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	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton South Nursing and Rehabilitation	905 Oaklawn 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 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** 42031 Based on observation, interview, and record review the facility failed to provide routine drugs and biologicals to its residents or obtain them under an agreement and failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 7 residents (Residents #44, #51, and #52) reviewed for pharmacy services. 1. Resident #44 was administered her ordered supplement and shared it with Resident #52 while the nurse was not present. 2. Resident #51 did not receive her ordered doses of Velphoro (A medication used for people receiving dialysis to bind phosphates in the blood for excretion to prevent excess build up, the chewable tablets are 500mg) from 8/26/24 to 8/30/24, 9/3/24, and 9/4/24. These failures could put residents at risk of not receiving the therapeutic effects of their ordered medications and supplements, adverse reactions, exacerbation of illness, and a general decline in health. The findings were: 1. Record review of Resident #44's face sheet dated 9/6/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, moderate with other behavioral disturbance (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anemia unspecified (condition of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues.), and unspecified protein-calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food). Record review of Resident #44's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 2 indicating the resident had severe cognitive impairment. The resident had unclear speech and was able to be understood only sometimes and was only sometimes able to understand. The resident only required set-up or clean up assistance with eating and had malnutrition but no significant weight gain or loss. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's care plan undated revealed a focus initiated on 2/2/21 and revised on 1/19/24 for nutritional problem and included shake supplements with lunch and dinner interventions were to administer medications as ordered and to observe and document effectiveness and to observe diet and intake and to record the amount consumed. Record review of Resident #52's face sheet dated 9/6/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, and cognitive communication deficit. Record review of Resident #52's Physician orders revealed no order for 2cal supplement. During an observation and interview on 9/3/24 at 12:50 p.m. Resident #44 was seated at a table in the dining room and had a clear plastic cup with measurements on it with a thicker brown liquid (appeared to be a shake supplement. unable to read the measurement but was approximately 100ml). The resident took two sips from the cup and set it on the table and slid it across the table towards a resident sitting directly across from her. Resident #52 picked up the cup, took a drink and set it down, picked it back up and took another drink then set it back on the table and slid it back towards Resident #44. Resident #44 took another drink and slid it back towards the other resident who took another drink and slid it back towards Resident #44 who then finished it. The nurse was not present with Resident #44. LVN A did arrive and witnessed the residents sharing the supplement and stated it was Resident #44's ordered supplement and she had given it Resident #44. Record review of Resident #44's physician orders revealed an order with a start date of 2/26/24 for 2 cal supplement (high calorie-480 calories per 8 ounces and high protein- 20grams per 8 ounces of supplement) 90ml three times daily. Record review of Resident #44's EMAR for September 2024 revealed 2 cal supplement was administered to the resident by LVN A for both the 9 a.m. and 1 p.m. doses on 9/2/24 and 9/3/24. Record review of Resident #44's EHR revealed no significant weight loss or ill effects from not drinking all her supplement. Record review of the Resident #52's EHR revealed no allergies to the supplement, no significant weight losses or gains, and no ill effects from the sharing of the supplement. In an interview on 9/3/24 at 1:15 p.m. LVN A stated possible consequences of the residents sharing the supplement was a possible infection control issue. LVN A stated she was familiar with both residents and there were no allergies or ill side effects from the sharing. LVN A further stated she usually stays and watches Resident #44 drink her supplement and further stated Resident #44 does not usually sit at a table with other residents. In an interview on 9/6/24 at 10:40 a.m. LVN A stated she had never witnessed Resident #44 share her supplement or attempt to and Resident #52 did not usually sit at that table and Resident #44 usually finished all her supplement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #51's face sheet dated, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with readmissions on 12/16/23 and latest readmission on 7/11/24. Her diagnoses included End Stage Renal Disease (ESRD- medical condition in which the kidneys cease functioning on a permanent basis leading to the need for long-term dialysis or a kidney transplant to maintain life), and dependence on renal dialysis (treatment for people whose kidneys are failing to remove waste products and excess fluid from the blood). Record review of Resident #51's admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 8 indicating the resident had moderate cognitive impairment. The resident had clear speech and was usually understood by others and usually understood others. The resident had ESRD and was dependent on renal dialysis. Record review of Resident #51's undated care plan revealed a focus for alteration in kidney function, ESRD, dialysis initiated on 12/17/23 and revised on 8/28/24 with interventions that included resident was on a renal diet and 1 liter fluid restriction, as ordered by Physician and to encourage patient to follow nutritional and hydration program. interventions. Record review of Resident #51's physician orders revealed an order with a start date of 8/26/24 for velphoro chewable tablet. Give 1 tablet by mouth before meals related to ESRD. Record review of Resident #51's EMAR for August 2024 revealed velphoro chewable tablet to be given before meals at 6:30 a.m., 11:30 a.m., and 4:30 p.m. was documented as not administered on 8/26/24 at 4:30 p.m., and on 8/27/24, 8/28/24, 8/29/24and 8/30/24 for all three doses on those days. Further review revealed it was documented as given to the resident for all three doses on 8/31/24. Record review of Resident #51's EMAR for September 2024 revealed velphoro chewable tablet to be given before meals at 6:30 a.m., 11:30 a.m., and 4:30 p.m. was documented as not administered on 9/3/24 at 4:30 p.m. and not administered on 9/4/24 at 6:30 a.m. Further review revealed it was documented as on hold from 9/4/24 at 11:30 a.m. to 9/7/24 at 6:30 a.m. Record review of Resident #51's progress notes revealed EMAR linked notes for velphoro were dated 8/26/24 at 7:54 p.m. the velphoro was pending delivery. On 8/27/24 at 9:00 a.m. medication on order, 8/27/24 12:43 p.m. pending arrival from pharmacy, 8/27/24 4:08 p.m. pending arrival from pharmacy. On 8/28/24 at 7:36 a.m. medication on order, pending arrival, charge nurse will call today on medication, 8/28/24 at 7:53 p.m. medication pending arrival, 8/29/24 at 8:35 a.m. and 12:14 p.m. medication n/a (not applicable) at this time, pending approval through pharmacy, DON, and charge nurse aware. On 8/30/24 at 10:00 a.m., 4:06 p.m., and 6:08 p.m. medication pending arrival from pharmacy. On 9/3/24 at 3:33 p.m. reordered medication, pending arrival from pharmacy. On 9/4/at 6:53 a.m. medication on order, pending arrival, charge nurse aware. Record review of Resident #51's physician orders revealed an order with a start date of 9/4/24 to hold velphoro. Record review of Resident #51's EHR revealed no abnormal lab work or other effects from not receiving her Velphoro phosphorous binder. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/6/24 at 10:40 a.m. LVN A stated Resident #51's velphoro was waiting on insurance approval through the pharmacy and when it was delivered, only 9 tablets were delivered and waiting on insurance approval again. But the pharmacy had delivered again. LVN A stated the physician had been contacted and the dialysis center and physician as well. LVN A stated there had been no ill effects of the resident not receiving doses of the ordered medication. In an interview on 9/6/24 at 10:45 a.m. the DON stated she was aware of Resident #51's velphoro not being available .The DON stated Resident #51's primary care physician had ordered Velphoro but a delay occurred because she was waiting on the resident's renal dialysis physician's approval to use the medication. Then there was an issue with the resident's insurance, but the facility did receive a partial order from the pharmacy . The DON stated a different phosphate binder had been approved through the insurance and pharmacy, but they were waiting on the approval of the resident's renal physician along with the proper dosage for the medication as the dosages were not interchangeable. The DON stated the resident was being monitored and the dialysis center was also aware, and the facility had received another partial order and the resident would be getting that until they received new orders. Review of the facility policy on administering medications revised April 2019 indicated . 4. Medications are administered in accordance with prescriber orders .26. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the Director of Nursing Services. Review of the facility policy on pharmacy services revised April 2019 indicated . The provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional standards of practice, and laws and regulations, including but not limited to . a help the facility identify needed supplies and services related to medications; c. Help the facility comply with its legal and regulatory requirements related to medications and medication management . h. Establish a reliable way to notify the facility in a timely fashion of issues and concerns related to medications and prescriptions; Review of the National Library of Medicine website accessed 9/10/24 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10695651/#:~:text=Most%20patients%20receiving%20dialysis%20rely,is%20associated%20with%20increased%20mortality published online October 23, 2023, revealed . Most patients receiving dialysis rely on dietary restriction and phosphate binders to minimize the risk of hyperphosphatemia (high phosphorous blood level), which is associated with increased mortality. However, dietary restriction is difficult because of hidden phosphate additives in processed foods and medications.

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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** 42031 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 5 residents (Resident #25) reviewed for pharmacy services. Resident #25's tube feeding bag was not labeled with the correct date, did not have the resident's name, time hung, or date and time to be taken down. This failure could put residents at risk of not receiving the correct tube feeding and could result in decreased continuity of care, and a general decline in health. The findings were: Record review of Resident #25's face sheet dated, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with hospice care. Her diagnoses included other cerebral infarction (also known as a stroke-refers to damage to tissues in the brain due to a loss of oxygen to the area, adult failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments. Manifestations of this condition include weight loss, decreased appetite, poor nutrition, and inactivity), moderate protein calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), and cachexia (weakness and wasting of the body due to severe chronic illness). Record review of Resident #25's admission MDS dated [DATE] revealed the resident the resident was unable to complete the BIMS and her cognitive skills were severely impaired. The resident was unable to respond and was dependent on staff for all turning and positioning, and the resident had a gastrostomy feeding tube. Record review of Resident #25's undated care plan revealed a focus initiated on 7/29/24 and revised on 8/14/24 for alteration in diet for gastrostomy feedings. Interventions included to give diet as ordered of Jevity 1.5 cal at 40ml/hour for 22 hours with 120ml flushes every 4 hours. Record review of Resident #25's physician orders revealed an order with a start date of 8/5/24 for Jevity 1.5 cal at 40ml/hour x 22 hours with 120ml flushes every 4 hours. During an observation on 9/3/24 at 11:30 a.m. Resident #25's the tube feeding was running via a pump at 40ml/hr, the feeding bag was clear and had blue ball point pen writing on it 9/8/23 Jevity 1.5 and the room # next to the room number on the feeding bag was a possible cursive capital G but unable to read. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's EMAR for September 2024 revealed the Jevity feeding was hung as ordered on 9/3/24 at 6:00 a.m. In an observation and interview on 9/3/24 at 11:40am, the ADON stated the bags were not labeled correctly and it should be dated for 9/3/24 not 9/8/23 and she would be correcting it as soon as possible. The ADON was unsure of how the bags were not labeled correctly and stated they should have the correct date, resident, formula, and rate it was to be administered. The ADON returned with new bags with proper labels with the correct date and information. Review of the facility policy on enteral feedings revised November 2018 indicated . h. Check the enteral nutrition label against the order before administration. Check the following information: resident name, ID and room number; type of formula; date and time formula was prepared; route of delivery; access site; method (pump, gravity, syringe); and rate of administration(ml/hr). 2. On the formula label document initials, date, and time the formula was hung.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 46677 Based on interview and record review the facility failed to provide a minimum of 80 square feet per resident in 43 of 43 resident rooms (A2 through A8, A10, B3 through B11, C2 through C5, C7, C9, C10, D2 through D7, E2 through E4, E6 through E8, and F1 through F8) reviewed for minimum for square footage per resident, in that: Resident rooms A2 through A8, A10, B3 through B11, C2 through C5, C7, C9, C10, D2 through D7, E3 through E6 through E8, and F1 through F8 did not have a minimum of 80 square feet per resident. This deficient practice could affect residents residing in rooms due to the reduced living space for the residents and could pose problems in the residents' activities of daily living. The findings were: Record review of previous room waiver, dated 09/06/2024,revealed the following: Resident rooms A2, A3, A5 through A8, and A10 measured 13 feet 7 inches by 11 feet 5 inches which provided 157.55 square feet of floor space. Dividing the 157.55 square feet of usable floor space by 2 resulted in 78.77 square feet of floor space per resident in these rooms. Room A4 measured 13 feet 6 inches by 11 feet 7 inches which provided 159.12 square feet of usable floor space. Dividing the 159.12 square feet of usable floor space by 2 resulted in 79.56 square feet of floor space per resident in this room. Room B3 measured 13 feet 6 inches by 11 feet 10 inches which provided 150.96 square feet of floor space. Dividing the 150.96 square feet of usable floor space by 2 resulted in 75.48 square feet of floor space per resident in this room. Rooms B4 through B6, B8 through B11, C7, C9, D4, E4, E7 and E8 measured 13 feet 6 inches by 11 feet 5 inches which provided 156.4 square feet of floor space. Dividing the 156.4 square feet of usable floor space by 2 resulted in 78.2 square feet of floor space per resident in these rooms. Room B7, C4, D3, and F7 measured 13 feet 6 inches by 11 feet 6 inches which provided 157.76 square feet of floor space. Dividing the 157.76 square feet of usable floor space by 2 resulted in 78.88 square feet of floor space per resident in these rooms. Room C2, C3, and C5 measured 13 feet 5 inches by 11 feet 5 inches which provided 155.25 square feet of floor space. Dividing the 155.25 square feet of usable floor space by 2 resulted in 77.63 square feet of floor space per resident in these rooms. Room C10, E5, F2, F3, F5, F6. and F8 measured 13 feet 7 inches by 11 feet 5 inches which provided 158.92 square feet of floor space. Dividing the 158.92 square feet of usable floor space by 2 resulted in 79.46 square feet of floor space per resident in these rooms. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Room D2, D5 through D7, E3. and E6 measured 13 feet 7 inches by 11 feet 6 inches which provided 157.55 square feet of floor space. Dividing the 157.55 square feet of usable floor space by 2 resulted in 78.77 square feet of floor space per resident in these rooms. Room F4 measured 13 feet 4 inches by 11 feet 4 inches which provided 152.76 square feet of floor space. Dividing the 152.76 square feet of usable floor space by 2 resulted in 76.38 square feet of floor space per resident in this room. An interview with Administrator on 09/06/2024 at 11:02 a.m., revealed Administrator would be requesting a room waiver on the same rooms from last year which did not provide residents with 80 square feet of floor space. Record review of Form 3740, Bed Classifications, provided by the Administrator on 09/03/2024 revealed that all resident rooms were double occupancy.