STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056392	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton Nursing and Rehabilitation Center	300 Neal Street Pleasanton, CA 94566

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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 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. Based on observation, interview and record review, the facility failed to ensure food service safety and sanitation requirements were followed when:1. A 7-pound can of cherry pie filling was observed to have a dent near the top of the can and was stored alongside regular cans outside the designated dented can area.2. A cheese grater, hung up with clean food preparation items, was found with a broken red plastic rim.3. A green cutting board, stored with clean food preparation items, was found with yellow debris and was marred (surface with deep gouges) on one side.These failures had the potential to cause food borne illness among vulnerable residents.Findings:1.During a concurrent observation and interview on 4/20/2026 at 3:00 p.m. with the Dietary Manager (DM), in the kitchen dry storage, a 7-pound can of cherry pie filling was observed to have a dent near the top of the can. The can was stored with items for use and not stored in the designated dented can area. The DM confirmed the can was dented. The DM stated the can did not belong with regular cans and that it should have been placed in the designated dented can area. During a review of the facility's policy and procedure (P&P) titled, General Food Preparation and Handling, [undated], the P&P indicated, 2. Food Storage. c. Food in broken packages or swollen or dented cans. will not be served Dented cans will be labeled and set aside in a designated area for return. 2. During a concurrent observation and interview on 4/20/2026 at 2:50 p.m. with the Dietary Manager (DM), in the kitchen, a red plastic rimmed cheese grater was observed with a crack in the red plastic. The red plastic was observed to be separated from the metal cheese grater. The cheese grater was stored with clean equipment. The DM confirmed that the red plastic around the cheese grater was broken and stated the cheese grater should not be stored for use. The DM further stated it should have been discarded as it can lead to an infection control issue. During a review of the facility's policy and procedure (P&P) titled, General Food Preparation and Handling, [undated], the P&P indicated, 5. Equipment. a. All food service equipment should be cleaned, sanitized, air-dried, and reassembled after each use. b. Plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of.3.During a concurrent observation and interview on 4/20/2026 at 2:54 p.m. with the Dietary Manager (DM), in the kitchen, a green plastic cutting board was observed stored on the shelving with clean equipment. The green cutting board was observed to have small yellow debris on it, as well as deep marring on one side of the board. The DM confirmed the yellow-colored debris and marring on the cutting board and stated it should have been replaced to prevent bacteria growth on the cutting board.During a review of the facility's policy and procedure (P&P) titled, General Food Preparation and Handling, [undated], the P&P indicated, 3. Food Preparation. Cutting boards will be cleaned and sanitized after each use.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure for one of 34 sampled residents (Resident 44) when a comprehensive assessment for self-medication administration was not completed prior to Resident 44 self-administering medications.This failure resulted in unmonitored medication use and had the potential to result in medication overuse and errors. Findings:During a review of Resident 44's Face Sheet (demographics), the face sheet indicated Resident 44 was admitted to the facility with a diagnosis of muscular dystrophy (progressive muscle weakness and loss of muscle mass over time).During a concurrent observation and interview on [DATE] at 9:39 a.m. with Resident 44 in her room, Resident 44 was lying in bed. Observed bottles of Biotin (nutrient the body needs in small amounts), Vitamin K2, Vitamin D3 (essential nutrients that work together), Vitamin E (nutrient the body needs in small amounts), and Magnesium Glycinate (dietary supplement), medication bottles on a shelf next to Resident 44's bedside. Resident 44 stated she took the medication supplements every day independently and those were stored on her shelf.During an interview on [DATE] at 9:09 a.m. with the Licensed Vocational Nurse (LVN 5), LVN 5 confirmed Resident 44 had medications at bedside and was self-administering the medications in her room.During an interview on [DATE] at 11:44 a.m. with the Case Manager (CM 1), CM 1 stated the Interdisciplinary Team (IDT) determined it was clinically appropriate for Resident 44 to self-administer Vitamin D and the physician wrote an order to do so. CM 1 further stated, however, the IDT did not determine if it was clinically appropriate for Resident 44 to self-administer Biotin, Vitamin E, or Magnesium Glycinate and there was no physician's order for Resident 44 to do so. CM 1 stated Resident 44 had been self-administering Biotin, Vitamin E and Magnesium Glycinate. CM 1 confirmed, that each individual medication needed an IDT assessment completed and a doctor's order for self-administration.During a review of Resident 44's Self-Administration Medication Safety Screen, dated for [DATE], the Self-Administration Medication Safety Screen indicated, Complete this assessment prior to resident initiating self-administration of medication and with any medication and with any medication order changes. The Self-Administration Medication Safety Screen further indicated that Resident 44 was not screened for the medications Biotin, Vitamin E, or Magnesium Glycinate for self-administration by the Interdisciplinary Team.During a review of Resident 44's Order Summary Report, for active orders as of [DATE], the Order Summary Report indicated, Resident 44 did not have self-administration orders for Biotin, Vitamin E, or Magnesium Glycinate. During a review of Resident 44's Medication Administration Record (MAR), dated [DATE], the MAR indicated, there was no documentation for Resident 44 to self administer the following medications, Biotin, Vitamin E, and Magnesium Glycinate.During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated February 2021, the P&P indicated, As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: The medication is appropriate for self-administration;.the resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to staff. Any medications found at the bedside that are not authorized for self administration are turned over to the nurse in charge for return to the family or responsible party. The nursing staff routinely checks self-administered medications and removes expired, discontinued, or recalled medications.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated [DATE], the P&P indicated, Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide a written bed hold notification to one of 34 sampled residents (Resident 142) and/or his representative upon Resident 142's transfer to an acute care hospital on 1/21/2026. This failure resulted in Resident 142 and/or his representative not informed of his rights to return to the facility following his hospitalization. Findings: During a review of Resident 142's admission Record (demographics), the admission record indicated Resident 142 was admitted to the facility with a diagnosis of congestive heart failure. During a review of Resident 142's Progress Notes, dated 1/21/2026 at 3:59 p.m., the progress notes indicated Resident 142 was having shortness of breath with his respiratory rate of 21-22 (high), oxygen saturation (the amount of oxygen you have circulating in your body) of 83 percent (low) and edema (swelling). Further review of the progress notes indicated Resident 142 was send out to the hospital on 1/21/2026. During a review of Resident 142's Transfer Orders, dated 1/21/2026, the transfer orders indicated Resident 142 was transfer to the emergency department. Further review of Resident 142's clinical record indicated there was no documented evidence of a bed hold notification provided to Resident 142 and/or his representative at the time of transfer. During an interview on 4/22/2026 at 2:56 p.m., with the Business Office Manager (BOM), the BOM stated there was no documented evidence of a written Bed Reservation Notification or any documentation of informing Resident 142 and/or his representative of the bed-hold upon Resident 142's transfer to the hospital on 1/21/2026. During a review of the facility's policy and procedure (P&P) titled, Bed-Holds and Returns, dated October 2022, the P&P indicated, 1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).

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	056392	A. Building B. Wing	04/24/2026

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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. Based on interview and record review, the facility failed to update the nursing care plan (an individualized plan that provides direction for a resident's medical care) for one of 34 sampled residents (Resident 95). This failure had the potential to affect the provision of care for Resident 95.Findings: During a review of Resident 95's admission Record (demographics), dated 4/21/2026, the admission record indicated Resident 95 had a diagnosis of Type 2 Diabetes Mellitus (when the body cannot properly use or produce enough insulin, leading to high blood sugar). During a review of Resident 95's Physician's Orders, dated 4/19/2026, the physician's orders indicated Resident 95 was on a soft and bite sized texture diet (tender, moist foods that require chewing but do not require biting-off). During an interview on 4/20/2026 at 4:04 p.m., with Resident 95, Resident 95 stated he was on a regular diet (normal, everyday foods of various texture). Resident 95 showed his teeth and stated he only had two bottom teeth. Resident 95 stated he cannot chew well and needed his food to be cut up. During a concurrent interview and record review on 4/22/2026 at 8:51 a.m., with the Case Manager (CM 1), Resident 95's At Risk for Altered Nutritional Status-Care Plan, last revised 4/10/2026 was reviewed. The care plan indicated Resident 95 had a regular texture diet. CM 1 stated Resident 95's altered nutritional care plan was not updated according to Resident 95's current physician's diet order. CM 1 stated the care plan should match the current diet order to avoid confusion. During an interview on 4/22/2026 at 9:14 a.m., with the Director of Nursing (DON), the DON stated the expectation was for the care plan to be updated to reflect the residents' current orders. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, 11. Assessments of residents are ongoing and care plans are revised as information about the residents' and the residents' conditions change.

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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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	056392	A. Building B. Wing	04/24/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is taken. 2. During a review of Resident 135's Face Sheet (demographics), the face sheet indicated Resident 135 was admitted to the facility with a diagnosis that included spondylosis (wear and tear on the joints and disks of the spine that cause pain and stiffness) without myelopathy (impaired spinal cord function) or radiculopathy (compression, irritation, or injury of spinal nerve root), lumbosacral (lower back and tailbone) region; and unspecified dementia (progressive decline in cognitive function), unspecified severity. During a concurrent observation and interview on 4/20/2026 at 3:56 p.m. with Resident 135, in Resident 135's room, Resident 135 was observed sitting in his wheelchair with a blanket over his lap. Resident 135 complained of low back pain and stated he does not get pain medications. Resident 135's son was also in Resident 135's room and stated his dad had frequent back pain and was not sure his father had received pain medication. During a review of Resident 135's admission MDS (Minimum Data Set - an assessment tool), dated 4/6/2026, the admission MDS indicated Resident 135's BIMS (Brief Interview for Mental Status) was a 4, (on a scale of 00-15; 04 indicated severe cognitive impairment). Further review of the admission MDS indicated Section J - Health Conditions, that Resident 135 did not have any pain in the last five days but did receive PRN pain medication. Further review of the admission MDS indicated that Resident 135 did not have a scheduled pain medication regimen. During an interview on 4/22/2026 at 10:12 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated that Resident 135 had complained of lower back pain and confirmed that Resident 135 had a PRN medication of Tylenol (brand name for acetaminophen) ordered. LVN 1 stated she would administer pain medication to Resident 135 when needed. LVN 1 stated that Resident 135 received PRN Tylenol during the NOC (overnight) shift around 3:00 a.m. and that she gave him another dose of PRN Tylenol in the morning. LVN 1 stated if the PRN Tylenol was not effective, or if Resident 135 had moderate to severe pain, she would notify the doctor because Resident 135 did not have pain medications ordered for pain higher than a 4. During a review of Resident 135's Physician Orders, dated 3/30/2026 at 6:40 p.m. the physician orders indicated, an order for Acetaminophen Tablet 325 MG (milligram – unit of measurement), give 2 tablets by mouth every 6 hours as needed for Mild Pain (1-4). NTE (not to exceed) 3 GM (gram – unit of measurement) in 24HRS. Further review of the physician orders indicated no other pain medication was ordered for pain level higher than a 4. During a concurrent interview and record review on 4/22/2026 at 11:09 a.m. with LVN 1, Resident 135's Medication Administration Record (MAR), dated April 2026 was reviewed. The MAR indicated that on 4/21/2026 at 11:19 a.m., LVN 1 administered PRN acetaminophen to Resident 135 for pain rated at a 6. LVN 1 confirmed that yesterday 4/21/2026 Resident 135 had a pain level of a 6 and she still administered Tylenol. LVN 1 stated she did not notify the medical doctor that Resident 135's pain level was higher than 4. During a concurrent interview and record review on 4/22/2026 at 11:22 a.m. with the Director of Nursing (DON), Resident 135's MAR, dated April 2026, was reviewed. DON confirmed that Resident 135 had five occurrences in April 2026 where his pain was higher than a 4 and received acetaminophen. DON stated her expectations were that staff should have notified the physician to clarify the order and to have Resident 135 re-evaluated for pain management prior to administering (continued on next page)

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	056392	A. Building B. Wing	04/24/2026

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Pleasanton Nursing and Rehabilitation Center	300 Neal Street Pleasanton, CA 94566

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acetaminophen. DON confirmed that administering acetaminophen for pain higher than a 4 could have led to ineffective pain management. During a review of Resident 135's Alteration in Musculoskeletal Status-Care Plan, r/t (related to) Lumbosacral Spondylosis w/o (without) myelopathy, dated 3/31/2026, indicated that Resident 135 would remain free from pain or at a level of discomfort acceptable to the resident. Interventions included: Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated April 2025, the P&P indicated, The medication regimen is implemented as ordered . Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.

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	056392	A. Building B. Wing	04/24/2026

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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. Based on observation, interview, and record review, the facility failed to ensure: 1. A set of keys for a treatment cart (a cart with wound care medications and supplies), were left unattended, unsecured and not kept with the licensed nurses. This failure had the potential for unauthorized staff to have access to the treatment cart. 2. Self-administration medications, such as Vitamin D (essential nutrients that work together) were not stored in a locked compartment for one of 34 sample residents (Resident 44). In addition the following additional medications for Resident 44, Biotin (nutrient the body needs in small amounts), Vitamin K (essential nutrients that work together), Vitamin E (nutrient the body needs in small amounts), and Magnesium Glycinate (dietary supplement), were stored in an open shelf in Resident 44's shared room. This failure had the potential to result in unauthorized access to medication, inappropriate medication use, medication error, or accidental ingestion for the vulnerable resident population.Findings: 1.During a concurrent observation and interview on 4/23/2026 at 9:18 a.m., with Licensed Vocational Nurse (LVN 3), in Nursing Station 1, LVN 3 retrieved a set of keys from a black binder on top of the counter where the set of keys were left unattended and unsecured. LVN 3 stated the keys were for a treatment cart. During a concurrent observation and interview on 4/23/2026 at 9:21 a.m., with LVN 3, LVN 3 was standing in front of an open treatment cart. LVN 3 stated the set of keys that were retrieved from the black binder in Nursing Station 1 was for the treatment cart in front of her. The treatment cart had ointments, creams, and wound care supplies. During an interview on 4/23/2026 at 10:48 a.m., with the Director of Nursing (DON), the DON stated the expectation was for the treatment cart keys to be held by the nurses at all times. 2. During a review of Resident 44's Face Sheet (demographics), the face sheet indicated Resident 44 was admitted to the facility with a diagnosis of muscular dystrophy (progressive muscle weakness and loss of muscle mass over time). During a concurrent observation and interview on 4/21/2026 at 9:39 a.m., with Resident 44 in her shared room, the following medication bottles of Biotin, Vitamin K2 and D3, Vitamin E, and Magnesium Glycinate, were observed unsecured in an open shelf next to Resident 44's bedside. Resident 44 stated she took the medication supplements every day and those were stored on her shelf. During an interview on 4/23/2026 at 9:09 a.m., with Licensed Vocational Nurse (LVN 5), LVN 5 confirmed that Resident 44 had medications stored at her bedside that were not locked or secured. LVN 5 stated Resident 44 did not need to lock or secure her medications because they were over the counter medications and they were safe on Resident 44's open shelf at her bedside. During an interview on 4/23/2026 at 2:08 p.m., with the Director of Nursing (DON), the DON stated all medications should be stored in a locked box that can be accessed by the self-administering resident. The DON stated when medications are not secured and locked, an unauthorized person could access them. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, (continued on next page)

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	056392	A. Building B. Wing	04/24/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated February 2021, the P&P indicated, Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control practices for two of 34 sampled residents (Resident 150 and Resident 8) when:1. A Maintenance Assistant (MA 1) and a Certified Nursing Assistant (CNA 1) did not wear personal protective equipment (PPE, specialized clothing or equipment worn by individuals to minimize exposure to hazards that cause serious workplace injuries or illnesses), in Resident 150's room, who was on contact precautions (series of procedures designed to minimize the transmission of infectious organisms by direct or indirect contact with an infected person or his/her surrounding environment).2. A Licensed Vocational Nurse (LVN 5) did not wear appropriate personal protective equipment (PPE, specialized clothing or equipment worn by individuals to minimize exposure to hazards that cause serious workplace injuries or illnesses), while administering medications through Resident 8's gastric tube (G-Tube, tube inserted through the belly to bring nutrition directly to the stomach). Resident 8 was on Enhanced Barrier Precautions (EBP, infection control interventions designed to reduce the spread of multidrug-resistant organisms, MRDO-a germ that is resistant to many antibiotics).These failures had the potential to result in the spread of infectious diseases among residents, staff, and visitors.Findings: 1. During a review of Resident 150's admission Record (demographics), dated 4/21/2026, the admission record indicated Resident 150 had a diagnosis of displaced intertrochanteric fracture (hip fracture) of the left femur. During a review of Resident 150's Physician's Order, dated 4/20/2026 at 4:14 p.m., the physician's order indicated Resident 150 was on contact precautions related to pending test results for C. Diff. During a review of Resident 150's Laboratory results for C. diff toxin, dated 4/21/2026, the laboratory results indicated Resident 150 was positive for C. diff. During an observation on 4/20/2026 at 7:08 p.m., a Contact Precautions sign was observed hanging next to Resident 150's room door. The Contact Precautions sign indicated, Stop. Contact Precautions. Special Enteric (relating to or affecting the intestine). Visitors and Personnel: Must speak to nurse before entering. Perform hand hygiene before entering room and wash hands with soap and water before leaving room. Put on gown before entering room. Remove gown before exiting room. Put on gloves before room entry. Discard gloves before exiting the room. Resident 150 was in his room lying in bed. MA 1 was in the room, holding a remote control in front of the television and had gloves and a face mask, but no gown. During an interview on 4/20/2026 at 7:11 p.m., with MA 1 and Licensed Vocational Nurse (LVN 2), MA 1 stated he was trying to fix Resident 150's television. MA 1 stated he should have worn a gown while inside the room. LVN 2 stated Resident 150 was on contact precaution to rule out C. diff (Clostridioides difficile, a bacteria causing severe diarrhea and colitis, primarily affecting people on antibiotics in healthcare settings). During a concurrent observation and interview on 4/21/2026 at 9:03 a.m. with CNA1, in front of Resident 150's room, CNA 1 walked inside Resident 150's room without a gown and gloves. CNA 1 talked to Resident 150 and moved around the items on Resident 150's meal tray. CNA 1 then hand sanitized her hands before leaving Resident 150's room. CNA 1 stated she gave Resident 150 ice chips. CNA 1 looked at the Contact Precautions signage next to Resident 150's room door. CNA 1 stated Resident 150 was on Contact Precautions for C. diff. and was told to only wear PPE when (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056392	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton Nursing and Rehabilitation Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing direct care such as changing Resident 150's incontinent brief. CNA 1 further stated she can either sanitize her hands or wash her hands with soap and water before leaving the room of a resident with C. diff. During an interview on 4/21/2026 at 12:08 p.m., with the Infection Control Preventionist (ICP), the ICP stated MA 1 and CNA 1 should have worn the appropriate PPE including a gown before entering Resident 150's room as indicated on the Contact Precautions signage. ICP further stated staff should wash their hands with soap and water before leaving a room that was on Contact Precautions for C. diff. During a review of the facility's policy and procedure (P&P) titled, Clostridioides (Clostridium) Difficile, dated December 2024, the P&P indicated, 6. Steps toward prevention and early intervention include: . e. frequent hand washing with soap and water by staff and residents; f. wearing gloves and a gown when caring for residents with potential infectious diarrhea or when handling feces or articles contaminated with feces. 11. Residents with diarrhea and suspected CDI (Clostridioides difficile Infection) are placed on contact precautions while awaiting laboratory results . 12. When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR (alcohol based hand rub) for the mechanical removal of C. difficile spores from hands. 2.During a review of Resident 8's Face Sheet (demographics), the face sheet indicated Resident 8 was admitted to the facility with a diagnosis of esophageal obstruction (blockage in the tube connecting the mouth to the stomach). During a review of Resident 8's, Physician Orders, dated 3/25/2025, the physician orders indicated, an order for Enhanced Barrier Precautions (EBP) for high contact resident care activities r/t [related to] enteral feeding. Further review of the physician orders indicated, to perform hand hygiene and apply personal protective equipment (PPE) gloves, gown and/or goggle/face shield.every shift for prevent transmission of multidrug-resistant organisms (MRDO-a germ that is resistant to many antibiotics). During an observation on 4/22/2026 at 10:15 a.m. in Resident 8's room, there was an EBP signage posted on the doorway of Resident 8's shared room that indicated Resident 8 was on EBP. The EBP signage instructed Enhanced Barrier Precautions (EBP).: [NAME] (put on) gown and glove. Licensed Vocational Nurse (LVN 5) entered Resident 8's room with 2 cups of water and Resident 8's morning medications. LVN 5 donned gloves, no gown and accessed Resident 8's G-Tube to administer medications. During Resident 8's medication administration, LVN 5's clothes came into contact with Resident 8's bed and bedside table. LVN 5 finished Resident 8's medication administration on 4/22/2026 at 10:33 a.m. (total of 18 minutes in Resident 8's room). During an interview on 4/22/2026 at 10:42 a.m. with LVN 5, LVN 5 confirmed that she did not wear a gown during Resident 8's G-Tube medication administration. LVN 5 stated that she was not required to wear a gown for medication administration in an EBP room. During an interview on 4/23/2026 at 10:14 a.m. with the Infection Control Preventionist (ICP), the ICP stated that gowns should be worn when medications are administered through a G-Tube. The ICP further stated that if a gown was not worn when a resident's G-Tube was used, it was a risk for transmitting MDROs to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056392	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton Nursing and Rehabilitation Center	300 Neal Street Pleasanton, CA 94566

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated December 2024, the P&P indicated, Enhanced Barrier Precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities.Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include:.device care or use (central line, urinary catheter, feeding tube.etc.) During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated July 2020, the P&P indicated, Staff shall follow established facility infection control procedures for the administration of medications, as applicable.