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	04/04/2026

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 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** 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 cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #2 and Resident #3) of 5 residents reviewed for abuse/neglect.The facility failed to report to the State Survey agency within the allotted time frame of 2 hours on 02/05/2026 around 12:52 PM when Resident #2 hit Resident #3 twice in the eye. This failure could place residents at increased risk for potential abuse due to unreported allegations of abuse.The findings included:Resident #2Record review of Resident #2's admission record dated 04/04/2026 revealed Resident #2 was a [AGE] year-old male who was admitted on [DATE]. Resident #2 was admitted with multiple diagnoses including dementia (cognition deficit), personal history of traumatic brain injury, and cognitive communication deficit. Record review of Resident #2's Quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 12 which indicated moderate cognitive impairment and was independent for majority of his ADLs. Resident #2 was not coded for behaviors. Record review of Resident #2's care plan revealed Date Initiated: 02/05/2026 Resident #2 has had an episode of physical aggression towards another male resident r/t dementia with agitation, irritability, and poor impulse control Goal: The resident will verbalize understanding of need to control physically aggressive behavior through the review date. Interventions: Analyze times of day, places, circumstances, triggers, and what de-escalate behavior and document. Assess and address for contributing sensory deficits. The resident will have no further episodes of physical aggression through the review date. Document observed behavior and attempted interventions in behavior log. Emergency detention warrant for psych evaluation ordered. Give the resident as many choices as possible about care and activities. Medication adjustment ordered. Observe and report PRN any s/sx of resident posing danger to self and others. PCS group to evaluate and treat as indicated. When the resident becomes agitated: Intervene before agitation escalate; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.Record review of the Resident #2's progress note dated 02/05/2026 12:52PM written by LVN F (did not witness the incident) revealed resident was witnessed in the dining room hitting another resident twice to the left eye, resident was redirected by staff and told to stop, resident left the dining room and went to his room, RP notified by ADON, MD notified, DON notified. Resident #3Record review of Resident #3's admission record dated 04/06/2026 revealed Resident #3 was a [AGE] year-old-male who was admitted on [DATE]. Resident #3 was admitted with multiple diagnoses including hemiplegia(paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side and aphasia (communication deficit) following cerebral infarction (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(stroke).Record review of Resident #3's Quarterly MDS dated [DATE] revealed Resident #3 had a BIMS score of 7 indicating severe cognitive impairment and needed partial/moderate assistance with ADLs. Record review of Resident #3's care plan revealed [Resident #3] has impaired cognition r/t prior CVA revision on: 07/13/2025 Goal: [Resident #3] will be able to communicate basic needs through the review date. Interventions: allow extra time for resident to respond to questions and instructions. Ask yes/no questions in order to determine the resident's needs. Communicate with the resident/family/caregivers regarding residents capabilities and needs. Communication: use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Discuss concerns about confusion, disease process, NH placement with resident/family/caregivers). Observe for and report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.Record review of the incidents and accidents report from 01/03/2026-04/03/2026 and there was 1 incident, 02/05/2026, regarding Resident #2, no other concern noted. On 04/03/2026 at 11:21AM, 4:09PM, and 04/04/2026 at 3:32PM attempted interview with previous administrator but unsuccessful. During an interview on 04/04/2026 at 3:49PM the administrator stated she has been with the facility for roughly 1 week and could not speak on the actions of the previous administrator. The administrator stated the incident on 02/05/2026 would necessitate a notification to local law enforcement which was completed, and to the state survey agency was not completed for an unknown reason. The administrator stated Resident #2 had never displayed any form of aggression to any other resident and was isolated to the 02/05/2026 incident. The administrator prior to 02/05/2026 Resident #2 had never exhibited any aggression to any residents and never found any indication of aggression prior to 02/05/2026 incident. The administrator stated Resident #3 did not sustain any skin irregularity or discoloration on 02/05/2026 nor verbalized being fearful of living at the facility. The administrator stated the state survey agency should have been notified of the incident on 02/05/2026 however does not know why the previous administrator did not complete the notification. The administrator stated the previous administrator was not available for interview as they were no longer corresponding or answering any attempts for communication. The administrator stated the well-being of Resident # 3, was not compromised and there were no negative effects due to the previous administrator not notifying the state survey agency. The administrator stated that going forward, she will notify the local law enforcement and state survey agency of all allegations of abuse not only as mandated by the facility's policy and procedure but also state regulations. Record review of the facility's Area of Focus: Abuse & Neglect policy and procedure issued:01/03/2022; Reviewed:11/24/2025 documented, Reporting Allegations: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facility) in accordance with state law through established procedures.