

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Pleasanton South Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 facility kitchen in that: 1. A 40-ounce package of honey ham was undated. 2. A 32-ounce container of liquid eggs was undated. 3. A clear carafe of yellow liquid was uncovered, unlabeled, and undated. 4. A 6-ounce container of raspberries was undated. 5. An open 16-ounce can of energy drink was on the table where residents' food was prepared. 6. The plate warmer was not plugged-in during lunch service. 7. A 1 pound block of margarine was undated. 8. A tray of approximately 24 cups of liquid was unlabeled and undated. 9. Two 3-quart containers of apple juice were undated. 10. A 5-pound container of sour cream was undated. 11. A tray of approximately 24 cups of milk was unlabeled and undated. 12. A 16-ounce bottle of soda and a plastic bag with two 24-ounces cans of energy drink were located in the refrigerator where food for resident meals was stored. 13. Personal belongings of kitchen staff were hanging on the side of the pantry shelves and touching food items intended for resident meals. 14. The small kitchen sink was stained with brown liquid. 15. A plastic container of food thickener was unlabeled and undated. 16. The dish sanitation machine had a sand-like residue on the top and sides. 17. A 12-ounce container of caramel sauce, labeled refrigerator after opening was open and not refrigerated. 18. The microwave door was soiled on the inside. These deficient practices could place residents who consume meals and snacks from the kitchen at risk for food borne illness. The findings were: Observations on 12/07/2025 between 12:15 p.m. and 12:30 p.m. revealed: 1. A 40-ounce package of honey ham in the three-door refrigerator was undated. 2. A 32-ounce container of liquid eggs in the three-door refrigerator was undated. 3. A clear carafe of yellow liquid in the three-door refrigerator was uncovered, unlabeled, and undated. 4. A 6-ounce container of raspberries in the three-door refrigerator was undated. 5. An open 16-ounce can of energy drink was on the table where residents' food was prepared. 6. The plate warmer was not plugged-in during lunch service. During an interview with Dietary Aide C on 12/07/2025 at 12:32 p.m., Dietary Aide C confirmed the three-door refrigerator contained a 40-ounce package of honey ham, 32-ounce container of liquid eggs, and a 6-ounce container of raspberries which were undated. Dietary Aide C also confirmed that the three-door refrigerator contained a clear carafe of yellow liquid which was uncovered, unlabeled, and undated, an open energy drink was located on the food preparation table, and the plate warmer was unplugged during lunch service. Observations on 12/10/2025 between 6:15 a.m. and 7:00 a.m. revealed: 7. A 1-pound block of margarine in the three-door refrigerator was undated. 8. A tray of approximately 24 cups of liquid in the three-door refrigerator was unlabeled and undated. 9. Two 3-quart containers of apple juice in the three-door refrigerator were undated. 10. A 5-pound container of sour cream in the three-door refrigerator was undated. 11. A tray of approximately 24 cups of milk in the three-door refrigerator was unlabeled and undated. 12. A 16-ounce bottle of soda and a plastic bag with two 24-ounces cans of energy drink were located in the three-door refrigerator where food for residents' meals was stored. 13. Personal belongings of kitchen staff were hanging on the side of the pantry shelves and touching food items intended for resident meals. 14. The small kitchen sink was stained with brown liquid. 15. A plastic container of food thickener was unlabeled and undated. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 6 of 7 residents (Resident #7, Resident #10, Resident #47, Resident #53, Resident #54, and Resident #63) who were reviewed for resident assessments. 1.The facility failed to document Resident #7's use of anticoagulant medication on the quarterly MDS (Minimum Data Set) assessment. 2.The facility failed to document Resident #10's use of scheduled (routine) pain medication on the admission MDS assessment.3.The facility failed to document Resident #47's use of hypoglycemic medication and lack of use of scheduled pain medication on the quarterly MDS assessment.4.The facility failed to document Resident #53's lack of use of PRN (as needed) pain medication on the quarterly MDS assessment. 5.The facility failed to document Resident #54's use of anticoagulant and antiplatelet medication on the quarterly MDS assessment.6.The facility failed to document Resident #63's use of antidepressant medication and lack of use of scheduled and PRN pain medication on the quarterly MDS assessment.This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being.The findings included:1.Record review of Resident #7's admission sheet dated 11/25/2025 with an original admission date of 10/20/2025 documented an [AGE] year-old male resident with diagnoses including chronic respiratory failure, hypertension (high blood pressure), type 2 diabetes mellitus, high cholesterol, and Alzheimer's dementia.Record review of Resident #7's MDS dated [DATE] documented a BIMS score of 3 indicating severe cognitive impairment and recorded the use of diuretics (medications which reduce the amount of fluid buildup in the body) and hypoglycemics (medications which reduce the amount of glucose in the blood). Further review of Resident #7's MDS revealed the assessment did not include the use of anticoagulant (blood thinner) medication, despite the resident receiving Apixaban (an oral anticoagulant medication).Record review of Resident #7's order summary documented an active order for the anticoagulant medication Apixaban with an order date of 11/25/2025.Record review of Resident #7's November 2025 MAR (medication administration record) documented the resident had been receiving Apixaban as prescribed. Further review of the November MAR recorded Apixaban was ordered as Apixaban 2.5mg, give 1 tablet via G-Tube two times a day related to paroxysmal atrial fibrillation (irregular heartbeat).Record review of Resident #7's care plan with an initiation date of 10/29/2025 documented the resident is at risk for complications related to use of anticoagulant medication for Dx A-fib, and the resident will remain without complications from bleeding or injury through next review date. The care plan further documented interventions including apply prolonged pressure to venipuncture sites, and observe for S/S of bleeding i.e. tarry stools, blood in urine, bruising, petechia (tiny spots of bleeding under the skin).2. Record review of Resident #10's admission sheet dated 11/08/2025 documented a [AGE] year-old female resident with diagnoses including type 2 diabetes mellitus, hyperlipidemia (high cholesterol), epilepsy (seizure disorder), hypertension, and down syndrome (a genetic condition where a person is born with an extra chromosome).Record review of Resident #10's MDS dated [DATE] documented a code of 3 under section C1000. Cognitive Skills for Daily Decision Making, with a code of 3 indicating Severely impaired-never/rarely made decisions and recorded the use of antibiotic, opioid, and anticonvulsant medication. Further review of the MDS revealed the assessment did not include the resident's use of scheduled pain medication in the last five days of the assessment, despite the resident receiving pain medication daily during the five day look back period between 11/10/2025 to 11/14/2025.Record review of Resident #10's order summary documented an active order for the analgesic medication Acetaminophen-Codeine with an order date of 11/10/2025.Record review of Resident #10's November 2025 MAR documented the resident had been receiving Acetaminophen-Codeine as prescribed. Further review of the November MAR recorded Acetaminophen-Codeine was ordered as Acetaminophen-Codeine 300-30mg, give 1 tablet by mouth (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every 6 hours for Wound.Record review of Resident #10's care plan with an initiation date of 11/10/2025 documented the resident has a need for pain management and monitoring related to sacral wound, urinary catheter, with a goal of will maintain adequate level of comfort as evidenced by no s/sx of unrelieved pain or distress, or verbalizing satisfaction with level of comfort through next review date. The care plan further documented the interventions including administer pain medication as ordered, evaluate need for routinely scheduled medications rather than PRN pain med administration, and evaluate need to provide medications prior to treatment or therapy.3. Record review of Resident #47's admission sheet dated 4/14/2025 with an original admission date of 11/28/2024 documented an [AGE] year old female resident with diagnoses including dementia, hypertension, acquired absence of right leg below knee, type 2 diabetes mellitus, chronic kidney disease and insomnia. Record review of Resident #47's MDS assessment dated [DATE] documented a BIMS of 14 indicating intact cognition and recorded the use of antibiotic, diuretic, antiplatelet, and anticonvulsant medication. Further review of Resident #47's MDS revealed the assessment documented the resident had received scheduled pain medication in the last 5 days of the assessment date, despite the resident having no order for scheduled pain medication. The resident's MDS did not document the use of hypoglycemic medication, despite the resident receiving Ozempic.Record review of Resident #47's order summary included an active order for the hypoglycemic medication Ozempic with an order date of 4/14/2025. Further review of the order summary did not include an active order for routinely scheduled pain medication.Record review of Resident #47's October 2025 MAR documented the resident had been receiving Ozempic as prescribed and had not been receiving a scheduled pain medication. Ozempic was ordered as Ozempic Subcutaneous Solution Pen-Injector 4mg/3mL, inject 1mg subcutaneously one time a day every Fri related to type 2 diabetes mellitus.Record review of Resident #47's care plan with an initiation date of 11/28/2024 documented the resident has alteration in Blood Glucose due to hyper/hypoglycemia r/t DMT2, CKD3, HX of infection, with a goal of will experience minimal signs and symptoms associated with hyperglycemia/hypoglycemia through next review date. Further review of the care plan documented interventions including administer medications as ordered, and monitor blood glucose levels per MD orders and report abnormal results per Physician parameters/guideline.4. Record review of Resident #53's admission sheet dated 12/08/2020 with an original admission date of 10/28/2018 documented a [AGE] year-old female resident with diagnoses including cerebral infarction (stroke), hypertension, depression, and cognitive impairment.Record review of Resident #53's MDS assessment dated [DATE] documented a BIMS of 10 indicating moderate cognitive impairment and recorded the use of anticoagulant and opioid medications. Further review of Resident #53's MDS documented the use of PRN pain medication during the five day look back period of the assessment, however the resident did not receive any PRN pain medication from 9/07/2025 to 9/11/2025.Record review of Resident #53's order summary included an active order for the analgesic Acetaminophen with an order date of 8/30/2023 and an active order for the analgesic Acetaminophen-Codeine with an order date of 9/21/2021. Record review of Resident #53's September MAR documented the resident was receiving Acetaminophen and Acetaminophen-Codeine as prescribed. Acetaminophen was ordered as Acetaminophen 325mg, give 650mg by mouth every 4 hours as needed for Moderate Pain. Acetaminophen-Codeine was ordered as Acetaminophen-Codeine 300-30mg, give 1 tablet by mouth every 6 hours as needed for Pain-Moderate. Further review of the September MAR revealed no doses of PRN Acetaminophen or PRN Acetaminophen-Codeine were administered or refused from 9/07/2025 to 9/11/2025.Record review of Resident #53's care plan with an initiation date of 1/11/2021 documented the resident has osteoporosis increasing her risk for spontaneous fractures, with interventions including give analgesics PRN for pain, resident may complain of pain, stiffness or weakness, and give medications as ordered, observe/document for side effects and effectiveness.5. Record review of Resident #54's admission sheet dated 3/05/2025 documented a [AGE] year-old male resident with diagnoses including cerebral infarction, diabetes, hyperlipidemia (high cholesterol), (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety, and hypertension. Record review of Resident #54's MDS assessment dated [DATE] documented a BIMS of 11 indicating moderate cognitive impairment and recorded the use of hypoglycemic medication. Further review of the assessment revealed the document did not record the use of anticoagulant or antiplatelet medication. Record review of Resident #54's order summary included an active order for the anticoagulant Xarelto with an order date of 3/05/2025 and an active order for the antiplatelet Clopidogrel with an order date of 3/05/2025. Record review of Resident #54's September 2025 MAR documented the resident was receiving Clopidogrel and Xarelto as prescribed. Clopidogrel was ordered as Clopidogrel 75mg, give 1 tablet by mouth one time a day for anticoagulant. Xarelto was ordered as Xarelto 10mg, give 1 tablet by mouth one time a day for anticoagulant. Record review of Resident #54's care plan with an initiation date of 3/06/2025 documented the resident is at risk for complications related to anticoagulant or antiplatelet medication r/t CAD, CVA, HLD with a goal of the resident will remain without complications from bleeding or injury through next review date. Further review of the care plan documented interventions including Apply prolonged pressure to venipuncture sites, monitor medication regime for medications which increase effects, and observe for adverse reaction: fever, skin lesions, anorexia, nausea, vomiting, cramps, diarrhea, hemorrhage, hemoptysis.6. Record review of Resident #63's admission sheet dated 11/26/2025, with an original date of 12/13/2022 documented a [AGE] year-old female resident with diagnoses including dementia, type 2 diabetes mellitus, cerebral infarction, hypertension, depression, and anxiety. Record review of Resident #63's MDS assessment dated [DATE] documented a BIMS of 12 indicating moderate cognitive impairment and recorded the use of scheduled and PRN pain medications in the last five days since the assessment date. Further review of the MDS revealed the assessment recorded the use of antianxiety, diuretic, antiplatelet, and anticonvulsant medications. The assessment did not record the use of antidepressant medication. Record review of Resident #63's order summary included an active order for the antidepressant Prozac with an order date of 01/27/2025 and an active order for the analgesic Tylenol with an order date of 6/05/2023. Further review of the order summary revealed the summary did not include an active order for scheduled pain medication. Record review of Resident #63's September 2025 MAR documented the resident had been receiving Prozac and Tylenol as prescribed. Prozac was ordered as Prozac 20mg, give 1 capsule by mouth two times a day. Tylenol was ordered as Tylenol 325mg give 2 tablets by mouth every 4 hours as needed. Further review of the September MAR revealed no doses of PRN Tylenol had been administered or refused during the five day look back period between 9/04/2025 through 9/08/2025 of the MDS assessment. During an interview with the Regional Support Nurse on 12/09/2025 at 2:37 PM, the Regional Support Nurse stated each staff member who inputs their section of the MDS assessment signs their section for accuracy, and an RN (registered nurse) must sign the MDS for completion. The Regional Support nurse further stated, if the MDS coordinator is also an RN, that individual is responsible for signing for both completion and accuracy. The Regional Support Nurse went on to state her expectation is for all sections of the MDS assessment to be accurate, and that accuracy was important because the MDS paints a clear picture of a resident and the care they are providing. During an interview with the DON (director of nursing) on 12/9/25 at 2:49 PM, the DON stated her expectation for the MDS assessments is that they be accurate, and that it is the responsibility of the MDS coordinator to check the assessments for accuracy. The DON further stated it is important for the MDS assessment to be accurate, because it gives an updated picture of a resident for a particular quarter, and if a resident needs assistance or has a change in condition, or needs services, they want to be able to provide the care the resident requires. Review of the facility policy titled Resident Assessment - RAI, with a revised date of 5/05/2025 noted 1. The current version of the RAI (MDS 3.0) will be utilized when conducting a comprehensive assessment of each resident in accordance with the instructions found in the RAI Manual. 2. The assessment will include at least the following: n. Medications.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment was as free of accident hazards as possible for two (Hall E and Hall F) of four resident hallways, in that: Supply closets on resident Hall E and Hall F were open and unlocked and contained potentially hazardous materials. This deficient practice could result in residents coming into contact with, and being harmed by, hazardous materials. The findings were: Observation on 12/07/2025 at 11:46 a.m. of the supply closet located at the front of resident Hall F revealed it was unlocked and contained hand sanitizing wipes, 160 count, labeled Flammable Keep Out of Reach of Children and two containers of germicidal wipes, 160 count each, labeled Hazardous to Humans and Domestic Animals. During an interview with LVN A on 12/07/2025 at 11:48 a.m., LVN A confirmed the supply closet was unlocked and accessible to residents and contained the above listed potentially hazardous materials. LVN A stated the closet was usually locked and should have been secure. Observation on 12/07/2025 at 2:10 p.m. of the supply closet next to the Administrator's office and across the hall from the dining room on Hall E revealed it was unlocked and contained germicidal wipes, 160 count, labeled Hazardous to Humans and Domestic Animals. During an interview with the Maintenance Director on 12/07/2025 at 2:12 p.m., the Maintenance Director confirmed the supply closet was unlocked and accessible to residents and contained the above listed potentially hazardous materials. The Maintenance Director stated the closet was usually locked and should have been secure. During an interview with the DON on 12/10/2025 at 9:30 a.m., the DON stated her expectation was for all staff to assist in ensuring potentially hazardous materials were stored securely so that residents would not come into contact with them. Record review of the facility policy, Safe and Homelike Environment, undated, revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records for each resident that were complete and accurately documented for 2 (Resident #27 and Resident #28) of 25 residents reviewed for clinical records, in that: Resident #27's diagnoses of Adjustment Disorder Unspecified and Other Specified Persistent Mood Disorders were not included on his list of diagnoses. Residents #28's diagnoses of Pain, Bilateral Cataracts, Poor Visual Acuity, and Adjustment Disorder with Mixed Disturbance of Emotions and Conduct were not included on his list of diagnoses. This failure could result in inadequate care due to incomplete and inaccurate medical records. The findings were: 1) Record review of Resident #27's facesheet, dated 12/09/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Nondisplaced Simple Supracondylar Fracture Without Intercondylar Fracture of Right Humerus (a break to the lower part of the humerus just above the elbow joint), Subsequent Encounter for Fracture with Routine Healing, Major Depressive Disorder, and Iron Deficiency Anemia Secondary to Blood Loss. Record review of Resident #27's admission MDS, dated [DATE], revealed a BIMS score of 9 which indicated moderate cognitive impairment. Record review of Resident #27's care plan, revised 12/08/2025, revealed [Resident #27] has a psychosocial well-being problem (potential) [related to] Recent Admission, [diagnoses]: Major Depression, restlessness. Further review revealed, [Resident #27] can become agitated, yelling, cursing, refusing care. Record review of Resident #27's psychological provider note, dated 12/03/2025, revealed diagnoses of adjustment disorder and Other specified persistent mood disorders, along with the prescription medication the resident was receiving for these diagnoses. Further review of Resident #27's clinical record and facesheet, dated 12/09/2025, revealed the resident's diagnoses of adjustment disorder and Other specified persistent mood disorders were not included in the list of diagnoses, and therefore were not populated onto the resident's facesheet. 2) Record review of Resident #28's facesheet, dated 12/09/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness on one side of the body after a stroke), Malignant neoplasm of brain (brain tumor), and Type 2 diabetes mellitus. Record review of Resident #28's Quarterly MDS, dated [DATE], revealed a BIMS score of 9 which indicated moderately impaired cognition. Record review of Resident #28's care plan, revised 03/30/2025, revealed, [Resident #28] is resistive/noncompliant with care [related to] refuses medications and at times demonstrates verbally aggressive behaviors. Record review of Resident #28's physician note, dated 09/17/2025 revealed diagnoses of Pain, Bilateral cataracts, and Poor visual acuity. Record review of Resident #28's psychological provider note, dated 11/18/2025 revealed a diagnosis of adjustment disorder with mixed disturbance of emotions and conduct. Further review of Resident #28's clinical record and facesheet, dated 12/09/2025, revealed the resident's diagnoses of Pain, Bilateral cataracts, Poor visual acuity, and adjustment disorder with mixed disturbance of emotions and conduct were not included in the list of diagnoses, and therefore were not populated onto the resident's facesheet. During an interview with the DON on 12/09/2025 at 5:15 p.m., the DON confirmed that facility's medical records system populated the resident's facesheet from the list of diagnoses and confirmed that the facesheet was the primary mechanism by which information about the residents was conveyed to outside providers such as hospitals and medical specialists. The DON confirmed Resident #27 and Resident #28 facesheets were missing diagnoses and confirmed that they should have been included due to the importance of providing an accurate and complete record of the resident's health. Record review of the facility policy, Maintenance of Electronic Clinical Records, undated, revealed, This facility will maintain electronic medical records for each resident in accordance with acceptable standards of practice. A complete and accurate electronic clinical record will be maintained on each resident.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents could call for staff assistance for 1 (Resident # 60) of 25 residents reviewed in that: Resident #60's call light was out of reach under the resident's bed. This deficient practice could result in delay of needed care and assistance. The findings were: The findings were: Record review of Resident #60's facesheet, dated 12/09/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified sequelae of cerebral infarction (residual effects lasting from a stroke), Hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness on one side of the body after a stroke), and Chronic obstructive pulmonary disorder (a condition involving constriction of the airways and difficulty or discomfort in breathing).Record review of Resident #60's Quarterly MDS, dated [DATE], revealed a BIMS score of 4 which indicated severe cognitive impairment. Record review of Resident #60's care plan, revised 01/11/2021, revealed [Resident #60] has an [activities of daily living self-care performance deficit [related to] Hemiplegia, Limited Mobility, Limited [range of motion], Musculoskeletal impairment, Stroke. The resident requires [extensive] assistance by 1 staff to turn and reposition in bed. The resident requires [extensive] assistance by 1 staff with personal hygiene and oral care. The resident requires [extensive] assistance by 1 staff for toileting.and Encourage the resident to use bell to call for assistance. Observation on 12/07/2025 at 11:50 a.m., revealed Resident #60 was in her bed, leaning with the top half of her body out of the bed, and her call bell was in the floor under the bed and out of reach. During an interview with Resident #60 on 12/07/2025 at 11:50 a.m., Resident #60 stated she wanted to get up and could not reach her call bell. During an interview with Medication Aide B on 12/07/2025 at 11:50 a.m., Medication Aide B confirmed that Resident #60's call bell was in the floor under the bed and out of reach. During an interview with the DON on 12/10/2025 at 9:30 a.m., the DON stated her expectation was for all staff to assist in ensuring resident call bells were within the resident's reach at all times so that residents may call for assistance when needed. Record review of the facility policy, Call Lights: Accessibility and Timely Response, undated, revealed, The purpose of this policy is to ensure the facility is adequately equipped with a call light at each resident's bedside.		