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	02/05/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to protect the rights of one (Resident #1) of four residents reviewed for resident rights. The facility staff took a picture of Resident #1 without her permission. This failure could place residents at risk for an infringement of fundamental rights and a dignified existence.Review of Resident #1's face sheet dated [DATE] revealed Resident #1 was last admitted on [DATE]. Resident #1's Face sheet also revealed admission and Primary Diagnosis ofMetabolic Encephalopathy (a general term for brain dysfunction caused by systemic illness, chemical imbalances, or toxins rather than a direct structural brain injury), Cirrhosis of the liver (the late stage of scarring of the liver caused by long term liver diseases and conditions), Chronic Hepatic Failure (the final, irreversible stage of long-term liver disease, where sever scarring replaces healthy tissue, crippling the liver's ability to function in detoxification, metabolism, and protein synthesis), Nutritional Anemia (low hemoglobin levels caused by a lack of essential nutrients, and Thrombocytopenia (having a lower-than-normal number of platelets in the blood). Record review of Resident #1'2 MDS Assessment Summary dated [DATE] revealed Resident #1 had a BIMS of 07 which indicated severe mental cognition impairment. The MDS also revealed Resident #1 used a walker for mobility, needed partial to moderate assistance for dressing her upper and lower extremities and only needed set up or supervision for eating and personal hygiene. Record review of Resident #1's care plan, undated, revealed Resident #1 was mobile using a wheelchair. The care plan also revealed Resident #1 had impaired cognitive function with interventions to provide a homelike environment. Record review of Employee Coaching form dated [DATE] confirmed Nurse A took a photo with her personal phone of Resident #1 to try and share the gravity of the situation with the ADON as she was preparing the resident to be sent to the Emergency Room. The Coaching section of the document revealed the following was provided as education to Nurse A: Pictures on private phones are not allowed, the Resident rights to privacy policy was reviewed, and communication devices are not allowed for patient care, documentation of findings and/or communication of emergent care. In an interview on [DATE] at 2:35 p.m., Resident #1's family member stated she heard a photo had been taken of her family member (Resident #1) and she felt like this compromised Resident #1's rights. Resident #1's family members stated they could not verify or produce the photograph at this time. In an interview on [DATE] at 11:00 a.m., LVN A she did take the picture of Resident #1 before sending Resident #1 to the hospital on [DATE], and she shared the picture with the ADON. LVN A stated she didn't take the picture to be ugly or to compromise the residents' rights. LVN A stated she took the picture to show them how much blood was on Resident 1's bed. LVN A stated she was suspended for two days for taking the picture and she received an official write up for it. LVN A stated she was not sure if it was against the facility policy to take pictures but also stated if she was taking the pictures with her personal phone then it was against the facility's policy. LVN A stated she did not think it was abuse or neglect and she was not doing it to abuse the resident. LVN A stated she (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not have taken the photo. LVN A stated she deleted the photo right away. LVN A then stated it was against resident rights since Resident #1 was unable to give her permission at the time she took the picture. LVN A stated she was aware she should not have done it. LVN A stated she received an in-service on resident rights during her coaching and suspension. In an interview on [DATE] at 10:50 a.m., the ADON stated a picture of Resident #1 was sent to her, and it was deleted immediately. The ADON stated she was reprimanded, but she was not the one who took the picture and therefore did not receive an official write-up for the photo being taken. The ADON stated Resident #1's rights were compromised and that was the facility failure at this time. The ADON stated, In the future moving forward we will not be taking pictures at all. The ADON stated staff were in-serviced and if a picture was needed to be taken staff would refer it to the leadership team to make that decision. In an interview on [DATE] at 11:04 a.m., the DON stated she worked there since [DATE]th, about 18 days, but she was informed about an incident occurring on [DATE] where Resident #1 was sent out of the facility and expired in the hospital. The DON stated she was made aware on [DATE] that a picture did exist and in fact was taken by LVN A there at the facility. The DON stated she was also aware that coaching was completed for LVN A regarding HIPPA, using cellular device improperly, and general in-servicing has been completed. The DON stated the facility failure was some panic happened and LVN A did not fall back on her teaching, and she failed when it came to properly protecting the resident's rights. The DON stated it was a lack in judgement on the part of LVN A, and moving forward, the expectation was for staff not to take pictures of any residents. In an interview on [DATE] at 11:32 a.m., the Administrator stated he had worked there since [DATE]. The Administrator stated on [DATE] he was made aware that Resident #1 expired in December and a picture may have been taken by a nurse. The Administrator was told an in-service and coaching was completed for LVN A on resident rights and the use of personal devices. The Administrator stated that was not acceptable behavior or what he expected for the future from the staff as this interfered with Resident #1's rights. Record review of the facility's undated Resident Rights policy, revealed; the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. The subsection of the policy titled Privacy and Confidentiality revealed Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.The resident has a right to secure and confidential personal and medical records.The resident has the right to refuse the release of personal and medical records except as provided at S483.70(i)(2) or other applicable federal or state laws. Record review of the facility's Personnel Handbook dated 2019 revealed, The use of personal communication devices during schedule work hours is not permitted at the facility. These devices include but are not limited to cell phones and laptop computers. Communication devices issues by the facility/company are permitted only as they are tools for the job and are to be used accordingly. The facility prohibits the use of any type of cell phone camera, digital camera, video camera, or other form of image-recording device without the express permission of the facility and of each person whose image is recorded.