STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676491	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Ridge Rehab & Nursing Center	401 Swift Street Refugio, TX 78377

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 2 residents (Resident #2) reviewed for quality of care and dignity. The facility failed to ensure staff were providing adequate incontinent care for Resident #2 and that staff knew not to photograph the scenario on 02/27/25. The failures could affect residents residing in the facility, resulting in not receiving needed care and affecting their dignity.Findings included:Record review of Resident #2's face sheet dated 06/11/24 revealed an [AGE] year-old male with diagnoses including heart failure, malnutrition, high blood pressure, fecal urgency, abnormalities of gait and mobility, and muscle weakness.Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 09, indicating moderate cognitive impairment. He was independent with eating and oral hygiene and required supervision for all transfers and bed mobility. He utilized a manual wheelchair and could self-propel. He was always incontinent of bladder and bowel, had a pressure-reducing mattress, and was at risk for MASD. He was receiving hospice services. Record review of Resident #2's care plan dated 06/12/24 revealed: The resident is on diuretic therapy. Date Initiated: 06/12/2024 Revision on: 09/26/2024. The resident will be free of any discomfort or adverse side effects of diuretic therapy through the review date. Date Initiated: 06/12/2024 Revision on: 07/19/2024. The resident has bowel incontinence. Date Initiated: 06/12/2024. The resident will not have any complications r/t bowel incontinenceDate Initiated: 06/12/2024. Apply barrier cream after every incontinence episode. Date Initiated: 06/12/2024 Check resident every two hours and assist with toileting as needed. Date Initiated: 06/12/2024. Provide peri care after each incontinence episode. Date Initiated: 06/12/2024. See care plans on Mobility, ADLs, Cognitive Deficit, Communication Date Initiated: 06/12/2024. The resident has a terminal prognosis and/or is receiving hospice services for the diagnosis of Acute on chronic combined systolic congestive and diastolic congestive heart failure. Date Initiated: 10/06/2024 Revision on: 06/12/2025. The resident's dignity and autonomy will be maintained at the highest level through the review date. Date Initiated: 10/06/2024 Revision on: 10/30/2024. Work with nursing staff to provide maximum comfort for the resident. Date Initiated: 10/06/2024. The resident has an ADL Self Care Performance Deficit. Date Initiated: 06/12/2024. The resident will maintain or improve the current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use, and Personal Hygiene; ADL Score) through the review date. Date Initiated: 07/04/2024 Bathing requires staff x2 for assistance. Date Initiated: 06/12/2024 Bed Mobility: requires staff x1 for assistance. Date Initiated: 06/12/2024. Toilet use: requires staff x2 for assistance Date Initiated: 06/12/2024. The resident has bladder incontinence. Date Initiated: 06/12/2024. The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Date Initiated: 06/12/2024 Revision on: 07/19/2024. Notify nursing if incontinent during activities. Date Initiated: 06/12/2024. Monitor/document for s/sx UTI (Urinary Tract Infection) Date Initiated: 06/12/2024. The resident has a pressure ulcer or potential for pressure ulcer development Date Initiated: 10/06/2024. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 10/06/2024. The resident needs assistance to turn/reposition at least every 2 hours. Date Initiated: 10/06/2024. Observation and interviews with Resident #2 and a family member on 09/09/2025 at 1:15 pm revealed he was sitting up in his recliner. He was alert and oriented x3. He had no complaints and talked about his time in the military. He said he was able to walk with assistance. A rollator walker was in front of him. The family member showed me the changing sheets staff and residents used to document Resident #2's incontinent care, and she explained that both the staff member and the resident had to sign the changing sheets. There was a sign inside his room on his wall that read Q 2-hour Checks. Resident #2 said he did not recall the incident.During a phone interview with Resident #2's family member on 09/09/2025 at 1:25 pm she said, pictures were taken by some of the girls, but they have left or been fired since then. She said she did not have any of the pictures and did not know who, if anyone, had them. She described the scenario as, Resident #2 had been soiled and wet all night. In the recliner where he slept, his legs and the floor around him were covered in dry, caked-on feces and dried urine. She said, That kind of treatment was negligent and cruel. She said she had discussed the situation with the DON, and the DON was very, very upset. She said there was a sign for checking Resident #2 every 2 hours on his wall. She said she was an old, retired nurse and what she saw was unbelievable. She said some of the CNAs came by every 2 hours on the dot, but others did not. She said staff had a sheet they sign

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of 2 residents reviewed for accidents and hazards.The facility failed to ensure CNA A provided adequate supervision and used a 2-person assist while providing incontinent care to Resident #1. CNA A left Resident #1's bedside, while she lay on her right side. Due to her positioning, Resident #1 fell off the bed. Resident #1 sustained a rib fracture and contusions (bruising) to her right cheekbone, forehead, and back on 06/02/25.A PNC (Past Non-Compliance) Immediate Jeopardy (IJ) situation was identified on 06/02/25. The PNC IJ was removed on 06/30/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents requiring supervision at risk for injury and accidents with potential for more than minimal harm.Findings included:Record review of Resident #1's face sheet dated 07/25/22 revealed an [AGE] year-old female with an admission date of 07/25/22 with diagnoses including dementia with agitation, heart disease, femur fracture, wrist fracture, traumatic brain bleed, muscle weakness, abnormal gait and mobility, muscle wasting and atrophy, anxiety, malnutrition, mental disorders, depression, insomnia, and herpes. Record review of Resident #1's quarterly MDS report dated 07/23/25 revealed Resident #1 had a BIMS score of 99, indicating severe cognitive impairment and was dependent on staff for all ADLs. Resident #1 required 2-person assistance for transfers via mechanical lift, bed mobility, and incontinent care. She could sit in a recliner-type wheelchair but could not self-propel due to upper and lower body impairment and contractures to her hands. She was incontinent of bladder and bowel.Record review of Resident #1's Care Plan dated 07/26/22 indicated she was dependent on staff for all ADLs and required 2-person assistance for transfers, bed mobility, and incontinent care. The following care plan updates were implemented after the incident on 06/02/25: Resident #1 has potential for pain due to contractures of the joints of both hands. She has limited use of her hands due to contractures and a recent fracture of a rib from a fall. Date Initiated: 06/02/2025 Revision on: 06/06/2025. The resident utilizes a bolster or concave mattress to prevent unintentional slipping or rolling out of bed. Date Initiated: 07/23/2025 The resident will not be injured from a fall from the bed. Date Initiated: 07/23/2025 Ensure the bolster is in place while the resident is in the bed. Date Initiated: 07/23/2025. The resident will receive assistance with all ADLs (bathing, dressing, grooming, toileting, eating, mobility) as needed, to maintain skin integrity, prevent infections, and promote comfort, while respecting their preferences and ensuring safety. Date Initiated: 06/06/2025. Revision on: 06/06/2025. The resident is at risk for falls r/t impaired cognition and poor safety awareness. The resident had a recent fall. Date Initiated: 06/02/2025. Revision on: 06/06/2025. The resident will not sustain serious injury through the review date. Date Initiated: 06/02/2025. Revision on: 06/06/2025. The resident will remain free from falls and injury by implementing safety measures, such as environmental modifications and supervision, and by increasing awareness of safety cues, with the support of staff and family, to promote a safe living environment. Date Initiated: 06/06/2025. Target Date: 10/15/2025. Mechanical lift with staff x2 to assist with transfers. Date Initiated: 06/02/2025 Resident may have a mattress with bolsters. Date Initiated: 06/11/2025 Resident to have a low bed and floor mat on both sides of the bed. Date Initiated: 06/02/2025 Revision on: 06/02/2025 Review information on past falls and attempt to determine the cause of falls. Record possible root causes. Record review of the physician notes dated 06/05/25: EXAM: .Resident #1 is functionally impaired due to the physiological changes of an advanced age state and moderate dementia. The patient requires medication management with continued treatment. Resident #1 is vulnerable to safety risks and requires ongoing supervision to maintain their protection from harm. Resident #1's vocabulary and fund of knowledge indicate her cognitive function is at/or below lifetime baseline, indicating a moderate state of dementia.Record review of the Facility's PIR dated 06/06/25 revealed the fall incident was on 06/02/25 at 10:40 am. There were no witnesses. Resident #1 was assessed by a nurse (LVN C), and the findings were redness to the right side of the forehead and cheekbone, and swelling of the cheekbone. Resident #1 was sent to a local hospital for evaluation. The Resident #1 returned the same day with diagnoses of contusions (bruises) to the right cheek and forehead, mid back, and a non-displaced rib fracture. CNA A was suspended on 06/02/25 pending investigation. Police Case #134533. Steps taken immediately and corrective action implemented by the facility beginning 06/02/25:Medical Director, RP, notified. Resident sent to hospital. In-service on Abuse & Neglect initiated. Staff statements obtained. Actual/alleged abuse/neglect monitoring