| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455687 | A. Building<br>B. Wing | 03/06/2025 |

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| Alameda Oaks Nursing Center | 1101 S Alameda<br>Corpus Christi, TX 78404 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039<br><br>Based on interviews and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for quality of care.<br><br>The facility failed to have a nurse evaluate Resident #1 after an unwitnessed fall. Resident #1 sustained a left distal femoral shaft fracture and a right tibia and fibula fracture.<br><br>The noncompliance was identified as PNC. The PNC began on 08/29/24 and ended on 09/05/24. The facility had corrected the noncompliance before the investigation began.<br><br>The failure could affect residents, resulting in not receiving needed care to maintain optimal health and placing them at risk for injury or deterioration in their condition.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet dated 03/04/25 revealed an [AGE] year-old female with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included acquired absence of left leg above knee, unspecified dementia, and depression.<br><br>Record review of Resident #1's discharge MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 2 (severe impairment).<br><br>Record review of Resident #1's care plan dated 11/05/24 revealed the focus Resident is at risk for falls r/t impaired mobility, weakness, impaired cognition, and pain initiated on 09/17/24 and revised on 11/06/24. Interventions listed for the focus included:<br><br>Anticipate and meet the resident's needs initiated on 05/29/24 and revised on 11/06/24.<br><br>Assist with ADL's as needed initiated on 03/02/24 and revised on 11/06/24.<br><br>Call light within reach initiated on 03/02/24 and revised ono 11/06/24.<br><br>Complete fall risk assessment initiated on 03/02/24 and revised on 11/06/24.<br><br>(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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs initiated on 06/04/24 and revised on 11/06/24.<br><br>May have [non-slip mats] to wheelchair initiated on 08/07/24 and revised on 11/06/24.<br><br>May have floor mats next to bed initiated on 06/04/24 and revised on 11/06/24.<br><br>Orient resident to room initiated on 03/02/24 and revised on 11/06/24.<br><br>Therapy evaluate and treat as ordered or PRN fall 05/28/24 resident currently on PT, therapy informed of fall resident DC'd off OT due to refusals initiated on 05/29/24 and revised on 11/06/24.<br><br>Will review medications for adverse reactions initiated on 06/04/24 and revised on 11/06/24.<br><br>Record review of the provider investigation report dated 09/05/24 revealed the following witness timeline:<br><br>Timeline - 8.29.24 [Resident#1]<br><br>Approximately 5:50 AM:<br><br>[CNA A], rounding on 400 hall and she hears resident saying help me help me.<br><br>[CNA A] attempts to get resident up. Resident states she cannot stand. [CNA A] leaves room to go get help.<br><br>[CNA A] gets other [CNA B] and asks her to help get [Resident #1] up off floor.<br><br>[CNA A] and [CNA B] enter [Resident #1's] room. Both get resident up from floor and assist her into wheelchair. Both aides then transfer her into bed and tuck her back into bed.<br><br>Both aides leave room and continue with final rounds. Neither report fall to nurse or other aides on their shift or oncoming shift.<br><br>Approximately 7:00 AM:<br><br>[CNA C] is rounding on 400 hall and goes to check [Resident #1].<br><br>[Resident #1] reports pain in her leg and wanting to see the Dr.<br><br>[CNA C] reports this to her nurse [RN D].<br><br>[RN D] calls doctor and Dr. order Xrays.<br><br>Xray results come in and [Resident #1] is transferred to hospital with acute left femur fracture.<br><br>Incident is reported to HHSC<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | All staff interviewed from night before, no one reports [Resident #1] having a fall.<br><br>[CNA B] and [CNA A] state they rounded on [Resident #1] was having increased weakness, however, was a self transfer and only required assistance to transfer into bed.<br><br>Staff inserviced on: Abuse/Neglect/Exploitation, Falls, and Transfers<br><br>Tuesday, September 2nd, 2024<br><br>Interview with aides [CNA A] and [CNA B] reveals that resident sometimes needed more assistance with transferring and toileting at night. [CNA B] states she asked [Resident #1] to pivot on transfer into bed but that there was no sign of pain [or] grimacing. [CNA A] agreed with interview.<br><br>Wednesday, September 3rd, 2024<br><br>Aides [CNA A] and [CNA B] interview along with Nurses [RN E] and [RN D]<br><br>[Resident #1] readmits to facility.<br><br>Interview of resident by [ADM] and DON. Resident revealed that she fell in door way when ambulating back to bed after having gone to restroom. She states she does not remember who came to help her but a nurse came to help her. When the resident stated she could not stand the nurse went to get another nurse and they both picked her up off the floor and transferred her to bed. Resident stated at the time she felt nothing and went back to sleep. Later, around 7a she felt pain and requested from a different nurse to see the doctor.<br><br>Aides interviewed again and statement of [CNA A] changes.<br><br>Aides [CNA A] and [CNA B] suspended pending investigation.<br><br>[CNA A] and [CNA B] terminated based off of investigation findings.<br><br>Record review of the provider investigation revealed the following interviews:<br><br>Resident #1 on 09/04/24<br><br>Around 7a I got up from bed to go to the restroom. I was going back to bed when I heard a pop and my leg gave out. I fell in my doorway. A nurse came right away and tried to help me off the floor but I could not stand. She left and came back with a second nurse. Both nurses helped get me off the floor and sat me in my wheelchair. They then wheeled me closer to my bed and transferred me into bed. I do not remember their names. I didn't feel any pain then. Later, another nurse came to check on me and I told her my leg was turned the wrong way and hurt and I needed to see the doctor. She said okay that she would tell someone. Another Nurse called the doctor and they did xrays on my leg and it was broken.<br><br>CNA A on 09/04/24<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | I was walking down 400 hall when I heard a resident saying help me help me. I entered [Resident #1's] room and found her on the floor in the doorway of the bathroom. I went to get the other [CNA B]. [CNA B] and I got her up. We put her in her wheelchair and then put her in bed. I asked [Resident #1] if she was okay and she said she was. We then kept rounding. We never told the nurse.<br><br>Record review of x-ray of Resident #1 dated 08/29/24 revealed a fracture through the left distal femoral shaft at the level tip of the intramedullary femoral stem, minimally comminuted (fracture that extends into the knee and up through the femur). Further review revealed a fracture of the right tibia and fibula.<br><br>Record review of a local hospital's patient records for Resident #1 dated 08/30/24 revealed the following plan: Regarding patient's left distal femur fracture, this fracture is not fixable and unfortunately is not convertible either. At this time [Doctor] has recommended a left above-knee amputation.<br><br>Interview was attempted with CNA A at 10:58 AM on 03/05/25, but CNA A could not be reached so a message was left.<br><br>Interview was attempted with CNA B at 11:00 AM on 03/05/25, but CNA B could not be reached so a message was left.<br><br>In an interview with the ADM at 11:22 AM on 03/05/25, the ADM stated they did not know Resident #1 had fallen from the incident on 08/29/24 until they interviewed her on 09/04/24. The ADM stated before they were able to interview Resident #1 they thought the breaks were from brittle bones. The ADM stated they originally thought the fractures caused the fall, and not the fall caused the fractures. The ADM stated Resident #1 had problems with her left knee, and she had several surgeries on it in the past few years. The ADM stated she believe the ultimate outcome of left leg above knee amputation of Resident #1 would not have changed even if the CNA's A and B had acted appropriately. The ADM stated CNA A and CNA B should have found a nurse to evaluate the resident on the floor before moving her at all. The ADM stated no employee had ever come to her to report another employee for possible abuse of a resident. The ADM stated the two CNA's involved in this incident had always been good CNA's. The ADM stated they conducted safe surveys after the incident and all residents reported they felt safe. The ADM stated they inserviced all employees on abuse, neglect, falls, and alerting staff if there was a fall. The ADM stated they made cards that all employees carried on their badges to inform them of the proper steps in case a resident fell .<br><br>In an interview with Witness #1 at 1:40 PM on 03/05/25, Witness #1 stated she was a good friend of Resident #1. Witness #1 stated she visited Resident #1 when she was in the hospital after her fall on 08/29/24. Witness #1 stated Resident #1 told her she went to the bathroom and fell . Witness #1 stated Resident #1 told her the CNA's tried to move her several times while she was in the bathroom, but her legs kept hurting more and more. Witness #1 stated the two CNA's had a tough time picking up Resident #1, but one of them bear hugged her and threw her in bed. Witness #1 stated Resident #1 told her she asked for the nurses to come back and check on her legs, but they left the room.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview with the NP at 2:49 PM on 3/5/25, the NP stated Resident #1 had infective hardware with multiple revision surgeries (surgery to correct or modify the results of a previous surgery) on her left knee. The NP stated Resident #1 was on IV antibiotics for an extended period of time before the fall on 08/29/24. The NP stated she initially sent the resident out to the hospital for swelling and the fractures in her legs. The NP stated there was potential the CNA's could have caused more damage when they moved her. The NP stated in this condition Resident #1's leg was in, any fall or twist could have injured it. The NP stated she still had Resident #1 as her patient, and Resident #1 was doing much better with pain control after the amputation.<br><br>In an interview with Resident #1 at 10:48 AM on 03/06/25, Resident #1 stated she remembered the facility she was at when she had her fall at the end of August. Resident #1 stated she was leaving her bathroom when her feet came out from under her. Resident #1 stated she did not remember hearing a pop before falling. Resident #1 stated he hips faced one way while her legs faced the other. Resident #1 stated it was very painful. Resident #1 stated when she told the nurses about her pain they did not believe her. Resident #1 stated one of the nurses told her bite the bullet for a bit while she moved her back into bed. Resident #1 stated she told the first two nurses that she wanted to see the doctor but they laughed at her. Resident #1 stated once she was back in bed she positioned her legs so they did not hurt as bad. Resident #1 stated it was not until a 3rd nurse came in 30 minutes later that started helping her for the pain.<br><br>In an interview with CNA C at 1:59 PM on 03/06/25, CNA C stated when she entered Resident #1's room around 7:00 AM on 08/29/24 it looked like Resident #1 was in severe pain and very uncomfortable. CNA C stated Resident #1 told her she was in pain. CNA C stated she went and got the nurse as soon as she realized the condition Resident #1 was in.<br><br>Record review of the facility policy titled Incident and Reportable Event Management issues 07/19/21, revised 08/15/23 and reviewed 09/25/24 revealed the following:<br><br>Incident/Injury<br><br>1. The licensed nurse should evaluate the resident and render first aide if needed<br><br>a. The nurses evaluation should be completed prior to moving a resident who has fallen, to determine presence of injury.<br><br>2. The licensed nurse should create an event note and include the following details;<br><br>a. The assessment details of the resident (including location details of the resident)<br><br>b. Presence or absence of injury, and any treatments rendered<br><br>c. If resident is able to report what occurred, this should be included in the notes<br><br>d. Notification of family or responsible party<br><br>e. Notification of physician and any orders received<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 3. The licensed nurse should create a risk report in the electronic system and identify the most appropriate type of event from the available options in the system.<br><br>4. The licensed nurse should also notify the following in accordance with state and federal requirements<br><br>a. Supervisor on duty and/or DON<br><br>In interviews beginning at 2:12 PM on 03/04/25 with staff from multiple shifts, the DON, ADM, CNA C, CNA F, LVN G, CNA H, CNA I, CNA J, LVN K, LVN L, MA M, CNA N, CNA O, CNA P, and RN Q were able to identify the proper procedures to follow when responding to a witnesses or unwitnessed fall. All staff knew not to move the resident before getting the nurse and referenced the card attached to their name badges to demonstrate the proper protocol. All staff were familiar with different types of abuse and neglect.<br><br>Record review and verification of the corrective action implemented by the facility beginning on 08/29/25:<br><br>The facility terminated the employment of CNA A and CNA B effective 09/05/24 verified by record review of the provider investigation, staff roster, and interview with the ADM.<br><br>Resident #1 was discharged to another nursing facility on 11/05/24 verified through record review of Resident #1's face sheet and interview with the ADM.<br><br>teams<br><br>Re-educated and in-services staff beginning on 08/29/25 verified through interviews with carious staff members and record review of in-services.<br><br>Abuse and Neglect<br><br>Exploitation<br><br>Falls<br><br>Transfers<br><br>Ad-Hoc QAPI conducted on 09/05/24 regarding incidents/accidents verified by interview with the ADM.<br><br>Reviewed all policies regarding falls on 09/05/24 verified by interview with the ADM.<br><br>Badge cards created on 09/05/24 for all staff to be worn at all times detailing proper step-by-step procedures for what to do if a resident fell or was found on the ground verified by interviews with various staff.<br><br>The noncompliance was identified as PNC. The PNC began on 08/29/24 and ended on 09/05/24. The facility had corrected the noncompliance before the investigation began. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038<br><br>Based on interview and record review, the facility failed to ensure that each resident received adequate supervision for one Resident (Resident #2) of three residents reviewed for supervision.<br><br>The facility failed to ensure Resident #2 received adequate supervision and did not exit the facility through the front door.<br><br>This failure could place residents requiring supervision at risk for injury and accidents.<br><br>The findings include:<br><br>Record review of Resident #2's face sheet dated 03/05/35 reflected a [AGE] year-old male with an original admitted [DATE]. Diagnoses included heart failure, type two diabetes (insufficient insulin production in the body), Alzheimer's disease (disease that destroys memory and thinking skills), and Dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life). Resident #2 was discharged on [DATE].<br><br>Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 1 (severe cognitive impairment).<br><br>Record review of Resident #2's care plan dated 11/11/24 reflected Resident #2 was at risk for elopement related to confusion/disorientation to place, impaired safety awareness, and aimless wandering. Interventions included frequent monitoring and wandering behavior at times. The plan did not indicate any previous elopement attempts.<br><br>In an interview on 3/5/25 at 9:26am the Central Supply staff member stated on 11/09/24 she was going to do a transport and was parking the facility bus upfront in the driveway when she saw Resident #2 sitting on the bench by the front door with no attempt to get up and walk. The Central Supply staff member stated she parked the facility bus and redirected Resident #2 back inside without incident. The Central Supply staff member stated Resident #2 stated he was just enjoying the fresh air. The Central Supply staff member stated a former maintenance assistant was outside at the time and stated Resident #2 was sitting outside for about 3-5 minutes according to a previous maintenance assistant who was outside at the time working. The Central Supply staff member said the former maintenance assistant said Resident #2 did not attempt to go anywhere or was not in any danger and if so, he would have intervened and called for assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 3/5/25 at 9:38 am LVN G stated there was a new receptionist who went on break and did not set the door alarm correctly (no wander guard system in use at facility). LVN G stated Resident #2 was found sitting on the bench near front door by a Central Supply staff member and stated Resident #2 was brought back into the facility. LVN G stated a head-to-toe assessment was conducted with no noted injuries. LVN G said at the time of the assessment, Resident #2 stated he was just sitting outside getting some fresh air. LVN G stated Resident #2 was placed on one-to-one monitoring. LVN G stated the facility elopement protocols were conducted, and all other residents were accounted for. LVN G stated Resident #2 did not display any exit seeking behaviors prior but was discharged to a secured unit at another facility.<br><br>Through interviews and record review, no residents were exit seeking and only had risks for elopement.<br><br>In an interview on 3/5/25 at 2:12 pm the ADM stated Resident #2 was at the back station and the receptionist who was new was trying to leave for lunch and locked the door but did not realize the door only locks on the outside and not the inside. The ADM stated Resident #2 was outside for about 3-5 minutes the Maintenance Assistant (no longer employed with facility) saw Resident #2 sitting on the bench and watching him work. The ADM stated that a Central Supply staff member pulled up to the facility moments after and realized Resident #2 was not supposed to be outside and brought him back in immediately and notified the nurse. The ADM stated Resident #2 was found right by the front door sitting on the bench approximately 6-7 feet. The ADM stated Resident #2 was not trying to leave the facility and was simply sitting outside with no immediate danger noted at the time. The ADM stated Resident #2 was assessed with no injuries and was transferred to another facility with a secured unit. The ADM stated all staff were in-serviced on elopement and drills were conducted beginning on 11/09/24 with all staff on all shifts.<br><br>In an interview on 3/5/25 at 2:45 pm the ADON stated Resident #2 would wander about the facility but was not exit seeking. The ADON stated she heard Resident #2 had exited the facility and was found sitting on the bench by the front door. The ADON stated Resident #2 was allowed to go outside but with supervision and usually goes outside in the courtyard area. The ADON stated staff were in-serviced on elopement, exit seeking behaviors, and elopement drills conducted beginning on 11/09/24 (verified through record review).<br><br>In a phone interview on 3/5/25 at 4:40pm the previous Receptionist stated she was going to lunch and normally someone relieves her but, on that day, there was no one to relieve her at that moment and waited for someone to relieve her. The receptionist stated she spoke to a charge nurse who said she could leave but lock the front door. The Receptionist stated she locked the door but was fairly new and thought she locked it correctly but guess she didn't. The Receptionist stated when she returned after lunch, that was when she learned Resident #2 had exited through the front door. The Receptionist stated she was shown how to lock the door but guess she did not alarm it correctly.<br><br>Record review of the facility's Elopement policy dated 01/03/2022 and revised on 11/19/2024 reflected:<br><br>Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | S483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>S483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. |