

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2024
NAME OF PROVIDER OR SUPPLIER  River Ridge Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3922 W River Dr Corpus Christi, TX 78410	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50039</p> <p>Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 (Resident #39) of 8 residents reviewed for abuse and neglect, in that:</p> <p>LVN A did not implement facility abuse policy related to reporting allegations of abuse to Resident #39's RP when CNA C was alleged to have abused Resident #39 on 10/22/24.</p> <p>This failure could place residents at risk of abuse and neglect.</p> <p>The findings included:</p> <p>Record review of Resident #39's face sheet dated 10/29/24 revealed a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Unspecified Dementia and Major Depressive Disorder.</p> <p>Record review of Resident #39's care plan dated 10/29/24 revealed no information regarding the reporting of abuse allegations.</p> <p>Record review of Resident #39's Quarterly MDS Assessment section C, Cognitive Patterns, dated 09/09/24 revealed a BIMS score of 6 (severe impairment).</p> <p>(continued on next page)</p>

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
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the provider investigation report dated 10/30/24 revealed the alleged abuse occurred on 10/22/24 at 11:00 PM. Further review revealed the alleged victim was Resident #39 and alleged perpetrator was CNA C. Further review revealed the incident category was Abuse. Further review revealed the following investigation summary, On October 22, 2024 at approximately 11:30pm [ADM] was notified by [DON] that our night shift charge nurse [LVN A] was bringing an allegation of Abuse and Neglect. LVN [A] states that she heard a resident yelling on the 200 hall and entered rom 209. She noticed [Resident #39] and [CNA C] in the resident's bed area. LVN [A] states that she heard the CNA [C] and resident yelling at each other and that the CNA [C] told the resident to 'Shut Up'[,] LVN [A] also stated that she observed the CNA [C] cover the resident mouth. The CNA [C] stated that she did not tell the resident to shut up but instead stated [Resident #39] please be quiet, there are people sleeping. Also stated she did not cover the resident's mouth but was actually attempting to to[sic] take paper out of her mouth. The LVN [A] and another [LVN B] assessed the resident for any injuries or concerns, they assessed her mouth and oral cavity and did not identify any concerns, or discoloration. Resident's physician notified. [ADM] interviewed the resident, unfortunately she did not remember or provide any information. She was in good spirits and she had no concerns. The CNA [C] was immediately suspended that night and it was decided to terminate the CNA [C] on 10/29/24.</p> <p>In an interview with the RP of Resident #39 on 10/28/24 at 1:18 PM, the RP stated Resident #39 did well at the facility. The RP stated Resident #39 was stubborn, but not combative. The RP stated she was not aware of any allegation of abuse made that involved Resident #39 being abused by CNA C at the facility.</p> <p>In an interview with the ADM on 10/28/24 at 1:43 PM, the ADM stated the DON contacted him at home around 11:30 PM on 10/22/24 to tell him LVN A may have witnessed potential abuse by CNA C. The ADM stated he had not called the RP to notify her of the abuse allegation. The ADM stated when there was an allegation of abuse, the doctor and RP should have been notified immediately by one of the nurses working at the time.</p> <p>In an interview with LVN A on 10/29/24 at 12:14 PM, LVN A stated she observed what she believed to be CNA C abusing Resident #39. LVN A stated she had only been working in the facility for a few weeks and was not sure of the process for reporting the abuse. LVN A asked LVN B for help and LVN B walked LVN A through the process of filing a complaint. LVN A stated the only person she called was the DON. LVN A stated she did not know if anyone called the RP of Resident #39. LVN A stated she performed an assessment on Resident #39 after the incident and did not find any injuries or markings.</p> <p>In an interview with LVN B on 10/29/24 at 2:37 PM, LVN B stated LVN A told her she had witnessed a CNA potentially abusing a resident. LVN B stated she called the NP to inform them about the potential abuse. LVN B stated she did not call the RP of Resident #39.</p> <p>In an interview with the DON on 10/29/24 at 1:10 PM, the DON stated she talked to LVN A on the phone immediately after the incident and told her to call the family of Resident #39 and document the incident. The DON stated she did a follow-up call with the RP of Resident #39 on 10/28/24 and learned at that time that LVN A never called the RP. The DON stated she usually made follow-up calls to the RPs within 3 to 5 business days after an allegation was made to inform them of the investigation results. The DON stated they should notify the RP as soon as possible after an allegation of abuse was made involving a resident. The DON stated the charge nurses on shift were the ones supposed to call the RP after an incident.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview with the RP of Resident #39 on 10/30/24 at 1:48 PM, the RP stated the DON called her sometime after this surveyor did on 10/28/24 to inform her of the incident.</p> <p>In an interview with Resident #39 on 10/30/24 at 3:30 PM, Resident #39 was unable to recall the incident with CNA C allegedly abusing her. Resident #39 stated the nurses were always nice to her and she had never had any issues with any of them.</p> <p>Record review of the facility policy Abuse Guidance: Preventing, Identifying and Reporting dated 02/17 and revised 10/22 revealed the following:</p> <p>Investigative Procedures Related to Allegations of Abuse, Neglect or Exploitation .</p> <p>Investigation should include, but is not limited to:</p> <p>Immediate notification of the alleged victim's practitioner and the family or responsible party.</p>		