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	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at River Ridge	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician for two (Resident#1 and Resident #2), of five residents reviewed for care management, that was consistent with professional standards of practice, comprehensive person-centered care plan, and goals and preferences.On 02/16/2026 the facility failed to notify Resident #1's physicians' team when a MRSA critical laboratory result.On 02/18/2026 the wound care nurse failed to notify the physician when she was made aware of a skin irregularity on Resident #2 right big toe.This failure could place residents at risk of not receiving prompt medical intervention management.The findings included:1. Resident #1Record review of Resident #1's admission record dated 02/20/2026 revealed Resident #1 was a [AGE] year-old female who was initially admitted on [DATE] and was readmitted on o 01/07/2026. Resident #1 was admitted with multiple diagnoses including sepsis (infection), unspecified organism 01/07/2026 severe sepsis without septic (infection) shock other specified abnormal findings of blood chemistry; pressure ulcer of sacral (buttock) region, stage 3; cognitive (intellectual) communication deficit.Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 8 indicating severe cognitive awareness and was dependent on staff for ADLs. Resident #1 was also coded for having unhealed pressure ulcers and a number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. Resident #1 was also coded for other local infections of the kin and subcutaneous tissue.Record review of Resident #1's care plan I have actual impairment to skin integrity STAGE 3 SACRAL WOUND unstageable coccyxDate Initiated: 01/07/2026 I will have no complications r/t pressure ulcer through the next review date. Interventions: Educate me and encourage good nutrition and hydration in order to promote skin integrity. Observe my fingernails. Keep my fingernails clean and trimmed. Observe my skin. Keep my skin clean and dry. Hydrate my skin with lotion, as needed. Report any skin alterations to nurse. Observe/document/report location, size and treatment of skin injury and/or any new or worsened alterations in skin integrity. Obtain lab work as ordered by physician. Provide wound treatment as ordered. Weekly treatment documentation to include measurement of each area(s) of skin breakdown: width, length, depth; type of tissue and exudate; and any other notable changes or observations. Report improvements and declines to the MD.Record review of Resident #1's Lab Results Report, dated: 02/16/2026 at 08:22AM revealed a red flag (critical) Methicillin Resistant staphylococcus aureus organism.Record review of Resident #1's progress notes for 02/16/26 revealed no indication the facility notified the physician of the critical lab result.Record review of Resident #1's vital signs from 02/15/2026 through 02/20/2026 revealed no concerns to indicate any signs or symptoms of infections.2. Resident #2Record review of Resident #2's admission record date 02/20/2026 revealed Resident #2 was a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #2 was admitted with multiple diagnoses including cutaneous abscess of abdominal wall (A cutaneous abscess is a localized collection of pus in the skin and may occur on any skin (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surface, and encounter for change or removal of nonsurgical wound dressing. Record review of Resident #2's Comprehensive MDS dated [DATE] revealed Resident #2 had a BIMS score of 12 indicating moderate cognitive impairment. Additionally Resident #2 was coded for needing partial/moderate assistance with ADLs and was coded for being at risk for developing pressure ulcers.Record review of Resident #2's care plan revealed date initiated:02/13/2026 the resident has actual impairment to skin integrity of the ABD r/t abscess The resident's Skin abscess of the ABD will be healed by review date. Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.Record review of Resident #2's vital signs from 02/18/2026 through 02/20/2026 revealed no concerns to indicate any signs or symptoms of infections.Record review of Resident #2's progress notes revealed,On 02/20/2026 at 9:20am NP A documented: The patient notified me of a black area to her right great toe. The pt is concerned because she had a toe amputation on that same foot. She states she told the Wound Care nurse approximately two days ago. Wound care nurse approached me and told me she was aware that to put the orders in is a process. There was no notification of this black area in question. I told the nurse to put in wound care orders ASAP.During an interview on 02/20/2026 at 2:53pm the treatment nurse stated on 02/18/2026 she was made aware by Resident #2 of a skin irregularity on her right big toe, and once she completed her assessment, it appeared to be a blood blister. The treatment nurse stated after she left Resident #2's room she notified the charge nurse (did not recall name) of the skin irregularity and continued on with her day. The treatment nurse stated she did not notify the physician, NP, nor on-call physician team as it was not within her scope to notify them of Resident #2's skin irregularity. The treatment nurse stated it is the responsibility of the charge nurse to notify the physician of the skin irregularity. The treatment nurse stated the facility does collaboratively work as a team to ensure the residents receive continual care, however reiterated it was not her responsibility to notify the physician of Resident #2's toe skin irregularity. The treatment nurse was asked what her scope of practice entailed, which she stated to perform skin assessments, perform wound care, and round with the wound care team, but reiterated she does not notify the physician of any skin irregularities that is within the scope of the charge nurses. The treatment nurse stated there was no negative outcome of Resident #2's skin irregularity.During an interview on 02/20/2026 at 3:44PM LVN A stated she worked on 02/16/2026 but was never made aware of Resident #1's MRSA laboratory result. LVN A stated typically the laboratory people will call the facility to notify the nurses when there is a critical result. LVN A reiterated during her shift she was never made aware of the laboratory results for Resident #1. LVN A stated part of her daily routine was to review the resident's full chart, which she completed at the beginning of her shift, and never saw any critical laboratory results. LVN A stated she was educated via a one-to-one that she must review the resident's chart twice a shift. LVN A stated MRSA is a microorganism that has the potential to affect a resident negatively. LVN A stated Resident #1 never exhibited any signs or symptoms of infection, she never exhibited fevers, chills, or pallor. LVN A stated she did not experience any negative outcome due to the missed critical MRSA results.During an interview on 02/20/2026 at 4:48 PM NP A stated she was concerned about two facility issues. NP A stated on 02/18/2026 while she was reviewing Resident #1's laboratory results, she observed a critical MRSA lab result dated 02/16/2026. NP A stated she was never made aware of the result. NP A stated the physician and physicians' team's expectation was that the facility notifies them of laboratory results especially if the laboratory results state critical. NP A stated that MRSA, if not treated promptly, could lead to septic shock which could affect Resident #1's well-being negatively. NP A stated she quickly incorporated (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antibiotics for Resident #1 on 02/18/2026 and Resident #1 appears to be fine with no signs or symptoms that necessitated emergent interventions. NP A stated while she was rounding on 02/20/2026 she spoke to Resident #2 who notified her of a concern regarding a dark skin irregularity on Resident #2's right big toe. NP A stated when she spoke to the treatment nurse, the nurse verbalized knowing about Resident #2's skin irregularity and interpreted the treatment nurse's response of to put the orders in is a process to mean that she did not want to dedicate time to advocate for orders. NP A reiterated the treatment nurse stated she saw the skin irregularity on 02/18/2026 and never advocated for orders. NP A stated while she conducted her assessment of skin irregularity on 02/20/2026 there was no cause for immediate or emergent interventions but placed order for an arterial doppler assessment for Resident #2. NP A stated the treatment nurse should have notified her, the physician, or even the on-call services on 02/18/2026 when she saw Resident #2's skin irregularity but did not. NP A reiterated when she assessed Resident #2's skin irregularity she did not believe the skin irregularity warranted an emergent intervention to send to the emergency room.During an interview on 02/21/2026 at 3:55PM the DON stated LVN A, on 02/16/2026 should have conducted two chart checks for Resident #1. The DON stated the expectation of the facility was for the nurses to complete two chart checks every shift to ensure nothing is missed. The DON stated she was made aware of the concern regarding Resident #1 roughly on 02/20/2026 when NP A wrote her a note and placed it under her door. The DON stated once she was made aware of the concern, she quickly conducted an assessment on Resident #1 and commenced an investigation on how the facility missed the critical value for Resident #1. The DON said when she completed her assessment on Resident #1 there were no signs or symptoms that warranted an emergency transfer to the emergency room. The DON stated MRSA could be caustic to any resident, and if not promptly treated it could lead to severe repercussions, however, stated Resident #1 never experienced any negative outcomes. The DON stated going forward she has in-serviced her staff to complete chart checks twice a shift and must notify the physician when there are critical laboratory results. The DON stated regarding Resident #2, the treatment nurse was correct in stating it was the responsibility of the charge nurse to notify the physician of Resident #2's skin irregularity. The DON stated if the responsibility was solely on the treatment nurse to notify the physician of all irregularities, she would not be able to complete her daily tasks. The DON stated she conducted a thorough assessment on Resident #2's skin irregularity on 02/20/2026 but looked like a blood blister and did not warrant an emergent transfer to the emergency room for evaluation and treatment. The DON stated the facility does work collaboratively amongst each other, and going forward, if any nurse is notified of skin irregularities it will be a collaborative effort to notify the physician and not solely the responsibility of the charge nurse.Record review of the facility's change in condition policy revised dated April 2025 revealed, our facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical/mental condition and/or statesThe nurse will notify the resident's attending physician or physician on call when there has been a (an):discovery of injury of an unknown sourcesignificant change in the resident's physical/emotional/mention conditione. need to alter the resident's medical treatment significantly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one resident (Resident #2) of five residents reviewed for wound care orders.The facility failed to ensure wound care orders were obtained for Resident #2's abdominal area wound from 02/12/2026 to 02/15/2026.This failure could place residents at risk for wound care complications or at risk of not receiving necessary wound care. Findings include: Record review of Resident #2's admission record date 02/20/2026 revealed Resident #2 was a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #2 was admitted with multiple diagnoses including cutaneous abscess of abdominal wall (A cutaneous abscess is a localized collection of pus in the skin and may occur on any skin surface, and encounter for change or removal of nonsurgical wound dressing. Record review of Resident #2's Comprehensive MDS dated [DATE] revealed Resident #2 had a BIMS score of 12 indicating moderate cognitive impairment. Additionally Resident #2 was coded for needing partial/moderate assistance with ADLs and was coded for being at risk for developing pressure ulcers.Record review of Resident #2's care plan revealed date initiated:02/13/2026 the resident has actual impairment to skin integrity of the ABD r/t abscess The resident's Skin abscess of the ABD will be healed by review date. Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.Record reviewed Resident #2's skin measurement assessment dated [DATE] and 02/18/2026 indicated measurements were resolving and decreasing in size. Record review of Resident #2's progress notes revealed,On 02/12/2026 at 7:51pm LVN B documented received a [AGE] year old female to room [room number] ,transferred per EMS.pt alert and responsive able to voice basic needs, pt able to follow simple commands.lungs CTA, no cough noted, .BS active X4 quads, abdomen soft and nontender, wound not to low mid-abdomen, wound measures 2cm x 3cm x 0.2cm, wound bed notedRecord review of Resident #2's skin assessment on 02/18/2026 revealed Length (cm): 2.2 Width (cm): 0.5 Depth (cm): 0.2.During an interview on 02/21/2026 at 10:35am LVN B stated she recalled admitting Resident #2 into the facility as a collaborative team effort. LVN B stated there is a system amongst the nurses that allows for equal admissions, and it was her turn to take the next admission which was Resident #2. LVN B stated she completed Resident #2's head-to-toe assessment on 02/12/2026 and recalled noting Resident #2 had an abdominal wound and documented the measurements. LVN B stated during her assessment she completed the full admission but forgot to place orders for wound care to evaluate and treat Resident #2. LVN B verbalized her remorse for forgetting to place orders for Resident #2 and going forward she has been re-educated by the DON to ensure wound care orders are placed for residents that are admitted with skin irregularities as well as as needed. LVN B stated Resident #2 did not experience any negative outcome due to her forgetfulness and reiterated she will be more mindful to ensure every irregularity is addressed.During an interview on 02/21/2026 at 3:55PM the DON stated LVN B should have placed an order for wound care to evaluate and treat when Resident #2 was admitted into the facility on [DATE]. The DON stated there could have been potential for Resident #2's skin irregularity to get worse but it did not. The DON stated she has in-serviced her clinical staff on the importance of ensuring every skin irregularity is advocated for by advocating and attaining wound care orders to evaluate and treat. The DON stated, while reviewing Resident#2's skin assessments dated 02/12/2026 and 02/18/2026 there was no significant measurement increase, and stated the measurement of Resident #2's abdominal skin irregularity had decreased in size and there was no negative outcome.Record review of the facility's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change in condition policy revised April 2025 revealed, our facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical/mental condition and/or states1. The nurse will notify the resident's attending physician or physician on call when there has been a (an):b. discovery of injury of an unknown sourced. significant change in the resident's physical/emotional/mention conditione. need to alter the resident's medical treatment significantly.Record 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. 1. Verify that there is a physician's order for this procedure.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain clinical records in accordance with accepted professional standards of practice, that were complete and accurately documented, for two (Resident #1) and (Resident #2) of five residents reviewed for wound care completion documentation.On 02/16/2026, LVN A failed to document wound care completion on Resident #1's TAR.On 02/15/2026-02/17/2026 the facility failed to document wound care completion on Resident #2's TAR.This failure could place residents at risk from accurately receiving and accounting for wound care completion. The findings included:1. Resident #1Record review of Resident #1's admission record dated 02/20/2026 revealed Resident #1 was a [AGE] year-old female who was initially admitted on [DATE] and was readmitted on o 01/07/2026. Resident #1's diagnoses included sepsis, unspecified organism 01/07/2026 severe sepsis without septic shock other specified abnormal findings of blood chemistry; cervical disc disorder with myelopathy, cervicothoracic region; secondary osteoarthritis, other specified site; nutritional marasmus; other lack of coordination; muscle wasting and atrophy, not elsewhere classified, multiple; hypo-osmolality and hyponatremia; dehydration; iron deficiency anemia secondary to blood loss (chronic); generalized anxiety disorder; chronic diastolic (congestive) heart failure; other neuromuscular dysfunction of bladder ; encounter for fitting and adjustment of urinary device; bed confinement status; wasting disease (syndrome) due to underlying condition; pressure ulcer of sacral region, stage 3; acute embolism and thrombosis of deep veins of left upper; extremity; essential (primary) hypertension; dysphagia, oropharyngeal phase; cognitive communication deficit.Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1 had a BIMS score of 8 indicating severe cognitive awareness and was dependent on staff for ADLs. Resident #1 was also coded for having unhealed pressure ulcers and a number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. Resident #1 was also coded for other local infections of the kin and subcutaneous tissue.Record review of Resident #1's care plan dated 01/07/26 indicated I have actual impairment to skin integrity STAGE 3 SACRAL WOUND unstageable coccyxDate Initiated: 01/07/2026 I will have no complications r/t pressure ulcer through the next review date. Interventions: Educate me and encourage good nutrition and hydration in order to promote skin integrity. Observe my fingernails. Keep my fingernails clean and trimmed. Observe my skin. Keep my skin clean and dry. Hydrate my skin with lotion, as needed. Report any skin alterations to nurse. Observe/document/report location, size and treatment of skin injury and/or any new or worsened alterations in skin integrity. Obtain lab work as ordered by physician. Provide wound treatment as ordered. Weekly treatment documentation to include measurement of each area(s) of skin breakdown: width, length, depth; type of tissue and exudate; and any other notable changes or observations. Report improvements and declines to the MD.Record review of the TAR dated February 2026 revealed Resident #1's wound care treatment was not documented on 02/16/2026.2. Resident #2Record review of Resident #2's admission record date 02/20/2026 revealed Resident #2 was a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #2 including cutaneous abscess of abdominal wall (A cutaneous abscess is a localized collection of pus in the skin and may occur on any skin surface, and encounter for change or removal of nonsurgical wound dressing. Record review of a Comprehensive MDS dated [DATE] revealed Resident #2 had a BIMS score of 12 indicating moderate cognitive impairment. Additionally Resident #2 was coded for needing partial/moderate assistance with ADLs and was coded for being at risk for developing pressure ulcers.Record review of Resident #2's care plan revealed date initiated:02/13/2026 the resident has actual impairment to skin integrity of the ABD r/t abscess The resident's Skin abscess (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the ABD will be healed by review date. Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.Record review of the TAR for February 2026 revealed Resident #2 did not have her wound care documented on 02/15/2026, 02/16/2026, and 2/17/2026.Record reviewed Resident #2's skin measurement assessment dated [DATE] and 02/18/2026 indicated measurements were decreasing in size. No concerns noted.During an interview on 02/20/2026 at 3:44PM LVN A stated on 02/16/2026 during her shift, she completed the wound care for Resident #1. LVN A verbalized specifically recalling the wound care treatment nurse, notifying her that wound care for Resident #1 needed to be completed by LVN A as the treatment nurse was to be leaving early on 02/16/2026. LVN A stated on 02/16/2026 she completed the wound care but may have forgotten to ensure she documented the wound care completion on either Resident #1's TAR or progress note. LVN A stated it was an isolated forgetfulness and will ensure going further, to accurately document care provided. LVN A stated there was no negative outcome as Resident #1 received care. LVN A reiterated several times she should have ensured to accurately document the care provided to Resident #1 but had forgotten. LVN A stated she has been given a one-to-one in-service regarding documentation by the DON.During an inter on 02/21/2026 at 12:42PM RN A stated on 02/15/2026 through 02/17/2026 during her shifts she completed wound care for Resident #2 however verbalized she was not familiar with how to document on Resident #2's TAR and therefore stated she did not document the completed care. RN A stated she was apologetic for the documentation discrepancy and going forward she would request help when she was not certain how to fulfill her documentation requirements. While reviewing the wound care measurement for Resident #2 with RN A, dated 2/12, and 2/18 there was no indication of further wound deterioration. RN A reiterated she did complete the wound care from 02/15/2026 through 02/17/2026 just failed to document the completion of her wound care in Resident #2's TAR. RN A stated she should have documented the completion of wound care in either a progress note or TAR but did not, however there was no indication of negative outcome due to the documentation deficiency. RN A stated she has been given one-to-one training about the importance of documenting, and going further will ensure she documents every form of care she provides.During an interview on 02/21/2026 at 3:55PM the DON stated LVN A should have documented Resident #1's wound care completion in either a progress note, or within the TAR for Resident #1's 02/16/2026 wound care. The DON further stated RN A should have also documented when she completed wound care for Resident #2 during her shifts on 02/15/2026 through 02/17/2026. The DON stated during her inquiries to every clinical staff member, that the wound care was completed by LVN A and RN A however they forgot to document their care. The DON stated for both residents #1 and #2 there was no decline in their well-being nor any indication of wound care measurement increases. The DON stated there was no negative outcome to the lack of documentation, but has facilitated an impromptu in-service regarding documentation expectation, and will ensure the clinical staff are aware of the importance of documenting every form of care completed.Record review of the facility's policy revision dated July 2017 revealed, 2. The following information is to be documented in the resident medical record: c. Treatments or services performed;