

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675672	Facility ID: 675672
		If continuation sheet Page 1 of 12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 5 residents (Resident #36 and Resident #19) reviewed for pharmacy services in that: The facility failed to compare the instructions written on Resident #36's blister pack with the physician's order for lisinopril (blood pressure medication) before it was administered on 01/28/26. The facility failed to ensure the nurse cart for 100-hall was free from expired insulin pens. The facility failed to ensure expired insulin was not administered to Resident #19 on 01/28/26. These failures could place residents at risk for non-therapeutic responses to medications. Findings included: 1. Record review of Resident #36's face sheet dated 01/29/26 revealed a [AGE] year-old female with an initial admission date of 12/13/25 and a current admission date of 01/05/26. The pertinent diagnosis included Essential Hypertension (high blood pressure without a single, identifiable cause). Record review of Resident #36's MDS assessment dated [DATE] revealed a BIMS score of 4 indicating severe impairment. Record review of Resident #36's comprehensive care plan dated 01/29/26 revealed the focus The resident has a pacemaker [related to] Atrial fibrillation (common, often chronic arrhythmia causing a rapid, chaotic, and irregular heartbeat, where the heart's upper chambers (atria) quiver instead of beating effectively) initiated on 12/16/25. An intervention listed for the problem stated Monitor/document/report PRN any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope (fainting), difficulty breathing, pulse rate lower than programmed rate, lower than baseline B/P initiated on 12/16/25. Record review of Resident #36's order summary revealed an active order in PCC (electronic health record) initiated on 01/05/26 for Lisinopril Oral Tablet 10 MG Give 1 tablet by mouth one time a day for HTN HOLD IF SBP IS LESS THAN 100. Record review of the blister pack containing Resident 36's lisinopril 10 MG revealed the order stated TAKE 1 TABLET BY MOUTH EVERY DAY HOLD IF SBP < 100 OR DBP < 60. During an observation of medication administration at 8:00 AM on 01/28/26, this surveyor observed MA A take Resident #36's blood pressure as 105/57 mm/Hg. MA A popped the medications she needed to administer morning medications to Resident #36 out of their blister packs into a small cup, including the lisinopril 10 MG. This state surveyor asked if she was ready to administer morning medications to Resident #36 and MA A stated she was ready to administer all required medications. This state surveyor stopped MA A before administering any medications to confirm whether the order in PCC or the order on the blister pack was correct. During an interview with MA A at 5:01 PM on 01/28/26, MA A stated before administering any medication she confirmed the right person, dose, drug, route and time. MA A stated she was supposed to compare the order on the blister pack to what the order stated in PCC and ensure there were no discrepancies. MA A stated if she saw a discrepancy between the two orders she would inform the charge nurse and then follow the nurses instructions. MA A stated she did not remember noticing the discrepancy before the state surveyor stopped her from administering medications to Resident #36. MA A stated administering blood pressure medications outside of parameters could cause a resident's blood pressure to decrease too much causing shakiness, dizziness or fatigue. In an interview with the DON at 4:08 PM on 01/29/26, the DON stated employees administering medications should verify they have the right name, dose, drug, time and route. The DON stated the discrepancy between the order in PCC and on the blister pack should have been caught by MA A before the medication was administered. The DON stated MA A should have called the charge nurse for assistance after discovering the discrepancy to determine which order was correct. The DON stated the order in PCC for Resident #36's lisinopril was correct so administering it to Resident #36 when their blood pressure was 105/57 mm/Hg was within the prescriber's parameters. The DON stated administering blood pressure medications outside of parameters could cause a (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's blood pressure to drop too low leading to dizziness, nausea and sweating. 2 and 3. Record review of Resident #19's face sheet dated 01/29/26 revealed an [AGE] year-old female with an initial admission date of 01/28/25 and a current admission date of 12/12/25. The pertinent diagnosis included Type 2 Diabetes (chronic disease where your body becomes resistant to insulin, leading to high blood sugar levels). Record review of Resident #19's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe impairment. Record review of Resident #19's comprehensive care plan dated 01/29/26 revealed the focus I have diabetes and I am at risk for complications associated with diabetes: Frequent Infections, Diabetic wounds, Vision Impairment, Hyper/Hypo-Glycemia (high and low blood sugar), Renal Failure (kidney failure), Cognitive/Physical Impairment initiated on 01/28/25. An intervention listed for the focus included Administer my medications as recommended by my doctor, monitor labs as indicated, Promptly report abnormal labs results and significant clinical findings to my doctor as indicated initiated on 01/28/25. Record review of Resident #19's order summary revealed an active order for Lantus . Pen-injector 100 UNIT/ML Inject 5 unit subcutaneously one time a day for Diabetes AND Inject 15 unit subcutaneously at bedtime for Diabetes Hold for [blood sugar] LESS THAN 100 initiated on 10/30/25. Record review of Resident #19's January medication administration record revealed LVN E administered 5 units of Lantus insulin at 7:00 AM on 01/28/26 to Resident #19. During an observation of the 100-hall nurse cart at 3:05 PM on 01/28/26, this state surveyor found a Lantus insulin pen with an open date of 12/25/25 in the top drawer. The label on the pen revealed it was ordered for Resident #19. In an interview with LVN E at 5:14 PM on 01/28/26, LVN E stated she was in charge of the 100-hall nurse cart during her shift. LVN E stated she was not aware there was an expired insulin pen in her cart when it was found by the state surveyor. LVN E stated insulin pens expired approximately 28 days after taking them out of the refrigerator. LVN E stated the Lantus insulin pen for Resident #19 in her cart would have expired on 01/22/26. LVN E stated she used the expired Lantus pen to administer insulin to Resident #19 in the morning of 01/28/26. LVN E stated expired insulin may not be as effective as unexpired insulin, leading to higher blood sugars in residents. In an interview with the DON at 4:08 PM on 01/29/26, the DON stated it was the nurse's responsibility to ensure their medication carts were maintained. The DON stated a nurse should check their cart at the beginning of their shift to ensure they had everything they needed, and no expired medications were in their cart. The DON stated expired medications should not be stored in the medication carts. The DON stated if an expired medication was in a cart, it could be accidentally administered to a resident inappropriately. The DON stated administering expired insulin could lead to less control over a resident's blood sugar. Record review of the facility policy titled Administering Medications revised on April 2019 stated the following: .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.12. The expiration/beyond use date on the medication label is checked prior to administering.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen refrigerator, 1 of 1 kitchen freezer and 1 of 1 dry storage room reviewed for sanitation and storage. 1.The facility failed to ensure items in the refrigerators were sealed.2.The facility failed to ensure items in the freezers were sealed, labeled, and dated.3.The facility failed to ensure items stored in the dry storage room were correctly sealed, dated, and labeled.4.The facility failed to ensure stove and oven were cleaned. 5.The facility failed to ensure utensils were free from scratches and food residue. 6.The facility failed to discard a pan with the non-stick coding scratched off. 7.The facility failed to keep the kitchen room walls and floor were clean.8. The facility failed to ensure the steam table wells were cleaned.9. The facility failed to ensure the can opener was cleaned.10. The facility failed to ensure the shelves where bakeware and cookware were stored were cleaned.11. The facility failed to ensure that the dry storage room clean of rodent droppings. -These failures could place residents at risk for complications from food contamination and illnesses. Findings included : In the initial observations tour of the facility kitchen on 01/27/26 at 8:25 AM revealed the floors were dirty concentrated in the in the refrigerator beginning at the entrance and freezer floor and the entrance. The refrigerator had a squeezable bag of cilantro and a bag of shredded carrots that were not sealed and exposed to air. The freezer had a bag of chicken nuggets, box of biscuits, a box dinner roll dough, a bag of okra, a bag of hashbrowns all open, undated, unlabeled, and exposed to air . The dry storage area revealed two items of stuffing mix undated, a bag of pasta undated and open exposed to air. In the dry storage room the racks used for storing boxed items were dirty. The dry storage room has rodent droppings on the floor. The stove was dirty with a black, burnt, stuck on substance which had accumulated at the bottom of the stove burners. The oven also had burnt, black, stuck on substance at the bottom of the oven. The outside of the stove had orange and yellow stuck on staining on the side of the oven door in the middle of the stove. The steam table wells needed to be clean and had brownish fluid with substances floating around. A rack with utensils for eating were scratched up, old, and dirty. The can opener was dirty with brownish buildup on opening side. The shelves where bake and cook ware were dirty with a oily film and food crumbs. A pan with the non-stick coding scratched off was found with other pots and pans being used. The walls behind the stove and [NAME] and food steamers had a yellowish sticky substance coating them. In an Interview on 01/27/26 at 8:56 AM with DA C she stated she tries to clean as much as she can while she works in the kitchen. DA C stated the stove is cleaned once a week and is done by any worker in the kitchen. DA C stated she knew that all food items are to be sealed closed once it is stored back in the freezer and refrigerator. DA C stated she did not know who left the items open but if she had seen the items open she would have covered them. DA C stated she did not see the rodent droppings and has never seen any rodents in the kitchen but did know of one incident where a mouse was had been seen in the dining room. DA C stated she had seen the pest control company come and spray but did not know for sure what they sprayed for. DA C stated the can opener was cleaned every day at the end of the day and as it gets dirty. DA C stated she had not seen the scratched pan used to cook recently but said it needs to be placed as the coating can get into the food and make the residents sick. DA C stated the shelves and racks where food and cooking items are stored are cleaned as needed. In an interview on 01/28/26 at 11:42 AM with DA B stated all staff was responsible for cleaning the kitchen every time it is used. DA B stated no one person is assigned a cleaning chore it a team effort. DA B stated he did not know who left the items found opening the dry pantry, refrigerator, and freezer but knew that they were to be seal closed so the food is not exposed to air. When he is working, he does most of the cooking and stated he did not know why the fluid in the steam well was dirty but when he works, he makes sure the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	steam wells are clean. DA B stated he did not know about the rodent droppings and has not seen a rodent in the kitchen. DA B stated he would clean the can opener if he used it but usually does not handle opening the cans. DA B stated the stove is cleaned once a week by the staff. DA B stated he cleans as much as he can during his shift to keep the residents from getting sick. DA B stated he had not seen any rodents in the kitchen or pantry but if he did, he would report it quickly so the pest control company can come and take care of the problem. In an interview with on 01/28/26 at 11:55 DA D stated she had not been employed for a long time and comes in as needed and helps clean the kitchen when she does work. DA D could not give too much information about the cleaning schedules but knew that the kitchen was cleaned every day. DA D stated she knew it was important to maintain the kitchen as clean as possible, so the residents do not get sick when they eat the food. DA D stated she knew that food was to be sealed closed and not exposed to air so that it does not come contaminated. DA D stated she had never seen any rodents in the kitchen during the times she had worked in the kitchen but knew to report any sightings to prevent residents from getting ill. In an interview with on 01/28/26 12:10 PM at the DM she stated all the kitchen staff was responsible for keeping the kitchen clean and in working order. The staff is responsible for making sure all items in the refrigerator, freezer, and dry pantry is to be sealed shut so that the food is not exposed to air. The DM stated the staff must have been in hurry and not sealed the items of food closed. The DM stated she will retrain the staff on the importance of not having food exposed to air and making sure it is all stored properly with label with dates. The DM stated she will look at all the cleaning schedules for the oven and stove and would make changes to keep them both clean. The DM stated she will replace the pans and utensils with new ones will observe the wear and tear on both to ensure that no resident could get sick from them. The DM stated the steam wells would be cleaned at the end of each day or as needed in between meal services. The DM stated the floors get mopped at the end of the day or after any spill will inspect the freezer and refrigerator floors more often to ensure they are cleaned more frequently. The DM stated the can opener should be cleaned after every use and could be the staff member was in a hurry and did not do so when it was last used. The DM stated the rodent droppings must have been recent as the floors are swept weekly and as needed if there is a spill. The DA stated there was no rodent sightings in the kitchen but knew of the sighting in the dining room and staff knew to report any sightings of rodents immediately to the maintenance man and it is to be logged into the pest control book so the the pest control company can come in and put boxes and spray or insects as well. No cleaning logs were provided detailing the days and times the kitchen was cleaned. In record review of the policy and procedure for Food Preparation and Service dated 11/2022, Food Receiving and Storage dated 11/2022, and Refrigerators and Freezers 11/2022 the policy stated: Food Preparation and Service - Food and nutrition services employees prepare, distribute, and serve with safe food handling practices. Food Receiving and Storage - Foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerator and Freezers - This facility will ensure safe refrigerator and freezer maintenance, temperature, and sanitation, and will observe food expiration guidelines. Policy and procedures for the stove/oven, steam tables and can opener were not provided by facility.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at River Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 3922 W River Dr Corpus Christi, TX 78410	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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-serviced 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 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. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an effective pest control program so the facility is free of pests and rodents for 1 of 1 kitchen reviewed for pests. The facility failed to have pest control effectively treat the kitchen and the rest of the facility for rodents. This deficient practice could place residents at risk of exposure to pests, diseases, infections, and diminished quality of life. Findings included: Observation and initial tour of the kitchen with the DM on 01/27/26 at 8:35 am revealed there were rodent droppings in the dry storage room floor. During the dry storage observation, the right back corner of the storage room had numerous rodents dropping covering the floor. The DM stated the rodents could carry diseases and could make the residents sick. In an interview with the DM on 01/27/25 at 8:45 AM, she said pest control comes once a month and sprays for pest and rodents. The DM stated she has not seen a rodent while she has been in the kitchen. The only sighting she knew of in the dining room, and it was reported, and pest control was requested through the pest control request log. The DM stated the kitchen is kept as clean as possible to keep pests and rodents down. The kitchen staff know to report any sighting immediately so the pest control company can come in and take care of the problem. In an interview on 01/29/26 at 2:09 PM with RN F she stated she saw a mouse by the ramp where residents are weighed daily about 3 to 4 weeks ago. She immediately reported it to maintenance and logged it in the pest control log so that pest control could come in take care of the problem. RN F stated she had not seen any more mice in that area. In an interview 01/29/26 at 2:21 PM with R #37 she stated she heard noises coming from her trash about two weeks ago and saw a mouse jump out of the trashcan and run across the floor. R#37 stated she also had a package of crackers that looked like they had been nodded on and opened. The told one of the CNA's about the two incidents but did not know if it had been reported. It was about. In a second interview on 01/29/26 3:00 PM the DM stated the pest control company was called to come in and put traps around in and out of the facility and look for the area they might be coming in from. The DM stated maintenance will be and fixing any areas that might be where the rodents come in. The DM stated she and the staff will make extra efforts to keep the dry pantry clean and the floor free of fallen food items. In an Interview on 01/29/2025 3:32 PM with the administrator he stated the pest control company had been contacted to come in and treat for rodents by putting box traps to capture them indoors and outdoors. The administrator also stated the facility was increasing their visits from the pest control company to keep the rodent problem under control. The administrator stated maintenance man will do repairs to any walls and closets that have holes to prevent any rodents from outside to be able to enter the facility. The administrator stated the kitchen staff was going to keep the kitchen clean to avoid any rodents from trying to enter the facility. The administrator stated it was of importance that the facility combats the problem of the rodents as the rodents can make resident sick. The administrator stated housekeeping, DM, and the MM will be monitoring the facility for rodent droppings in any other areas in the kitchen and in the facility. The administrator stated all staff is responsible for reporting any kind of pest throughout the facility. In an interview on 01/29/26 at 3:45 PM the Maintenance Man stated he will be taking care of the all the holes in wall to keep rodents out. The MM stated he will be asking if any residents have any new sightings of rodents and make sure pest control comes in to take care of the problem. The MM stated he did not have previous records of times the pest control came in to control the rodent problem, but the new company stated in October of 2025 and has called for them to come and spray for insects and rodents each month and as needed. In record review of the sighting logs on 01/29/26 the log dated 11/21/25 to 01/07/26 on 11-21-25 a mouse was witnessed by staff at fax machine; 12/08/25 roaches and mice were spotted in the 300 hall and kitchen, Resident room [ROOM NUMBER]; 12/14/2025 room [ROOM NUMBER] and 410 a mouse ran across hall seen by family member; 12/15/25 mice seen on self in dining room and 400 hallway running across hall in to linen room; 01/03/26 room [ROOM NUMBER] (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBER] resident saw mouse on dresser and staff saw mouse running in closed window in dining room.01/07/26 log book monthly service by MM. In record review of the pest control company receipts for Perfect Pest Control dated 11/20/25,11/25/2025, 12/02/25,12/22/2025 and 01/07/2026 the last pest control montly visit was on 01/07/26.The dates of 11/25.25 and 12/22/25 were emergency rodent services. In record review of the facility pest control policy it stated, Our facility shall maintain an effective pest control program. The facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.Pest control services are provided by Perfect Pest Control.Windows are screened at all times.Only approved FDA and EPA insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas. Garbage and trash are not permitted to accumulate and are removed from the facility daily. Maintenance services assist, when appropriate and necessary, in providing pest control services.		