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	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St 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 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 develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that 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 2 residents (Resident #1 and #2) of 10 residents reviewed for comprehensive person-centered care plans. The facility failed to accurately reflect Resident #1's fall prevention interventions, including low bed, anti-skid socks (socks with rubber on soles to stop slipping), and anti-skid tape on the floor (tape with a gritty type substance to reduce slipping), but did reflect hipsters (which she did not wear) in her comprehensive person-centered care plan. The facility failed to accurately reflect Resident #2's fall prevention interventions, including low bed, anti-skid socks, anti-tip devices on wheelchair, and anti-skid tape on the floor in his comprehensive person-centered care plan. This deficient practice affects residents at risk for falls and could result in injury r/t inaccurate or missed interventions.The findings included: Record review of Resident #1's electronic face sheet dated 01/14/2026 reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (encompasses a group of lung diseases that block airflow and make it difficult to breathe), hypoxemia (low levels of oxygen in the blood causing difficult breathing and fatigue), dementia (loss of cognitive functioning that interferes with daily life and activities), adult failure to thrive (overall physical and functional decline), fatigue (extreme tiredness)and falls (move from a higher to a lower level without control). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected that she scored 1 of 15 on her BIMS which indicated her cognitive status was severely impaired. She required extensive assistance with her ADLs. Resident #1 used a wheelchair for locomotion and had a history of falls. Record review of Resident #1's comprehensive person-centered care plan dated 11/24/2025 reflected Focus, had an actual fall, interventions, hipsters (padded briefs that protect the hips) are to be worn while resident is up to help prevent injuries from falls, dated initiated, 11/18/2025. The comprehensive care plan for Resident #1 did not reflect that she wore anti-skid stockings, had a low bed and anti-skid tape on the floor next to her bed. Record review of Resident #1's FRA dated 11/24/2025 reflected Resident #1 had recent multiple falls, was unable to independently come to a standing position, and exhibited loss of balance while standing and required direct assistance to move from place to place. She scored 28 on her FRA which indicated she was at high risk for falls. Observation of Resident #1 on 01/14/2026 at 10:45 am revealed she was sitting in a wheelchair being taken to her room for her teeth to be examined by the dentist and she did not have hipsters. Observation of Resident #1 on 01/15/2026 at 09:20 am in her room revealed she was lying on a low bed, call light within reach, and there was anti-skid tape on the floor beside her bed. She wore non-skid socks. 2. Record review of Resident #2's (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic face sheet dated 01/14/2026 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), difficulty in walking (refers to a condition where an individual struggles to maintain a normal gait), vascular dementia (major cognitive impairment), and insomnia (sleep disorder that makes it difficult to fall or stay asleep). Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected he scored 1 of 15 on his BIMS which indicated his cognitive status was severely impaired. He required extensive assistance with his ADLs and had a history of falls. Record review of Resident #2's comprehensive person-centered care plan dated 11/21/2025 reflected Focus, falls, and did not include the interventions of: antiskid strips on floor, antiskid socks, anti-tip devices on wheelchair or low bed. Record review of Resident #2's FRA dated 10/09/2025 reflected he scored 23 which signified he was at high risk for falls. He exhibited loss of balance while standing and required direct assistance to move from place to place. Observation of Resident #2 on 01/14/2026 at 10:50 am revealed he was sitting in a wheelchair in the common area of the facility and had anti-tip devices on his wheelchair. Observation of Resident #2 on 01/15/2026 at 08:00 am revealed he was lying in bed in his room. The bed was in the low position; he had antiskid socks on and there was antiskid tape on the floor next to where he would get out of bed. During an interview on 01/15/2026 at 11:00 am with RN B, who performed Resident #1's FRA dated 11/24/2025 and frequently took care of the resident, she stated the resident wore non-skid socks, had a low bed and anti-skid tape on the floor next to her bed. She stated they tried hipsters and Resident #1 called them stupid and would take them off. She stated she could not recall the last time she had the hipsters. She stated the care plan accuracy was important because the CNAs could pull up her Kardex (form with resident's specific care requirements) which was created for them to know things about her care such as low bed, or non-skid socks. She stated Resident #2 had anti-tip devices on his wheelchair. During an interview on 01/15/2026 at 11:36 am with CNA C, who cared for Resident #1, she stated that Resident #1 did not wear hipsters, had a low bed, non-skid socks, and anti-skid tape on the floor. She stated CNA's have access to a Kardex, which is created by the residents' care plan. She stated it was important for the resident's care plan to be accurate, for the Kardex to be accurate, so care would not be missed. She stated Resident #2 had antiskid socks, tape on the floor, low bed, and anti-tip devices on his wheelchair. During an interview on 01/15/2026 at 12:30 pm with night nurse LVN D, she stated that Resident #1 did not use hipsters, and staff tried to keep her near the nurse's station in front to be able to monitor her. She stated Resident #1 had a low bed and wore anti-skid socks. She stated Resident #2 had a low bed, anti-skid tape on the floor and wore anti-skid socks. She stated Resident #2 had antiskid socks, tape on the floor, low bed, and anti-tip devices on his wheelchair. During an interview on 01/15/2026 at 3:25 pm CNA E stated Resident #1 was at high risk for falls, did not wear hipsters, had a low bed, and wore anti-skid socks. She stated the resident no longer used a walker and was now in a wheelchair. She stated Resident #2 had a low bed, antiskid socks, tape on the floor, and anti-tip devices on his wheelchair. During an interview on 01/16/2026 at 10:55 a.m., RN A, who had only worked at the facility for 2 months, stated she did the MDS assessments and participated in the care plan development and updates. She stated Resident #1's hipsters needed to be removed since they were not a physician's order, and she did not wear or want them, and her nonskid socks, low bed and anti-skid tape needed to be added to the care plan, so care would not be missed. She stated Resident #2's fall prevention interventions needed to be put into his care plan. During an interview on 01/16/2026 at 11:20 am, the DON stated the care plan process is a team effort and the interventions missing on Resident #1's care plan must have been overlooked. She (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #1's hipsters needed to be taken off the care plan, and the low bed, anti-skid socks and tape needed to be put into the care plan and Resident #2's fall prevention interventions. She stated she was accountable for nursing care at the facility and did not want care to be provided wrong or to be missed. Record review of the facility policy and procedure titled Comprehensive Care Plans dated 2025 reflected, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs.