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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 W. 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 MDS assessment accurately reflected the resident's status for 1 of 5 residents (Residents #1) reviewed for assessments: Resident #1's MDS dated [DATE] did not indicate she had a fall since her last MDS assessment. These failures could place residents at risk for inadequate care due to inaccurate assessments.Findings included: Record review of Resident #1's face sheet dated 06/24/2026 revealed a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that include unspecified dementia, unspecified severity, with other behavioral disturbances (cognitive decline), unsteadiness on feet and other abnormalities of the gait and mobility (impaired patterns of walking and movement that deviate from normal coordination, balance or rhythm). Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 0 out of 15 indicating the resident's cognition was severely impaired. Further review of the MDS under Section J - Health Conditions revealed the assessment indicated Resident #1 had zero falls' in section J1800. Any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS), whichever is more recent. Record review of Resident #1's care plan provided on 06/24/2026 revealed a focus area for the following: Falls: . had an actual fall r/t unsteadiness on feet initiated on 05/11/2026. Record review of Resident #1's progress note dated 05/11/2025 revealed Resident #1 had a fall on 05/11/2026. During an interview on 06/26/2026 at 12:57 p.m., MDS A stated they failed to enter that the resident had a fall after her last assessment. MDS A confirmed Resident #1 had a fall on 05/11/2026 and that it should have been reflected on Resident #1's MDS assessment dated [DATE]. MDS A stated the risk to an inaccurate MDS could be that the fall would not be recorded on the facility's quality measures report. During an interview on 06/26/2026 at 1:06 p.m., the DON confirmed Resident #1 had a fall on 05/11/2026. The DON stated the MDS dated [DATE] should have accurately reflected that Resident #1 had a fall. The DON stated the risk of an inaccurate MDS could be their log of falls could become inaccurate as well. Review of the facility's policy titled, MDS 3.0 Completion, with no date, revealed: Policy Explanation and Compliance Guidelines: According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional compacity, using the RAI specified by the state.

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