STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675502	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by an interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 3 of 5 residents (Resident #2, Resident #3, and Resident #4) reviewed for care plans. 1. The facility failed to ensure Resident #2's care plan was revised to reflect a fall sustained on 7/19/24. 2. The facility failed to ensure Resident #3's care plan was revised to reflect falls sustained on 8/17/24 and 8/18/24. 3. The facility failed to ensure Resident #4's care plan was revised to reflect a fall sustained on 8/30/24. These failures could place residents at risk of current needs not being met. Findings included: 1. Record review of Resident #2's Admission Record, dated 9/16/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia (group of thinking and social symptoms that interferes with daily functioning), dysphagia (difficulty swallowing) , cognitive communication deficit (difficulty with thinking and language), aphasia (disorder that affects a person's ability to communicate), hypertension (high blood pressure), unsteadiness on feet, history of falling, and anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #2's Care Plan, dated 6/11/24, revealed the following: [Resident #2] had an actual fall on 6/29. He was attempting to get up from the toilet by himself .Revision on:7/02/2024 . Record review of Resident #2's quarterly MDS assessment, dated 7/3/24, revealed the Resident #2 had a BIMS score of 00, suggesting severe cognitive impairment. Record review of Resident #2's Progress Notes revealed: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective Date: 07/19/2024 [6:04 pm] Type: **Event Initial Note . Res found sitting on restroom floor with shoes on, attempting to toilet self without assistance .Author: [LVN A] Effective Date: 07/20/2024 [10:43 am] . Unwitnessed fall 7/19 .Author: [LVN A] Effective Date: 07/21/2024 [6:04 pm] . Unwitnessed fall 7/19 .Author: [LVN A] Effective Date: 07/22/2024 [10:47 am] . [Resident #2] to receive ST evaluation of swallow function, related to current diet modifications, as possible contributing factors to impaired safety and strength, increasing patient's risk of falls. Author: [DOR] . A progress note dated 7/25/24, revealed an IDT review Unwitnessed fall. Further review of this entry revealed Resident #2 received a referral to ST. During an observation and interview on 9/16/24 at 1:11 pm, Resident #2 was sitting in his wheelchair in the hallway and lead the state investigator into the dining room for the interview. Resident #2 was clean, groomed, and there were no visible injuries noted. Resident #2 said he had fallen two times but did not remember the dates, he added that it had been a while. During a telephone interview on 9/16/24 at 2:45 pm, LVN A said she remembered Resident #2 was in the bathroom on the floor when he was found on 7/19/24. LVN A further stated Resident #2 said he was attempting to use the toilet himself. LVN A said she did not know who was responsible for updating the care plans. LVN A further stated it was important for care plans to be current because there were interventions the nurses needed to implement. During an interview on 9/16/24 at 5:09 pm, the DON said Resident #2's care plan had not been updated after the fall on 7/19/24 and should have been updated following the fall. 2. Record review of Resident #3's Admission Record, dated 9/16/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia (group of thinking and social symptoms that interferes with daily functioning) , hypertension (high blood pressure), unsteadiness on feet, dysphagia (difficulty swallowing) , cognitive communication deficit (difficulty with thinking and language), repeated falls, and anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #3's Care Plan revealed the following: [Resident] has had an actual fall on 6/17/2024 .Date Initiated: 05/28/2024. Revision on: 09/05/2024 . Record review of Resident #3's quarterly MDS assessment, dated 7/12/24, revealed Resident #3's had a BIMS score of 00, suggesting severe cognitive impairment. Record review of Resident #3's Progress Notes revealed: Effective Date: 08/17/2024 [5:27 pm] Type: **Event Initial Note . Unwitnessed fall with laceration/discoloration to back of head .Res sitting in front dining area attempting to stand up without assistance, lost balance and fell to floor and hit head .Author: [LVN A] (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective Date: 08/18/2024 [6:34 am] . Unwitnessed in front dining room . Upon assessment, noted resident to be on the floor on his right side with his right arm underneath him and legs stretched out in front of him. Noted wheelchair to be turned over onto its left side. Noted pool of blood from underneath right side of head . Resident was assessed for injury and noted 2cm laceration to above right eyebrow and raised, hard, nickel-sized knot to above right eye laceration. When resident asked what happened, resident is unable to give description due to disease process . Author: [RN C] Effective Date: 08/18/2024 [6:19 pm] . Unwitnessed fall .Author: [LVN A] Effective Date: 08/18/2024 [6:29 pm] . Unwitnessed fall in front dining room .Author: [LVN A] A progress note dated 8/19/24, revealed an IDT review Unwitnessed fall. Further review of this entry revealed no new interventions were suggested. A progress note dated 8/22/24, revealed an IDT review Unwitnessed fall. Further review of this entry revealed new intervention suggested was increased signage in resident's room to remind resident to call, don't fall. During a telephone interview on 9/16/24 at 4:17 pm, RN C said she did not know how Resident #3 fell on [DATE]. RN C said she thought he might have tried to push himself back from the dining room table. RN further stated she ran into the dining room and found Resident #3 on the floor. During a telephone interview on 9/16/24 at 4:28 pm, LVN A said on 8/17/24 Resident #3 was in dining room and attempted to stand and walk but lost his balance. LVN A further stated Resident #3 was able to walk but was very unsteady. LVN A said Resident #3 fell on his bottom and then fell back and hit his head. During an interview on 9/16/24 at 5:09 pm, the DON said Resident #3's care plan had not been updated after the falls on 8/17/24 and 8/18/24. The DON further stated Resident #3's care plan should have been updated following the fall. The DON said the last fall documented Resident #3's care plan was 6/17/24. The DON further stated the interventions should have been evaluated and changed as needed. 3. Record review of Resident #4's Admission Record, dated 9/16/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions) , hemiplegia (paralysis of one side of the body) , type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), hypertension (high blood pressure), and anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #4's quarterly MDS assessment, dated 7/11/24, revealed Resident #4's cognitive skills for daily decision making were severely impaired. Record review of Resident #4's Care Plan, dated 9/3/24, revealed the following: Resident had an actual fall with no injury .Date Initiated: 09/03/2024 . Record review of Resident #4's Progress Notes revealed: (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective Date: 08/30/2024 [2:30 am] . resident observed on floor mat laying on back. resident stated he fell . unable to give description. vitals within normal limits. skin assessment done. slight redness noted to left knee. no complaints of pain. neuros started. assisted resident back in bed.Author: [LVN B] Effective Date: 08/30/2024 [6:36 pm] . Unwitnessed fall 8/30 .Author: [LVN A] Effective Date: 08/31/2024 [6:41 pm] . Unwitnessed fall 8/30 .Author: [LVN A] Effective Date: 09/03/2024 [10:24 am] . [Resident #4] is referred to PT related to fall on 08/30/24 .Author: [DOR] A progress note dated 9/3/24, revealed an IDT review unwitnessed fall. Further review of this entry revealed Resident #4 was not receiving therapy services and was referred to therapy. During an observation and interview on 9/13/24 at 5:00 pm, Resident #4 was lying in his bed, he was clean, groomed, and there were no visible injuries noted. Resident #4's bed was in the lowest position and a floor mat was in place. Resident #4 said he had not had any falls recently and it had been about a month since he experienced a fall. Attempted interview on 9/16/24 at 4:20 pm with LVN B was unsuccessful. During an interview on 9/16/24 at 5:09 pm, the DON said she started working at the facility on 7/22/24 or 7/23/24. The DON said Resident #4's care plan had not been updated after the fall on 8/30/24. The DON said the facility did not have a MDS nurse, so she was responsible for updating the care plans. The DON further stated it was important for the care plans to be current and accurate for resident safety and so appropriate patient care could be provided. The DON added, the care plan was a guide to provide care to residents and if they were not accurate the staff did not know what services the residents required. The DON said since she started working at the facility, she had not had the opportunity to do any care planning because she had to work on the floor. The DON said she completed a few audits of resident records but had not been consistent. During an interview on 9/16/24 at 7:15 pm, the AIT said the DON and the Administrator were responsible for ensuring care plans were updated. The AIT further stated the care plans were expected to be updated after falls. The AIT said it was important for care plans to be current, so residents received care specific to them and their needs, and all caregivers were aware of changes. The AIT further stated not updating care plans in a timely manner could result in a lack of care and lack of providers knowing how resident care should be provided. Record review of the facility's policy, titled Care Plans, Comprehensive Person-Center, revised March 2022, revealed: .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 5 residents (Resident #3) reviewed for quality of care. The facility failed to ensue that staff conducted (4 of 14 neuro checks done) neurological assessments for 72 hours per facility protocol after an unwitnessed fall with laceration to above right eye on 08/18/2024 for Resident #3. These failures could result with residents not receiving the necessary interventions in a timely manner, by not recognizing a change of condition that could result in a decline in health. Findings included: Record review of Resident #3's Admission Record, dated 9/16/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia (group of thinking and social symptoms that interferes with daily functioning) , hypertension (high blood pressure), unsteadiness on feet, dysphagia (difficulty swallowing) , cognitive communication deficit (difficulty with thinking and language), repeated falls, and anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #3's Care Plan revealed the fall on 8/18/24 was not documented. Record review of Resident #3's quarterly MDS assessment, dated 7/12/24, revealed Resident #3's had a BIMS score of 00, suggesting severe cognitive impairment. Record review of Resident #3's Progress Notes revealed: Effective Date: 08/18/2024 [6:34 am] . Unwitnessed in front dining room . Time of event: [5:30 am] .Upon assessment, noted resident to be on the floor on his right side with his right arm underneath him and legs stretched out in front of him. Noted wheelchair to be turned over onto its left side. Noted pool of blood from underneath right side of head .Resident was assessed for injury and noted 2cm laceration to above right eyebrow and raised, hard, nickel-sized knot to above right eye laceration. When resident asked what happened, resident is unable to give description due to disease process . neuro checks are within normal limits for resident .Author: [RN C] Effective Date: 08/18/2024 [6:19 pm] . Unwitnessed fall .Full ROM to all extremities per res baseline .Ax1 . neuro checks x3 days .Author: [LVN A] Effective Date: 08/18/2024 [6:29 pm] . Unwitnessed fall in front dining room .neuros wnl .Author: [LVN A] Effective Date: 08/19/2024 [11:39 pm] . S/P fall day 2/3 .AROM/PROM present. Res continues with usual functional and cognitive routine .A&O to self .Observation/monitoring per facility protocol .Author: [RN E] (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 9/16/24 at 4:17 pm, RN C said she did not know how Resident #3 fell on [DATE]. RN C said she thought he might have tried to push himself back from the dining room table. RN further stated she ran into the dining room and found Resident #3 on the floor. RN C said the facility protocol was to complete neurological assessments for 72 hours after an unwitnessed fall. RN C further stated as a charge she always completed neurological assessments when they were required, adding she completed them during her shift. RN C stated when neurological assessments were required, the information was passed along during shift report. RN C further stated she did not know why the assessments were not completed, adding once she passed the information to the following shift it was their responsibility to complete the assessments. RN C said the DON was responsible for ensuring neurological assessments were completed by the nurses. RN C said it was important to complete neurological assessments as needed to monitor for changes in condition as a possible result of falls, adding residents may develop brain bleed or something like that. During a telephone interview on 9/16/24 at 4:28 pm, LVN A said she did not know why the neurological assessments for Resident #3 were not completed. LVN A said the nurses made sure neuro checks were initiated and completed. LVN A further stated the DON was responsible for ensuring neuro checks were completed. LVN A said neurological assessments were important because changes could be noticed, and staff could intervene by ensuring the physician was called or the resident was sent to the hospital, if needed. LVN A said she did not know why the assessments were not completed, adding the facility used agency staff. LVN A further stated agency staff were told to complete neurological assessments as needed but did not know if they were completing them. Attempted interview on 9/16/24 at 2:47 pm with RN E was unsuccessful. During an interview on 9/16/24 at 3:23 pm, the DON said the facility protocol was to complete neurological assessments as listed on the Neurological Record. During an interview on 9/16/24 at 5:09 pm, the DON said the IDT was responsible for ensuring neurological assessments were completed, especially her. The DON said it was facility protocol to complete neurological assessments after all unwitnessed falls because it was unclear whether the resident hit their head or not. The DON said neurological assessments should have been completed after Resident #3's fall on 8/18/24. The DON said she was unable to find the Neurological Record for Resident #3 following the 8/18/24 fall. The DON further stated it was important for neurological assessments be completed to ensure the staff were aware if there was a deviation from the resident's neurological baseline. During an interview on 9/16/24 at 7:15 pm, the AIT said the DON was responsible for ensuring neurological assessments were completed. The AIT further stated it was important neurological assessments were completed for follow-up purposes and to ensure there were not neurological changes or damage following a fall. The AIT said staff may not be able to intervene as quickly if they were not aware of neurological changes, there could be a delay in care. Record review of the Neurological Record revealed frequency of assessments were as follows: Every 30 min. x 4 Every 1-hour x 4 hours (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Every 4 hours x 24 hours Every 8 hours x for remaining 72 hours. Record review of Resident # 3's electronic record revealed no nuerologial assesment aside from the 4 neurolgical assessments noted in Resident #3's progress note on 08/18/2024 @ 06:34 AM, 08/18/2024 @ 06:19 PM, 08/18/2024 @ 06:29 PM and 08/19/2024 @ 11:39 PM. Record review of facility's procedure, titled Neurological Assessment, revised October 2010, revealed: The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition .Steps in the Procedure . 3. Perform neurological checks with the frequency as ordered or per falls protocol .

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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 - Few	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** 39251 Based on interviews, and record review, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 5 residents (Resident #4) reviewed for clinical records. The facility failed to ensure Resident #4's neurological assessments were accurately documented in the resident's record following a fall on 8/30/24. This failure could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #4's Admission Record, dated 9/16/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions) , Hemiplegia (paralysis of one side of the body) , Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Hypertension (high blood pressure), and Anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #4's quarterly MDS assessment, dated 7/11/24, revealed the Resident #4's cognitive skills for daily decision making were severely impaired. Record review of Resident #4's Care Plan, dated 9/3/24, revealed the fall on 8/30/24 was not documented. Record review of Resident #4's Progress Notes revealed: Effective Date: 08/30/2024 [2:30 am] . resident observed on floor mat laying on back. resident stated he fell . unable to give description. vitals within normal limits. skin assessment done. slight redness noted to left knee. no complaints of pain. neuros started. assisted resident back in bed.Author: [LVN B] Effective Date: 08/30/2024 [6:36 pm] . Unwitnessed fall 8/30 .Monitor/neuros x3 days, neuros WNL for resident .Author: [LVN A] Effective Date: 08/31/2024 [6:41 pm] . Unwitnessed fall 8/30 . Monitor/neuros x3 days, neuros WNL . Author: [LVN A] Effective Date: 09/01/2024 [2:16 am] . Unwitnessed fall . Neuros being performed .WNL for resident .Author: [RN C] (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Effective Date: 09/01/2024 [2:16 am] . Unwitnessed fall . Neuros being performed .WNL for resident .Author: [RN C] Effective Date: 09/01/2024 [4:26 pm] . Unwitnessed fall . Neuros being performed .neuros completed at 5pm .Author: [LVN A] Effective Date: 09/02/2024 [4:26 pm] . Unwitnessed fall on 8/30 at 0200 . monitoring and neuro checks . Author: [RN D] The facility was unable to locate Resident #4's Neurological Record for the 8/30/24 fall during the investigation. During an observation and interview on 9/13/24 at 5:00 pm, Resident #4 was lying in his bed, he was clean, groomed and there were no visible injuries noted. Resident #4's bed was in the lowest position and a floor mat was in place. Resident #4 said he had not had any falls recently and it had been about a month since he experienced a fall. During an interview on 9/16/24 at 1:39 pm, RN D said she completed a neurological assessment on 9/2/24 for Resident #4 and documented it on the Neurological Record. RN D further stated she documented on paper because she did not realize the facility had started documenting neurological assessments in the computer . During a telephone interview on 9/16/24 at 2:45 pm, LVN A said she remembered completing neuro checks on Resident #4 following the fall on 8/30/24 but did not remember what days. LVN A further stated there should have been 3 sheets of paper documenting the neuro checks . I put them under the DON's door so that they would not get lost. Attempted interview on 9/16/24 at 4:20 pm with LVN B was unsuccessful. During an interview on 9/16/24 at 3:23 pm, the DON said the facility protocol was to complete/document neurological assessments as listed on the Neurological Record, referring to Resident #4's assessment dated [DATE] . The DON had a folder with neurological assessment on her desk, the DON said some of the neurological records might have been in a box in the medical records office. Record review of Resident #4's Neurological Record, dated 9/3/24, revealed frequency of assessments were as follows: Every 30 min. x 4 Every 1-hour x 4 hours Every 4 hours x 24 hours Every 8 hours x for remaining 72 hours. (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 - Few	During an interview on 9/16/24 at 5:09 pm, the DON said the IDT were responsible for ensuring neurological assessments were completed, especially her. The DON said it was important for neurological assessments to be completed to ensure the staff were aware if there was a deviation from the resident's neurological baseline. During an interview on 9/16/24 at 7:15 pm, the AIT said the DON was responsible for ensuring neurological assessments were completed. The AIT further stated it was important neurological assessments were completed for follow-up purposes and to ensure there were not neurological changes or damage following a fall. The AIT said staff may not be able to intervene as quickly if they were not aware of neurological changes, there could be a delay in care. Record review of facility's procedure, titled Neurological Assessment, revised October 2010, revealed: The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition .Documentation The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 4. All assessment data obtained during the procedure .