STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675672	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for supervision.1. The facility failed to ensure CNA A followed 2-person assist as stated on Resident #1's care plan when she transferred Resident #1 from her wheelchair to bed on 11/01/25 at around 7:00 PM.2. The facility failed to ensure CNA A followed Resident #1's care plan and used a 2 person assist when she provided incontinent care on 11/01/25 around 8:30 PM and on 11/02/25 around 4:00AM. Which resulted in acute proximal and mid left lower leg fractures.An Immediate Jeopardy (IJ) was identified on 11/08/25. While the IJ was removed on 11/10/25, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk of injuries and not receiving the appropriate level of assistance and care. The findings include:Record review of Resident #1's face sheet, dated 11/10/25, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Alzheimer's disease with late onset (progressive brain disorder that caused memory loss and difficulty with thinking, reasoning and daily tasks), age-related osteoporosis (disease that weakens bones) with current pathological fracture, unspecified site, subsequent encounter for fracture with routine healing and Other specified arthritis (inflammation or swelling of one of more joints), multiple sites. Record review of Resident #1's state optional MDS assessment, dated 08/12/25, reflected Resident #1 had a BIMS score of 02, which indicated severe cognitive impairment. Resident #1 was coded as requiring two+ persons physical assist for transfers and bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). Record review of Resident #1's care plan, with an initiated date of 12/20/22, reflected Resident #1 was a 2 person assist for transfers, and bed mobility, with an initiated date of 12/20/22, and was a 2 person assist for incontinent care, with an initiated date of 05/15/23. Record review of Resident #1's notes, dated 11/01/25 at 10:19 PM, written by LVN B, stated Resident c/o pain to left leg, no noted abnormalities to leg medication given will continue to monitor. Record review of Resident #1's change in condition form, dated 11/02/25 at 5:30 AM, stated Resident #1 had uncontrolled pain and change in skin color or condition that started the morning of 11/02/25 and stated, Resident had c/o of leg pain upon assessment of leg it was noted that resident had discoloration to leg. Record review of Resident #1's skin assessment, with an effective date of 11/02/25 at 6:00 AM, completed by LVN B, identified bruising to the front of the left lower leg that was 10cm x 11cm and stated, Resident was noted to have discoloration to below knee. Discoloration was light green in color resident states pain to left lower extremity no redness or swelling noted. Record review of Resident #1's notes, dated 11/02/25 at 9:41 AM, written by LVN C, stated at 6:45 AM nurse practitioner returned call from LVN B and ordered stat knee x-ray, LVN C requested left knee, tibia, ankle and foot x-ray due to left lower leg swelling, pain and purplish discoloration. Record review of Resident #1's order summary report included an order or stat x-ray of left knee, tibia, ankle and foot for pain and discoloration with an order date of 11/02/25. Record review of Resident #1's notes, dated 11/02/25 at 10:51 AM, written by LVN C, stated at 10:20 AM reflected x-ray results were received and showed acute proximal and mid left leg fractures and stated to send referral to orthopedic clinic and new orders were provided for tramadol. Record review of Resident #1's x-ray impressions of the left tibia and fibula from the exam taken on 11/02/25 stated, Acute proximal and mid left lower leg fractures. Record review of Resident #1's nursing note, dated 11/03/25 at 9:41 AM, by LVN C, reflected she followed up with the orthopedic clinic regarding the clinical faxed over on 11/02/25 and they confirmed they were received. Record review of Resident #1's nursing note, dated 11/03/25 at 11:25 AM, by LVN C, reflected MD E at orthopedic clinic would not be able to see Resident #1 due to location of fractures but would forward clinical paperwork to MD F. Record review of Resident #1's nursing note, dated 11/03/25 at 3:18 PM, by the DON reflected she notified the responsible party for Resident #1 that the orthopedic clinic was unable to see Resident #1 due to insurance and was made aware of the option to send her to the hospital for evaluation and treatment to which Resident #1's responsible party agreed to. Record review of Resident #1's order summary report included an order to send Resident #1 to the emergency room to evaluate and treat for acute proximal and mid left leg fractures, with an order date of 11/03/25. Record review of Resident #1's notes, dated 11/03/25 at 3:50 PM, by LVN C, reflected transportation was at the

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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 to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #3) reviewed for medical records accuracy, in that: The facility failed to transcribe Resident #'3's paper care plan to her electronic care plan that was accessible by staff. This failure could affect residents whose records were maintained by the facility and could place them at risk for errors in care, treatment and medication administration. The findings include: Record review of Resident #3's face sheet, dated 11/08/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: legal blindness, as defined in the USA (visual acuity of 20/220 or worse or field of vision 20 degrees or less), age-related physical debility, other osteoporosis (thin brittle bones) without currently pathological fracture, and repeated falls. Record review of Resident #3's Minimum Data Set assessment, dated 10/04/25, revealed Resident #3 had a BIMS score of 06, which indicated she was severely cognitively impaired. Record review of Resident #3's change in condition, completed by LVN C, reflected Resident #3 had a fall on the morning of 10/18/25 which resulted in a quarter size bump to head. Record review of Resident #3's care plan did not include any documentation related to falls that occurred on 10/18/25. Record review of Resident #3's care plan included a focus of I am at risk falls related to: stiffness of unspecified joint, repeated falls, age related physical debility. with a date initiation of 09/21/24. There was no verbiage related to Resident #3's fall on 10/18/25. During a record review and interview with MDS Nurse G on 11/07/25 at 4:00 PM, she stated on the day of Resident #3's fall on 10/18/25 their system was down so she used a paper care plan to document the fall and interventions, but stated she failed to upload it into Resident #3's chart and had the paper documents in her office. Record review of a paper document provided by MDS Nurse G was a copy of an admission checklist with Resident #3's name written on it along with Care Plan which stated, Focus, 10/20/25 risk for injuries/Fall. 10/18/25 - actual Fall.Goal 10/20/25 Injuries will resolve without complications through my review date.Interventions 10/20/25 Bed stand/furniture moved to prevent falls. During a record review and interview with the DON on 11/10/25 at 3:18 PM, he stated MDS Nurse G was responsible for completing the care plan for Resident #3 and items such as skin, activities of daily living and falls should be included in the care plan. The DON reviewed Resident #3's care plan in her electronic chart and stated she saw interventions but did not see her fall from 10/18/25. The DON stated Resident #3's fall was not on the care plan because they were in the process of switching from their old company to their new copy and the system was shut down so they did a paper care plan. The DON stated the information from the paper care plan should have been added to Resident #3's electronic chart. The DON stated it was important to include falls on the care plan so when someone checked the care plan, they would be aware of the residents' fall history. The DON stated MDS Nurse G monitored the care plans to ensure they had all required information and was not sure how often she did, but thought it was done quarterly. The DON stated MDS Nurse G was trained in developing the care plans and what should be included within the last 6 to 12 months. The DON stated she did not know exactly what the care plan stated in regard to including fall history. The DON stated she could not provide an answer on how not including a residents fall history on their care plan could negatively impact them but it was there to make other staff aware of their fall history. During an interview with MDS Nurse G on 11/10/25 at 3:52 PM, she stated she was responsible for completing the care plan for Resident #3. MDS Nurse G stated falls should be included on the residents care plans. MDS G stated Resident #3's fall from 10/18/25 was not in the electronic system because their system was down at the time and she put it on paper and had not uploaded it. MDS Nurse G stated the information on Resident #3's paper care plan should have been added into her electronic chart. MDS Nurse G stated it was important to include falls on the care plan because if anything happened there would be a record you could go back to and see what incident happened and what the goals and interventions were. MDS Nurse G stated she reviewed and monitored the care plans to ensure they had all the required information. MDS Nurse G stated she monitored the care plans by running an order list in the morning to show any orders from the day before and by adding anything that was discussed in the morning meetings that needed to be added. MDS Nurse G stated she previously was trained on developing the care plan and what should be included, she stated she was trained on this when she first started through an MDS training, MDS Nurse G did not provide a date to this training. MDS Nurse G stated in regard to fall history on the care plan the facility policy