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	07/03/2024

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

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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 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** 50532 Based on observation, interview, and record review, the facility failed to provide services with reasonable accommodation of resident needs and preferences, for 1 of 5 residents (Resident #300) reviewed for accommodation of needs. The facility did not provide Resident #300 an accessible call light that she could physically use. This failure could place residents who utilized call lights at risk for not having his/her needs met, help in event of an emergency or place residents with a history of falls at risk for additional falls and injuries. Findings included: Record review of the admission record for Resident #300 reflected Resident #300 was admitted to the facility on [DATE], was a [AGE] year-old female with diagnoses that included Parkinson's disease (chronic and progressive movement disorder that causes tremors, stiffness or slowing of movement), neuralgia (nerve pain) and neuritis (inflammation of the peripheral nervous system), lack of coordination, muscle weakness, anemia, muscle spasm, disorientation, and history of falling. Record review of Resident #300's Care Plan revised on 06/28/24 reflected a focus on the resident has an ADL self-care performance deficit r/t confusion, impaired balance with interventions/task, encourage the resident to use bell to call for assistance and observe and report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record review of Resident #300's Skilled Nursing Documentation dated 06/30/24 noted primary reason for admission #2 as neurologic, section 6, musculoskeletal, abnormal. Section 6b. Muscle tone is mixed with Parkinson tremors. Record review of Resident #300's Incomplete MDS assessment dated for 07/05/24 reflected Section GG Functional Abilities and Goals was blank. MDS Section O 400, listed 70 minutes of Occupational Therapy given for 2 days started on 06/27/2024 and 61 minutes of Physical Therapy given for 2 days started on 06/27/2024. Section O 0500 Restorative Nursing Programs was blank. Observation on 07/03/24 at 08:43 AM Resident #300 was observed in bed, with the call light wrapped on the right-side rail. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/03/2024 at 08:50 AM., LVN D administered medications to Resident #300. The call light was wrapped on the right-side rail. Observation on 07/03/24 at 09:03 AM, Resident #300 observed unable to get or use her call light that was on the right bedrail. Interview and observation on 07/03/24 at 09:28 AM DON observed Resident #300 in the room. DON asked resident to press call light, and resident attempted again to get the call light and was able to get the call light cord but was unable to grasp the portion of the call light and press for assistance. DON stated they would get Resident #300 a touch pad call light. DON stated that the resident would not get the help they need and could result in harm if they were unable to use the call light. She replied that the resident had two falls. DON stated that mobility issues or limited range of motion should be documented in the comprehensive assessment and MDS assessments, by admitting nurse or MDS nurse. Interview on 07/03/24 at 10:02 AM Resident #300 stated she has had not been able to push the button on the call light since she came into the facility but still tried to use it. She stated she would call out and the staff sometimes heard her and came or sometimes another resident heard her and called the staff. Interview on 07/03/24 at 10:14 AM CNA A stated that Resident #300 would call out or they would ask the resident during rounds if she needed anything prior to the resident getting the touch pad call light. Interview on 07/03/24 at 03:35 PM Administrator stated Resident # 300 was able to utilize the call light when she was first admitted , but that she has had seizures almost daily so that may be why she cannot now. She stated that when a resident has a change in condition, there is an assessment done in general where vitals are documented, and the physician notified but not specifically for the use of the call light. ADM stated that if a resident is unable to use the call light, they would be assisted during rounds, and what can happen is it may take a little longer than normal. Interview on 07/03/24 at 03:48 PM DON stated that in-service on call lights and rounds is done at least once a month, with last in-service done in June or end of May 2024. Interview on 07/03/24 at 05:10 PM Administrator stated that comprehensive assessments, change in condition assessments and MDS assessments are completed but that there is no specific item to assess a resident's ability to use the call light. Although assessment dated [DATE] documented Resident # 300 required assistance to eat, it is not the same losing fine motor skills to losing gross motor skills and Resident # 300 had her call light withing reach. Interview on 07/03/24 at 05:17 PM RN C stated she only had Resident #300 yesterday, and today. As far as she can tell Resident #300 was not able to use a call light. She does frequent checks to make sure Resident #300 is ok, every 30 minutes, besides the 2 hour rounds that CNAs do, but this is her self-practice. RN C said there is no procedure or policy for ensuring a resident can use the call light. The times she has had Resident #300, she has not seen her able to use the call light due to both cognitive and physical changes. RN C said most of the time in her shift Resident # 300 is asleep and has minimal communication. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/03/24 at 05:22 PM LVN B stated Resident #300 would press her call light prior to today, and that today with the touch pad, she called about four times. Record review of the facility policy titled Resident Call System revised 01/04/23 and reviewed 01/15/24 reflected, the facility must be adequately equipped to allow residents to call for assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident beside. Procedure: Facility associates should always be aware of call lights; associates should answer call lights whether they are assigned to provide care to that resident. 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. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy for 1 of 10 residents (Residents #22] reviewed for privacy. The facility failed to ensure Resident #22's bedroom door was closed for privacy as she requested. This failure could place residents at risk of having their bodies exposed to the public, resulting in emotional distress and a diminished quality of life. The findings included: Record review of Resident #22's face sheet dated 05/22/23 reflected an [AGE] year-old female with an original admitted [DATE]. Pertinent diagnoses included dementia, stroke, depression, anxiety, and limited range of motion. Record review of Resident #22's quarterly MDS assessment dated [DATE] reflected a BIMS score of 13, indicating she was cognitively intact. She required moderate assistance with oral and personal hygiene, substantial assistance with dressing and positioning, and was dependent on staff with toileting, showering, and footwear. She was incontinent of bladder and bowel. Her active diagnosis was medically complex conditions. Record review of Resident #22's care plan dated 06/06/2024 on page 1 reflected Resident #22 preferred that her door be kept closed with an initiation date of 03/16/23 and a revision date of 06/06/24. The goal documented resident will have her preference to keep door closed met with an initiation date of 03/16/23 and a revision date on 06/06/24. Interventions indicated close door after care, food delivery, any interactions with an initiation date of 03/16/23. Observation of Resident #22's door beginning on 07/01/24 at 11:00 am through 07/03/24 throughout all days of the survey revealed her door was open wide. In an interview with Resident #22 on 07/01/24 at 4:05 pm, Resident #22 stated she had requested her door be kept shut ever since she was admitted because she did not like the noise that came from the hallway. She stated the staff never shut her door and that made her angry. In an interview with the DON on 07/03/2024 at 2:29 PM, the DON stated residents should have their preferences acknowledged. The DON stated that if resident's privacy was not protected, they could get embarrassed, ultimately leading to emotional distress. 50039

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on interview and record review, the facility failed to ensure that seight residents (Resident #4, Resident #32, Resident #23, Resident #26, Resident #22, Resident #28, Resident #18, and Resident #38) of twenty-four residents reviewed for professional standards, received care in accordance with professional standards of practice and the comprehensive person-centered care plan. 1.) The facility did not ensure that the Physician Order for monthly weight was followed for Resident #4. 2.) The facility did not ensure that the Physician Order for weekly weights was followed for Resident #32. 3.) The facility did not ensure that the Physician Order for monthly weight was followed for Resident #23. 4.) The facility did not ensure that the Physician Order for monthly weight was followed for Resident #26. 5.) The facility did not ensure that the Physician Order for monthly weight was followed for Resident #22. 6.) The facility did not ensure that the Physician Order for weekly weight was followed for Resident #28. 7.) The facility did not ensure that the Physician Order for weekly weight was followed for Resident #18. 8.) The facility did not ensure that the Physician Order for weekly weight was followed for Resident #39. These failures could affect residents who required regular weight monitoring and could result in severe weight loss or weight gain and place them at risk for not receiving the appropriate care and interventions resulting in a decreased quality of life. The findings included: 1.) Resident #4 Record review of Resident #4's face sheet dated 7/1/24 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included dementia (general decline in cognitive abilities that affect the person's ability to perform everyday activities), cerebral infarction (when blood supply to part of the brain is blocked or reduced), contracture (shortening or hardening of muscles tendons or other tissues often reach deformity and rigidity of joints) to the left hand, type two diabetes (insufficient insulin production in the body), muscle wasting and atrophy (waste away). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's physician's orders dated 5/6/24 stated: Monthly weights. Record review of Resident #4's weight summary reflected weights of 199.4lbs on 5/4/24, and a weight of 196. 1lbs on 7/2/24. A -1.65% weight loss. No weight was documented for the month of June 2024. Record review of #4's care plan with an initial date of 1/11/24 and a revision date of 5/29/24 stated: Resident #4 had a nutritional problem or potential nutritional problem: mechanically altered diet. Interventions/Tasks included: Monthly weights. Resident #4 was non-intervewable. 2.) Resident #32 Record review of Resident #32's face sheet dated 7/1/24 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included cerebral palsy (group of conditions that affect movement and posture), scoliosis (sideways curvature of the spine), hypoglycemia (blood sugar/glucose level in the body is lower than the standard range), and muscle wasting. Record review of Resident #32's physician orders dated 5/8/24 stated: Weekly weights. Record review of Resident #32's weight summary reflected a weight of 120.2 lbs on 5/30/24, and a weight of 123.0 lbs on 7/2/24. A 2.33% weight gain. No weight was documented for the month of June 2024. Record review of Resident #32's care plan with an original date of 10/04/23 stated: Resident #32 had a nutritional problem related to BMI below normal and history of intravenous hydration needs, presence of a feeding tube related to impaired swallowing. Interventions/Tasks included: Weekly weights. Resdient #32 was non-interviewable. 3.) Resident #23 Record review of Resident #23's face sheet dated 07/02/2024 reflected an [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Alzheimer's Disease (progressive brain disease that causes a mental decline affecting the quality of daily living) and Heart Failure (disease in which the heart can no longer pump enough blood to meet the body's needs). Record Review of Resident #23's physician's orders dated 05/05/2024 stated: Monthly Weights (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #23's weight summary reflected weights of 147.4lbs on 04/10/2024, 155.4lbs on 05/05/2024, and 141.0lbs on 07/03/2024 resulting in an overall -4.34% weight loss. No weight was documented in June 2024. Record review of Resident #23's care plan dated 05/13/2024 stated the resident was At risk for weight fluctuation related to current health status. Interventions included Monthly Weights. 4.) Resident #26 Record Review of Resident #26's face sheet dated 07/01/2024 reflected an [AGE] year-old male with an admitted [DATE]. Pertinent diagnoses included Generalized Muscle Weakness, Nausea with Vomiting, and Paroxysmal Atrial Fibrillation (a type of irregular heartbeat in the upper chambers of the heart that can last up to a week but usually ends within 24 hours). Record review of Resident #26's physician orders dated 05/06/2024 stated Monthly Weights Record review of Resident #26's weight summary reflected weights of 103.6lbs on 04/10/2024, 108.4lbs on 05/05/2024, and 110.6lbs on 07/02/2024 resulting in an overall 6.76% weight gain. No weight was documented in June 2024. Record review of Resident #26's care plan dated 05/24/2024 stated the resident was at risk for weight fluctuation related to current health status. Interventions included Monthly Weights. 5.) Record review of Resident #22's face sheet dated 05/22/23 reflected an [AGE] year-old female with an original admitted [DATE]. Pertinent diagnoses included dementia, stroke, depression, anxiety, and limited range of motion. Record review of Resident #22's physician orders dated 05/08/2024 stated Monthly Weights. Record review of Resident #22's weight summary reflected weights of 160.0 lbs. on 04/09/2024, 162.4 lbs. on 05/05/2024, and 160.6 lbs. on 07/02/2024 resulting in an overall 1.8 % weight gain. No weight was documented in June 2024. Record review of Resident #22's care plan dated 06/06/2024 on page 4 reflected Resident #22 had a potential fluid deficit r/t impaired mobility/vision/communication, history of urinary tract infections with an initiation date of 06/06/23 and a revision date of 06/06/24. Interventions included observe and report as needed . recent/sudden weight loss .with an initiation date of 06/06/23. Page 7 reflected Resident #22 was at risk for weight fluctuation r/t current health status with an initiation date of 03/16/23. The goal indicated Resident #22 wished to maintain current weight through next review. 6.) Record review of Resident #28's face sheet dated 11/21/23 reflected a [AGE] year-old male with an original admitted [DATE]. Pertinent diagnoses included tracheostomy (a surgical hole through the neck into the trachea (windpipe) for breathing), throat cancer, protein-calorie malnutrition, a feeding tube, depression, anxiety, and diabetes. Record review of Resident #28's physician orders dated 05/08/2024 stated Weekly Weights. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's weight summary reflected weights of 139.0 lbs. on 04/09/2024, 140.0 lbs. on 05/05/2024, and 136.5 lbs. on 07/02/2024 resulting in an overall 1.5 % weight gain. No weight was documented in June 2024. A weekly weight was not done on May 14, 2024. Record review of Resident #28's care plan dated 06/06/2024 on page 9 reflected Resident #28 required tube feeding with an initiation date of 08/01/22 and a revision date of 01/11/23. Interventions included weekly weights with an initiation date of 08/28/23. Page 12 reflected Resident #28 was at risk for weight fluctuation r/t current health status with an initiation date of 07/06/21. The goal indicated Resident #28 wished to maintain current weight through next review with an initiation date of 08/02/21 and a revision date of 03/28/24. 7.) Resident #18 Record review of Resident #18's face sheet dated 07/01/24 indicated a [AGE] year old male admitted [DATE]. Pertinent diagnoses included dysphagia (difficulty swallowing), unspecified protein-calorie malnutrition (inadequate intake of food as a source of protein, calories, and other essential nutrients), hypothyroidism (the thyroid gland does not make enough thyroid hormone), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #18's Physician Order Summary dated 07/01/24 revealed an order that read, Monthly Weights that was dated 05/08/24 with order status, Active. Record review of Resident #18's Weight Summary dated 07/01/24 revealed on 03/06/24 weight was 111. 2lbs, on 04/09/24 weight was 104.8lbs, on 05/04/24 weight was 106.4lbs and on 07/02/24 weight was 111. 1lbs which resulted in an overall even weight. There was no weight documented for the month of June 2024. Record review of Resident #18's Care Plan revealed FOCUS: At risk for weight fluctuation r/t current health status initiated 01/25/24, GOAL: Resident (#18) wishes to maintain current weight through next review initiated 01/25/24, and INTERVENTIONS/TASKS: Assistance with meals as needed and Diet order regular/puree/nectar (regular diet, pureed, with nectar thick fluids), double portions all meals, meals served in bowls initiated 01/25/24 and revised 06/06/24. There was no intervention or task for weight monitoring. 8.) Resident #39 Record review of Resident #39's face sheet dated 07/01/24 indicated a [AGE] year-old male originally admitted [DATE] and readmitted [DATE]. Pertinent diagnoses included apraxia (neurological disorder that causes difficulty with speech), dysphagia following cerebrovascular accident (difficulty swallowing after damage to the brain from an interruption of its blood supply), nausea with vomiting, and hemiplegia/ hemiparesis (one side of the body is weak/ paralyzed) following a non-traumatic subarachnoid hemorrhage (bleeding in the brain not caused by an external force). Record review of Resident #39's Order Summary Report on 07/01/24 revealed an order that read, Monthly weights that was dated 05/06/24 with order status, Active. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's Weight Summary on 07/03/24 revealed on 04/09/24 weight was 177.8lbs, on 05/04/24 weight was 176.8lbs, and on 07/03/24 weight was 159.8lbs, which resulted in an overall -10. 12% weight loss over 3 months. There was no weight documented for the month of June 2024. Record review of Resident #39's care plan revealed FOCUS: At risk for weight fluctuation r/t current health status initiated 05/17/22, GOAL: Resident (#39) wishes to maintain current weight through next review initiated 05/17/24, revision on 03/01/24, target date 06/19/24, and INTERVENTIONS/TASKS: Assistance with meals as needed. Date Initiated: 05/17/2022, Diet order: CCHO (Controlled carbohydrate) diet, regular texture, thin liquids, picante sauce with meals, divided plate, Double Portions per family request-Discontinued due to excessive weight gain, Date Initiated: 05/17/2022, Revision on: 10/03/2023, Educate resident and family regarding potential weight fluctuation, Date Initiated: 05/17/2022Monthly weights Date Initiated: 05/06/2024. Record review of Resident #39's Quarterly Nutrition Data Collection signed on 05/23/24, the RD stated in the summary, Resident's weight is stable x180 days with no significant changes this review. Resident receives a therapeutic diet due to Diabetes Mellitus Type 2 (a form of diabetes where the pancreas does not make enough insulin and the body has trouble controlling blood sugar) diagnoses. Glucose checks do not appear to be well-controlled, usually ranging between 200-400. Noted started on new diabetes medication Mounjaro. Therapeutic diet remains appropriate as a support for management of glucose levels. Resident consumes 50-100% of meals per documentation. Skin is free of pressure injuries. Intake appears adequate to meet nutritional needs. Recommend continue current nutritional Plan of Care. The RD also documented in the space for Comments on any updates to focus, goals, and/or interventions: Goals: (1) Maintain current weight with no significant change >5%/30 days (2) Maintain skin free of pressure injuries (3) Maintain positive hydration status with no s/s of dehydration. In an interview on 07/02/24 at 01:36pm the DON stated the facility's electronic patient chart was the only place weights should be recorded. The DON stated usually CNA A was in charge of weighing and recording resident weights. The DON stated CNA A got behind on weighing residents for the month of June 2024. The DON stated while CNA A was the main person who was in charge of weighing residents, any direct care and administrative nursing staff could weigh residents as well. The DON stated she and the Unit Manager were the ones to make sure resident weights were done as ordered. The DON stated it was unacceptable resident weights were not done as ordered. The DON stated there was no systematic approach to monitoring when and if resident weights were being done on a timely schedule other than verbal communication. The DON stated they became aware of the issues a couple days ago. The DON stated by not weighing residents as ordered, staff would not be aware of any significant issues with weight loss and residents could become ill. In an interview on 07/02/24 at 01:43pm the Unit Manager stated usually weekly weights were done on Sundays and monthly weights were done by the 10th of every month. The Unit Manager stated the DON and himself were in charge of overseeing that weights were done and entered in a timely manner, and they failed to do so. The Unit manager stated it was brought to their attention last Thursday during a QAPI meeting but did not remember who mentioned the issue or what the outcome was. The Unit manager stated by not weighing residents, staff would not be aware of any significant issues with weight loss and residents could become ill due to a significant weight loss. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/02/24 at 01:54 pm CNA A stated she was the main person that took and documented resident's weights but that anyone could take resident weights. CNA A stated she verbalized throughout the month of June 2024 to the Unit manager that she had fallen behind on taking resident weights and stated, everyone who was on shift was trying to help but they just did not get it done. CNA A stated she had no other explanation for why staff did not get resident weights done. CNA A stated that some weights were done but was unable to provide documentation of the resident weights that were taken for the month of June 2024. CNA A stated after resident weights were done, the RD usually went over the resident weights and if the RD had questions or concerns, the RD would follow up and ask questions regarding resident weights. CNA A stated the RD did not go to her about missing resident weights but that was usually discussed in the IDT meetings that were held once a week with administrative personnel. CNA A stated during the month of June, no administrative staff came to her with concerns about the missing resident's weights. In an interview on 07/02/24 at 02:06pm the ADM stated monthly weights were usually done by the 10th of every month. The ADM stated when she found out about resident weights not getting done for the month of June 2024, it was discussed in a QAPI meeting and the weight policy was reviewed with the IDT team. The ADM stated it was decided in the QAPI meeting that the resident weights would resume in July 2024. The ADM stated the medical director was part of the QAPI team and agreed to start resident weights in July 2024. The ADM stated the medical director did not express any concerns for any residents who resided in the facility. The ADM stated adverse effects of weight loss could happen such as loss of muscle mass, overall decline in resident health, and possible skin breakdown. In an interview on 07/02/24 at 02:14pm the RD stated she was usually at the facility once a week to see new and readmissions residents as well as conduct a full comprehensive assessment, resident BMI's, ideal body weight ranges, diet, diagnoses, and assess resident skin integrity. The RD stated she noticed the resident weights were not done for June 2024 and told the ADM approximately last week. The RD stated around the 10th of June 2024 she started to get concerned the resident weights were not done. The RD stated she usually ran the monthly weight report around the 10th of every month and completed a weight variance report on the residents that was automatically sent as a report to the facility administration. The RD stated she worked from home and was only in the facility once for the month of June 2024. The RD stated an email was sent on 6/20/24 to DON and the Unit Manager concerning the missing resident weights for the month of June. The RD stated she did not see a response from administration about her summary visit but usually did not get a response about her reports. The RD stated she expected to get a response from the facility since June 2024 resident weights were not entered but did not receive one. The RD stated severe weight loss could result in loss of muscle mass and overall decline in health, and skin breakdown. In an interview on 07/03/24 at 01:36 PM the RD stated weight range for Resident #39 was between 144-176 pounds. The RD stated Resident #39 is in his ideal weight class and she did not feel the weight loss had adversely affected the resident because he was in his ideal weight range. RD stated sugars have been more controlled and BMI is 24.2, which is considered normal for his age. RD stated resident was assessed 07/03/24 and was communicating at his baseline and did not display any signs or symptoms of a person who was experiencing severe weight loss. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/03/24 at 01:56 PM, the ADM stated that resident had uncontrolled blood sugars and was put on Mounjaro to control his blood sugars and that he had been refusing medications. The ADM stated a weight below 144 was when adverse effects of weight loss could happen like loss of muscle mass, overall decline in health, and skin breakdown. The ADM stated she felt the weight loss had not affected the resident but felt like the medication Mounjaro had been affecting his weight. ADM stated resident had been feeling nauseous and had been vomiting and was prescribed Zofran which he had been taking daily since 6/24/24. The ADM stated when she found out about weights not getting done, it was QAPI'd and policy was reviewed. The ADM stated it was decided that the weights would resume in July. The ADM stated the medical director was part of the QAPI team and was there when the missed weights were discussed, and he agreed to start the weights in July. The ADM stated the MD did not express any concern for any residents at that time. In a phone interview on 07/03/24 at 02:42 PM Resident #39's doctor stated that resident is being seen by the nurse practitioner and that the doctor had not seen him yet. The doctor stated that severe weight loss means, in general, a weight loss of 100lbs in 6 months. The doctor stated he was not aware of the weights not being done in June until someone in the facility told him. The doctor stated the facility definitely should have contacted someone about Resident #39's weight loss. The doctor stated severe weight loss, could shorten a resident's life span and cause malnutrition, skin issues, wounds, and so on. The doctor stated he would expect the facility to care plan things like weight monitoring and management. In a phone interview on 07/03/24 at 04:53 PM with the NP, she stated that Resident #39's weight loss was not unexpected because he was on Mounjaro and his double portions had been stopped. The NP stated that his blood sugars were doing better and his A1C (Hemoglobin AIC- test that measures the average amount of glucose attached to hemoglobin in red blood cells over the past three months) was lower. The NP stated Resident #39's labs were looking better also. The NP stated she did not believe that there were any adverse effects from his weight loss since he is still within his ideal body weight. She stated that if a resident had a large, unexpected weight loss, she would expect to be notified about it. She stated she was not aware of the weights not being done in June. She stated that a large, unexpected weight loss could lead to malnutrition, skin breakdown, delayed wound healing, possible hospitalization . The NP stated If residents were not weighed as ordered, it would not be possible to track if they were gaining or losing weight and the resident could have an unexpected significant or severe weight loss. Record review of the facility's Weights and Heights Policy dated 8/23/23 stated: Policy All residents are weighed within 24 hours of admission and weekly for 4 weeks and as needed thereafter or more as determined by the RAR committee and/or physician order. Height is measured on admission and annually. Documentation Documentation associated with weight measurement includes: Patient's weight in kilograms (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date and time of measurement 46038 49157 50039

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, physicians orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #23) residents reviewed for respiratory care. The facility failed to ensure Resident #23's oxygen tubing was changed every night shift on Sunday as ordered. This failure places residents at an increased risk of infection leading to a decline in health. The findings included: Record review of Resident #23's face sheet dated 07/02/2024 reflected an [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Alzheimer's Disease (progressive brain disease that causes a mental decline affecting the quality of daily living) and Heart Failure (disease in which the heart can no longer pump enough blood to meet the body's needs). Record review of Resident #23's MDS assessment section C, cognitive patterns, dated 04/30/2024 reflected a BIMS score of 7 (severe cognitive impairment). Record review of Resident #23's MDS assessment section O, Special Treatments, Procedures and Programs, dated 04/30/2024 reflected no oxygen use. Record review of Resident #23's order summary report revealed an active order to Change oxygen tubing and nebulizer circuit every night shift every Sun[day] with a start date of 05/05/2024. The same order summary report also revealed an active order to Clean oxygen concentrator filter with soap and water every night shift every Sun[day] with a start date of 05/05/2024. The same order report summary also revealed an active order for Oxygen at 2 liters/minute continuously via nasal cannula while in bed with a start date of 06/23/2024. During an observation on 07/01/2024 at 10:10 AM, the tubing on the oxygen concentrator (medical device used to give an individual extra oxygen) in Resident #23's room contained a label dated 06/16/2024. At this time, the resident was lying in bed sleeping with the nasal cannula in place with 2 liters/minute flow rate. During an observation of the oxygen concentrator on 07/02/2024 at 1:34 PM in Resident #23's room, the tubing on the device contained the same label dated 6/16/2024. During an observation of the oxygen concentrator on 07/03/2024 at 11:01 AM in Resident #23's room, the tubing on the device contained the same label dated 6/16/2024. In an interview with Resident #23 on 07/01/2024 at 11:15 AM, Resident #23 was unable to remember if the oxygen tubing had been changed recently. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 07/03/2024 at 2:29 PM, the DON stated that they date oxygen tubing at the facility weekly. The DON stated that they try to change the tubing on Sundays, but that sometimes it may occur on a different day as necessary. The DON stated that if the oxygen tubing was not changed on time the resident could get sick from dirty tubing. In an interview with LVN D on 07/03/2024 at 3:00 PM, LVN D stated that oxygen tubing should be changed out every Sunday during the 10:00 PM - 6:00 AM shift. LVN D stated that the tubing should be dated when it was changed out. LVN D stated that if the tubing was not changed when ordered then the resident could get sick. Record Review of facility policy Oxygen Administration (Safety, Storage, Maintenance) last revised on 2/27/24 stated: Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when setup or changed out.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46038 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked treatment cart for 1 of 1 treatment cart reviewed for storage of drugs. The facility's treatment/medication cart was left unlocked by the nurse's station (only one nurse's station) with the drawers facing outward. This deficient practices could affect residents who have medications in the nurse's treatment/medication cart and could result in lost medications, drug diversion, harm due to accidental ingestion of unprescribed medications. Findings included: Observation on 07/01/24 at 10:30am revealed an unlocked medication/treatment cart located by the nurse's station. The medication/treatment cart was against the nurse's station and one staff member (LVN B) was located at the nurse's station. There were two residents by the nurse's station near the treatment cart. This surveyor opened the top drawer recognizing the treatment cart being unlocked. Multiple medications in bulk bottles were easily assessable and removable. This surveyor was able to open all drawers and go through various medications and treatment supplies. In an interview on 07/01/24 at 10:31am, LVN B stated he did not know the treatment cart was unlocked. LVN B stated the treatment cart belonged to the LVN F and was unlocked because a resident was bleeding down the hall and LVN B came to grab supplies and left to tend to resident. LVN B stated all treatment/medication carts should be locked at all times so residents or visitors could not have access to supplies and medications. In an interview on 07/01/24 at 10:37am LVN F stated she was alerted there was a resident who was possibly bleeding. LVN F stated the resident just had a surgical procedure and had a history of picking at the surgical staples. LVN F stated all staff went to the resident's room to assist and she grabbed supplies needed and forgot to lock the treatment cart. LVN F stated the cart should be locked at all times for resident safety and so residents could not get into the treatment cart and gain access to supplies and medications. LVN F stated the last in-service on locked treatment/medication carts was approximately sometime last month but could not remember. In an interview on 07/01/24 at 10:53am the DON stated all treatment/medication carts should be locked at all times for the safety of residents and other unauthorized people. The DON stated anytime a staff member leaves the treatment/medication carts unattended, the treatment/medication cart should be locked even if there was a resident emergency. The DON stated the last in-service on locking treatment/medication carts was about a month ago. Record review of General Dose Preparation and Medication Administration Policy dated 1/1/22 stated: 7. Facility should ensure that medication carts are always locked when out of sight or unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44748 Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation. 1. The facility failed to ensure the ice machine was clean. 2. The facility failed to ensure drinking glasses were clean. 3. The facility failed to ensure non-stick pans were not eroded. 4. The facility failed to ensure pots and pans were not dented. 5. The facility failed to ensure pest control was effective. 6. The facility failed to ensure personal items were not on prep carts or in walk-ins. 7. The facility failed to ensure proper cleaning was done according to their daily kitchen cleaning log. 8. The facility failed to ensure the walk-in freezer was in good operating condition. 9. The facility failed to ensure the lights in the walk-in refrigerator, freezer, and vent hood were in good operating condition. 10. The facility failed to maintain cleanliness of the ovens, floor, and air vents on the ceiling. These failures could place residents at risk of foodborne illnesses. Findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and initial tour of the kitchen beginning on 07/01/24 at 9:05 am revealed the ice machine had a removable reddish substance along the entire edge of the ice chute. 25 of 25 drinking glasses had a heavily coated whitish yellow substance on the insides. There were 2 non-stick pans the finish was eroded from, one completely gone except the sides. The other non-stick pan was on the stove and had deep scratches throughout the center of the finish. There was one large pot that was heavily dented, and 5 small holding pans that had deep dents with crevices in the inside corners and scratches on the inside bottoms. There were ants on the prep table next to the stove. The ants were on and around the can opener attached to the prep table. The ants were crawling across the top of the prep table to the other side as well as up the back wall and into a moderate crack in the wall. There was a 25-pound container of powdered beef base on the lower shelf of the prep table (that had the ants on it) with the lid askew. There was a large block of ice build-up in the walk-in freezer that was so heavy, the ceiling of the walk-in freezer was drooping. There were 2 open, partially full 16-ounce sodas on the shelf of the walk-in refrigerator. There was a purse on the lower shelf of a prep cart. The walk-ins were dimly lit and there were no lights under the vent hood. The ovens were dirty with build-up inside and outside. There was a dark brown-black substance along the floor where it met the walls behind the stove and prep tables. There was an approximate 1-inch hole in the corner of the wall where it met the floor, with what appeared to be possible rodent droppings. The air vent and return air on the ceiling had thick layers of a dark brown/black substance covering them. In an interview with the Assistant DM, on 07/01/24 at 9:15 am she stated she did not know what the stuff on the ice chute was and it looked dirty. She stated they were having issues with their water softener, and that caused the haziness in the drinking glasses. She stated the drinking glasses were on the clean rack for use. She stated she would not want to drink from any of the 25 glasses. She stated the residents could get sick from whatever was inside the drinking glasses. She stated the kitchen staff did not really use the large, damaged non-stick pan and said it should have been removed from the pot rack it was on long ago because that rack was for the pans they used. She would not say why she did not remove it or what the risk was to residents from using a non-stick pan with an eroded finish. She stated the other damaged non-stick pan on the stove was not that bad. She stated the large, dented pot on the pot rack was used for boiling water that was used for food such as potatoes. She stated the dented holding pans were not being used right now because of the low census. She stated she did not know bacteria could grow in crevice's the dents made, and she guessed the residents could get sick from that. Regarding the 25-pound container of powdered beef base on the lower shelf of the prep table (that had the ants on it) with the lid askew, she stated there was probably not ants in there. (She did not check the contents of the container prior to replacing the lid) She stated the kitchen staff followed a daily cleaning schedule for the floors, prep tables, the stove and microwaves. She stated she could not remember what else was on the daily cleaning schedule. She stated she did not know where or how the large block of ice came from in the walk-in freezer, and that it was maintenance's job to fix it. She stated she did not know what they were doing about the ice build-up in the walk-in freezer, but it had been there a while. She stated the lights in the walk-ins had always been very dim and it was difficult to see anything in the walk-ins because if food went bad, it was not noticeable. She stated the lights in the vent hood just went out one day. She stated she never reported any of the lights because she assumed the DM and maintenance already knew. She stated the air vents on the ceiling could use some cleaning. She stated kitchen staff were not allowed to have personal items in the walk-in refrigerator because it could cause cross contamination and make residents sick. She stated the purse on the prep cart was hers because she was in a hurry this morning and just tossed it there. She stated she was going to move it. She stated she would tell maintenance about the ants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the ADM on 07/03/24 at 5:20 pm, she stated she was aware the kitchen needed a lot. She stated she had been in the facility since 06/13/24 and was trying to get things done. She stated she was not aware of the extent of repairs the kitchen needed. She stated the MS had not made her aware of the condition of the walk-in freezer. Record review of the kitchen daily cleaning log dated 04/2024-06/29/24 revealed there was no section for the ice machine. The section for stove top and grill was blank for 04/26/24, 06/19/24, and 06/26/24 and 06/28/24. The section for floors was blank for 05/04/24, 06/28/24. Record review of kitchen in-services revealed no significant ongoing training on infection control and the prevention of food contamination, as stated in the facility's policy. Record review of the facility policy titled Prevention of Cross Contamination revised 04/26/23 documented under Policy, All food and nutrition services associates are trained in infections control techniques to prevent the contamination of food and the spread of infection to ensure that food is stored, prepared, distributed, and served in accordance with professional standards for safety, and per federal, state, and local requirements. Under Procedure, 1. The director of food and nutrition or designee provides training to departmental new hires on infection control techniques. Categories of infection control training will include a minimum of a. Biological contamination, b. Chemical contamination, c. physical contamination, f. equipment. 2. The director of food and nutrition services and registered dietician provide ongoing training on infection control and the prevention of food contamination. 3. The director of food and nutrition or designee will check food storage, food preparation, and food service areas daily to ensure proper steps are being followed. 4. Foodservice associates may drink from a closed beverage container if handled to prevent contamination of a. The associates' hands, b. the container, c. exposed food, clean equipment, utensils, linens, and unwrapped items. 5. The following assists in preventing contamination of food and spread of infection. G. All equipment, utensils, counters, workstations, and cutting boards are cleaned and sanitized per department guidelines. 6. Ice used in connection with food or drink will be obtained from a sanitary source and handled and dispensed in a sanitary manner. F. Inside of bin will be cleaned according to facility cleaning schedule. Routine Housekeeping 7. Rodent and pest control must be provided on an established schedule, and as needed. Record review of the facility policy titled, Cleaning Schedule revised 12/17/21 documented under Policy, The director of food and nutrition services develops a cleaning schedule, with assistance from the registered dietician, to ensure that the food and nutrition services department remains clean and sanitary at all times. Equipment and Utensil Cleaning and Sanitization, A potential cause of foodborne outbreaks is improper cleaning (washing and sanitizing) of equipment and protecting equipment from contamination via splash, dust, grease, etc., Procedure 1. The director of food and nutrition services develops a cleaning schedule to include all equipment and areas to be cleaned. 4. The director of food and nutrition services monitors the cleaning schedule to ensure the tasks are completed timely and appropriately. The facility policy on Food Storage was not received.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 44748 Based on observation, interview and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 walk-in freezers, 1 of 1 walk-in refrigerators, 1 of 1 air intake vent, and 1 vent hood reviewed for essential equipment in the kitchen. The facility failed to ensure the walk-in freezer was free of ice build-up, the door properly closed, and the inside light was bright enough. The facility failed to ensure the light in the walk-in refrigerator was bright enough. The facility failed to ensure the air intake and return air vent was clean. The facility failed to ensure the vent hood lights and the exhaust fan worked. These failures could place the residents at risk of potential fire hazards. There findings were: Initial observation of the kitchen on 07/01/24 at 9:05 am revealed a large block of ice build-up in the walk-in freezer appearing to be attached to the ceiling that was so heavy, the ceiling of the walk-in freezer was drooping. The door of the walk-in freezer did not close properly and there was a large gap between the door and the floor when shut. The walk-in refrigerator and the walk-in freezer were so dimly lit it was difficult to identify the contents. There were no lights under the vent hood. The air vent and return air on the ceiling had thick layers of a dark brown/black substance covering them. The air from the vents was directed at the center of the kitchen where the food holding table and plates were. In an interview with the Assistant DM on 07/01/24 at 9:15 am she stated the lights in the walk-ins had always been very dim and it was difficult to identify what foods were in there. She stated the lights in the vent hood just went out one day. She stated the exhaust fan on the vent hood was making a screeching sound and she was not sure if the vent hood exhaust fan worked. She stated she never reported any of the lights because she assumed the DM and maintenance already knew. She stated the air vents on the ceiling could use some cleaning. She stated she did not know what they were doing about the ice build-up in the walk-in freezer, but it had been there a while. She stated the MS knew about the exhaust fan. She stated it was maintenance's job to fix things. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the MS on 07/03/24 at 4:50 pm, he stated he did not know about the dim lighting in the walk-ins. He stated he spoke with an electrician about new fixtures for the vent hood lights and a new belt for the exhaust motor because it screeches. He could not say when he had spoken to an electrician, or the name of the electrician he spoke to. Regarding the air vent and return vent, the MS stated he started cleaning them 2 weeks ago but got pulled away to work on something else. He stated the ice build-up in the walk-in freezer had been like that since before he started working at the facility over 1 1/2 years ago. He stated he spoke to regional (did not know the name) and was told by them to support the ceiling in the walk-in freezer by putting beams up to support the ceiling. The MS stated, The walk-in freezer was condemned by two restaurant supply companies a year ago. He stated, They wouldn't touch it. The MS stated the temperatures in the walk-ins were ok. He stated the ceiling in the walk-in freezer could collapse. He stated the walk-in freezer needed to be replaced. In an interview with the DM on 07/03/24 at 5:10 pm, she stated she had not noticed the lights were dim in the walk-ins. She stated the walk-in freezer was a mess, meaning the door did not close properly and caused condensation. She stated the ice build-up in the walk-in freezer had been there 2-3 years. She stated the walk-in freezer could stop working at any time. The facility policy on food storage and maintaining equipment were requested. In an interview with the ADM on 07/03/24 at 5:20 pm, she stated she was aware the kitchen needed a lot. She stated she had been in the facility since 06/13/24 and was trying to get things done. She stated she was not aware of the extent of repairs the kitchen needed. She stated the MS had not made her aware of the condition of the walk-in freezer. Record review of the facility's paid kitchen invoices revealed the kitchen exhaust system was cleaned on 02/05/24 and 05/15/24. There were no invoices for the walk-in freezer, the walk-in cooler lights, or the vent hood. Record review of the maintenance log reflected one entry dated 06/25 and was for a leaking sink in the kitchen. The facility policy on Food Storage and maintaining equipment were not received.

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	07/03/2024

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

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observations, interviews, and record reviews, the facility failed to maintain as effective pest control program for 1 of 1 kitchen reviewed for sanitation. There were ants on a prep table on and around the can opener, all over the top of the prep table, and crawling up the wall into a crack. There was evidence of rodent droppings on the kitchen floor adjacent to the wall. There was a hole in the baseboard adjacent to the floor near the rodent droppings. These failures could place residents at risk of living in an unsafe, unsanitary environment, and cross contamination of food. Findings were: Initial observation of the kitchen on 07/01/24 beginning at 9:05 am revealed there were ants on the prep table next to the stove. The ants were on and around the can opener attached to the prep table. The ants were crawling across the top of the prep table to the other side and up the back wall into a moderate crack in the wall. There was a 25-pound container of powdered beef base on the lower shelf of the prep table (that had the ants on it) with the lid askew. There was a dark brown-black substance along the floor where it met the walls behind the stove and prep tables. There was an approximate 1-inch hole in the corner of the wall where it met the floor, with what appeared to be possible rodent droppings. In an interview with the Assistant DM on 07/01/24 at 9:15 am she stated she would tell maintenance about the ants. She would not answer regarding whether the ants were a problem, if they could get into any food type item, or what could happen to residents if the ants could get into any type of food type item. She did not answer as to whether she had ever seen mice or rodents in the kitchen. She stated she thought there were sticky traps in the kitchen, but she could not say where they were located, how long they had been there, or who was responsible for checking them. In an interview with the MS on 07/03/24 at 4:50 pm, he stated the facility kept a pest control log he was responsible for. He stated the pest control company was at the facility on 07/02/24 to treat the ants and would be back in two weeks. He stated the pest control company sprayed for ants whenever they (they pest control company) were there. He stated he had not seen any mice for a while and could not determine what a while meant. He stated there were sticky traps usually by the bread and in the back room of the kitchen. He stated he did not know exactly where they were or if the sticky traps were even there. He stated the pest control company was responsible for them. He stated the maintenance logs were hand-written and the facility did not use an electronic work order system. He stated the maintenance logs were kept at the nurse's station. He stated he did not know how he knew when items were resolved because he did not keep the requests after he addressed the problem(s). The pest control log and maintenance log were requested. (continued on next page)

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	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DM on 07/03/24 at 5:10 pm, she stated the process of reporting problems in the kitchen was to go to maintenance. She stated there was a maintenance log specifically for the kitchen, separate from the other maintenance logs. She stated maintenance kept the kitchen maintenance log. She stated she had worked in the facility for [AGE] years. She said nothing when asked if she had ever seen mice, ants, or rodents in the kitchen. In an interview with the ADM on 07/03/24 at 5:20 pm, she stated she was aware the kitchen needed a lot. She stated she had been in the facility since 06/13/24 and was trying to get things done. She stated she was not aware of the extent of repairs the kitchen needed. She stated the MS had not made her aware of the condition of the walk-in freezer. Record review of the pest control service contract dated 07/14/16 included monthly interior and exterior service for insect control, rodent control, and fly control. Record review of pest control services rendered dated 04/02/24, 05/07/24, and 06/04/24 reflected none of the invoices had detailed what kind of prevention the pest control company treated for. There was no invoice for 07/02/24. Record review of the maintenance log reflected one entry dated 06/25 and regarded a leaking sink in the kitchen. Facility policy regarding physical environment or pest control was requested but not received.