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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER Pleasanton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Neal Street Pleasanton, CA 94566	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) within 2 hours for two of 34 residents (Resident 5 and Resident 223).This failure had the potential to result in serious adverse physical, psychosocial, and emotional harm for Resident 5 and Resident 223.Findings:During a review of Resident 5's Face Sheet (demographics), [undated], the face sheet indicated Resident 5 was admitted to the facility with diagnosis of fracture (broken bone) of the right talus (small bone that connects the lower leg to the foot).During a review of Resident 5's Minimum Data Set (MDS, standardized assessment tool), dated 3/25/2026, the MDS indicated, Resident 5 had a BIMS (brief interview for mental status) score of 13, cognitively intact.During a review of Resident 223's Face Sheet (demographics), [undated], the face sheet indicated Resident 223 was admitted to the facility with diagnosis of a displaced fracture (broken bone that has snapped into two or more pieces) of the left femur (thigh bone).During a review of Resident 223's admission MDS, dated 3/6/2026, the admission MDS indicated, Resident 223 had a BIMS score of 15, cognitively intact.During an interview on 4/21/2026 at 10:16 a.m. with Resident 5, Resident 5 stated that during the PM (afternoon) shift, on 3/20/2026, Certified Nursing Assistant (CNA 3), entered her room to change and clean her after a bowel movement. Resident 5 further stated that CNA 3 seemed upset and was rough while she was cleaning her back side. Resident 5 stated she informed CNA 3 that she was experiencing pain and asked CNA 3 not to clean her back side so roughly, however, CNA 3 continued to care in the same manner. Resident 5 stated that after CNA 3 finished her care, CNA 3 then helped her roommate Resident 223. Resident 5 further stated that CNA 3 was rude and used foul language while providing care to Resident 223. Resident 5 stated that Resident 223 was very upset after CNA 3 finished her care. Resident 5 stated the next morning (3/21/2026) when CNA 2 came to her bedside she informed CNA 2 about the incident the night before. Resident 5 declined to name CNA 3 who provided rough care to the surveyor when asked.During an interview on 4/23/2026 at 2:48 p.m. with CNA 2, CNA 2 stated Resident 5 informed her on 3/21/2026 during the AM (morning) shift that the night before on 3/20/2026, the PM shift CNA 3 was rough and rude with her and Resident 223 while providing care. CNA 2 stated that she informed the Licensed Vocational Nurse (LVN 6) about the incident, and LVN 6 asked her to get a statement about the allegation of abuse from Resident 5 and Resident 223. CNA 2 stated that after the statement was given to her, she asked the Clinical Coordinator (CC 1) what she should do with Resident 5's and Resident 223's allegation of abuse statement. CC 1 instructed CNA 2 to slide the allegation of abuse statement under the Director of Staff Development's (DSD) door. CNA 2 further stated she slid Resident 5's and Resident 223's shared statement under the DSD's door during her AM shift on 3/21/2026.During an interview on 4/23/2026 at 3:24 p.m. with the DSD, the DSD stated CNA 2, LVN 6, and CC 1 were made aware of Resident 5's and Resident 223's allegation of abuse on 3/21/2026, however, it wasn't reported to Social Services and to him until 3/26/2026. The DSD further stated that rough care is considered an allegation of abuse and the staff should have reported the allegation immediately to the abuse coordinator. The DSD confirmed that the allegation of abuse was not reported to CDPH within 2 hours.During an interview on 4/23/2026 at 3:58 p.m. with the Director of (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Services (DSS), the DSS stated Resident 5's and Resident 223's allegation of abuse was reported to her on 3/26/2026 and she reported it to CDPH on 3/26/2026.During an interview on 4/23/2026 at 4:48 p.m. with the Administrator (Admin), the Admin stated allegations of abuse should be reported immediately to him, as he was the abuse coordinator. The Admin further stated that rough care provided by a CNA was considered an allegation of abuse. The Admin confirmed that Resident 5's and Resident 223's allegation of abuse was not reported to CDPH within 2 hours, and that once the staff was aware of the allegation of abuse they should have reported it immediately to him.During a review of [Facility] Facsimile Transmittal Sheet, dated 3/26/2026, the Facsimile Transmittal Sheet indicated that CDPH was notified via fax of Resident 5's and Resident 223's allegation of abuse on 3/26/2026 at 5:20 p.m. (5 days after the allegation was reported by Resident 5 and Resident 223).During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, dated 7/1/2020, the P&P indicated, Reports of abuse, neglect, exploitation.shall be promptly reported to local, state, and federal agencies.An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately but not later than: Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interviews and record review, the facility failed to implement physician orders for two of 34 sampled Residents (Resident 2 and Resident 135) when:1.A STAT (immediate) X-ray (medical imaging test to take pictures of the inside body) was not implemented timely per physician order, when the contract vendor did not show up to the facility and the facility failed to follow up with the vendor. This resulted in Resident 2 being transferred to an outside hospital for an X-ray, obtained approximately 28 hours later. 2.Resident 135' s PRN (as needed) pain medication was not administered according to physician's orders. These failures resulted in delayed treatment for Resident 2 and the potential to result in inadequate pain relief for Resident 135. Findings: 1.During a review of Resident 2's admission Record, dated 4/21/2026, the admission record indicated, Resident 2 was admitted to the facility with diagnosis that included muscular dystrophy (progressive muscle weakness) and first and second thoracic vertebrae fracture (broken of the top two bones of the mid-back, below the neck). During a review of Resident 2's Brief Interview for Mental Status (BIMS; a cognitive assessment tool), dated 2/9/2026, the BIMS indicated, Resident 2's score was 13 (which indicated an intact cognitive function). During a review of Resident 2's Progress Notes, dated 1/30/2026, the progress notes indicated, Resident 2 had a fall on 1/30/2026 at 1:13 p.m. During a review of the Provider Notification and Feedback, dated 1/30/2026, the provider notification indicated, the Medical Doctor (MD 1) ordered a STAT (immediately) X-ray on 1/30/2026 at 1:17 p.m. for Resident 2. During a review of Resident 2's Hospital X-ray Results, dated 1/31/2026, the X-ray results indicated, an X-ray was conducted on 1/31/2026 at 5:40 p.m. and the results indicated Resident 2 had a left foot fracture and right knee fracture. During an interview on 4/20/2026 at 4:46 p.m., with Resident 2, Resident 2 stated she requested an X-ray after she fell during therapy on 1/30/2026. Resident 2 further stated her request for the X-ray was not done immediately until her family member contacted the facility the following day on 1/31/2026. During an interview on 4/21/2026 at 2:05ˆp.m., with the Director of Nursing (DON), the DON stated a STAT X-ray order should be completed within six hours. The DON stated STAT X-ray orders indicated urgency, time-critical care and a delay could result in harm for Resident 2. The DON further stated there was a gap with their contract vendor and this was not an acceptable standard of practice. During an interview on 4/23/2026 at 8 a.m., with MD 1, MD 1 stated she ordered a STAT X-ray on 1/30/2026 for Resident 2 due to clinical symptoms of pain. MD 1 stated, her expectation for STAT X-rays must be done within four to six hours. MD 1 further stated receiving the STAT X-ray 26 hours later caused a delay in Resident 2's medical intervention and was an indication of poor quality of care. During a review of the facility's policy and procedure (P&P) titled, Request for Diagnostic Services, dated April 2007, the P&P indicated Orders for diagnostic services will be promptly carried out as instructed by the physician's order. Emergency request must labeled stat to assure that prompt action (continued on next page)

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