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	12/03/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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 0553 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 ensure residents participated in the care planning process with the resident and the resident's representative for 1 of 5 residents (Resident #1) reviewed for comprehensive care plans in that: The facility failed to ensure care plan meetings were held with Resident #1 and/or the resident's representative. This failure could place residents at risk of not being involved in developing the plan for the care they will receive.The findings included:Record review of Resident #1's face sheet dated 10/01/25 revealed a [AGE] year-old female with an admission date of 08/31/23 and a discharge date of 08/18/25. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (ongoing inflammation and narrowing of the airways, making it difficult to breathe) and Alzheimer's Disease (progressive brain disorder that causes memory loss, cognitive decline, and behavioral changes). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 (severe impairment). Record review of Resident #1's comprehensive care plan dated 08/18/25 revealed it had been developed with interventions made in the care plan throughout her stay at the facility. The care plan did not address how often a care plan meeting should be held. Record review of the most recent care plan meeting attendance sheet dated 03/06/25 revealed Resident #1's representative was in attendance via phone call. In an interview with the RP for Resident #1 at 2:18 PM on 09/30/25, the RP stated the last time she was involved in a care plan meeting with the facility was in March of 2025. The RP stated she had not been notified about any other care plan meetings after the meeting in March of 2025. In an interview with the SW at 11:22 AM on 10/01/25, the SW stated he started working at the facility on 07/16/25. The SW stated he had not had a care plan meeting with Resident #1 or her representative since he had worked at the facility. The SW stated care plan meetings should be held at least quarterly, and possibly more often depending on the needs of the residents. The SW stated he tried to sync up their quarterly care plan meetings with comprehensive assessments. The SW stated he scheduled the care plan meetings. The SW stated it was important to invite the resident and resident representative to the care plan meetings to ensure everyone was on the same page regarding the resident's care. In an interview with the ADM at 11:43 AM on 10/01/25, the ADM stated the last care plan meeting for Resident #1 the facility had evidence for was held was on 03/06/25. The ADM stated there had not been any major changes in the care of Resident #1 since the last care plan meeting. The ADM stated the SW was responsible for scheduling care plan meetings. The ADM stated it was important to involve the resident and resident representative in the care planning process so everyone could share their opinion and be on the same page regarding care. Record review of the facility policy Comprehensive Care Plans and Conferences written on 01/26/23 and revised on 08/29/25 revealed the following policy: .2. The IDT must, at a minimum, consist of the resident's attending physician, a registered nurse and nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and to the extent possible, the resident and resident representative, if applicable.4. The facility should provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation.7. The resident's care plan must be reviewed after each assessment, as required by 483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 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 immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) reviewed for change in condition. The facility failed to ensure Resident #1's RP was notified immediately when her oxygen saturation fell to 82% on 08/14/2025. This failure could place residents at risk of their representative being unaware of their change in condition.The findings included:Record review of Resident #1's face sheet dated 10/01/25 revealed a [AGE] year-old female with an admission date of 08/31/23 and a discharge date of 08/18/25. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (ongoing inflammation and narrowing of the airways, making it difficult to breathe) and Alzheimer's Disease (progressive brain disorder that causes memory loss, cognitive decline, and behavioral changes). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 (severe impairment). Record review of Resident #1's comprehensive care plan dated 08/18/25 revealed the focus [Resident #1] has occasional episodes of SOB [related to] COPD initiated on 03/09/25 and revised on 07/04/25. Interventions listed for the focus included .oxygen at 2 liters via nasal cannula when necessary initiated on 4/25/25 and revised on 05/09/25. Record review of Resident #1's order summary revealed Resident #1 had an order for Oxygen at 2 liters/minute via nasal cannula as needed for shortness of breath initiated on 05/09/25 and discontinued on 08/20/25.Record review of Resident #1's oxygen saturation log revealed Resident #1 received oxygen via nasal cannula when her oxygen saturation was measured at 82% on 08/14/25. Record review of the change in condition evaluation completed by ADON dated 08/14/25 revealed Resident #1 experienced abnormal vital signs, decreased food and/or fluid intake, and functional decline on the morning of 08/14/25. Further review revealed Resident #1 experienced a sudden decreased level of consciousness along with a low-grade fever of 99.1 degrees Fahrenheit. Further review revealed Resident #1 had SOB, non-productive cough, abnormal lung sounds, and common cold symptoms. Further review revealed the ADON documented the physician was notified on 08/14/25 and the RP was notified on 08/21/25. In an interview with the RP at 2:18 PM on 09/30/25, the RP stated she was not notified of the change in condition for Resident #1 on 08/14/25. The RP stated she found about the change of condition when she requested Resident #1's medical records after she was discharged on 08/18/25. In an interview with the ADON at 4:04 PM on 09/30/25, the ADON stated she filled out the change in condition evaluation for Resident #1 on 08/14/25. The ADON stated she noticed Resident #1 had coughing, SOB, had not gotten out of bed, and generally did not look well. The ADON stated she was pretty sure she called the RP but could not specifically remember doing it. The ADON stated she thought she might have accidentally checked the wrong date on the evaluation for when she notified the RP. The ADON stated after a change in condition the RP should be notified right afterwards because it was important to keep them updated on the residents' status in case they had any relevant information. In an interview with the DON at 5:03 PM on 09/30/25, the DON stated she did not know why the change of condition form for Resident #1 stated the RP was notified a week after the change in condition occurred. The DON stated the date and time the RP was notified should be entered after the RP was contacted. The DON stated the RP should have been notified right away once the resident was stabilized after a change of condition so they may ask questions, come visit, or request medical treatments. Record review of the facility policy Changes in Resident's Condition or Status dated 11/26/18 and reviewed 08/29/25 revealed the following policy:.(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is - .(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 5 residents (Resident #1) reviewed for accuracy and completeness of clinical records.The facility failed to accurately document oxygen use by Resident #1 nine times during the month of August 2025 in the MAR. This failure could result in residents' records not accurately reflecting the residents' status or condition.The findings included:Record review of Resident #1's face sheet dated 10/01/25 revealed a [AGE] year-old female with an admission date of 08/31/23 and a discharge date of 08/18/25. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (ongoing inflammation and narrowing of the airways, making it difficult to breathe) and Alzheimer's Disease (progressive brain disorder that causes memory loss, cognitive decline, and behavioral changes). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 (severe impairment). Record review of Resident #1's comprehensive care plan dated 08/18/25 revealed the focus [Resident #1] has occasional episodes of SOB [related to] COPD initiated on 03/09/25 and revised on 07/04/25. Interventions listed for the focus included . oxygen at 2 liters via nasal cannula when necessary initiated on 4/25/25 and revised on 05/09/25. Record review of Resident #1's order summary revealed Resident #1 had an order for Oxygen at 2 liters/minute via nasal cannula as needed for shortness of breath initiated on 05/09/25 and discontinued on 08/20/25. Record review of Resident #1's MAR revealed Resident #1 was never administered 2 liters/minute of oxygen via nasal cannula in the month of August 2025. Record review of Resident #1's oxygen saturation log revealed Resident #1 received oxygen via nasal cannula when her oxygen saturation was measured on 08/07/25, 08/08/25, 08/12/25, 08/13/25, 08/14/25, 08/15/25, 08/16/25, 08/17/25, and 08/18/25. In an interview with the ADON at 10:21 AM on 10/01/25, the ADON stated Resident #1 would occasionally use oxygen, but Resident #1 had a habit of removing it herself. The ADON stated she was not sure about specific days that Resident #1 used oxygen, except for 08/14/25, in which she was certain Resident #1 received oxygen via nasal cannula on that day because she helped the floor nurse treat Resident #1 with oxygen. The ADON stated it was important to sign the MAR anytime medication was administered to a resident to track and trend medication usage and possibly adjust therapies. In an interview with the DON at 10:40 AM on 10/01/25, the DON stated Resident #1 would mostly use oxygen in the evenings. The DON stated she knew Resident #1 used her oxygen more after a shortness of breath incident on 08/14/25. The DON stated it was her and the ADON's responsibility to train staff on proper documentation. The DON stated it was important to sign the MAR after medication was administered to ensure medication was not given twice and to have an accurate record to look back on and make medication changes. Record review of the facility policy General Dose Preparation and Medication Administration written on 12/01/07 and revised on 11/15/24 revealed the following policy: .6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following:6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms.