident #44's face sheet dated 07/09/2024 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] with the diagnosis of diabetes (a metabolic disorder in which the body has high glucose levels for prolonged periods of time), dementia (a group of symptoms that affect memory, thinking, and daily life), and fibromyalgia (disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances). Record review of the quarterly MDS assessment for Resident #44, dated 05/18/2024 revealed Resident #44 had a BIMS of 05, which indicated a severe cognitive impairment. Resident #44 was dependent on staff for toileting, bathing, dressing and bed mobility. Resident #44 had weight of 218 pounds. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's monthly weights revealed: February 2024: 229.6 pounds-6th month weight June 2024: 196 pounds - 30-day weight- 33.6-pound/14.6 % weight loss in less than 180 days July 2024: 193.5 pounds- current weight-36.1 pound/ 15.7 % weight loss in 180 days. Record review of a progress note for Resident #44 dated 06/27/2024 written by the DON revealed: Resident triggered for 7.5 % weight loss in the last 180 days. Current weight 196 pounds. Previous weight 06/02/2024-195.8 pounds. Diet order for CCD diet. She also has access to outside foods. Resident has what appears to b3e yeast infection under bilateral breast and inner left elbow Will monitor weights for status changes. Updated resident's daughter notified. Notified MD. Record review of the comprehensive care plan last updated 07/04/2024 for Resident #44 was reviewed and no care plan was noted that addressed significant weight loss, interventions, or desired weight loss. During an interview on 07/09/2024 at 10:00 a.m., Resident #44 stated she was unaware she had weight loss. Resident #44 stated she really wanted to get her weight down to around 150 pounds to help with care giver burden. During an interview on 07/10/2024 at 11:18 a.m , the MDS Coordinator stated she was responsible for the creation and implementation of the comprehensive care plan and to revise the care plans when new MDS assessments were completed. She stated it was the responsibility of all nurses to update the care plan with changes as they occur. She stated the department head nurses had a meeting each week to discuss weight loss, falls, and wounds. She stated during this meeting care plans should be updated with the changes of wounds, significant weight changes with interventions, and falls with interventions. She stated there had recently been big changes with department head nurses and they had a new DON, ADON, and treatment nurse. She stated they had not gotten back on track with weekly meetings and that is more than likely why care plan had not been updated. The MDS Coordinator stated not updating care plans to include diagnoses and significant weight changes could affect the resident's care provided. She stated it was important to keep those items updated to ensure the most accurate care was given to the residents. During an interview on 07/10/2024 at 1:38 p.m., the DON stated the MDS nurse had many responsibilities and she was more than competent to complete the required work. The DON stated she recently started allowing a nurse to come assist the MDS Coordinator with care plans 2 days per week. During an interview on 07/10/2024 at 1:15 p.m., the ADM stated he was aware of the care plans needed to be updated. He stated the facility had a nurse now that would come help with care plans 1-2 days per week in an attempt to provide support to the MDS Coordinator. The ADM stated it was his expectation that all care plans be completed a timely. The ADM stated it could affect resident care if the care plan was not finished and updated timely. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered revealed, .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment and updated with information about the resident as it occurred.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interviews and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 of 13 residents (Residents #13 and Resident #44) reviewed for care plans. 1. The facility failed to revise and update Resident #13's nutrition care plan with the diet change of puree diet with honey thickened liquids. 2. The facility failed to revise and update Resident #44's comprehensive care plan about her discontinued IV medications, discontinued use of a foley catheter, healed DTI to left heel, tobacco use, antibiotic use, UTI diagnosis, hypnotic use, anticoagulation use, and healed pelvic abscess. These deficient practices could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1. Record review of Resident #13's face sheet dated 07/09/2024 revealed she was and 82-years-old female, admitted to the facility on [DATE]. She had diagnoses of Parkinson's Disease (chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), dysphagia (difficulty swallowing), and depression. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #13 had a BIMS of 08, which indicated moderate cognitive impairment. The MDS also revealed Resident #13 required moderate assistance with ADLs and was on a mechanically altered diet. The MDS assessment indicated Resident #13 had a diagnosis of Parkinson's Disease. Record review of Resident #13's consolidated physician orders dated July 2024 indicated an order dated 05/09/2024 indicated to change her diet from puree diet with nectar thickened liquids to puree diet with honey thickened liquids. Record review of Resident #13's care plan revealed a nutrition care plan dated 06/13/2024 to provide Resident #13 a puree diet with nectar thickened liquids. 2. Record review of Resident #44's face sheet dated 07/09/2024 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] with the diagnosis of diabetes (a metabolic disorder in which the body has high glucose levels for prolonged periods of time), dementia (a group of symptoms that affect memory, thinking, and daily life), and fibromyalgia (disorder that affects muscle and soft tissue characterized by chronic muscle pain, tenderness, fatigue and sleep disturbances). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the quarterly MDS assessment for Resident #44, dated 05/18/2024 revealed Resident #44 had a BIMS of 05, which indicated a severe cognitive impairment. Resident #44 was dependent on staff for toileting, bathing, dressing and bed mobility. The MDS was coded revealing Resident #44 had a foley catheter, had an IV, had a foot ulcer, received hypnotic therapy, and had a pressure ulcer to her left heel. Record review of Resident #44's care plan dated 05/16/2024, indicated Resident #44 had an indwelling catheter, was receiving hypnotic medication daily, had a pelvic abscess, used tobacco daily, had a pressure ulcer to her left heel, had a UTI, was on antibiotic therapy, was on anticoagulation therapy, and was on IV therapy. Record review of Resident #44's consolidated physician orders dated May, June and July 2024 indicated the following: Resident #44's pressure ulcer was healed on 06/24/2024. Resident #44's indwelling foley catheter for Resident #44 was discontinued 06/14/2024. Resident #44's IV therapy was discontinued on 06/14/2024. Resident #44's UTI was resolved on 05/21/2024. Resident #44's anticoagulant medication was discontinued 02/04/2024. Resident #44's antibiotic was completed on 01/30/2024. During an observation of incontinent care on 07/10/2024 at 10:00 a.m., Resident #44 was noted to be incontinent of bladder and had no catheter. She was noted to have no pelvic abscess, no pressure ulcer to her left heel, and had no IV access. During an interview on 07/10/2024 at 10:45 a.m., the MDS Coordinator said social services, the DON, and herself worked on care plans. She said the care plans were reviewed and revised during care plan meetings with the IDT. She said it was herself and social services' responsibility to make sure care plans were current. She said she did not make sure changes were made to resident's care plans after care plan meetings. She stated all of the changes Resident #44 had should have been updated to reflect her current situation. She stated not updating these items could lead to the resident not receiving appropriate care. During an interview on 07/10/2024 at 1:43 p.m., the DON said the MDS Coordinator was responsible for updating care plans. She said care plans were revised with the IDT quarterly, as needed, and at care plan meetings. She said the care plans should be revised to accurately reflect the resident and it guided the resident's care. She said the MDS Coordinator should be monitoring if care plans are revised and updated. She said the facility had a consultant that assisted the MDS Coordinator and the facility now allowed an assistant 1-2 days per week to help keep up with the care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 2:33 p.m., the ADM said care plans were created after comprehensive assessments, updated after quarterly assessment and after out of cycle done by the IDT. He said physician orders were reviewed during IDT meetings for updates. He said Resident #13's diet order should have reflected what her current physician order stated. He stated Resident #44 had multiple changes that needed to be updated on her care plan to reflect the individual changes that have occurred. Record review of a facility's Care Area Assessment policy revised 2001 indicated .care area assessment will be used .to develop individualized care plans .link between assessment and care planning .review the triggered CAAs .history taking, physical assessments, gathering of relevant information .sequencing of clinically significant events . Assessment of residents are ongoing and care plans are revised as information about the resident and the residents' condition change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 or 8 residents (Resident #24) reviewed for respiratory care. The facility failed to change the oxygen tubing for Resident #24. These failures could place residents at risk for of respiratory infections. Findings included: Record review of Resident #24's face sheet dated 01/27/24 indicated she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #24 had diagnoses including Acute Kidney Failure (A condition in which the kidneys suddenly can't filter waste from the blood), Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors), and Anemia (A problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). Record review of Resident # 24's quarterly MDS assessment dated [DATE] indicated Resident #24 had a BIMS score of 00, which indicated severe cognitive impairment. Resident #24 was dependent on staff for assistance with ADLs. Resident #24 required oxygen therapy. Record review of Resident #24's order summary report dated 6/24/24 revealed an order for oxygen at 2 liters per nasal cannula. Order indicated to change and label tubing weekly and on Sunday. Record review of Resident #24's care plan revealed a problem revised on 2/13/24 to give oxygen therapy as ordered by the physician. During an interview and observation on 7/8/24 at 7:24 a.m., Resident #24's nasal cannula was dated for 6/17/24. Resident # 24 said it has been a while since anyone has changed her oxygen tubing. She said she doesn't know the last time someone had changed it. She said she uses it every night as she sleeps. During an observation on 7/9/24 at 9:22 a.m., Resident #24's nasal cannula was dated for 6/17/24. Resident # 24's nasal cannula had not been replaced with new tubing. During an interview on 7/10/24 at 12:55 p.m., with the ADM he said that it was the responsibility of night nurses to change nasal cannula for residents . He said that his staff are to follow the care plans and orders for residents. He said that nasal cannula should have been changed weekly. He said residents could be placed at risk of respiratory infection. During an interview on 7/10/24 at 1:04 p.m., with the DON she said that the night nurses are responsible for changing nasal cannula. She said that not changing the oxygen tubing would place the residents at an adverse risk. She said it is best practice to change nasal cannula weekly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 residents reviewed for pharmacy services (Resident #42) 1. The facility failed to keep a record receipt of Resident #42's-controlled medication Hydrocodone. The failures could place residents at risk of not having accurate records of medication administration which could result in diminished health and well-being. Findings included: 1.Record review of the undated face sheet for Resident #42 indicated he was a [AGE] year old male that admitted [DATE] with diagnoses that included: Displaced Mid-cervical fracture of left femur (fracture of the left hip), cervical disc disorder (degeneration of the cervical spine) with myelopathy (nervous system disorder that affects the spinal cord) , high cervical region, rheumatoid arthritis (chronic inflammatory disorder usually affecting small joints in the hands and feet.) and low back pain. Record review of the MDS assessment dated [DATE] indicated Resident # 42 had clear speech, understood others, and understood by others. She had a BIMS of 13 indicating she was cognitively intact. Record review of the care plan initiated on 6/25/2024 revealed Resident #42 had potential for pain related to fracture of left femur with goal to have an acceptable pain level through next review date with interventions to acknowledge presence of pains and discomforts, administer pain medication as ordered and administer as needed pain medication for breakthrough as ordered by Physician, turn, and reposition during rounds and massage bony prominences. Record review of medication administration record dated 6/1/2024- 6/30/2024 for Resident #42 indicated, Hydrocodone 7.5-325 mg 1 tablet every 6 hours as needed for pain was prescribed on 6/17/2024. The medication administration record revealed Resident #42 had 2 doses of Hydrocodone 7.5 mg-325 mg tablet on 6/18/2024 at 1:11 AM PRN dose and 12:00 PM prior to new order for oxycodone. Record review of a packing slip dated 6/17/2024 indicated the facility received Resident #42's Hydrocodone 7.5-325 mg 30 quantity on 6/17/2024. Record review of medication destruction of controlled substances dated 6/25/2024 revealed Hydrocodone 7. 5-325 mg had 25 tablets destructed by Pharmacist and DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 9:18 AM, CMA A said there was an incident where a CMA was off on her counts, and she came in to cover the shift. CMA A could not recall what medication was missing or off on counts. CMA A said she thought it was determined the CMA who had the counts off was giving the medication and not documenting in the medication administration record. CMA A said you should document when a medication is administered. CMA A said the other CMA was suspended and had not worked since the day of the off counts. CMA A said staff were questioned, drug tested and educated again on medication administration. CMA A said a narcotic medication that was discontinued should be given to the DON as soon as possible. CMA A said other non-narcotic medications can be left in the medication storage room. During an interview on 7/10/2024 at 9:57 AM, LVN B said Resident #42 did not have any medication come up missing and she could not recall if Resident #42 had any narcotic off counts for his Hydrocodone. LVN B said when a medication comes in, we would write the medication down on the white sheet with counts, home meds and moved medication would have the date received and 1 or 2 sheets of paper, card numbers and the discontinued medication would correspond with the white sheet. LVN B said this was implemented when the new DON came to the facility. LVN B said if narcotic counts were off she would not accept the keys to the medication cart. LVN B said she would not want to be responsible. LVN B said she would contact the ADON and DON and wait for guidance. LVN B said she would take the narcotic sheet to the DON and count with her immediately when a narcotic was discontinued. During an interview on 7/10/2024 at 11:20 AM, the ADON said Resident #42 had Hydrocodone delivered to the facility on [DATE]. The ADON said there was a discrepancy of the count of Hydrocodone. The ADON said the facility went through a process with the Pharmacy consultant. The ADON said the discrepancies were accounted for. The ADON said the facility immediately counted all narcotics and called the pharmacy to identify when the Hydrocodone was sent and who was on schedule. The ADON said the DON spoke with staff and attempted to identify when the off counts were identified. The ADON said the nurses are responsible for the medication carts before the Medication Aides start an hour later than the nurses. The ADON said the facility did a drug screen on staff who worked, and all staff received negative drug screens. The ADON said the Pharmacist consultant came in after the discrepancy was identified and they did a count with ADON and DON. The ADON said the DON is the only one who can accept the discontinued narcotic medications. The ADON said the staff should keep the narcotics on the medication cart if it was the weekend if discontinued and continue to count until the DON returns on Monday. The ADON said the DON keeps the medication locked up in her office until time for medication destruction. The ADON said she is not aware of any medications missing. The ADON said the medication aide was suspended and the facility ended their work relationship with the medication aide. During an interview on 7/10/2024 at 1:04 PM, the DON said at 9 PM the nurse on the floor reported 2 Hydrocodone tablets missing. The DON said she could not identify where the 2 Hydrocodone went. The DON said the Medication Aide told her she did not count with the 7-6 PM shift. The DON said the medication aide was pregnant and she did not know what happened to the Hydrocodone. The DON said she expects the staff to document on the Medication administration record, the narcotic count sheet and expects counts to be performed each shift. The DON said she performed a narcotic audit on 6/25/2024 and they did not find any missing medication. The DON said the pharmacist consultant provided a new sheet to help reconcile medication and the DON said she was monitoring the narcotics daily until the next consult with the pharmacist in 3 months. The DON said the nurses are to bring the sheet once the medication is zero out then she gives the completed sheet to medical records. The DON said she has new processes in place to ensure the issue of narcotic counts are resolved. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 2:17 PM the ADM said if a narcotic is discontinued, the card should be removed from the medication cart. The ADM said if a narcotic count was off the staff should notify the DON immediately. The ADM said missing narcotics or off counts could place the facility at risk for drug misconduct or improper administration of narcotics. The ADM said narcotics were destructed weekly and monthly for sure. The ADM said he expects the nurses and medication aides to count narcotics each shift. During record review of the facility's policy revised December 2012 titled Controlled Substances revealed . The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of s II and other controlled substances .Policy Interpretation and Implementation .1 .Only authorized licensed nursing and pharmacy personnel shall have access .2.The DON services will identify staff members who are authorized to handle controlled substances .4.If the count is correct, an individual resident-controlled substance record must be made for each resident who will be receiving a controlled substance. Do not enter more than one prescription per page. This record must contain: .Name of resident .Name and strength of the medication .quantity received . Name of Physician .Prescription number . Name of issuing pharmacy .date and time received .time of administration .method of administration . signature of person receiving medication .signature of nurse administering medication .9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and nurse going off duty must make the count together. They must document and report any discrepancies to the DON . 10. The DON services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall give the ADM a written report of such findings .11. The DON services shall consult with the provider pharmacy and the ADM to determine whether any further legal action is indicated.

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Treviso Transitional Care	1154 East Hawkins Parkway Longview, TX 75605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (a medication used: in excessive doses (including duplicate therapy) for 1 of 6 residents (Resident #54) reviewed for unnecessary medications The facility failed to ensure Resident #54 did not receive duplicate medication therapy for metoprolol (blood pressure medication), venlafaxine (antidepressant), trazadone (antidepressant used as sleep aide), pantoprazole (acid-reflux medication), MiraLAX (laxative), and vitamin D3. This failure could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the duplicate use of these medications) and receiving unnecessary medications. Findings included: Record review of Resident #54's face sheet dated 07/09/2024 indicated Resident #54 was an 85-years-old female, admitted to the facility on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), and vitamin deficiency (a deficiency of one or more essential vitamins). Record review of Resident #54's significant change MDS assessment dated [DATE] indicated Resident #54 was usually understood and usually understood others. The MDS indicated Resident #54's BIMS score was 07 which indicated moderate cognitive impairment and required maximum assistance for bed mobility, dressing, toilet use, personal hygiene, and bathing. Record review of the care plans for Resident #53 revealed the following care plans: Antidepressant usage- educate the resident and family about risk, benefits, and side effects and/or toxic symptoms of antidepressant usage dated 01/21/2024. Antihypertensive usage- resident has the potential for complications related to hypertension (high blood pressure). Give antihypertensive medications as ordered. Observe for side effects such as orthostatic hypotension and increased heart rate dated 01/21/2024. Resident has GERD (gastroesophageal reflux disease). Give proton pump inhibitor (drug class for pantoprazole) once daily. Monitor resident for side effects, dated 01/21/2024. Resident has a history of constipation. Give laxatives as ordered. Monitor resident for bowel movements at least every 3 days dated 01/21/2024. Record review of Resident #54's consolidated MD orders dated 07/08/2024 revealed the following duplicate orders: 06/29/2023- Trazadone 50mg give 1 tablet at bedtime for insomnia. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/14/2024- Trazadone 50mg give 1 tablet at bedtime for insomnia. 03/27/2024- Venlafaxine 75mg give 1 tablet by mouth twice daily related to depression. 06/14/2024-Venlanfaxine 75mg give 1 tablet by mouth twice daily related to depression. 06/30/2023- Pantoprazole sodium 40 mg give one tablet daily for GERD. 06/14/2024- Pantoprazole sodium 40 mg give one tablet daily for GERD. 02/02/2024- Metoprolol tartrate 50mg one tablet by mouth twice daily for hypertension. Hold if systolic blood pressure is <110 and/or diastolic blood pressure is <60. 06/14/2024- Metoprolol tartrate 50mg one tablet by mouth twice daily for hypertension. Hold if systolic blood pressure is <110 and/or diastolic blood pressure is <60. 02/03/2024- MiraLAX oral pack-17 grams one packet by mouth once daily for constipation. 06/14/2024- MiraLAX oral pack-17 grams one packet by mouth once daily for constipation. 07/04/2023- Vitamin D3 50 mcg give one by mouth one time a day for dietary supplement. 06/14/2024- Vitamin D3 50 mcg give one by mouth one time a day for dietary supplement. Record review of Resident #54's June 2024 MAR revealed the following: Trazadone 50mg give 1 tablet at bedtime for insomnia with the start date of 06/29/2023 was administered each day between 6 p.m. and 1 a.m. from 06/01/2024 to 06/30/2024. Trazadone 50 mg give 1 tablet at bedtime for insomnia with start date of 06/14/2024 was also administered from 06/14/2024 to 06/30/2024 each day between 6 p.m. and 1 a.m. Resulting in 16 duplicate doses of trazadone administered in June 2024. Venlafaxine 75mg give 1 table twice daily related to depression with the start date of 03/27/2024 was administered twice daily from 06/01/2024 to 06/30/2024. Venlafaxine 75mg give 1 tablet twice daily related to depression with the start date of 06/14/2024 was also administered twice daily from 06/14/2024 to 06/30/2024. Resulting in 32 duplicate doses of Venlafaxine administered in June 2024. Pantoprazole sodium 40mg give one tablet daily for GERD with the start date 06/30/2023 was administered once daily from 06/01/2024 to 06/30/2024. Pantoprazole sodium 40mg give one tablet daily for GERD with the start date 06/14/2024 was also administered once daily from 06/14/2024 to 06/30/2024. Resulting in 16 duplicate doses of Pantoprazole sodium administered in June 2024. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol tartrate 50mg one tablet by mouth twice daily for hypertension with the start date 02/02/2024 was administered twice daily with vital signs recorded from 06/01/2024 to 06/30/2024 with the exception (blood pressure out of parameters) of 06/17/2024 (BP 110/56), 06/18/2024 (BP 112/58), 06/21/2024 (BP118/58), 06/22/2024 (BP 120/56) (morning dose), and 06/23/2024 (BP 112/54) (evening dose) in which the medication was held and the MD was informed of the low blood pressures. Metoprolol tartrate 50mg one tablet by mouth twice daily for hypertension with the start date 06/14/2024 was also administered twice daily with vital signs recorded from 06/14/2024 to 06/30/2024 with the exception (blood pressure out of parameters) of 06/17/2024, 06/18/2024, 06/21/2024, 06/22/2024 (morning dose), and 06/23/2024 (evening dose) in which the medication was held and the MD was notified of the low blood pressure. Resulting in 24 duplicate doses of Metoprolol administered in June 2024. MiraLAX oral pack 17 grams one pack by mouth daily with the start date of 02/03/2024 was administered once daily from 06/01/2024 to 06/30/2024. MiraLAX oral pack 17 grams one pack by mouth daily with the start date of 06/14/2024 was administered once daily from 06/14/2024 to 06/30/2024. Resulting in 16 duplicate doses of MiraLAX administered in June 2024. Vitamin D3 50mcg one capsule one time daily with the start date 07/04/2023 was administered once daily from 06/01/2024-06/30/2024. Vitamin D3 50mcg one capsule one time daily with the start date 06/14/2023 was administered once daily from 06/14/2024-06/30/2024. Resulting in 16 duplicate doses of Vitamin D3 administered in June 2024. Record review of July 2024 MAR for Resident #54 revealed: Trazadone 50mg give 1 tablet at bedtime for insomnia with the start date of 06/29/2023 was administered each day between 6 p.m. and 1 a.m. from 07/01/2024 to 07/08/2024. Trazadone 50 mg give 1 tablet at bedtime for insomnia with start date of 06/14/2024 was also administered from 07/01/2024 to 07/08/2024 each day between 6 p.m. and 1 a.m. Resulting in 8 duplicate doses of trazadone administered in July 2024. Venlafaxine 75mg give 1 table twice daily related to depression with the start date of 03/27/2024 was administered twice daily from 07/01/2024 to 07/08/2024. Venlafaxine 75mg give 1 tablet twice daily related to depression with the start date of 06/14/2024 was also administered twice daily from 07/01/2024 to 07/08/2024. Resulting in 16 duplicate doses of Venlafaxine administered in July 2024. Pantoprazole sodium 40mg give one tablet daily for GERD with the start date 06/30/2023 was administered once daily from 07/01/2024 to 07/08/2024. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pantoprazole sodium 40mg give one tablet daily for GERD with the start date 06/14/2024 was also administered once daily from 07/01/2024 to 07/08/2024. Resulting in 8 duplicate doses of Pantoprazole sodium administered in July 2024. Metoprolol tartrate 50mg one tablet by mouth twice daily for hypertension with the start date 02/02/2024 was administered twice daily with vital signs recorded from 07/01/2024 to 07/08/2024 with the exception (blood pressure out of parameters) of on 07/04/2024(B/P 112/58). Metoprolol tartrate 50mg one tablet by mouth twice daily for hypertension with the start date 06/14/2024 was also administered twice daily with vital signs recorded from 07/01/2024 to 07/08/2024 with the exception (blood pressure out of parameters) of 07/04/2024. Resulting in 15 duplicate doses of Metoprolol administered in July 2024. MiraLAX oral pack 17 grams one pack by mouth daily with the start date of 02/03/2024 was administered once daily from 07/01/2024 to 07/08/2024. MiraLAX oral pack 17 grams one pack by mouth daily with the start date of 06/14/2024 was administered once daily from 07/01/2024 to 07/08/2024. Resulting in 8 duplicate doses of MiraLAX administered in July 2024. Vitamin D3 50mcg one capsule one time daily with the start date 07/04/2023 was administered once daily from 07/01/2024 to 07/08/2024. Vitamin D3 50mcg one capsule one time daily with the start date 06/14/2023 was administered once daily from 07/01/2024 to 07/08/2024. Resulting in 8 duplicate doses of Vitamin D3 administered in July 2024. During an interview and record review on 07/09/2024 at 9:02 a.m., CMA G stated she was aware of the duplicate orders for Resident #54. CMA G stated she contacted Unit Manager M on 06/15/2024 when she first noticed the duplication on the MAR for Resident #54. She stated Unit Manager M explained to her that the orders would appear duplicated on the MAR and she should administer the medications as on the MAR. CMA G stated the information had not seemed correct to her, but as a CMA the LVN had more knowledge on the medications and the system. CMA G stated when she worked, she continued to administer the medications as they appeared on the MAR for Resident #54. She stated she carefully took Resident #54's blood pressure prior to administering any blood pressure medications and held the medication the few times it was outside of parameters. CMA G showed this surveyor a text message from Unit Manager M confirming the directions to give the medications as ordered on the MAR. CMA G stated she had not reported the duplicate medications to anyone else because the Unit Manager M was her supervisor. During an interview and record review on 07/09/2024 at 9:10 a.m., CMA H stated she was giving Resident #54's medication as ordered on the MAR. She stated she had occasionally held the BP medication for Resident #54 if the blood pressure was out of parameters. She stated she told the ADON or the charge nurse if she had to hold the medication so they could call the MD to inform them. CMA H stated she had not noticed any change in Resident #54's behavior. She stated she was easily aroused when she was asleep and was up most of the day wheeling round the facility. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/09/2024 at 9:25 a.m., Resident #54 was up in a wheelchair attempting to self-propel. She was awake and alert with no signs of sedation or acute illness. Attempted to call Unit Manager M x 3 (07/09/2024 at 9:30 a.m., 07/09/2024 3:30 p.m., and 07/10/2024 11:10 a.m.) with no return response. During an interview on 07/09/2024 at 9:35 a.m., the DON stated she was not aware Resident #54 received duplicate drug therapy for trazadone, metoprolol, pantoprazole, MiraLAX, vitamin D3 and venlafaxine. She stated she would immediately access the resident and call the MD. The DON stated duplicate drug therapy could be harmful to the resident and cause organ damage, hospitalization or even death in some extreme cases. The DON stated Unit Manager M checked all newly written orders for Resident #54's hall. The DON stated Unit Manager M quit on 06/12/2024, two days prior to the duplicate orders being written for Resident #54. She stated the ADON that stated 07/01/2024 took over the responsibility of checking new orders. The DON stated the backup to ensure no duplicate orders occurred was the pharmacy consultant came monthly and reviewed all resident medication for duplicate therapy. The DON stated the last pharmacy review was 06/11/2024 (3 days prior to the orders being duplicated) and he was due back 07/11/2024 (3 days after the duplication was discovered). The DON stated the charge nurses would not be aware of the duplicate medication unless the CMA reported it to them because they did not review medications. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/09/2024 at 11:10 a.m., MD N stated he conducted a tele-med (over the internet) exam of Resident #54 on 07/08/2024 at 2:00 p.m. He stated after reviewing her vital signs and having the tele-med exam he felt there was no harm to the resident. He stated he carefully reviewed the medications she was receiving in duplicate. He stated metoprolol was a medication that controlled blood pressure as well as heart rate. He stated the normal range of daily dosage of metoprolol was from 50mg to 450 mg a day. He stated Resident #54 was not adversely affected by receiving 100mg and he knew this because he was called the 3 or 4 times when the medication aide held the blood pressure medication because Resident #54's blood pressure was outside of perimeters and they blood pressures reported were not alarmingly low. He stated the normal dosage of trazadone for a sleep aide was between 25 mg to 100mg at bedtime. He stated by Resident #54 receiving only 50mg at bedtime and tolerating it well with no side effects or sedative effects, she was not harmed by the medication. He continued by stating that it would take almost an entire bottle of vitamin D3 to have an amount that would cause harm. He stated the normal range of dosage for venlafaxine was between 37.5mg and 300mg per day. He stated Resident #54 had no sedation, no hallucinations, no constipation, and no loss of appetite, which were side effects of receiving too much. Pantoprazole was used in people that spent a great deal of time in the bed to prevent stomach ulcers and control acid reflux. He stated the standard dose was 40mg once to twice daily, and by not having a decrease in appetite he felt Resident #54 had not been adversely affected by pantoprazole. He stated MiraLAX was a medication to soften the stool to prevent constipation. He stated it was generally ordered once daily, but he saw no harm in her taking two caps of MiraLAX instead of one. He stated no episodes of continuous diarrhea had been reported to him. He stated he made some medication changes when he met with Resident #54 to ensure she would not be harmed by a prolonged use of higher doses of the medications. He stated he changed the MiraLAX to prn, he kept the metoprolol at 100mg and changed the frequency to daily, he changed pantoprazole to once daily and kept the venlafaxine at 150mg with a frequency of daily. The trazadone was changed to 50mg at bedtime and he was going to reassess her in one week to see if she was responding well to the decreased frequency of some of the medications. He stated he would continue to monitor Resident #54 and stated he could name 1000 potential adverse reactions to medications and Resident #54 was not suffering from any at this time. He stated he expected his orders to be followed and not duplicated because there is a potential for adverse reactions to high doses of some medications, but he felt the facility had a good system in place for monitoring for duplicate mediations by having the ADON or unit manager review them daily and the pharmacy consultant review them monthly. During an observation on 07/10/2024 at 8:15 a.m., Resident #54 was up in her wheelchair eating breakfast in the dining room. No sedation noted. Resident #54 had a good appetite and ate 75% of her breakfast. During an interview on 07/10/2024 at 2:07 p.m., the ADM said he expected nursing administration to handle review of all medications and ensure all residents were receiving the right medication and right dose. The ADM stated he was unaware until yesterday when the DON informed him Resident #54 received duplicate medications. The ADM stated it was the ADON or unit manager's responsibility to review all medications and the DON was the one that checked behind them. Requested policy for Unnecessary Medications from DON on 07/09/2024 and 07/10/2024 and no policy was given prior to exit. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Process: Patient Safety during drug therapy (2024), https://www.nursingcenter.com/clinical-resources/nursing-drug-handbook/ndh-toolkit/nursing-process was accessed on 07/11/2024 indicated .drug therapy is a complex process that can easily lead to adverse patients events .applying the nursing process .assessment, nursing diagnosis .during drug therapy enables the nurse to systemically identify the drug therapy needs of each patient .administer medication utilizing the eight rights .right drug . right reason .right dose .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, record review, and interview, the facility failed to store all drugs and biologicals in locked compartments for 1 of 5 medication carts (400/500 hall cart) reviewed for pharmacy services. 1. The facility failed to lock 1 medication carts for hall 400/500 medication cart. These failures could place residents at risk of not having their medications available as prescribed, a drug diversion, and an adverse reaction. Findings included: During an observation and interview on 7/10/2024 beginning at 9:36 AM, LVN B left the medication cart for hall 400 unlocked while administering medication to Resident # 285. During administration, it was observed LVN B leaving medication cart pulled facing the door and cart remaining unlocked. Resident #285 was requiring assistance and care prior to medication and the medication cart was out of LVN B sight. LVN B was observed going into the bathroom to wash her hands, leaving the cart out of visual observation. Observed cart unlocked from 9:36 AM to 9:43 AM with 3 housekeepers observed in the hallway while medication cart was unlocked. LVN B said she could not see the medication cart while providing care. LVN B said she did not think it needed to be locked since she was close to the cart. LVN B said someone could get into the medication cart and take medications that do not belong to them. Record review of the undated face sheet for Resident #285 indicated she was an [AGE] year old female that admitted [DATE] with diagnoses that included: Traumatic compartment syndrome of tight upper extremity (when an injury or repeated stress causes swelling and bleeding inside a muscle compartment), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) , Chronic obstructive Pulmonary disease (a group of lung diseases that block air flow and make it difficult to breath) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). During an observation on 7/10/2024 at 10:00 AM, LVN C was present during observation of the medication cart and identified as medications for hall 400 and 500, revealed in the top-drawer vitamins, over the counter medications such as aspirin, insulin pens and syringes. Observed in second drawer scheduled medications such as clonidine, magic mouthwash, and albuterol. The third drawer was the narcotic drawer which was locked inside the medication cart. LVN C said she was responsible for the medication cart she was assigned to. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 11:00 AM, LVN C said medication carts should never be left unlocked. LVN C said the medication carts need to be locked up even if the medication cart is in the doorway. LVN C said the medication cart should be within eye site. LVN C said a resident could take medication out of the cart that are not prescribed to them, and they could be allergic to the medication, or it could harm them including death. LVN C said other staff or visitors could also get in the medication cart if left unlocked. The nurse with the keys is responsible for the medication cart. During an interview on 7/10/2024 at 11:20 AM, the ADON said medication carts are supposed to be locked. The ADON said the medication carts can be in sight or touch and would not be a good idea to leave cart unlocked while providing care. The ADON said she expected the medication carts to be locked. The ADON said anyone passing by could open the medication cart and take medications not prescribed to them and they could have an adverse reaction. During an interview on 7/10/2024 at 2:17 PM, the ADM said he expects nurses and medication aides to keep medication carts locked. The ADM said the medication cart should be unlocked when pulling medications, supplies or counting medications. The ADM said the medication cart should be in eye site and the nurse should not turn back on an unlocked medication cart. The ADM said an unlocked medication cart puts them at risk for thief of medication and another resident, staff or visitor could get in the medication cart and take a medication not prescribed to them. The ADM said an adverse reaction to medication could occur and cause the person harm or become sick. During an interview on 7/10/2024 at 2:32 PM, the DON said she expected nurses and medication aides to keep medication carts locked while not in use. The DON said she has started an in-service to the nurses and medication aides on keeping the medication carts locked. The DON said an unlocked medication cart could result in a drug diversion. Review of a Storage of Medication revised April 2017 indicated, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received .7. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others .10.Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety. 1. The facility failed to store all cardboard boxes off the floor. 2. The facility failed to ensure the outside of the microwave and the wall next to the beverage table was clean and sanitary. 3. The facility ensure that all food items in the freezer and walk in cooler were properly dated and labeled. These failures could place residents at risk of foodborne illness and food contamination. Findings include: During an observation on [DATE] at 6:14 a.m., there were two (2) carboard boxes containing clear liquid frying oil sitting on the floor of the pantry. During an observation on [DATE] at 6:15 a.m., the microwave was sitting on a stainless-steel table. There was a brown buildup on the outside of the microwave. During an observation on [DATE] at 6:16 a.m., a coffee dispenser was sitting on a plastic bin with a white lid on the beverage table. The white lid and the nearby wall had dry brown splashes. During an observation on [DATE] at 6:17 a.m., in the walk-in cooler there was a tray containing 6 plastic cups of unknown fruit slices. There were two (2) plastic cups of a thick beige colored food item. There were three (3) cups of a creamy, thick, yellow food item covered in plastic wrap with no label. Each food item was dated , d+[DATE]. During an observation on [DATE] at 6:20 a.m., in the walk-in freezer there was an unknown breaded food item in a plastic bag dated ,d+[DATE] with no label. There was a large plastic bag with and unknown yellow food item with no date or label. (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	07/10/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:03 a.m., the Dietary Manager she said when a delivery was delivered, cardboard boxes were supposed to be put up. She said cardboard boxes should not be sitting on the floor at all. She said a cardboard box sitting on the floor could not negatively affect a resident. She said the oil inside the boxes were in jugs inside the boxes. She said all kitchen staff were responsible for wiping down equipment. She said her first day at the facility was [DATE] and she was currently working on a cleaning schedule for the staff. She said she expected for all equipment to have been kept clean. She said the cook and the dietary aides were responsible for dating and labeling food items. She said if a food item was opened it should have been dated and labeled before it was put away. She said she made rounds every morning to make sure this was done. She said, all of this would have been caught when I got here. She said the unlabeled food items in the freezer had been thrown away. She said if unlabeled foods were cooked properly they could not negatively affect a resident. She said resident allergies were addressed on the meal tickets and snack labels for each resident. During an interview on [DATE] at 1:06 p.m., the Administrator said all cardboard should have been stored off the floor or broken down and discarded in a timely manner. He said he expected to have sanitary and clean equipment in the kitchen. He said all equipment should have been cleaned according to the cleaning schedule. He said the Dietary Manager, Dietary Aides, and Cooks were responsible for making sure the kitchen was clean. He said cardboard boxes and equipment that has not been cleaned had the potential for unsanitary issues with food and produce. He said he expected every food source or condiment to have proper food labels and dated. He said the Dietary Department staff were responsible for labeling and dating food items. He said food items not dated or labeled properly could pose a risk for expired food to be served or risk of serving improper diet based on allergies or diagnoses. Record review of an Equipment facility policy last revised in ,d+[DATE] indicated, .All foodservice equipment will be clean, sanitary, and in working order .All equipment will be routinely cleaned and maintained .All non-food contact equipment will be clean and free of debris . Record review of a Food Storage: Cold Foods facility policy last revised on ,d+[DATE] indicated, .all foods will be stored wrapped or in covered containers, labeled and dated . Record review of a Food Storage: Dry Goods facility policy last revised on ,d+[DATE] indicated, .All items will be stored on shelves at least 6 inches above the floor . Review of a 2022 Food Code for the U.S. Food and Drug Administration indicated, .Annex 4. Establish First-In-First Out (FIFO) Procedures. Product rotation is important for both quality and safety reasons. First-In-First-Out (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking food as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS (temperature control storage) foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirement .