STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455687	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Oaks Nursing Center	1101 S Alameda Corpus Christi, TX 78404

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** 47371 Based on observations, record review, and interviews, the facility failed to ensure residents were treated with respect and dignity and care for each resident in a manner and in an environment, that promoted maintenance or enhancement of his or her quality of life, for one Resident (Resident #2) of 5 residents reviewed for dignity issues. On 04/29/2025 at 11:04AM and 11:55AM Resident #2's foley catheter drainage bag did not have a privacy bag, leaving the urine visually exposed to visitors and staff. This failure could place residents at risk of feeling uncomfortable or embarrassed and could decrease a residents' self-esteem and/or quality of life. Findings were: Record review of Resident #2's admission record dated 04/29/2025 revealed Resident #2 was a [AGE] year-old-male who was admitted on [DATE]. Additionally, Resident #2 was admitted with a diagnosis of benign prostatic hyperplasia (urinary obstructions) with lower urinary tract symptoms. Record review of Resident #2's Admissions MDS was not yet completed due to Resident #2 being admitted on [DATE]. Record review of Resident #2's Care Plan date initiated:04/25/2025 revealed the resident has Indwelling Foley Catheter: 18F/10cc bulb r/t BPH, bilateral hydronephrosis, and urinary retention. Goal: Will have no complications r/t indwelling catheter use. Interventions: Catheter care every shift, educate resident and/or family regarding indwelling catheter and care. Record review of Resident #2's Physician Orders dated 4/24/2025 revealed, Indwelling catheter to straight drainage. Size: 18 Fr/ Bulb: 10 cc. Change for infection, obstruction or when the closed system is compromised. As needed for Change for infection, obstruction or when the closed system is compromised. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/29/2025 at 11:04AM and 11:55AM Resident #2 was in bed, with call light within reach. Additionally, upon further observation there was a visible foley catheter with roughly 200-300ml of yellow urine in the foley bag. Furthermore, while in the immediate hallway, where Resident #2's room was situated, there were roughly 4-5 people including staff and visitors, who walked past Resident #2's room. During an interview on 4/29/2025 at 12:09PM CNA A stated privacy bags were placed by nurses and not CNAs. CNA A stated CNAs were allowed to provide perineal care and incontinent care but could not place privacy bags. CNA A stated she did not know the reason as to why CNAs were not allowed to place privacy bags on foley catheters. CNA A stated privacy bags were utilized to ensure the resident maintained their right to privacy and to ensure resident's urine was not visible. CNA A stated if a foley catheter did not have a privacy bag, a resident could feel embarrassed or hurt. CNA A stated it was within the nurse's scope of practice to place a privacy bag on Resident #2's foley catheter. CNA A stated she did not recall when she attended an in-service regarding foley catheter care or privacy bags. During an interview on 04/29/2025 at 12:17PM LVN C stated Resident #2 was moved to the 300 hall over the weekend. LVN C stated prior to his room change, Resident #2 was in the 100 hall for several weeks. LVN C stated, while observing Resident #2 in his room, Resident #2 should have a privacy bag on his foley catheter but did not. LVN C stated all clinical staff could place privacy bags and it was not the sole responsibility of the nurses. LVN C did not give a definitive answer as to how a resident could have been affected given that Resident #2 was cognitively impaired. LVN C stated privacy bags were utilized to ensure Resident #2's right to privacy and it could have been compromised due to the catheter being visible to visitors and staff. LVN C stated he would rectify the situation by placing a privacy bag on Resident#2's foley catheter. LVN C stated he could not recall the last in-service he attended regarding foley catheter care and privacy bags. During a phone interview on 04/29/2025 at 2:23PM the DON stated the dignity bag or privacy bags were utilized to cover the urine output within the foley catheters. The DON stated the expectation was for all foley catheters to have some sort of covering. The DON stated privacy coverings were used to ensure that resident's urine output was not seen by the visitors to ensure the resident's right to privacy. The DON stated she could not definitively state how a lack of privacy covering could affect residents with foley catheters. The DON referenced her own familial experience to justify that a lack of privacy covering on a foley catheter may not compromise the psycho-social well-being of a person. The DON reiterated privacy bags/shields should be utilized for all foley catheters to ensure the resident's right to privacy. The DON stated she had been employed at the facility for roughly 1 week and did not recall attending an in-service regarding foley catheter privacy bags. Requested foley catheter care/privacy bag in-services on 04/29/2025 at 1:54PM to the Administrator, did not receive by the time of the exit conference. Record review of the facility's Dignity policy and procedure issued date: 05/19/2019; reviewed 09/26/2024 documented, Procedure: 2. Promoting resident independence and dignity while dining, such as avoiding: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Refraining from practices demeaning to residents, such as leaving urinary catheter bags uncovered.

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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** 47371 Based on interviews and record review, the facility failed to ensure that all alleged violations involving the reasonable suspicion of a crime were reported immediately to a law enforcement entity for its political subdivision, within two hours if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, for 1 (Resident #1) of 5 residents reviewed for abuse/neglect. The facility failed to report to the local law enforcement agency within the allotted time frame of 24 hours on 11/24/2024 around 2 PM when Resident #1 notified LVN A that LVN B allegedly had thrown her into a wheel chair. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse. The findings included: Record review of Resident #1's admission record dated 04/26/2025 revealed Resident #1 was a [AGE] year-old-female who was admitted on [DATE]. Additionally, Resident #1 was admitted with diagnoses Parkinson's disease (neurological disease that affected movement), and dysphagia (swallowing problem). Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 which meant she was cognitively aware and needed setup or clean-up assistance for her ADLs. Record review of Resident #1's care plan Date Initiated: 06/28/2024, The resident has an ADL self-care performance deficit r/t Confusion, impaired balance touch pad needed/ in place due to unable to press call bell. Observe and report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Praise all efforts at self-care. PT/OT evaluation and treatment as per MD orders . Record review of the written statement by LVN A dated 11/24/24 revealed during an interview, Resident #1 stated [LVN B] grabbed her by her arm and leg and threw her into a wheelchair . During a phone interview on 04/29/2025 at 2:23 PM the DON stated she had been employed with the facility for roughly 1 week. The DON stated once an allegation of abuse was made, the facility would activate their abuse protocols which would consist of protecting the resident, calling the police if needed, and reporting the allegation to state agencies. The DON stated she would assume any form of abuse would be a criminal offense and if proven true the person could get into a lot of trouble. The DON stated she could not speak to the actions or lack of actions regarding the previous DON, but in her professional opinion if there was an allegation of physical abuse, she would notify local law enforcement. The DON did not definitively state what could transpire if the local law enforcement were not notified of the allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/2025 at 2:41PM the Administrator stated when she was made aware of the allegation on 11/24/2024, she enacted the facility abuse protocol. The Administrator stated she treated the allegation as a physical abuse allegation. The Administrator stated she ensured the LVN B who was the alleged perpetrator was removed from the facility and the facility schedule, pending the investigation results. The Administrator stated she notified Health and Human Services Commission of the allegation of physical abuse. The Administrator stated she directed her clinical staff to ensure the safety of Resident #1 and ensured the nursing staff performed a head-to-toe assessment. The Administrator stated Resident #1 stated the allegation of abuse transpired in June 2024 and therefore focused their record review for June 2024 to ensure there were no skin irregularities noted. The Administrator stated Resident #1 notified LVN A on 11/24/24 that LVN B threw her in a geriatric chair roughly in June 2024. The Administrator stated she did not contact the local law enforcement on 11/24/2024 regarding the allegation of physical abuse due to the allegation transpiring in June 2024. The Administrator stated her reason for not calling local law enforcement was due to the allegation timeframe of June 2024. The Administrator stated LVN B was allowed to return to the facility as there was no evidence of any physical abuse. The Administrator stated Resident #1 no longer resided within the facility. The Administrator did not verbalize a definitive answer when asked as to what could potentially happen if local law enforcement were not notified of an allegation of physical abuse. The Administrator stated once the investigation into Resident #1's allegation concluded there was no evidence of the physical abuse. The Administrator verbally clarified, going forward any allegation of abuse would be notified to the proper authorities and state agencies . Record review of the facility's Abuse-Protection of Residents policy and procedure issued:10/04/2022; Reviewed: 06/17/2024 documented, Procedure: The following methods to ensure the protection of residents during an investigation may include but are not limited to; 5. Notification of the alleged violation to other agencies or law enforcement authorities.