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	11/20/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 3 residents (Residents #1, #2, and #3), reviewed for pharmaceutical services, in that: 1. LVN A failed to administer Resident #1's Morphine at his scheduled time on 10/09/25.2. LVN A failed to administer Resident #3's Tramadol at her scheduled time on 10/09/25.3. LVN B administered Resident #2's Tramadol without an order in place.The findings included: 1. Record review of Resident #1's face sheet, dated 10/10/25, revealed the resident was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses that included: other chronic pain (pain that last more than 3 months), peripheral vascular disease (circulation disorder caused by narrowing, blockage or spasms in blood vessels), secondary osteoarthritis (joint degeneration caused by another medical condition), right ankle and foot, hemiplegia (paralysis of one side of body) and hemiparesis (one side weakness) following cerebral infarction (a stroke - death of brain tissue due to lack of blood flow) affecting left dominant side. Record review of Resident #1's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 indicating no cognitive impairment. Record review of Resident #1's care plan, with an initiation date of 06/17/24 had a focus that stated Resident #1 was on pain medication therapy related to chronic pain with an initiation date of 03/08/25 with interventions that included to administer analgesic medication as ordered by physician with an initiation date of 03/08/25. Record review of Resident #1's active physician's orders, retrieved on 10/10/25, revealed an order for Morphine Sulfate ER Tablet Extended Release 15mg with a start date of 10/02/25 and an indefinite end date stated it was to be administered two times a day, at 9:00 am and 5:00 pm. Record review of Resident #1's narcotic sheet revealed LVN A had signed that she administered Resident #1's morphine at 7:57 pm on 10/09/25. During an interview with Resident #1 on 10/09/25 at around 8:05 pm, he stated he had just gotten his morphine not too long ago. He stated he did not have any pain between 5:00 pm and the time of interview. Resident #1 stated he had a meeting after dinner, but stated he had not asked to hold his medication. During an interview with LVN A on 10/09/25 at 8:28 pm, she stated Resident #1 had morphine scheduled at 5:00 pm, and stated she administered it at 7:57 pm. LVN A stated she did not know Resident #1 had morphine scheduled at 5:00 pm and stated it was not given on time because she was busy and stated it was her first time doing med pass and she did not know there were so many scheduled narcotics. LVN A also stated Resident #1 had a lot of family in his room and they were having a meeting and she did not want to interrupt. LVN A stated Resident #1 never complained of pain from the time his morphine was scheduled at 5:00 pm to the time it was administered at 7:57 pm. LVN A stated it was important to provide medication at the time it was scheduled so that residents' pain would not get out of control. LVN A stated she had been trained over medication administration and following physician orders when she was hired in September of 2025. LVN A stated the facility policy for medication administration stated medications were due at the time they were ordered. LVN A stated she did not follow the facility policy. LVN A stated not administering medication such as morphine on time could negatively impact residents because they could have pain. During an interview with the DON on 10/10/25 at 6:48 pm, she stated Resident #1 had orders for Morphine 2 times a day, once at 9:00am and 5:00pm. The DON stated Resident #1 received his morphine late on 10/09/25 at 7:57pm. The DON stated LVN A was responsible for administering the medication to Resident #1 at the time it was late and stated it was late because Resident #1 had stuff going on with a family member trying to get power of attorney. The DON stated Resident #1 did not have any negative outcome due to receiving his medication late and did not verbalize any pain to her. The DON stated it was important that residents got their medications for the continuity of care and stated that residents with chronic pain were used to having medication at a certain time, and it was their duty to make sure they were free of pain and their pain was at a certain level to where they were comfortable. The DON stated LVN A had been trained upon hire by the SDC over medication administration and following the scheduled times. The DON stated as per their facility policy medication had to be given in a timely manner, and stated they had a 1-hour window to administer. The DON stated LVN A did her best to follow the policy in this situation, and did not state if she did or did not follow the policy. The DON stated not providing medication at the scheduled time could negatively impact residents because they could start to withdraw or start having behaviors and yelling out, or they could get anxiety. 2. Record review of Resident #3's face

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 are complete and accurately documented for 3 of 3 residents (Resident #1, #2 and #3) reviewed for medical records accuracy, in that: 1. Facility staff failed to document Resident #1's administered tramadol on his medication administration record in September 2025 and October 2025. 2. Facility staff failed to document Resident #2's administered tramadol on her medication administration record in September 2025 and her administered morphine in October 2025. 3. Facility staff failed to document Resident #3's administered Morphine on her medication administration record in October 2025. This failure could affect residents whose records were maintained by the facility and could place them at risk for errors in care, treatment and medication administration.The findings included: 1.Record review of Resident #1's face sheet, dated 10/10/25, revealed the resident was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses that included: other chronic pain (pain that last more than 3 months), peripheral vascular disease (circulation disorder caused by narrowing, blockage or spasms in blood vessels), secondary osteoarthritis (joint degeneration caused by another medical condition), right ankle and foot, hemiplegia (paralysis of one side of body) and hemiparesis (one side weakness) following cerebral infarction (a stroke - death of brain tissue due to lack of blood flow) affecting left dominant side. Record review of Resident #1's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 indicating no cognitive impairment. Record review of Resident #1's care plan, with an initiation date of 06/17/24 had a focus that stated Resident #1 was on pain medication therapy related to chronic pain with an initiation date of 03/08/25 with interventions that included to administer analgesic medication as ordered by physician with an initiation date of 03/08/25. Record review of Resident #1's order summary report revealed an order for tramadol oral tablet 50 MG every 12 hours as needed for pain with a start date of 06/18/25 and discontinue date of 10/01/25. Record review of Resident #1's order summary report revealed an order for tramadol oral tablet 50 MG every 6 hours as needed for pain with a start date of 10/01/25 and a current order status of active as of 10/10/25. Record review of Resident #1's narcotic sheet revealed LVN C had signed that she administered Resident #1 with his ordered tramadol on 09/24/25 at 10:10am. Record review of Resident #1's narcotic sheet revealed LVN B had signed that he administered Resident #1 with his ordered tramadol on 09/24/25 at 9:00pm and on 10/05/25 at 8:00am and 8:00pm. Record review of Resident #1's order for tramadol on his September 2025 and October 2025 MAR revealed staff did not sign off that his medication was administered on 09/24/25 at 10:10am and 9:00pm and 10/05/25 at 8:00am and 8:00pm. During an interview with LVN C on 10/10/25 at 2:10 pm, she confirmed that she provided Resident #1 with his tramadol on 09/24/25 at 10:10 am. LVN C reviewed Residents #1's September MAR and stated it was blank, and it meant it was not signed as administered. LVN C stated she was responsible for documenting the administration of the medication. LVN C stated she did not recall why she did not document the medication was administered on Resident #1's MAR. LVN C stated the administration of Resident #1's medication should have been documented on his MAR and stated it was important to do for resident safety and because some physicians will look at the MAR and not the narcotic sheet and may discontinue a medication if they see It was not being given. LVN C stated she had been trained over medication administration and documentation and stated she was last trained on 10/09/25. LVN C stated the facility policy stated they were to document medication provided on both the narcotic sheet and the MAR. LVN C stated she had not followed the facility policy. LVN C stated not documenting the administration of medication on the MAR could impact residents safety. During an interview with LVN B on 10/10/25 at 3:06pm, he confirmed that he provided Resident #1 with his tramadol on 09/24/25 at 9:00pm and on 10/05/25 at 8:00am and 8:00pm. LVN B reviewed Residents #1's September and October MAR and stated he had not documented on the MAR. LVN B stated he was responsible for documenting the administration of the medication. LVN B stated he was planning to go back and document but he forgot. LVN B stated the administration of Resident #1's medication should have been documented on his MAR, and it was important to do so to ensure someone was not over medicated and make sure it was being monitored correctly. LVN B stated he had been trained over medication administration and documentation, and he was last trained by the DON a week or 2 prior. LVN B stated the facility policy stated they were to document medication provided on both the narcotic sheet and the MAR. LVN B stated he had not followed the facility policy. LVN B