Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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
	455687	A. Building B. Wing	12/20/2025

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F 0655 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 record review and interview, the facility failed to develop a baseline care plan that included the instructions needed to provide effective and person-centered care of the residents, for one (Resident #1) of five residents reviewed for base line care plans for newly admitted residents. 1) The facility did not develop a baseline care plan that addressed Resident #1's diabetes mellitus when he was admitted on [DATE]. This failure could place residents at risk of not having their needs met and increase the risk of adverse events regarding diabetes mellitus exacerbation or complications. The findings included: Record review of Resident #1's admission record dated 12/19/2025 revealed Resident #1 was initially admitted on [DATE] and readmitted [DATE]. Resident #1 discharged home with home health services on 09/22/2025. Resident #1 was admitted to the facility with multiple diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease, and heart disease. Record review of Resident #1's discharge MDS dated [DATE] revealed Resident #1 had a BIMS score of 12-Moderate cognition impairment and needed partial/moderate assistance with ADLs and was coded for type 2 diabetes with diabetic peripheral angiopathy without gangrene (narrowing of arteries in the legs due to diabetes but without tissue death). Record review of Resident #1's NURSING: Baseline Care Plan assessment admission date 09/18/2025 revealed #18 was not check marked for Resident has Diabetes Mellitus. Record review of Resident #1's Care Plan Report date initiated 09/18/2025 revealed it did not include a care plan for diabetes mellitus. During an interview on 12/19/2025 at 3:37PM the MDS Coordinator stated while she reviewed the baseline care plan assessment, box number 18 was not checked marked. The MDS Coordinator stated number 18 was entitled resident has diabetes mellitus. The MDS Coordinator stated if Resident #1 had diabetes mellitus the baseline care plan would be reflective of the admitting diagnosis. The MDS Coordinator stated Resident #1 was admitted to the facility on [DATE] for respite care and discharged on 09/22/2025. The MDS Coordinator stated LVN A failed to check mark number 18 by mistake. The MDS Coordinator stated there was no negative outcome due to Resident #1's baseline care plan lacking his admitting diagnosis of diabetes mellitus. The MDS Coordinator stated while she reviewed Resident #1's baseline care line, Resident #1's diagnosis of diabetes mellitus should have been within his baseline care plan. The MDS Coordinator stated baseline care plans are important because they outline the individualized plan of care, but reiterated there was no negative outcome from the missed baseline care assessment of diabetes mellitus for Resident #1. The MDS Coordinator stated the usual procedure for admission/readmissions begins when the admitting nurse facilitates the admission baseline care plan assessment, which will then be reviewed by the RN which used to be the previous DON. The MDS Coordinator stated that going forward she will be more diligent while reviewing baseline care plans as well as comprehensive care plans. During an interview on 12/20/2025 at 10:32AM LVN A stated Resident #1 was admitted on [DATE] for a 5-day respite stay. LVN A stated she was Resident #1's admitting nurse and recalled Resident #1 had diabetes mellitus. LVN A stated while reviewing Resident #1's baseline care plan assessment, dated 09/18/2025, she had forgotten to click the resident has diabetes mellitus box, and since she did not check mark the box on the admission assessment, the baseline care plan did not populate interventions/care plan for diabetes mellitus. LVN A stated Resident #1 never suffered any negative outcomes due to the missed diabetes mellitus diagnosis on the baseline care plan. LVN A stated she recalled Resident #1 received oral antidiabetic medication. LVN A stated she followed Resident #1's physician orders, and completed glucose monitoring, and oral antidiabetic medication administration. LVN A stated the procedure for facilitating a baseline care plan commences when the admission nurse populates a care plan assessment. Once the care plan assessment was completed, an RN would review the assessment and sign off that the assessment was accurate and addresses the admitting diagnoses. Once the RN signed off, a baseline care plan would then be populated within Resident #1's electronic health record. LVN A stated lastly, the MDS Coordinator would review the baseline care plan as a third review. LVN A stated she accidentally missed clicking the resident has diabetes mellitus box. LVN A stated she should have clicked that specific box, but did not, and therefore affected the accuracy of Resident #1's baseline care plan. However, LVN A stated there were no negative outcomes for the missed check mark. LVN A stated baseline care plans are important as they reflect the individualized plan of care for Resident #1. LVN A stated going forward she will be more diligent in clicking the admission assessment boxes to ensure the baseline care plans are accurate. During an interview on 12/20/2025 at 11:34AM the Interim DON stated she became the