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	08/06/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of their personal and/or medical records for 7 of 10 residents reviewed for residents' rights. The facility failed to ensure LVN-D locked and/or closed the medication cart computer screen and left multiple residents' information exposed. The facility also failed to ensure LVN-D turned over or put away paperwork or report sheets with multiple residents' information on it. This failure could place residents at risk of resident-identifiable information being accessed by unauthorized persons. The findings include: In an observation on 08/06/25 at 8:10 AM revealed LVN-D's medication cart laptop screen was left opened with multiple residents' information exposed. While examining the laptop and information on the screen, LVN-D walked out of a resident's room, reached past this surveyor and closed the screen. In an observation on 08/06/25 at 9:31 AM revealed a report sheet with multiple residents' information left face up on LVN-D's medication cart. While examining the paperwork and getting a photo of it, LVN-D walked out of a resident's room and grabbed the paper. In an interview on 08/06/25 at 9:32 AM, LVN-D stated she should have locked and closed her laptop screen as well as placed the paper facedown or away because they had residents' information on them, and anyone could have walked by and seen it. She stated she knew it was considered a HIPAA violation to leave resident information exposed. She stated she was really busy and had forgotten to lock the screen or turn the paper over when she walked away. In an interview on 08/06/25 at 9:33 AM, the DON stated it was considered a HIPAA violation to leave residents' information exposed where anyone could have seen it or stolen it. She stated she had just in-serviced LVN-D over this topic this morning. In an interview on 08/06/25 at 9:35 AM, the ADON stated leaving residents' information out in the open for anyone to read or take was considered a HIPAA violation, and the nurses knew they were not supposed to do this to keep the information private and accessible to only those authorized to access it. Record review of the facility document titled Nursing Facility Residents' Rights, dated November 2021, revealed in part, Dignity and Respect: You have the right to: Access personal and clinical records, which will be maintained as confidential and may not be released without your consent. Record review of the facility's policy titled Resident Rights, revealed in part The facility will ensure its associates are educated to the importance of resident's rights. Any violation or potential violation should be reported immediately to their supervisor, the Director of Nursing, Social Services, or Executive Director.

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews and record reviews, the facility failed to provide and document sufficient preparation and orientation of resident representatives to ensure safe and orderly transfer or discharge from the facility.The facility failed to provide written transfer notices to residents, representatives, and the local ombudsman in a language and manner they understand.This failure could place residents at risk of not receiving information regarding their options, rights, and protection from inappropriate transfers or discharges. Findings included:In an interview with the ADM on 08/05/2025 at 10:41 am, she said the facility had not been sending out written transfer notifications. In an interview with the Ombudsman on 08/05/25 at 2:15 pm, she said she had not been getting written notifications of transfer from the facility. In an interview and record review with the ADM on 08/05/2025 at 4:30 pm, she said she developed and provided a performance improvement plan regarding written transfer policies at this time. In an interview with the ADM on 08/06/2025 at 10:41 am, She said the BOM would have been responsible for sending the letters to the resident, the resident representative, and the ombudsman. She said she did not know why they were not sending out transfer notifications.Record review of the facility's discharge report dated 05/01/25-08/04/25 revealed 55 discharges: 21 to an acute care hospital, 6 to funeral homes, 1 to hospice, 3 to nursing homes, 19 to private homes with home health services, and 5 to private homes without home health services. Record review of the facility's policy reviewed on 11/19/24 titled, Area of Focus: Discharge Process and Bed Holds revealed under Notice before transfer, before a facility transfers or discharges a resident, the facility must: (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they can understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident. Consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in comprehensive assessment for 1 (Resident #70) of 6 residents reviewed for care plans. The facility failed to ensure Resident #70's care plan was implemented by not having the resident's call light within reach on 08/04/25 at 2:10 PM. This failure could place residents at an increased risk of needs going unmet or harm.The findings included:Record review of Resident #70's face sheet dated 08/04/25 revealed a [AGE] year-old male with an admission date of 02/10/21. Resident #70's Pertinent diagnoses included hemiplegia and hemiparesis affecting the right dominant side (complete paralysis to right side of body), aphasia (unable to speak), and dementia (decline in mental ability that interferes with daily life). Record review of Resident #70's quarterly MDS assessment dated [DATE] revealed a BIMS score could not be obtained because the resident was rarely or never understood. Record review of Resident #70's comprehensive care plan revealed the focus [Resident #70] is at risk for falls r/t right-sided hemiplegia and hemiparesis, impaired condition initiated on 02/10/21 and revised on 07/15/25. An Intervention for this focus included Call light within reach initiated on 02/10/21. During an observation on 08/04/25 at 2:10 PM, Resident #70's call light cord and button were coiled up on the floor approximately 3 feet away from the head of the bed on Resident #70's right side. In an interview with Resident #70 on 08/04/25 at 2:10 PM, Resident #70 was unable to answer questions due to his inability to speak. Resident #70 was able to nod his head up and down or side to side to indicate yes or no answers. Resident #70 was asked if he knew how long his call light had been on the floor out of reach and he shrugged his shoulders. Resident #70 was asked if his call light was on the floor out of reach very often and he shook his head side to side. Resident #70 was asked if he was able to communicate with nursing staff in the halls with any means other than the call light and he shook his head side to side. In an interview with CNA B on 08/04/25 at 2:15 PM, CNA B stated residents' call lights were supposed to be clipped to the side of the bed within reach of the resident. CNA B stated he did not know how Resident #70's call light fell on the floor out of reach. CNA B stated it was important for residents to be able to access their call lights so they could notify the nursing staff if they had any problems. In an interview with LVN A on 08/04/25 at 2:20 PM, LVN A stated residents' call lights were supposed to be clipped to the side of the bed within reach of the resident. LVN A stated he was in Resident #70's room sometime after lunch and thought the call light was on Resident #70's bed. LVN A stated it was important for any resident to be able to access their call light so they could contact the nursing staff if they had any problems. LVN A stated it was especially important for Resident #70 to have his call light because he was unable to speak or yell to get attention. LVN A stated if a resident could not access their call light, they could accidentally injure themselves and not be able to get the nurses attention for help. In an interview with the DON on 08/06/25 at 2:50 PM, the DON stated it was important for all residents to have access to their call lights so all their needs could be met by the nursing staff. The DON stated if residents could not reach their call light, then they could have trouble informing the CNA's and nurses on the floor of any problems they had. The DON stated this issue could lead to a resident experiencing harm and then receiving a delayed response by the staff. Record review of the facility's policy Person Centered Care Planning last reviewed 09/05/2024 revealed the following: . The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights. that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews, and record review, 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 and 1 of 1 nutrition room for storage, preparation, and sanitation.1.The facility failed to ensure dinnerware was cleaned and dried properly.2.The facility failed to ensure the pots, pans, and utensils used to cook and prepare food were in good working condition. 3.The facility failed to ensure items in the refrigerator and freezer were labeled, dated, and sealed properly.4.The facility failed to ensure items in the refrigerator and freezer were not expired.5.The facility failed to ensure boxes in the freezer were not stacked to the ceiling.6.The facility failed to ensure the steam table wells were clean.These failures could place residents at risk for food contamination and foodborne illness.Findings were:Observation and initial tour of the kitchen on 08/04/25 at 10:05 am revealed 24 of 31 clear plastic drinking glasses that had a thick removable whitish substance on the inside bottoms and sides and were wet inside on the clean rack. The trays had no drainage mats under the glasses. There were approximately a hundred plastic plate covers on clean racks that had a removable whitish substance on the tops where the hand holds were, the sides, and around the inner edge where the plastic cover rested on the plates. There were 2 non-stick type pans with flaking coating in the bottoms and sides and were hanging on the clean rack. One of them was badly dented. There were 2 large cooking pots that were badly pitted around the bottoms of the insides. The pits were dark brown/black. There was a dirty metal spatula, a dented and bent metal pastry scraper, and a plastic spatula with chips around the edges in a clean bin. There were multiple trays of glasses with different beverages in them and several pitchers filled with brown liquid in the refrigerator. The trays and pitchers were unlabeled and undated in the refrigerator. There were 6, 4-ounce containers of apple juice in a pan dated 06/01-06/07 in the refrigerator. There was a 20-pound box of frozen hash browns, a large box of frozen breaded yellow squash, and a large box of sweet corn on the cob that were not tightly sealed and opened to the air in the freezer. The hash browns were covered with ice crystals. There was a 1-gallon zip type bag of what appeared to be shredded cheese that was opened to the air and a 1-gallon zip type bag of what appeared to be cheese slices opened to the air in the walk-in freezer. There was a large accumulation of ice hanging from the ceiling onto a large box of an unknown product. Boxes in the walk-in freezer were stacked to the ceiling. 4 of 4 steam table wells had a flaking, yellow/white substance on the bottoms, sides, and floating in them. Observation during a return visit to the kitchen on 08/06/25 at 1:30 pm revealed the same boxes in the freezer were stacked to the ceiling.In an interview with the DM on 08/04/25 at 10:27 am, she said she did not know what the removable white substance was inside the drinking glasses, or the plastic plate covers. She said the glasses should have drying mats under them to drain properly. She said the plastic plate covers were in use. She said if the residents touched the cover to remove it from the plate, it could cause cross contamination as well as the edges of the plates where the cover rested on them. She said the non-stick type pans on the dry rack were only used for making grilled cheese sandwiches. She said kitchen staff used metal utensils in the non-stick type pans and had not been trained on using non-metal utensils in non-stick type pans. She said the flaking coating in the pans could get into the food and possibly make the residents sick. She said she guessed the large cooking pots were pitted inside. She said she did not know why there were brown/black substances in the pits. She said, If it was food in the pits, I guess it could get in the food. She said cross contamination could occur and make residents sick. She said the metal spatula was in a clean bin and did not look clean. The DM said the dented and bent metal pastry scraper did not look safe to use because the metal was sharp and could cut someone. She said it should have been thrown away. She said the plastic spatula with chips around the edges should have been thrown away because the plastic was coming off, could get in the food and make residents sick. She said she was unaware of labeling and dating food and beverages on trays in the refrigerator and freezer when the products were going to be used that day. She said they did not always use all the products on the trays the same day. She said there was a box of the containers of apple juice in the freezer and the 6, 4-ounce individual containers of apple juice were thawing in the refrigerator. She said the box use by date was 14 days after thawing (verified). She said the containers of apple juice in the refrigerator were past their use by date. She said the expired apple juice could have made residents sick. She said she was unaware bagged frozen food inside boxes had to be tightly sealed after opening. She said nothing about the open zip-type 1-gallon bags of cheese. She said the ice build-up in the walk-in freezer had been there for a year. She said repairs for the kitchen were reported in the daily morning meetings. She said

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 ensure, in accordance with accepted professional standards and practices, to maintain medical records on each resident that was complete and accurately documented for one resident 1 of 7(Resident #00) residents reviewed for medical records. The facility failed to ensure Resident #00's MARS was revised to reflect the accuracy of times the resident took hydrocodone-Acetaminophen Tablet 10-325 milligrams taken as needed for pain control on 04/09/2025.This failure could place residents at risk for not receiving appropriate and timely pain care relief to meet their current needs.The findings included:Record review on 08/06/25 of Resident #00's facesheet documented a [AGE] year-old male who was admitted to the facility on [DATE]. Resident # 00 had diagnoses which included diabetes(a group of diseases that result in too much sugar in the blood), necrotizing fasciitis (a serious bacterial infection that destroys the tissue under your skin called fascia) , pressure ulcers(injury to skin and underlying tissue resulting from prolonged pressure on the skin) of heel unstageable, pressure ulcer of sacral region(the anatomical area located at the base of the spine, where the lower back meet the pelvis) stage 4 cutaneous(skin) of limb, skin transplant, encounter of sepsis aftercare.Record review of Resident #00's Minimum Data Set, dated)03/03/25 documented Resident #00 had a BIMS of 14, which indicated the resident's cognitive function was intact. Resident #00 required assist with one-person physical assist for transfers, dressing, toileting, and personal hygiene. Resident #00 had 2 stage 4 pressure ulcers and 2 unstageable pressure ulcers due to coverage of wound bed by slough (dead tissue that accumulates on the surface of a wound, often appearing as a moist, yellow, tan or white layer)or eschar(dead tissue that eventually sloughs off healthy skin after an injury). Resident #00 was receiving insulin injections and IV medications. Record review of resident #00's Care Plan dated 03/22/25 revealed Resident expresses chronic pain related to immobility, limited range of motion to joints, wounds and neuropathy. The Resident is on pain Medication therapy related to wounds and neuropathy. Administer ANALGESIC medications as ordered by physician. Observe for side effects and effectiveness every shift. Record review of Resident's #00's March 2025 Physician's Orders revealed Resident's #00 was prescribed hydrocodone-Acetaminophen tablet 10-325 MG give1 tablet by mouth every 4 hours as needed for pain. The MARS and the Narc Sheet did not match as the Narc sheet showed dates the medication was removed from blister pack. The blister pack did have medication missing and matched the Narc sheet. Record review of the MARs is did not have dates documented on the days the Narc sheet documented medication administered. Record review of the of the narcotic sheet reveal that on 04/09/25 the time of 7:20 pm a pill was documented to be administered to Resident #00 and was signed out by the [NAME] LVN at 7:20 shift ended at 7:00pm.In an interview on 08/06/2025 at 1:30 pm, the Administrator stated the MARs and Narcotic sheet were to match up when compared. The Administrator said the nurse or med aid were to document in these days areas when a narcotic was dispensed to the resident in order to keep accurate account of the amount and the time the resident received their narcotic medication. The Admin stated if the two forms of documentation did not match it could cause an error in dispensing the medication that could put the resident at risk of overdosing and possibly death. In an interview on 08/06/2025 at 2:47 PM with the ADON she stated keeping the narcotic sheet and the resident's MAR accurate kept the resident safe and free of medication mistakes. The ADON stated the nurses were to document in both records as the medication was given to the resident. The ADON stated correctly documented dates and times of resident receiving medication help track drug diversion.The ADON stated she would recheck and match the both records themselves randomly this incident occurred between the time she checked them twice a month In an interview on 08/07/25 the DON stated it was of great importance to maintain accuracy in all aspects of the resident's records but more with the correct documentation of the Narcotic sheet and MAR. The DON stated inconsistencies in the documentation of date and times could keep the resident from getting their medications or getting their medication too early that could cause the resident to have an overdose which could result in hospitalization or death. The DON stated surprise audits of residents records with narcotics were done to prevent such errors from occurring. Record review of the facility policy stated It is the policy of this facility that reports allegations of drug diversion are promptly and thoroughly investigated. Residents have the right to live at ease in a safe environment. Complaints and grievances will be investigated and will be reported as required by law if the investigation reveals any alleged violations and /or misappropriation of resident property

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 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 observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #54) reviewed for infection control practices. 1.The facility failed to ensure the ADON (who was also the ICP) knew the proper technique for cleansing the wound and keeping it clean during wound care. 2. The facility failed to ensure CNA-C performed hand hygiene between providing Resident #54 incontinent care and applying a clean brief. These fails could place residents at risk for cross contamination and infection. The findings include: Record review of Resident #54's face sheet, dated 08/05/25 revealed an [AGE] year-old-female with an admission date of 07/24/25. Resident #54's Pertinent diagnoses included Displaced Intertrochanteric Fracture of Right Femur with Subsequent Encounter for Closed Fracture with Routine Healing (a common type of hip fracture which typically required surgical intervention for proper healing) and Type 2 Diabetes (a chronic condition which affects the way your body metabolizes sugar). Record review of Resident #54's admission MDS assessment dated [DATE] revealed a BIMS score of 03, which indicated severely impaired cognition. The MDS also revealed Resident #54 had a surgical incision or wound. Record review of Resident #54's physician orders with a start date of 07/28/25, revealed an order for wound care to the right hip surgical incision, cleanse with normal saline, pat dry with gauze, and cover with a dry dressing daily (the order was not clear and did not specify to perform wound care to all four surgical incision areas). The Physician orders did not reveal an order for EBP. Record review of Resident #54's care plan, initiated 07/24/25 and revised 07/28/25 revealed Resident #54 had a break in skin integrity related to right hip surgical incision with interventions to include treatment as ordered and weekly skin checks. In an observation on 08/04/25 at 11:33 AM revealed Resident #54's room had no EBP sign and no PPE supplies. In an observation on 08/05/25 at 9:40 AM of Resident #54's incontinent care and wound care revealed CNA-C provided incontinent care without cleaning or sanitizing her hands in between cleaning Resident #54 and removing the old brief and applying the new, clean brief, then assisting with positioning Resident #54 for wound care. CNA-C was observed placing her dirty, gloved hand over the uncovered 4th surgical wound on Resident #54. CNA-C kept her dirty gloved hand over the surgical site with sutures throughout the entire wound care process. The ADON was observed cleansing and covering 3 of the 4 open surgical wounds. The 4th surgical wound to the lateral aspect of Resident #54's right leg was observed to have gone without wound care. In an interview on 08/04/25 at 10:52 AM, the ADON stated she was also the ICP, and she was the one who typically obtained the order for EBP and placed the EBP signs outside of the residents' doors. She stated the floor nurses did it sometimes upon admission, but if it was not ordered upon admission, she typically obtained the order, hung the signs and placed the PPE outside the residents' rooms. In an interview on 08/05/25 at 10:45 AM, CNA-C stated she should have used hand sanitizer and changed her gloves after cleaning and removing Resident #54's dirty brief. She stated she got nervous and forgot to do it. She stated she did not see the wound on Resident #54's leg or she would not have put her dirty hand over the top of the wound while she assisted to hold Resident #54 in position for wound care. She stated touching the wound with her dirty glove could cause cross contamination and cause the resident to have an infection. In an interview on 08/05/25 at 3:05 PM, the ADON stated CNA-C should have used hand sanitizer and changed her gloves after cleaning and removing Resident #54's dirty brief, and she should have reminded her about hand hygiene and clean gloves as well as reminded her not to touch Resident #54's open wound. The ADON stated she was not sure why the 4th surgical area was not previously covered, and why it was not listed in the orders, so she had the order clarified, and went back and performed wound care on the area. She stated touching Resident #54's surgical wound with a dirty glove could have caused cross contamination and caused an infection. She stated she started an in-service with all staff regarding proper hand hygiene and proper incontinent care. The ADON stated Resident #54 should have previously been placed on EBP precautions, and she must have just overlooked it. Record review of the facility's EBP policy, revised 04/22/25, revealed The facility should use Enhanced Barrier Precautions (EBP) as an additional MDRO mitigation strategy for residents that meet the following criteria, during high-contact resident activities; 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. (A) Wounds generally include chronic wounds, to include pressure ulcers, diabetic foot ulcers