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	07/18/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's right to be treated with respect and dignity for 1 (Resident #14) of 8 residents reviewed, in that: Resident #14 was referred to as a feeder in the assisted dining room. This deficient practice could cause psychosocial harm due to feelings of embarrassment and loss of dignity. The findings were: Record review of Resident #14's face sheet, dated 07/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: altered mental status, dysphagia oral phase (difficulty swallowing), and unspecified dementia (difficulty with memory). Record review of Resident #14's quarterly MDS assessment, dated 06/21/2025, revealed a BIMS score of 00 which indicated severe cognitive impairment. Further review revealed Resident #14 required assistance to complete activities of daily living, including eating. Record review of Resident #14's care plan, edited 06/09/2025, revealed, [Resident #14] is at risk for nutritional impairment [related to] receiving therapeutic diet . [Resident #14] requires a divided plate and queuing with meals. Further review revealed, Cognitive loss/ dementia or alteration in thought processes . Promote dignity. Converse with resident and ensure privacy while providing care. An observation on 7/15/25 at 11:26 AM revealed LVN B in the assisted dining room, verifying diets on trays before CNAs pass trays out. LVN B noted that Residents sitting in that table the assisted dining table as feeders. During an interview with LVN B on 7/15/25 at 11:50 AM, it was revealed she used a poor choice of words when she used the word Feeder and should of used assisted dining table. During an interview with the DON on 07/15/2025 at 1:14 p.m., the DON I stated it was unacceptable to refer to residents who require assistance with dining as feeders, and that she expected staff members not to do so. Record review of the facility policy, Quality of Life - Dignity, Revised August 2021, revealed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1.Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth . 7. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.

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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	675502	A. Building B. Wing	07/18/2025

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observations, Interviews, and Record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 6 residents (Resident #12 & Resident # 31) reviewed for call light. The facility failed to ensure Resident #12 and # 31's call light was within reach. This failure could place residents at risk of not being able to call for assistance when needed. Findings include: 1.Record review of Resident # 12's face sheet dated 7/15/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident # 12 had a diagnosis that included: Hemiparesis on the left side (refers to weakness on the left side of the body), anxiety disorder (group of mental health conditions that cause fear, dread) and Muscle weakness (refers to a reduced ability of one or more muscles to generate force). Record review of Resident # 12's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 9, which indicated moderate cognitive impairment. Review of Resident #12's Quarterly MDS assessment, dated 6/13/25, reflected under section G, G0300, option # 3, which stated that the patient was unsteady on their feet, and required assistance X 2 for ADL care. Record review of Resident # 12's Quarterly care plan, revised 8/1/2024, revealed a care plan with interventions ensure the call light is within reach. Observation and interview on 7/15/25 in Resident # 12's room at 10:30 AM revealed that the call light was found on the floor under the bed. Resident # 12 stated they did not know how the call light ended on the floor and did not know what he would do if he needed assistance today. Record review of Resident # 31's face sheet dated 7/15/25, revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident # 31 had diagnoses that included: Parkinson's disease (is a progressive neurodegenerative disorder that primarily affects movement), bipolar disorder (is a mental illness that causes unusual shifts in mood, energy) and anxiety disorder (involve more than occasional worry or fear). 2.Record review of Resident # 31's Quarterly MDS dated [DATE] reflected a BIMS score of 9 which indicated moderate cognitive impairment. Review of Resident #31's Quarterly MDS assessment, dated 5/12/25, reflected under section G, G0300, option # 3, which stated that the patient was unsteady on their feet, and required assistance X 2 for ADL care. Record review of Resident # 31's Quarterly care plan, revised 7/1/2024, revealed a care plan with interventions ensure the call light is within reach. Observation and Interview on 7/15/25 in Resident #31's room at 10:33 AM revealed that the call light was found under the mattress. Resident # 31 stated she did not know where her call light was and would hope and pray that someone would come in and check in on her today. During an interview on 07/15/25 at 10:40 AM, CNA C stated that she was the assigned nursing assistant for Resident # 12 and Resident # 31. She mentioned that he did not know how Resident #12s and Residents # 31's call light ended up on the floor, but she picked it up and clipped it to Resident #12's and Residents # 31's bedspread. she also noted that if both Resident's lacked access to the call light, it could potentially lead to a fall if they needed assistance. During an interview with the DON on 7/15/25, at 1:00 PM, she emphasized the importance of ensuring that the call light is accessible to all residents. She stated that the lack of accessibility to a call light for any resident could lead to a potential negative outcome if assistance is needed. The DON also mentioned that charge nurses currently monitor this task during their daily morning rounds, and she oversees this process. Record review of facility policy Call Light/Accessibility and Timely Response, dated 2024, revealed Staff will ensure the call light is within reach of Resident and secured, as needed .

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	675502	A. Building B. Wing	07/18/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 6 residents (Resident #5) reviewed for accuracy of records as evidenced by: The facility failed to ensure Resident #5's MDS assessment accurately recorded the number of days that insulin injections were received during the last 7 days prior to the assessment. This failure could place residents at risk of missing treatments or medications leading to a decline in health or overall well-being.Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 6 residents (Resident #5) reviewed for accuracy of records as evidenced by: The facility failed to ensure Resident #5's MDS assessment accurately recorded the number of days that insulin injections were received during the last 7 days prior to the assessment. This failure could place residents at risk of missing treatments or medications leading to a decline in health or overall well-being. The findings included: Record review of Resident #5's admission sheet, dated 5/25/25, showed a [AGE] year-old female resident with diagnoses including Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD) (a progressive lung disease that makes it difficult to breathe), Hypertension (high blood pressure), Hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone leading to a slowdown in metabolism and anxiety disorder. Review of Resident #5's quarterly MDS assessment, dated 6/27/25, documented the resident with a BIMS of 9, indicating moderate cognitive impairment and a diagnosis of Diabetes Mellitus in Section I - Active Diagnoses. Further review of the MDS assessment Section N - Medications N0350 Insulin noted an answer of 0 to the statement Insulin injections - record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. Review of Resident #5's most recent care plan, dated 5/28/25, documented the resident was monitored for complications related to Diabetes Mellitus with interventions including Document any beginning stages of breakdown, notify wound consultant/nurse and MD; Encourage ambulation if not contraindicated; Encourage good nutritional and oral fluid intake. Review of Resident #5's order summary included an order active as of 5/29/25 for NovoLog Flex Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 150 = 0 Units Hold insulin; 151 - 200 = 2 units Administer subcutaneously; 201 - 250 = 4 units Administer subcutaneously; 251 - 300 = 6 units Administer subcutaneously; 301 - 350 = 8 units Administer subcutaneously; 351 - 400 = 10 units Administer subcutaneously; anything over 400 call MD., subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). Review of Resident #5's June 2025 Medication Administration Record (MAR) documented the resident received insulin injections on 25 of 26 days preceding the date of the MDS assessment on 6/27/25. During an interview with the MDS Coordinator on 7/17/2025 at 12:34 PM, the MDS Coordinator stated she opens the MDS assessment, and lets the team know so each member can do their part. When everyone is finished, the MDS Coordinator stated she puts all the information in and closes the assessment and submits it. For insulin data, the MDS Coordinator stated she runs the administration report, looks at the time frame, sees if a resident was under the parameter or refused medication, and then enters the number of days the insulin was given into the system. When asked why it is important for the MDS assessment to contain accurate data, the MDS Coordinator stated it is important for the MDS to be accurate because it paints the picture of what the resident is receiving. Record review of the facility's policy titled Conducting an Accurate Resident Assessment, with a copyright date of 2025, noted Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The policy further noted The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identities resident strengths to maintain or improve medial status, functional abilities, and psychosocial status.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the Pre-admission Screening and Resident Review (PASRR) program for residents with newly evident or possible severe mental illness for 2 of 4 residents (Resident #4 and Resident #15) reviewed for PASRR services. The facility failed to identify Resident #4 and Resident #15 as having diagnoses of mental illness including Major Depressive Disorder (MDD) on the PASRR Level I screening which would require a PASRR Level II assessment. This deficient practice could place residents at risk of a diminished quality of life related to not receiving or benefiting from specialized PASRR services.The findings included: 1.Record review of the face sheet for Resident #4, dated 7/15/25, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Major Depressive Disorder (MDD) (a serious mental health condition characterized by persistent feelings of sadness and loss of interest in activities) , Diabetes mellitus (is a group of metabolic disorders characterized by high blood sugar levels) and Left-sided hemiplegia (is a form of paralysis or severe weakness affecting the entire left side of the body). Record review of the quarterly MDS assessment for Resident #4, dated 2/3/2025, revealed a BIMS score 13, indicating intact cognition. Record review of the quarterly MDS assessment for Resident #4, dated 2/6/25, revealed section 1, Active diagnoses: Psychiatric Mood Disorder. Record review of Resident #4's physician's monthly orders dated July 15, 2025, revealed no medications for diagnoses of Major depressive disorder. Record review of Resident #4's PASRR Level 1 dated 8/2/24 revealed Section C was marked 0 under Mental Illness which indicated Resident #4 did not have any evidence or an indicator for Mental Illness. Interview with Resident #4 on 7/16/25 at 12:45 PM revealed he had had a diagnosis of some form of depressive disorder since he was a young man, and could not recall the diagnosis date, but recalled taking medication for it at times. 2. Review of Resident #15’s admission sheet with an admission date of 4/6/18 and a readmission date of 9/28/20 noted the resident had diagnoses including MDD (4/6/18), heart disease (4/6/18), anxiety disorder (12/12/18), Type 2 Diabetes Mellitus (9/28/20), Vascular Dementia (9/28/20), and Gastro Esophageal Reflux Disease (GERD) (10/29/21). Review of Resident #15’s quarterly MDS assessment, dated 6/2/25, noted the resident had a BIMS of 0, indicating severe cognitive impairment and required total dependence for mobility and self-care. (continued on next page)

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	675502	A. Building B. Wing	07/18/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15’s order summary indicated the resident received monitoring for “depressive symptomology, cyclical and rapid mood shifts (tearfulness, sadness, hopelessness, loss of interest or pleasure, weight loss/gain, reduced/increased appetite, worthlessness, guilt, concentration and/or sleeping difficulties, thoughts of being better off dead, suicidal ideations, etc.” Review of Resident #15’s most recent care plan, dated 7/9/24, documented the resident had a diagnosis of depression with interventions including “out of room daily, encourage participation in activities, facilitate verbalization of fears/frustrations, medications as ordered.” Review of Resident #15’s PASRR Level I screening, dated 4/5/18, documented in section C0100. Mental Illness an answer of “0 (No)” to the question “Is there evidence or an indicator this is an individual that has a Mental Illness?” In section C0200. Intellectual Disability the PASRR Level I screening documented an answer of “0 (No)” to the question “Is there evidence or an indicator this is an individual that has an Intellectual Disability?” In section C0300. Developmental Disability the PASRR Level I screening documented an answer of “0 (No)” to the question “Is there evidence or indicators that this is an individual that has a Developmental Disability (Related Condition) other than an Intellectual Disability (e.g. Autism, Cerebral Palsy, Spina Bifida)?” During an interview with the MDS Coordinator on 07/16/25 at 10:50 AM, the MDS coordinator stated she was responsible for referring and screening all residents for re-evaluations of level I PASARR screening if they had a mental illness to the local health authority. She stated she was unaware Resident #4 and Resident #15 had a mental illness, as she had not had time to review all residents' active diagnoses. She further stated that not referring residents with a mental illness for a Level 2 evaluation could result in residents not benefiting from resources. During an interview with the DON on 7/16/25 at 3:34 PM it was revealed the MDS coordinator should have referred Resident #4 and Resident #15 to the local health authority for evaluation. The DON stated that she expected the MDS coordinator to follow facility policy regarding PASARR 2 screenings to ensure that all residents with mental health conditions receive all possible assistance. Review of the facility policy titled admission Criteria, with a copyright date of 2001, documented “All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. ” The policy further documents The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. ”

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	675502	A. Building B. Wing	07/18/2025

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment that was free from accident hazards and provide assistive devices to each president to prevent avoidable accidents 1 of 2 residents (Resident #12), reviewed for accidents and hazards: The facility failed to ensure Resident #12 had fall mats in place These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident # 12's face sheet dated 7/15/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident # 12 had a diagnosis that included: Hemiparesis on the left side (refers to weakness on the left side of the body), anxiety disorder (group of mental health conditions that cause fear, dread) and Muscle weakness (refers to a reduced ability of one or more muscles to generate force). Record review of Resident # 12's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 9, which indicated moderate cognitive impairment. Review of Resident #12's Quarterly MDS assessment, dated 6/13/25, reflected under section G, G0300, option # 3, which stated that the patient was unsteady on their feet, and required assistance X 2. Record review of Resident # 12's care plan, 6/12/25 revealed interventions to use fall mats on floor when in bed. During an observation and interview on 7/15/25 at 10:15 a.m., Resident #12 was in bed with the fall mat located on the foot of bed not on floor. Resident # 12 stated the fall mat was to cushion his fall in case he ever fell from bed as he forgets at times he cannot walk. During an observation and interview on 7/15/25 at 10:40 a.m., CNA C stated the evening shift on 7/14/25 must have forgotten to place the fall mat when they placed Resident # 12 in bed. She was aware Resident # 12 was supposed to have fall mats in place when in bed but she had not had a chance to do proper rounds today and that by her not placing fall mat for Resident # 12, he risked possible injury if she would have fallen from bed.During an interview on 7/15/25 at 11:40 a.m., the DON stated, Resident #12 had a high BIMS score and was alert and oriented. However, it was her expectation that all staff use fall mats for all high risk fall Residents when in bed. She would reeducate all staff on the process as not using fall mats on high fall risk Residents could lead to an injury. Record review of the facility policy and procedure titled, Fall Prevention Program, 2024, revealed in part, .Policy: Provide additional interventions as directed by the resident's assessment, including but not limited to assistive devices.

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	675502	A. Building B. Wing	07/18/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a system of record of the disposition of all controlled drugs to enable accurate reconciliation for 1 of 5 residents (Resident #31) reviewed for pharmacy services. The facility failed to ensure Resident #31's medication reconciliation log for the Schedule II medication (substances with a high potential for abuse, with use potentially leading to severe psychological or physical dependence) Norco 5/325 accurately reflected the number of doses administered.This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain, and a decreased quality of life. The findings included:Record review of Resident #31's admission sheet dated 11/28/24 documented a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, anxiety disorder, hypertension (high blood pressure), recurrent depressive disorders, hyperlipidemia (high cholesterol), and pseudobulbar affect (a condition that is characterized by episodes of sudden uncontrollable and inappropriate laughing or crying.) Record review of Resident #31's most recent quarterly MDS assessment dated [DATE] documented the resident was moderately cognitively impaired for daily decision-making skills and had received scheduled and as needed pain medication regimen in the last five days.Record review of Resident #31's comprehensive care plan dated 5/28/25 documented the resident needs pain management and monitoring for chronic pain syndrome with goals of maintaining adequate level of comfort, not experiencing a decline in function related to pain, and achieving acceptable pain level goal daily.Record review of Resident #31's MAR (Medication Administration Record) for July 2025 included the following:-Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day for chronic pain. Further review of the MAR noted the resident received the morning dose of pain medication administered by the Medication Aide on 7/17/25 at 7:35 AM with 16 doses remaining.Record review of the controlled medication reconciliation log for Resident #31's Norco 5/325 located on the medication aide cart, noted 17 doses available of Resident #31's Norco 5/325, however only 16 doses were observed in the blister pack of medication. During an interview with the Medication Aide on 7/17/25 at 7:35 AM, when asked why it was important to deduct a controlled medication on the reconciliation log immediately after administering a dose, the Medication Aide stated, if you don't sign a medication out right away, you could forget to do it later causing the count to be off. Record review of the facility policy titled Controlled Substance Administration & Accountability, with a copyright date of 2025, noted All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. The policy further documented, In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form.Record review of the facility's policy titled Medication Administration with a copyright date of 2025, noted Policy Explanation and Compliance Guidelines: 21. If medication is a controlled substance, sign narcotic book.

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	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for one of two medication carts (nurse medication cart) and one of one medication rooms observed for drug storage and labeling, as evidenced by:1. The facility failed to ensure the medication room contained no unexpired supplies.2. The facility failed to ensure all insulin pens located inside the nurse medication cart were properly labeled with opened dates.These failures could place residents at risk of receiving inadequate treatments or false results. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for one of two medication carts (nurse medication cart) and one of one medication rooms observed for drug storage and labeling, as evidenced by:1. The facility failed to ensure the medication room contained no unexpired supplies.2. The facility failed to ensure all insulin pens located inside the nurse medication cart were properly labeled with opened dates.These failures could place residents at risk of receiving inadequate treatments or false results. The findings included: During an observation on [DATE] at 7:45 AM of the nurse medication cart with LVN A, it was discovered that one of five insulin pens did not have an opened date documented anywhere on the pen. During an interview with LVN A on [DATE] at 7:45 AM, when asked why it was important to make sure the insulin pens were dated, LVN A stated if insulin pens were not dated, it would not be known how long they had been in use, and the medication could be expired. During an observation of the medication room on [DATE] at 8:35 AM with the DON, it was discovered that one package of flu collection swabs (4/2025) and one package of specimen collection kits (2024) were expired. During an interview with the DON on [DATE] at 8:35 AM, when asked what could happen if expired supplies were used to obtain specimens for testing, the DON stated the supplies might not work properly or provide inaccurate results and the expectation is that staff using the medication room clean out expired supplies upon discovery. Review of the facility's policy titled Labeling of Medications and Biologicals with a copyright date of 2025, noted Labels for individual drug containers must include: h. The expiration date when applicable.Review of the facility's policy titled Medication Administration with a copyright date of 2025, noted Policy Explanation and Compliance Guidelines: 13. Identify expiration date. If expired, notify nurse manager.