STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675428	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton South Nursing and Rehabilitation	905 West Oaklawn Rd Pleasanton, TX 78064

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status for one (Resident #6) of six residents reviewed for notification of changes. The facility failed to notify Resident #6's family when she expired (died) on [DATE]. This failure could place residents at risk of their family/RP not being aware of the residents' condition. The findings included: Record review of Resident #6's face sheet, dated [DATE], revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including: malignant neoplasm of the brain (cancerous tumor of the brain), epilepsy (seizures), and altered mental status. The face sheet indicated Resident #6 was discharged on [DATE] (location not documented). Record review of Resident #6's death MDS assessment, dated [DATE], revealed she was discharged due to death in the facility. Record review of Resident #6's care plan, dated [DATE], revealed the resident was on hospice care with interventions to encourage visitors and notify hospice at time of death. Record review of Resident #6's progress notes, dated [DATE] at 9:41 p.m. documented by LVN A, revealed, .while making rounds resident noted without respirations, hospice notified .hospice nurse stated not to call family until they got there. There were no further entries on the progress notes. Record review of Resident #6's hospice visit note, dated [DATE], revealed the hospice company confirmed time of death on [DATE] at 11:20 p.m. The note revealed the local police were notified, the local funeral home was notified and the residents family member was notified (unknown time) with note: unable to determine if patients {family member} is grieving appropriately. During an attempted interview on [DATE] at 4:18 p.m., Resident #6's family member declined to be interviewed and ended the call. During an interview on [DATE] at 4:32 p. m., LVN A stated when Resident #6 expired he did not notify the family of her death. He stated when a resident passes away the first thing he would do was notify the family. He stated he wanted to notify the family. He stated his normal procedure was to notify family, call hospice, call the police, and call the DON. LVN A stated when he notified the hospice RN, she told him not to notify the family. He stated he could not remember the hospice RN's name or who exactly it was that told him. He stated he just remembered hospice said they would take care of everything (after death details). He stated that was the first time that had happened (where he was asked not to make notifications). LVN A stated he told someone in the facility management that hospice said not to notify Resident #6's family but he could not remember who and he could not remember how they responded. LVN A stated he did not follow up with the hospice company to ensure the resident's family was notified. He stated family was not present at the time of Resident #6's death. During an interview on [DATE] at 5:15 p.m., the DON stated Resident #6 was a super sweet lady whose family member was having a hard time with her death. She stated the family member was upset Resident #6 was dying. She stated she assumed hospice did not want the facility to notify Resident #6's family member because he would get loud. The DON stated on a normal death, they should notify family, hospice, physician and facility management. She stated each hospice company was different and had their own preferences. The DON stated she was not sure what the facility policy was for family notification upon death when hospice was involved. The DON stated accurate documentation and notification were important because they wanted to make sure the family had a good death experience. She stated the facility did not have many deaths and did not have much practice. During an interview on [DATE] at 12:03 p.m., a hospice representative stated he attended to Resident #6 as an RN but was not present on the date of her death. He stated hospice coordinated care with the nursing facility. He stated the facility nurse would contact hospice at the time of death. He stated the hospice company would then offer to send a nurse to assist with the death details. He stated the hospice company would never tell a facility not to notify next of kin. He stated he considered it callous not to notify family immediately. The hospice representative stated he was aware of some dynamics between the family and the facility but was not aware of any directives from hospice not to notify next of kin. Record review of the facilities policy titled Notification of Changes, last revised [DATE], revealed: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification included: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. clinical complications 4. a transfer or discharge of the resident from the facility. Record review of the facility's

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 2 of 6 residents (Resident's #5 and #6) reviewed for clinical records. The facility failed to document Resident #6's and Resident #5's death, pronouncement of death, and details of notifications. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: Record review of Resident #6's face sheet, dated [DATE], revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including malignant neoplasm of the brain (cancerous tumor of the brain), epilepsy (seizures), and altered mental status. The face sheet indicated Resident #6 was discharged on [DATE] (location not documented). Record review of Resident #6's death MDS assessment, dated [DATE], revealed she was discharged due to death in the facility. Record review of Resident #6's care plan, dated [DATE] revealed the resident was on hospice care with interventions to encourage visitors and notify hospice at time of death. Record review of Resident #6's progress notes, dated [DATE] at 9:41 p.m. documented by LVN A, revealed, .while making rounds resident noted without respirations, hospice notified .hospice nurse stated not to call family until they got there. There were no further entries on the progress notes. Record review of Resident #6's medical record revealed the physician discharge summary, notes/documentation on pronouncement of death, notification of local law enforcement for death, and disposition of the body were not documented in the medical record. During an interview on [DATE] at 4:32 p.m., LVN A stated he was trained and would normally document notifications including notification of the police of a death in the facility, pronouncement of death and disposition of the body but he did not because the hospice company stated they would take care of everything. He stated this was the first time this had happened because normally he could document these things. 2. Record review of Resident #5's face sheet, dated [DATE], revealed a [AGE] year-old male admitted on [DATE] with diagnoses including senile degeneration of brain, chronic respiratory failure and anxiety disorder. The face sheet indicated the resident was discharged on [DATE] to a local funeral home. Record review of Resident #5's discharge MDS assessment, dated [DATE], revealed the resident died in the facility. Record review of Resident #5's progress notes, dated [DATE], revealed RN documented Resident #5 was moved into a private room for a continued decline and that family was at bedside. The next entry was [DATE] when RN B documented the DME company picked up Resident #5's equipment and supplies. Record review of Resident #5's medical record revealed there was no documentation of the resident's death, pronouncement of death, notification of required entities, or disposition of the body. During an interview on [DATE] at 4:45 p.m., RN B stated she documented Resident #5's move to a private room because she was declining on hospice. She stated this occurred on a Friday. She stated the family was with the resident when she left and the resident was still alive. RN B stated when she returned the following Monday, she learned the resident died. During an interview on [DATE] at 4:58 p.m., RN C stated on an unknown date right after change of shift, Resident #5 passed away. She stated a CNA (unknown) told her the resident passed. RN C stated the resident was on hospice and had a DNR order. She stated she went to the room and listened for heart and breath sounds and verified the resident had expired. RN C stated she was the RN on duty, so she pronounced the death. RN C stated she then called the DON, the family, hospice, and the funeral home once the family decided. She stated the police came to the facility and she received a case number. She stated the family came and spent a long time with the resident. RN C stated she could not believe she failed to document the events. She stated she did not know what happened. She stated she did not save the note. She stated she messed up. RN C stated she should have documented it directly into the progress notes. She stated she was aware the facility policy required documentation of events of the death. She stated it was important to document, so the resident's medical records were accurate. During an interview on [DATE] at 5:15 p.m., the DON stated staff were expected to document family, hospice and other notifications. She stated the staff should clean and make the resident presentable so the family could spend time with them. She stated the staff should document the decline and the expiration. They should document vital signs that were assessed, and if appropriate, contact hospice or palliate care or the physician. She stated they should document how they find the resident, notification of local police, whether the JP responded and pronouncement of death. The DON stated this documentation was important because it painted the picture