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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455687 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/12/2026 |
| NAME OF PROVIDER OR SUPPLIER Alameda Oaks Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for one (Resident #1) of four residents reviewed for call light placement. The facility failed to ensure Resident #1's call light was within reach. This failure could place residents at risk of needs and accommodation being unmet. Record review of a face sheet dated 3/12/2026 indicated Resident #1 was a [AGE] year-old female, re-admitted [DATE] (initial admission date 11/13/2025), with diagnoses of Acute and Chronic Respiratory failure with Hypoxia (occurs when the lungs cannot adequately oxygenate the blood), Encounter for attention Tracheostomy (routine maintenance needed for a tracheostomy), Dependence on supplemental oxygen, Hemiplegia and Hemiparesis following cerebral infarction (partial paralysis or weakness after a stroke), and Persistent Vegetative State (a disorder or consciousness following severe brain injury where a patient may be awake but have no awareness of themselves or their surroundings). Review of a quarterly MDS assessment, dated 2/24/2026, indicated Resident #1 should not be interviewed for a BIMS due to the resident was rarely/never understood. The MDS indicated Resident #1 was unable to answer questions for cognitive review. The MDS also indicated Resident #1 needed maximum assistance with all activities of daily living, all functional abilities regarding mobility were not assessed due to Resident #1's active diagnosis of Persistent Vegetative state. Record review of Resident #1's care plan, undated, revealed, Resident #1 had a focus goal of being unable to communicate with others related to persistent vegetative state with an intervention of the resident being provided a specialized call device that is easier to operate. During an observation on 3/11/2026 at 2:15 p.m., Resident #1 was in her room with no call light within reach. Resident #1's call light was clipped to itself behind the resident on the wall. (Resident #1 was not interviewed due to current diagnosis). During an interview on 3/12/2026 at 10:45 a.m., Resident #1's family member stated the facility was responsive to his requests for his family member. The family member stated the facility was good about repositioning Resident #1, she was kept clean and the facility staff ensured her vent and feeding tube are well maintained. During an interview on 3/11/2026 at 2:15 p.m., LVN B stated she was unaware Resident #1's call light was not within her reach, but that it should be within her reach. LVN B stated CNA A may have repositioned the resident and did not place it back within reach of Resident #1. LVN B stated this resident unable to respond to any stimuli and cannot use the call light. During an interview on 3/11/2026 at 2:25 p.m., CNA A stated she did care for Resident #1 today and did reposition Resident #1 in bed with LVN B. CNA A stated she was unsure why the call light was not placed within reach of the resident. CNA A stated it was expected for the call lights to always be within reach of all residents, including Resident #1. CNA A stated since Resident #1 was without her call light and does not move or respond to stimuli she does not think anything would have changed with this resident. CNA A stated she ensured Resident #1 was checked on and repositioned during her rounds which are every 2 hours. During an interview on 3/11/2026 at 2:45 p.m., the DON stated it expected that all residents should have a call light pinned on the bed, blanket, or within reach of the resident, including Resident #1. The DON stated even though Resident #1 was not aware of her surroundings the resident could go into respiratory distress. The DON stated she provided (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>re-education to staff about call lights being in reach of all residents to include Resident #1. Record review of facility policy titled, Resident Call System reviewed 12/23/2025 and revised 01/04/2023, reflected, 1. Facility associates should always be aware of call lights and 5. The call light should be positioned within reach of the resident. Return demonstration may be used when educating the resident about call light use. If the resident is unable to demonstrate appropriate call light use, the nurse must be notified to determine an adequate alternative. A. The call system must be accessible to residents while in their bed or other sleeping accommodation within the residents' room. B. The call system must be accessible to the resident at each toileting and bath or shower facility and would be accessible to a resident lying on the floor in this area.</p> | | |