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	04/18/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources are reported not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 3 Residents (Resident #1) reviewed for Abuse, in that: The facility did not report an allegation of Abuse to the State Survey Agency (HHSC) within 24 hours of Resident #1 falling off the bed. This deficient practice could affect any resident and could contribute to further neglect. The findings were: Review of Resident's # 1 face sheet dated 4/16/ 2025, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: schizoaffective disorder (mental disorder that changes how people think, feel and act, major depressive disorder (mental state characterized by persistent loss of interest in activities), and Dementia (the loss of cognitive functioning, thinking, remembering, and reasoning). Record review of resident #1's quarterly MDS assessment dated [DATE] revealed a blank BIMS score, indicating the resident could not complete the interview. Record review of Resident # 1's care plan dated 4/17/24 revealed that the [resident's name] is at risk for falls; the goal is not to have a fall with injury. Record review of the facility incident report dated 2/4/25 for Resident # 1 revealed he fell from bed at 8:45 A. M unwitnessed . Record review of Texas Unified Licensure Information Portal (TULIP) on 4/18/25 at 11:41 A.M. revealed that no self-reported incidents regarding allegations of Abuse were reported for Resident # 1 on 2/4/25 . (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN A on 4/16/25 at 9:55 A.M. revealed that she notified DON of the fall on 2/4/25, approximately 30 minutes after it occurred. RN A stated she did not note any injuries to the resident at the time of her assessment. Interview with the DON on 4/18/25 at 11:25 A.M revealed the administrator was responsible for reporting allegations of abuse to HHSC; however she stated her understanding was allegations of Abuse should be reported within 2 hours. Interview with the Administrator on 4/18/25, at 12:18 P.M. revealed she did not report the fall involving Resident #1, as there were no injuries. However, upon reviewing the abuse guidelines from HHSC, she acknowledged that she should have reported the fall within two hours of having knowledge that Resident # 1 required hospitalization. Record review of facility policy titled, Abuse, Neglect, and Exploitation, dated 2021, reflected, Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, interviews, and record reviews the facility failed to ensure each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; and the health of individuals in the facility would otherwise be endangered for 1 of 3 (Resident #4) reviewed for discharge. Resident #4 was transferred to the hospital for a psychological evaluation on 3/25/2025 and was not allowed to return to the facility. The facility failed to document the bases of Resident #4's discharge. This could affect all residents and could result in residents not having the opportunity to appeal the discharge from the facility. The Finding were: Record review of Resident #4's admission record dated 4/15/2025 was documented he was admitted on [DATE] and re-admitted on [DATE] with diagnoses of Dementia, paranoid schizophrenia, major depressive disorder, legal blindness, and anxiety. The admission record was documented dated of discharge was 3/26/2025 at 7:19 PM (19:19) to acute hospital. Record review of Resident #4's consolidated orders revealed he had orders for observations for behaviors, schizophrenia monitor for characteristics of schizophrenia paranoid tendencies Olanzapine 5 mg, give 1 tablet by mouth two times a day for agitation, and Uzedy subcutaneous suspension prefilled syringe 200mg/0.56 ml (Risperidone) inject 200 mg subcutaneously one time a day every 2 months starting on the 12tj for 1 day for psychosis. Record review of Resident #4's discharge MDS dated [DATE] revealed his Cognition for daily decision making was moderately impaired and for Behavior symptoms was physical, verbal, and other behaviors directed toward others occurred 4-6 days and rejected care. Resident #3's return was not anticipated. Record review of Resident #4's care plan was documented he had impaired physical functioning related to deficit, cognition, impairment, and impaired vision, had a potential for mood problem or altercation in mood related to disease process. risk for behaviors related to demonstrate physically abusive behaviors towards staff and himself, at risk for violence, directed at self/others related to diagnosis of schizoaffective disorder, auditory hallucinations have been reported, has history of wanting to self-harm, and had disturbed sensory perception related to glaucoma, legally blind. offer verbal cuing and redirections as needed. Resident #4's care plan was documented as cancelled in front of each Focus/problem and all the care plans were resolved on 4/2/2025. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's progress notes, dated 3/26/2025 at 7:18 PM was documented Resident sent out 911 for aggressive behavior combative to staff breaking window in bedroom. Centric physicians notified orders to send to ER for eval/TX. Brother notified. Resident sent to hospital. Resident #4's progress note dated on 3/26/25 at 2:35 was documented resident #4 banging on walls, yelling for his probation officer. direct care staff assisting with redirecting resident, hollering, cursing, banging on walls. Record review of Resident #4's psychological note dated 1/17/25 was documented Record review of Resident #4's chart from 10/17/2024 to 3/26/2025 revealed no discharge summary report. Record review of Resident #4's psychological note dated 1/17/2025 was documented Pt seen today for psychiatric follow up evaluation for medication management. Also seen to follow up on recent psychotropic. medication adjustments. Pt seen today in bed. His privacy is maintained. His exam is limited secondary to his psychiatric and cognitive impairment. Denies depression or anxiety today. Continues to have labile moods. Has ongoing outbursts and agitation. His Ativan was recently switched to Clonazepam earlier this week by Dr. [NAME]. His PRN Ativan has not been effective per staff. He cannot be redirected with non pharmacological interventions per nurse. He reports eating and sleeping well. He has not been exhibiting any suicidal threats or gestures. Continues to have paranoia and delusions. His Latuda was recently changed to Zyprexa as staff report having better effect with medication when recently being used as PRN. No adverse effects reported at this time. Denies recent tobacco, and cannabis use reported. He has been refusing medication when upset. Pt encouraged to take medications as ordered today. Psychiatric follow up evaluation for medication management. Follow up on recent psychotropic medication adjustments Psychiatric diagnoses include Schizoaffective Disorder, GAD, Cognitive Impairment, Tobacco Dependence. In Remission, Hx of Substance Abuse. Pt seen for complex psychiatric issues that require continued monitoring, evaluation, medication review and treatment dx-Pt seen today for psychiatric follow up evaluation for medication management. Also seen to follow up on recent psychotropic medication adjustments. Pt seen today in bed. His privacy is maintained. His exam is limited secondary to his psychiatric and cognitive impairment. Denies depression or anxiety today. Continues to have labile moods. Has ongoing outbursts and agitation. His Ativan was recently switched to Clonazepam earlier this week by Dr. [NAME]. His PRN Ativan has not been effective per staff. He cannot be redirected with non-pharmacological interventions per nurse. He reports eating and sleeping well. He has not been exhibiting any suicidal threats or gestures. Continues to have paranoia and delusions. His Latuda was recently changed to Zyprexa as staff report having better effect with medication when recently being used as PRN. No adverse effects reported at this time. Denies recent tobacco, and cannabis use reported. He has been refusing medication when upset. Pt encouraged to take medications as ordered today. Record review of emergency department notes indicated the following: by complainant. * On1/20/2025 at 9 PM revealed spoke to ADM of facility who stated Resident #4 was not allowed back at the facility despite. patient being cleared medically and psychiatrically during stay. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 1/31/2025 at 9:35 AM notified this nurse that the Resident #4 had been discharged out of the system and no longer lived at the facility. Record review of Resident #4's progress note dated 3/26/2025 at 7 :18 - PM Resident sent out 911 for aggressive behavior combative to staff breaking window in bedroom. [company]physicians notified orders to send to ER for eval/TX . [family] notified. Resident sent to hospital. Record review of email contact with complainant on 4/16/25 at 1:12 PM stated she spoke to the ADM prior to reporting to the STATE and she got absolutely no where. The Hospital complainant concerns where that Resident #4 was not allowed to come back to the facility after his evaluation discharge from the hospital. Interview on 4/16/2025 at 2 PM with the ADM stated Resident #4 was going to be sent back to facility after an evaluation, then he went to psych hospital. The ADM stated Resident #4 had been back to facility hmm2x , this last time the hospital sent him back right away without an evaluation. The ADM stated when he was at hospital- [company] found him group home. The ADM stated Resident #4 has not been back to facility, since first hospital visit. The ADM stated Resident#4 had behaviors that made other residents not safe. The ADM stated Resident #4 was not discharged . Interview on 4/17/2025 at 12:10 PM Resident #4's family stated he felt like Resident #4 was shipped off to psych hospital and was told by facility they would not take Resident #4 back. Family of Resident #4 stated the ADM let him know Resident was not allowed back to facility due to his behaviors. Family of Resident #4 stated the facility was aware of his behavior when he was admitted . Record review of policy dated 2025 Transfer and Discharge, was documented Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all resident regardless of their payment source . 3. The facility's transfer/discharge notice will be provided to the resident and residents representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided., 10. Emergency Transfers to Acute Care . i. The resident will be permitted to return to the facility upon discharge from the acute care setting. j. not permitting a resident to return following hospitalization constitutes a discharge.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, interviews, and record reviews the facility failed to a comprehensive person-centered care plan for each resident, consistent with the resident rights and includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 10 (Resident #3) residents in that: Resident #3's care plan for his pacemaker was not complete with name, serial number and when he last seen the cardiac physician. This failure could affect residents by placing them at risk of not receiving necessary services and care. The Findings were: Record review of Resident #3's admission record dated 4/15/2025 indicated an admission date of 10/18/24 and readmission date of 3/25/2025. Resident #3 had a diagnosis of cardiac pacemaker. Record review of Resident #3's significant change MDS dated [DATE] revealed he had a BIMS score of 15/15 (cognitively intact) and had a cardiac pacemaker. Record review of Resident #3's consolidated physicians orders for April 2024 documented a diagnosis was a pacemaker. Further review reveled the cardiac pacemaker serial number and how to care for the device was not addressed. Record review of Resident #3's MAR for April 2025 did not address how to care for his cardiac pacemaker. Record review of Resident #3's care plan dated 3/7/2025, initiated on 11/13/2024 revealed he had a cardiac pacemaker, interventions were to avoid electro mechanical interference. The care plan did not include the name, serial number of the pacemaker. The care plan did not indicate a recent cardiac MD appointment to check the status of the cardiac pacemaker. The care plan did include what signs and symptoms to report to the MD immediately. No appointment for cardiac MD in Resident #4's chart. Observation and interview on 4/18/2025 at 1:05 PM Resident #3 laid in bed and stated he had a cardiac pacemaker., RN A stated Resident #3 did have a cardiac pacemaker. Interview on 4/18/25, at 12:18 P.M. with the ADM and DON had no reply when discussed Resident #3's pacemaker did not have information about Resident #4's pacemaker, such as serial # and etc. and his most recent cardiac appointment. They did not respond. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of policy on Comprehensive Care plans dated 2025 was documented: Policy: it is the policy of this facility to develop and implement a comprehensive person-centered care plan for which resident, consistent with resident rights, that includes measurables objectives and timeframe to meet a resident medical nursing, and mental psychosocial needs and all services that are identified i the resident comprehensive assessment and meet professional standards of quality . 3.The compressive care plan will describe, at a minimum, the following a. the services that are to be furnished to attain or maintain the resident highest practicable physical, mental and psychosocial well-being.

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure residents received treatment and care based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 10 (Resident #3) resident in that: Resident #3's care plan for his pacemaker was not his last cardiac physician appointment. This failure could place residents at risk for not receiving appropriate care and treatment and/or a decline in their health. The Findings were: Record review of Resident #3's admission record dated 4/15/2025 with admission date of 10/18/24 and readmission date of 3/25/2025. Resident #3 had a diagnosis of cardiac pacemaker. Record review of Resident #3's consolidated physicians orders for April 2024 was documented in his diagnosis was a pacemaker, but not as an order for cardiac pacemaker serial # and how to care for the device. Record review of Resident #3's MAR for April 2025 revealed not care for his cardiac pacemaker. Record review of Resident #3's significant change MDS dated [DATE] revealed he had a BIMS score was 15/15 (cognitively intact) and had a cardiac pacemaker. Record review of Resident #3's care plan dated 3/7/2025 was documented, iniated on 11/13/2024 he had a cardiac pacemaker and did not include the name, serial number and etc, or if he had a recent cardiac MD appointment to check the status of the cardiac pacemaker. The care plan did include report signs and symptoms to MD immediately. Observation on 4/18/2025 at 1:05 PM with Resident #3 lying in bed, RN A confirmed he had a cardiac pacemaker. Interview on 4/18/2025 at 1:05 PM with RN A confirmed Resident #3 had a cardiac pacemaker. Interview on 4/18/2025 at 1:06 PM with Resident # 3 stated he had a cardiac pacemaker. Interview on 4/18/25, at 12:18 P.M. with the ADM and DON had no reply when discussed Resident #3's pacemaker with no cardiac appointment. Asked for a pacemaker policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of policy on Comprehensive Care pans dated 2025 was documented: Policy: it is the policy of this facility to develop and implement a comprehensive person-centered care plan for which resident, consistent with resident rights, that includes measurables objectives and timeframe to meet a resident medical nursing, and mental psychosocial needs and all services that are identified i the resident comprehensive assessment and meet professional standards of quality. 3.The compressive care plan will describe, at a minimum, the following a. the services that are to be furnished to attain or maintain the resident highest practicable physical, mental and psychosocial well-being.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure that 1 of 12 residents (Resident #2) reviewed for medication errors was free of any significant medication errors. The facility failed to administer medication (Glargine, a drug to lower blood sugar) as prescribed for Resident #2. This deficient practice could place residents at risk of inadequate therapeutic outcomes, increased adverse side effects, and a decline in health. The findings included: Record review of admission face sheet, dated 4/16/2005, revealed Resident # 2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included vascular dementia (occurs when there is damage to regions in the brain, affecting memory), Type two diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and major depressive disorder (persistent feeling of sadness and loss of interest). Record review of the quarterly MDS assessment, dated 3/3/2025, revealed Resident # 2 had a BIMS score of 06, which indicated moderate to severe cognitive impairment. Record review of the care plan for Resident # 2, dated 7/26/22, revealed a problem area: Resident # 2 has hyperglycemia related to diabetes with anticipated approaches of: administer medications as ordered. Record review of physician orders for the month of April 2025 revealed that Resident # 2 had the following orders: *Insulin Glargine 100 Units / ML, Inject 15 units subcutaneously every morning. Record review of the medication Insulin administration record for Resident # 2 from 2/4/25 to 3/8/25 revealed missed insulin doses documented as (held per M.D orders) on: 2/4/25, 2/13/25, 2/18/25, and 3/8/25. Record review of Resident #2's physician's monthly orders for February 2025 and March 2025 did not reveal any orders to hold insulin per M.D orders. Interview on 4/16/2025 at 11:35 A.M., Resident # 2's family member stated that she had been informed by the Department of Veterans Affairs case manager that the nursing facility nurse held insulin glargine without an M.D. order, which could cause elevated spikes in blood sugar. Interview was attempted with the Department of Veterans Affairs case manager on 4/16/24 at 12:30 PM, and the case manager did not return the phone call. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN A on 4/17/25 at 8:30 A.M. revealed she held the Insulin Glargine for Resident # 2 on 2/4/25, 2/13/25, 2/18/25, and 3/8/25 without an M.D. order because she was concerned Resident # 2 would go hypoglycemic as he did not want to eat breakfast and she forgot to document her reasoning in progress notes. RN A stated she was now aware that Insulin Glargine was a long-acting insulin and not rapid, therefore there was no need to hold insulin. RN A noted by holding insulin Glargine without an M.D order, Resident # 2 risked unpredictable spikes in blood sugar. An interview with the DON on 4/18/25 at 9:45 A.M. revealed she expected licensed nurses to follow M.D. orders regarding insulin, as failure could cause unexpectedly elevated blood sugars. The DON stated licensed nurses were responsible for their own practice, but she would monitor all licensed nurses in the facility at random for compliance with M.D. orders. Record review of a facility licensed nurse job description, revised 05/2019, revealed that the job requires the ability to perform duties promptly and within prescribed sequences and schedules.