

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  01/29/2026
NAME OF PROVIDER OR SUPPLIER  Avir at River Ridge		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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatments and services consistent with professional standards of practice to promote healing, prevent infection, and prevent development of new ulcers for 1 of 5 residents (Resident #50) reviewed for pressure ulcers. The facility failed to ensure Resident #50's Foley catheter was not leaking, causing the brief over the pressure ulcer to be saturated with urine, failed to ensure the WCN followed proper hand hygiene and clean glove protocol, failed to ensure incontinent care prior was provided prior to wound care; and failed to use proper wound care cleansing techniques. These failures and deficient practices could place residents at risk for cross contamination, infection, and new or worsening pressure ulcers. The findings included: Record review of Resident #50's face sheet, dated 01/28/2026, revealed a [AGE] year-old female with an original admission date of 11/26/2025, and a current admission date of 01/07/2026. Pertinent diagnoses included Sepsis (a life-threatening condition caused by the body's extreme response to an infection which could include symptoms such as fast breathing, fever, confusion, and severe pain, and if not treated quickly, sepsis could lead to shock, organ failure, or death), Congestive Heart Failure (or CHF, a chronic condition where the heart cannot pump enough blood to meet the body's needs, leading to fluid buildup and other various symptoms), and Wasting Syndrome (also known as cachexia, a serious condition characterized by significant weight loss, muscle wasting, and loss of appetite, often associated with chronic diseases). Record review of Resident #50's admission MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderately impaired cognition. The MDS assessment also indicated Resident #50 had one or more unhealed pressure ulcers/injuries. The MDS also indicated that Resident #50 was dependent in toileting hygiene and had an indwelling catheter. Record review of Resident #50's care plan, initiated 01/07/2026, revealed resident had actual impairment to skin integrity as a stage 3 sacral wound (ulcers that have progressed to the third stage have broken completely through the top two layers of the skin and into the fatty tissue below). Interventions included observe, document, and report location, size, and treatment of skin injury, as well as any new or worsened alterations in skin integrity. Weekly treatment included measurement of the area of skin breakdown, as well as any other notable changes or observations, and report improvements or declines to the provider. The care plan also revealed Resident #50 had a Foley catheter related to skin breakdown, initiated 11/26/2025 and revised 12/04/2025. Record review of Resident #50's wound note dated 01/11/2026 revealed wound was now being noted as an unstageable wound (ulcers that are difficult to diagnose due to the bottom of the wound is covered by slough [tan, yellow, green, or brown debris] or eschar [a hard tan, brown, or black plaque] with a moderate amount of serous drainage. Measurements included length 13cm x width 12cm x depth 0.3cm, with 40% slough and 60% granulation tissue Record review of Resident #50's physician orders started 01/19/2026 revealed an order to insert urinary catheter one time only for healing for 30 days. The orders also</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  675672	Facility ID:  675672  If continuation sheet Page 1 of 6

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>revealed an order started 01/08/2026 to cleanse stage 3 pressure ulcer to) Coccyx with wound cleanser, dry with gauze. Apply Thera Honey (a product designed to promote healing and prevent infection in various types of wounds), apply calcium alginate, and cover with bordered silicone bordered gauze daily and as needed. In an observation on 01/28/2026 at 11:05 AM, the WCN prepared and performed wound care on Resident #50's sacral wound. The old dressing, which was saturated with urine, was removed. The WCN failed to wash or sanitize hands and change gloves when moving from a dirty area to a clean area during wound and incontinent care by not sanitizing hands and putting on clean gloves prior to re-entering the package of clean wipes, and not sanitizing or washing hands and putting on clean gloves when she paused wound care to grab the urine and feces soaked brief to pull it down and to the side away from the wound because it kept sliding up and touching the wound. She also failed to put on an adequate amount of hand sanitizer to sanitize her hands, as well as not rubbing her hands together allowing enough time for hand sanitizer to dry prior to putting on gloves. The WCN cleansed the wound from the outside to the inside, wiping from top to bottom, instead of working from the inside to the outside (clean to dirty) in a circular motion. In an interview on 01/29/2026 at 11:42 AM, the WCN stated Resident #50 had the Foley catheter ordered and placed to assist with wound care healing, but the catheter constantly leaked, and the brief stayed wet all the time. She stated she was not sure why the catheter leaked, but it had always leaked. The WCN stated she should have made sure Resident #50 had a clean brief prior to performing wound care, as well as not touched the dirty brief during wound care. The WCN stated not cleaning the wound effectively, handling the dirty brief during wound care, and entering the clean package of wipes with contaminated gloves could have caused cross-contamination and lead to infection and worsening of the wound. She also stated a urine-soaked brief over the wound could lead to infection or worsening of the wound. The WCN nurse stated that although she felt like Resident 50's wound looked better, it had progressively gotten bigger and now has developed slough over it. The WCN also stated she realized she was cleaning the wound inappropriately and ineffectively because she was tried to be gentle and not cause Resident #50 any more pain. In an interview on 01/29/2026 at 2:07 PM, the NP stated she had seen Resident #50, but she had not seen her wound. The NP said typically the wound care nurse updated her while she was in the facility to make rounds, if there were any changes the WCN was supposed to have let her know. She stated she did not recall being called or told about any big changes with Resident #50's wound. other than the DON calling and requesting an order for the Foley catheter to aide in wound healing. She stated if the wound was increasing in size, even if it has gone back down to the original size, and even if the WCN was saying it looked better, she should have been notified, and she did not recall getting any calls or notifications regarding the wound progression or regression, but she stated she had seen a note in which one of the nurses had called to get an order for a foley catheter to assist with wound healing, but that was the only one she was able to find. She stated if she had known it had increased in size, drainage, slough, or just not healing in general, she would have put in a referral for a wound care specialist to see Resident #50. The NP stated considering the worsening of the wound, with measurements going up and down, and considering the CNA and LVN were not cleaning their hands appropriately during incontinent care and wound care, and considering the nurse had performed wound care while the resident was in a urine soaked brief with feces in it, and the nurse touched the brief during wound care, things such as these could contribute to cross-contamination and the wound not healing and possibly worsening. In an interview on 01/29/2026 at 3:05 PM, the DON stated re-entering a package of clean wipes with dirty gloves which have both touched urine and feces could be considered cross-contamination. The DON stated the technique utilized by the WCN to clean the wound could</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>contaminate the wound and reintroduce bacteria into the wound. She stated wound care was supposed to be performed from the inner to the outer (cleanest to dirtiest) (she made a circular motion with her hand while showing to clean from the inside to the outside in a circular motion). The DON stated if a nurse touched a wet and dirty brief during wound care and did not clean their hands and change their gloves afterward, it could have caused cross contamination, which could lead to infection and worsening of the wound. The DON also stated she had obtained the order for the Foley catheter aide in Resident #50's wound healing, but she was never notified by the WCN or any other staff that the Foley catheter was leaking, and Resident #50 was staying wet. The DON stated this could one of the reasons Resident #50's wound had gone up and down and was not healing. Review of the facility's Wound Care policy, revised October 2010, revealed The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Use disposable cloth to establish clean field on resident's overbed table. Place all items to be used during the procedure on the clean field. Be certain all clean items are on clean field. Discard disposable items into designated container. Wash and dry hands thoroughly. Wipe reusable supplies with alcohol as indicated (i.e. outsides of containers that were touched by unclean hands, scissor blades, etc.). Take only disposable supplies that are necessary for the treatment into the room. Review of the facility's Hand Hygiene policy, revised February 2018, revealed 1. Hand Hygiene is indicated: A. Immediately before touching a resident B. Before performing an aseptic task C. after contact with blood, body fluids, or contaminated surfaces D. After touching a resident E. After touching a resident's environment F. before moving from work on a soiled body site to a clean body site on the same resident G. immediately after glove removal. 4. Single-use disposable gloves should be used: A. before aseptic procedures B. when anticipating contact with blood or body fluids.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 12 of 12 residents reviewed for infection control practices. The facility failed to ensure all residents on EBP in the facility had EBP signs posted on residents' doors or walls outside of the rooms. The facility also failed to ensure the WCN and CNA-H followed properly sanitized their hands and changed their gloves during wound and incontinent care on 01/28/2026 for Resident #50's. The WCN and CNA-H also failed to sanitize hands and apply clean gloves prior to getting wipes out of the clean container of wipes. These failures and deficient practices could place residents at risk for the wrong PPE being utilized, cross-contamination, and possible infection. The findings included: Record review of Resident #50's face sheet, dated 01/28/2026, revealed a [AGE] year-old female with an original admission date of 11/26/2025, and a current admission date of 01/07/2026. Pertinent diagnoses included Sepsis (a life-threatening condition caused by the body's extreme response to an infection which could include symptoms such as fast breathing, fever, confusion, and severe pain, and if not treated quickly, sepsis could lead to shock, organ failure, or death), Congestive Heart Failure (or CHF, a chronic condition where the heart cannot pump enough blood to meet the body's needs, leading to fluid buildup and other various symptoms), and Wasting Syndrome (also known as cachexia, a serious condition characterized by significant weight loss, muscle wasting, and loss of appetite, often associated with chronic diseases). Record review of Resident #50's admission MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderately impaired cognition. The MDS assessment also indicated Resident #50 had one or more unhealed pressure ulcers/injuries. The MDS also indicated that Resident #50 was dependent in toileting hygiene and had an indwelling catheter. Record review of Resident #50's care plan, initiated 01/07/2026, revealed resident had actual impairment to skin integrity as a stage 3 sacral wound (ulcers that have progressed to the third stage have broken completely through the top two layers of the skin and into the fatty tissue below). The care plan also revealed Resident #50 had a Foley catheter related to skin breakdown, initiated 11/26/2025 and revised 12/04/2025. Record review of the list of residents on precautions, from the DON, dated 01/29/2025, revealed 12 residents throughout the facility were on EBP. In an observation on 01/27/2026 at 8:25 AM, it was observed multiple rooms, to include multiple rooms on Halls 100, 200, 300, and 400, as well as Resident #50's room, had PPE containers, but no EBP signage, which was used to explain to providers, staff, and visitors the proper PPE which must be worn for the high contact activities, such as dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and/or wound care. In an observation on 01/28/2026 at 11:05 AM, the WCN failed to wash or sanitize hands and change gloves when moving from a dirty area to a clean area during wound and incontinent care by not sanitizing hands and putting on clean gloves prior to re-entering the package of clean wipes, and not sanitizing or washing hands and putting on clean gloves when she paused wound care to grab the urine and feces soaked brief to pull it down and to the side away from the wound because it kept sliding up and touching the wound. She also failed to put on an adequate amount of hand sanitizer to sanitize her hands (per the directions apply enough hand sanitizer to cover all surfaces of the hands), as well as not rubbing her hands together allowing enough time for hand sanitizer to dry prior to putting on gloves. The WCN cleansed the wound from the outside to the inside, wiping from top to bottom, instead of working from the inside to the outside (clean to dirty) in a circular motion. After wound care was completed, the</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>WCN and CNA-H were noted to perform incontinent care on Resident #50, in which both CNA-H and the WCN re-entered the clean container of wipes with dirty gloves to clean Resident #50. The WCN then exited the room while CNA-H finished cleaning and changing Resident #50's brief, in which she used the same gloves and never performed hand hygiene or changed gloves until she had completed the incontinent care and placed a clean brief under Resident #50. CNA-H was noted to carry the container of contaminated wipes out of Resident #50's room. In an interview on 01/29/2026 at 11:42 AM, the WCN stated she knew which residents were on EBP because it was on their charts and there was a sign inside the room over the bed. She stated she was not sure if there was supposed to be a sign posted on the door or outside of the room, but it would make sense so anyone entering knew the proper PPE to utilize prior to entering the room. She also stated should have made sure Resident #50 had a clean brief prior to performing wound care, as well as not touched the dirty brief during wound care. The WCN stated not cleaning the wound effectively, handling the dirty brief during wound care, and entering the clean package of wipes with contaminated gloves could have caused cross-contamination and lead to infection and worsening of the wound. The WCN also stated she realized she was cleaning the wound inappropriately and ineffectively because she was trying to be gentle and not cause Resident #50 any more pain. In an interview on 01/29/2026 at 2:07 PM, the NP stated considering the CNA and LVN were not cleaning their hands appropriately during incontinent care and wound care, and considering the nurse had performed wound care while a resident was in a urine soaked brief with feces in it, and the nurse touched the brief during wound care, things such as these could contribute to cross-contamination and wounds not healing and/or possibly worsening. In an interview on 01/29/2026 at 3:05 PM, the DON stated she thought as long as the EBP signs were posted in the residents' rooms for staff and visitors, then it was okay. She stated she had not realized they had to be posted on the door or the wall outside the residents' rooms just like the contact precaution signs. The DON also stated staff were not supposed to take items into the room of residents on precautions, then bring them back out of the room because it could have caused cross-contamination and could lead to infections. She also stated re-entering a package of clean wipes with dirty gloves which had both touched urine and feces could be considered cross-contamination. The DON stated the technique utilized by the WCN to clean the wound could cause cross contamination of the wound and reintroduce bacteria into the wound. The DON stated if a nurse touched a wet and dirty brief during wound care and did not clean their hands and change their gloves afterward, it could have caused cross contamination, which could lead to infection and worsening of the wounds. In an interview on 01/29/2026 at 5:19 PM, CNA-H stated she did not recall being in-service over hand washing and changing gloves in between tasks on the same resident when going from dirty to clean. She stated reaching into the clean wipes container after your gloves are contaminated could cause cross-contamination. CNA-H also stated touch the clean linens or clean brief with dirty or contaminated gloves could cause cross-contamination. Record review of an in-service for Standard Precautions Hand Washing and Glove Use, dated 10/03/2025, revealed Any employee touching blood, body fluids, secretions, excretions and contaminated items must wear gloves. Clean gloves must be put on between tasks and procedures involving the same residents. Record review of the facility's Enhanced Barrier Precautions policy, revised February 2025, revealed Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>medical devices. 11. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. Review of the facility's Perineal Care policy, revised February 2018, revealed 1.b. Gather needed supplies: washcloth or disposable wipes (pre-moistened wipes), gloves and PPE, additional supplies as needed if heavy soiling is present. 3. If resident is heavily soiled with feces, turn resident on side and clean away feces with tissue, wipes or incontinent brief. Discard soiled gloves along with the soiled brief and/or wipes in trash bag. Cover the resident, provide safety measures and wash hands with soap and water. 4. Cover the resident with a sheet or bath blanket. Raise cover to expose perineum. 5. Sanitize hands and put on gloves (PPE as indicated). 6. Proceed with perineal care. Review of the facility's Hand Hygiene policy, revised February 2018, revealed 1. Hand Hygiene is indicated: A. Immediately before touching a resident B. Before performing an aseptic task C. after contact with blood, body fluids, or contaminated surfaces D. After touching a resident E. After touching a resident's environment F. before moving from work on a soiled body site to a clean body site on the same resident G. immediately after glove removal. 4. Single-use disposable gloves should be used: A. before aseptic procedures B. when anticipating contact with blood or body fluids.</p>