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	02/26/2026

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from any significant medication errors for 4 of 10 residents (Resident #2, Resident #5, Resident #8, and Resident #16) reviewed for medication errors in that:1. The facility failed to ensure Resident #2's blood pressure altering medications were administered and/or documented as ordered on 02/04/26 and 02/25/26. 2. The facility failed to ensure Resident #5's blood pressure altering medication was administered and/or documented as ordered on 22 of 76 opportunities from 02/01/26 to 02/26/26.3. The facility failed to ensure Resident #8's blood pressure altering medications were administered, and/or documented as ordered on 02/08/26.4. The facility failed to ensure Resident #16's blood pressure altering medications were administered, and/or documented as ordered on 02/17/26.These failures could place residents who receive blood pressure altering medications at an increased risk for complications such as decreased blood pressure, decreased pulse, exacerbation of symptoms and disease process, and potential hospitalization.Findings included:1. Record review of Resident #2's admission record reflected a [AGE] year-old male originally admitted to the facility on [DATE] with most recent admission on [DATE]. Diagnoses included acute on chronic congestive heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs), hypertensive heart disease with heart failure and chronic kidney disease (high blood pressure that caused heart failure and kidney damage), obstructive sleep apnea (when the throat muscles relax and block the airway causing breathing to stop during sleep), paroxysmal atrial fibrillation (an irregular, often fast heartbeat that starts and stops on its own), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), and unspecified dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities). Record review of Resident #2's admission MDS dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment.Record review of Resident #2's care plan dated 11/19/25 reflected the following:Focus: The resident has congestive heart failure initiated on 11/19/25. Interventions listed for the focus included, Give cardiac medications as ordered initiated on 11/19/25. Focus: [Resident #2] has hypertension r/t hypertensive heart disease initiated on 11/19/25 and revised on 12/17/25. Goals for the focus included, The resident will maintain a blood pressure within the following parameters: SBP >100 or DBP > 60, or HR > 60 through the review date initiated on 12/03/25 and revised on 12/17/25. Interventions listed for the focus included, give anti-hypertensive medications as ordered. initiated on 11/19/25. Focus: The resident takes an antiarrhythmic initiated on 11/19/25. Interventions for the goal included, Administer the medication as ordered by the physician, obtain any ordered or as directed vital sign (pulse or BP) prior to administration. Hold the medication if required and notify the physician initiated on 11/19/25.Record review of Resident #2's physician order summary on 02/24/26 reflected the following orders:Lisinopril Oral tablet 2.5mg, give 1 tablet by mouth one time a day (in the morning) related to hypertensive heart disease with heart failure. Hold if BP <100/60. Started on 11/19/25.Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25mg. Give 1 tablet by mouth one time a day (in the morning) related to hypertensive heart and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease. Hold if SBP < 100 or DBP < 60, or HR< 60. Started on 12/13/25.Record review of Resident #2's MAR for February 2026 reflected the following:On 02/04/26, for Resident #2's Lisinopril, LVN G documented X in the space for the blood pressure and she did not administer it due to, vitals outside of parameters however for Resident #2's Metoprolol (to be given/held at the same time as his Lisinopril) LVN G documented 111/73 in the space for the blood pressure and documented that she administered it.On 02/25/26, LVN B documented 105/78 in the space for blood pressure for Resident #2's Lisinopril and Metoprolol. LVN B documented she did not administer either medication due to vitals outside of parameters.2. Record review of Resident #5's admission record reflected an [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included acute kidney failure with dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), hypertension (high blood pressure), hypotension (low blood pressure), and heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs).Record review of Resident #5's quarterly MDS dated [DATE] reflected a BIMS score of 5 which indicated severe cognitive impairment. Record review of Resident #5's physician order summary on 02/26/26 reflected the following order:Midodrine HCl Oral tablet 10mg. Give 1 tablet by mouth three times a day (8:00 am, 2:00 pm, and 8:00 pm) related to hypotension. Hold if SBP is greater than 120. Ordered on 09/02/24.Record review of Resident #5's February 2026 MAR and blood pressure summary reflected the following:02/01/26 at 8:00 pm, LVN E documented 122/52 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.02/02/26 at 8:00 am, LVN B documented 121/59 in the space for blood pressure and documented she administered the Midodrine when it was outside of the parameters to administer give it per the physician's order.On 02/03/26 at 8:00 pm, RN F documented 121/58 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/04/26 at 8:00 pm, LVN E documented 126/54 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/08/26 at 8:00 am, LVN D documented 138/57 in the space for blood pressure and documented she administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/09/26 at 8:00 pm, LVN E documented 134/68 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/10/26 at 8:00 pm, LVN E documented 140/52 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/11/26 at 8:00 am, LVN B documented 152/46 in the space for blood pressure and documented she administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/11/26 at 8:00 pm, RN F documented 142/56 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/13/26 at 8:00 am, LVN G documented x in the space for blood pressure and documented she did not administer the Midodrine because the vital signs were outside the parameters for administration. The blood pressure summary reflected there was no blood pressure documented on 02/13/26 at 8:00 am.On 02/13/26 at 8:00 pm, LVN E documented 132/52 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/15/26 at 2:00 pm, RN A documented 126/64 in the space for blood pressure and documented she administered the Midodrine when it was outside of the parameters to administer it per the physician's order. On 02/16/26 at 8:00 pm, RN F documented 126/68 in the space for blood pressure and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/18/26 at 8:00 am, LVN G documented x in the space for blood pressure and documented she did not administer the Midodrine because the vital signs were outside the parameters for administration. The blood pressure summary reflected there was no blood pressure documented on 02/18/26 at 8:00 am.On 02/18/26 at 8:00 pm, LVN E documented 128/52 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/19/26 at 8:00 pm, LVN E documented x in the space for blood pressure and documented he did not administer the Midodrine because the vital signs were outside the parameters for administration. The blood pressure summary reflected Resident #5's blood pressure was 132/52 at 8:41pm. On 02/23/26 at 8:00 am, LVN G documented x in the space for blood pressure and documented she did not administer the Midodrine because the vital signs were outside the parameters for administration. The blood pressure summary reflected there was no blood pressure documented on 02/23/26 at 8:00 am.On 02/23/26 at 8:00 pm, LVN E documented 132/54 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/24/26 at 8:00 am, LVN G documented x in the space for blood pressure and documented she did not administer the Midodrine because the vital signs were outside the parameters for administration. The blood pressure summary reflected there was no blood pressure documented on 02/24/26 at 8:00 am.On 02/24/26 at 8:00 pm, LVN E documented 124/50 blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/25/26 at 8:00 pm, RN F documented 122/68 in the space for blood pressure and documented he administered the Midodrine when it was outside of the parameters to administer it per the physician's order.On 02/26/26 at 8:00 am, LVN B documented 158/91 in the space for blood pressure and documented she administered the Midodrine when it was outside of the parameters to administer it per the physician's order.3. Record review of Resident #8's face sheet, dated 02/26/26, revealed an [AGE] year-old male with an admission date of 01/17/25. Resident #8's pertinent diagnosis included Essential Hypertension (high blood pressure with no identifiable secondary medical cause). Record review of Resident #8's Comprehensive MDS Assessment, dated 12/16/25, revealed a BIMS score of 99 which indicated the interview could not be completed. Record review of Resident #8's comprehensive care plan, dated 02/26/26, revealed the focus The resident has a history of hypertension initiated on 01/21/25. An intervention listed for the focus included Give anti-hypertensive medications as ordered. initiated on 01/21/25. Record review of Resident 8's order summary revealed an active order for Lisinopril (blood pressure medication) Oral Tablet 20 MG with instructions HOLD IF SBP IS LESS THAN 110 OR DBP IS LESS THAN 60, AND NOTIFY MD initiated on 02/06/25. Record review of Resident #8's MAR for February 2026 revealed lisinopril was administered by LVN D on 02/08/26 with blood pressure 100/60. 4. Record review of Resident #16's face sheet, dated 02/26/26, revealed a [AGE] year-old male with an original admission date of 05/09/24 and current admission date of 04/29/25. Resident #8's pertinent diagnosis included Essential Hypertension. Record review of Resident #16's Quarterly MDS Assessment, dated 12/31/25, revealed a BIMS score of 10 which indicated moderate impairment. Record review of Resident #16's comprehensive care plan, dated 02/26/26, revealed the focus The resident has hypertension initiated on 05/10/24 and revised on 05/22/24. An intervention listed for the focus included Give anti-hypertensive medications as ordered. initiated of 05/10/24. Record review of Resident 16's order summary revealed an active order for Metoprolol Tartrate (blood pressure medication) Oral Tablet 25 MG with instructions HOLD IF SBP < 110, DBP < 60, or HR < 60 initiated on 07/30/25. Record review of Resident #16's MAR for February 2026 revealed metoprolol tartrate was administered by RN A on 02/17/26 with heart rate 56. In an interview on 02/26/26 at 2:00 pm, LVN B stated for a resident on blood pressure altering medications, vitals and hold parameters had to be checked prior to administration. She stated Resident #2's BP meds should have been given as the blood pressure was within parameters to give it. She stated (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5's Midodrine should not have been given as her BP was within hold parameters. LVN B stated it was important to give medications as they were ordered to prevent extreme hypertension (high blood pressure) or hypotension (low blood pressure). If medications were given outside of parameters it could cause the resident to have adverse events which could lead to hospitalization or death. LVN B stated she did not think she gave Resident #5 the Midodrine on 02/26/26, but may have accidentally checked it as given. LVN B stated it was important to document the vital signs on the MAR for easy access to the information.In an interview on 2/26/26 at 2:30 pm, the ADON stated it was important to give medications as ordered to avoid any adverse reactions. She stated if medications were given/held outside of parameters it could lead to adverse reactions such as stroke due to high blood pressure or hypotension that caused syncope, falls, or cardiac arrest. The ADON stated nurses were in-serviced on medication administration annually and the last one was about 6 months ago. In an interview on 02/26/26 at 3:03 pm, the DON stated it was important to give or hold medications as ordered to prevent the resident's blood pressure dropping too low (with blood pressure lowering medications) and causing dizziness, falls, or hospitalization. She stated if blood pressure raising medications were given when the blood pressure was already high, it could cause a stroke, hospitalization, or even death. The DON stated In-services for medication administration were done annually, and she was not sure when the last one was done. In an interview with RN A at 3:41 PM on 02/26/26, RN A stated she would not have administered metoprolol to Resident #16 outside of parameters, and that it was most likely a documentation error. RN A stated the documentation needed to be accurate because it could cause other problems down the line if decisions were made with incorrect information. RN A stated administering blood pressure medications outside of parameters could lead to hypotension or bradycardia (abnormally slow resting heart rate) and cause the resident to fall. In an interview with LVN D at 4:15 PM on 02/26/26, LVN D stated she would not have administered the lisinopril to Resident #8 outside of parameters, and that it must be a documentation error instead. LVN D stated it was important to have accurate records for residents to know what was actually given in case other inventions must be made in the future. LVN D stated administering blood pressure medications outside of parameters could lead to hypotension in the resident causing dizziness and a fall. LVN D stated if Midodrine was administered to Resident #5 when her blood pressure was already elevated, it could have raised it higher and caused hypertension which could lead to heart attack or stroke. In an interview on 02/26/26 at 4:40 pm, LVN G stated in reference to Resident #2, the only time she gave one blood pressure medication and not the other was if the resident's HR was outside of parameters for the second medication. She stated she was not sure why she would hold Resident #2's Lisinopril but give him the Metoprolol and she thought she may have documented it that way by mistake. LVN G stated it was important to document blood pressures when medications were held because, it needed to be documented why it was held or given. LVN G stated in reference to Resident #5's Midodrine, if it was given when her BP was too high it could cause a stroke. On 02/26/26 at 4:54 pm, contact with LVN E for interview was unsuccessful. Record review of the undated facility policy Medication Administration and General Guidelines revealed the following: .2. Medications are administered in accordance with written orders of the attending physician.

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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, interviews and record review, the facility failed to distribute and serve food with proper accordance with professional standards for food service safety. The kitchen staff member failed to wear the beard restraint properly to prevent hair from contacting food.The facility staff member failed to wear gloves during lunch and handled Resident #4's food bare handed. These failures could place residents who receive meals and/or snacks from the kitchen at risk for food contamination and food borne illness.Findings Include: Observations during the lunch hour in the dining room revealed on 02/25/26 at 12:30 PM revealed the MR who was helping to serve residents was in line to receive a tray from the kitchen to give to the residents proceeded to touch Resident #4's biscuit and push it back onto her plate and then to try to open the biscuit for her without wearing gloves. Resident #4 has asked MR for help because she could not do it herself. The food was plated and handed to staff to hand out to the residents by DA H, and the beard restraint was being worn improperly not covering the mustache only the beard. Record review of Resident #4's face sheet dated 02/26/26 revealed a 63-female initially admitted on [DATE] with a diagnosis of Post Traumatic Stress Disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event such as a natural disaster, war, violent crime, or serious accident), Muscle wasting and Atrophy, not elsewhere classified. In a interview with Resident #4 she stated she did not have a problem with the food served by the facility. Resident #4 stated she enjoys eating the food is was very good and has never gotten sick from eating it. In an interview on 02/25/26 at 1:03 PM with the MR she stated she was only trying to help Resident#4 with her the biscuit so that she could eat it. The MR stated she did not remember about touching the food without gloves because it could cause cross contamination and make the resident sick. The MR state it had been a while since we received training on serving the residents and cross contamination. The MR stated she will talk to the nurse about receiving training about infection control and serving the residents. The MR stated that she will be more careful about touching food without gloves if resident asks for help. In an interview 02/25/26 at 1:19 PM with DA H stated he was not aware that his beard restraint was being worn incorrectly. The DA H stated it must have moved while he was working or was not put on correctly initially. The DA H stated wearing the beard restraint was to prevent cross contamination of food served to the residents. The DA H stated it had been a long time since he had a training for the proper way to wear work attire. In an Interview with02/25/26 at 1:46PM DA I she stated it was important to wear a hairnet and a beard restraint to keep hair and cross contamination out of food that is served to the residents which could make resident ill. DA I stated she knew she was suppose to wear a hair net at all times from training she received 6 months ago. DA I stated she knew not to handle food with bare hands because it can make residents ill. In an interview on 02/26/26 at 11:15 AM with the DM she stated kitchen staff are required to wear protective clothing, beard guards and hair nets while working in the kitchen. Kitchen staff and other facility staff helping serve residents not to touch food with bare hands and are to use a gloves or a napkin if retrieving out of package. The MD stated not wearing gloves could cause cross contamination and could make the residents sick. The DM stated she will do training on the proper attire to wear while working in the kitchen, handling and serving food to residents. In record review of the facility policy and procedure titled Dietary Food Service Personnel Policy and Procedures dated 01/2012 stated Sanitation and Food Handling Hair nets and hats covering the hairline are worn at all times. [NAME] Guards are required for facial hair.Do not handle food with bare hands. Use the proper utensil or wear disposable gloves. Remember to change gloves after touching anything that should not contact food, Including clothing, hair doorknobs, etc.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 of 5 residents (Resident #3) reviewed for resident rights. The facility failed to place a privacy cover over Resident #3's catheter bag while she was in bed at 10:16 AM on 02/25/26 This failure could place residents at risk of feeling embarrassed or exposed. Findings included:Record review of Resident #3's face sheet dated 02/25/26 revealed a [AGE] year-old female with an original admission date of 04/19/24 and a current admission date of 10/22/24. The pertinent diagnosis included paraplegia (impairment or loss of motor and sensory function in the lower extremities). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating cognition was intact. Record review of Resident #3's comprehensive care plan dated 02/25/26 revealed the focus The resident has Indwelling Catheter initiated on 04/19/24 and revised on 05/22/24. Interventions listed for the focus included Perform Catheter care at least every shift and at each incontinent episode initiated on 02/24/26 and revised on 02/24/26. Record review of Resident #2's order summary revealed an active order for Ensure foley bag is in privacy bag while in bed or [wheelchair] every shift initiated on 04/19/24. During an observation at 10:16 AM on 02/25/26, Resident #3 was lying in bed in her room. The door to her room was closed. Resident #3's catheter bag was in plain view once in the room with no privacy cover over it. During an observation at 3:10 PM on 02/25/26, Resident #3 was in her wheelchair in a common area with a privacy cover over her catheter bag. In an interview with Resident #3 at 10:16 AM on 02/25/26, Resident #3 stated the catheter bag was usually covered by a privacy cover. Resident #3 stated she did not know it was uncovered right now. Resident #3 stated it did not bother her too much, but she preferred if the privacy cover was used. In an interview with LVN B at 3:12 PM on 02/25/26, LVN B stated residents with catheter bags should always have a privacy cover over it unless the resident requested otherwise. LVN B stated CNA C came up to her around 10:00 AM and told her Resident #3 did not have a privacy cover over her catheter bag. LVN B stated she gave a privacy cover to CNA C to put over the bag at that time. LVN C stated it was important to ensure privacy covers were used for catheter bags to protect the dignity of residents. In an interview with CNA C at 3:25 PM on 02/25/26, CNA C stated she noticed Resident #3 did not have a privacy cover on her catheter bag around 10:00 AM that morning. CNA C stated she received a new privacy cover from LVN B and placed it over Resident #3's catheter bag. CNA C stated that was the first time she had seen Resident #3 without a privacy cover over her catheter bag. CNA C stated it was important to keep privacy covers over catheter bags to protect the residents' dignity. In an interview with the DON at 3:30 PM on 02/25/26, the DON stated privacy covers should always be used for catheter bags unless the resident requested to not use one. The DON stated it was important to use privacy bags to protect residents' privacy and dignity. The DON stated it was a team effort to ensure residents' privacy covers were in place at all times. Record review of the undated facility policy titled Resident Rights revealed the following: 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.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to coordinate to obtain and document a physician's order for an existing advanced directive of DNR status for 1 of 6 (Resident #2) residents reviewed for advance directives.The facility failed to ensure Resident #2's DNR was ordered and scanned into his EMR when it was signed by his RP on [DATE].This failure could place residents at risk of not having their advance directives followed.Findings included:Record review of Resident #2's admission record reflected a [AGE] year-old male originally admitted to the facility on [DATE] with most recent admission on [DATE]. His diagnoses included acute on chronic congestive heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs), hypertensive heart disease with heart failure and chronic kidney disease (high blood pressure that caused heart failure and kidney damage), obstructive sleep apnea (when the throat muscles relax and block the airway causing breathing to stop during sleep), paroxysmal atrial fibrillation (an irregular, often fast heartbeat that starts and stops on its own), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), and unspecified dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities). Record review of Resident #2's admission MDS dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment.Record review of Resident #2's care plan dated [DATE] reflected the focus, Resident is a full code initiated on [DATE]. The goal was, Request for CPR to be initiated will be followed initiated on [DATE] with target date [DATE]. The interventions included, Initiate BLS CPR if the resident is without a heartbeat or not breathing. Notify EMS initiated on [DATE] by the ADON.Record review of Resident #2's physician order summary on [DATE] reflected an active verbal order for Full Code dated [DATE].Record review of Resident #2's Out-Of-Hospital-Do-Not-Resuscitate (OOH-DNR) Order dated [DATE] reflected his RP signed it on [DATE]. Record review of Resident #2's miscellaneous forms screen in PCC reflected Resident #2's DNR had an effective date of [DATE], but was not uploaded into PCC until [DATE] by MR. Record review of Resident #2's Request for Do No Resuscitate form effective [DATE] at 4:17 pm, signed by the ADON reflected the RP made the request for DNR on [DATE] at 3:00 pm and the physician was notified on [DATE] at 3:00 pm. This form also reflected in Section F.3, Per the request above, the physician has ordered a DNR for this resident? Answered, Yes. In an interview on [DATE] at 8:45 am, the ADON stated DNR paperwork could be done by any licensed staff. The ADON stated she used anyone who was non-licensed to witness and once the RP or patient signed the DNR in front of witnesses, whoever initiated the DNR called doctor. If the SW helped with the DNR, then she would text the ADON, DON, and administrator (in a group text) so they could let the physician know. The ADON stated after the physician signed the DNR form, it went to medical records and MR uploaded (scanned) it into the chart then once it was uploaded in the chart, the order was put in, the care plan was updated, and a progress note was written. The ADON stated if it was a weekend, she had a folder to put it into and gave it to her first thing Monday morning. If it was a critical matter, she called the MR and had her come to the facility to scan it in. The ADON stated she did not know why Resident #2's DNR was not scanned into his EMR until [DATE]. The ADON stated whoever initiated the DNR needed to follow up and make sure the order got put in and it got care planned. The ADON stated if it was the SW, she notified the ADON or DON so they could follow up. The ADON stated she initiated Resident #2's DNR but forgot to put the order in after it was signed. She stated the order should be entered and the care plan updated the same day the doctor signed the DNR. The ADON stated it was important the DNR was ordered so the resident's wishes were honored and if Resident #2 had coded (did not have a pulse) before [DATE], staff would have done CPR, which was against his and/or his RP's wishes. In an interview on (continued on next page)

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	02/26/2026

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.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 2:15pm, the MR stated she had folders at the nurse's station; any paperwork that needed to be scanned into the resident's EMR was put into that folder and she checked them every morning and evening on weekdays. She stated she did not know why the original DNR for Resident #2 was not scanned into his EMR until almost 2 months later. The MR stated typically, any advance directives were given directly to her to scan in and not placed in the folder. She stated after the DNR was scanned into the EMR, it was placed in the resident's folder in her office. The MR stated if a resident signed a DNR on the weekend, it was placed in the box on the outside of the DON's door or the nurses held on to it and gave it to her on Monday morning. The MR stated if it needed to be entered right away they called her and she came to the facility and scanned it in. She stated it was important that advanced directives were in the EMR so if the resident coded, the staff knew whether or not to perform CPR. If advance directives were not available the staff could do something that was against the resident's/ RP's rights/wishes. In an interview on [DATE] at 3:03 pm, the DON stated when a DNR was signed by the resident/RP and witnesses, the doctor was notified, a DNR request form was completed in the resident's EMR, and an order was put in by whichever nurse got the DNR. The DON stated the paper copy of the DNR was uploaded by MR if it was during the week or by the nurse if it was on the weekend. She stated if the nurse did not know how to scan it into the EMR, the paper copy was held at the nurse's station until Monday morning. The DON stated it was important to order the resident's code status, so the resident's/ RP's wishes were respected. If the code status was changed and not ordered, it could lead to the resident getting or not getting the desired treatment.Record review of the facility's undated Resident Rights policy reflected in part: 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.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.Self-determination - The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice.2. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.12. The facility must comply with the requirements specified in 42 CFR part 489. subpart I (Advance Directives).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #5) reviewed for infection control.1. The facility failed to ensure Resident #5 had an order for EBP (Enhanced Barrier Precautions) due to her right chest dialysis catheter.This failure could place residents at risk of cross-contamination and development or spread of infection.Record review of Resident #5's admission record reflected an [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included acute kidney failure with dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), type 2 diabetes mellitus (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), hypertension (high blood pressure), hypotension (low blood pressure), and heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs).Record review of Resident #5's quarterly MDS dated [DATE] reflected a BIMS score of 5 which indicated severe cognitive impairment. Record review of Resident #5's physician order summary report on 02/26/26 reflected the following orders: Assess dialysis device: Location Right Chest Dialysis Catheter every shift with start date of 11/05/24. Monitor dialysis catheter for infection, pain, and bleeding every shift with start date of 11/05/24.There was not an order for EBP.Record review of Resident #5's care plan dated 04/08/22 reflected a focus of, The resident needs dialysis, hemodialysis r/t renal failure MWF initiated on 03/21/24 and revised on 09/25/25. The goal was the resident would have no s/sx of complications from dialysis through the review date, initiated and revised on 10/07/24 with target date 03/31/26. The interventions did not include EBP due to her right chest dialysis catheter.Observation of Resident #5's room on 02/24/26 at 10:00 am, 02/25/26 at 9:00 am, and 02/26/26 at 2:00 pm reflected no EBP sign on the door and no PPE inside or outside of Resident #5's room.In an interview on 02/26/25 at 2:30 pm, the ADON, who was also the infection preventionist, stated EBP was used for residents that had PICC lines, feeding tubes, urinary catheters, and some types of wounds. When asked about Resident #5's dialysis catheter, she stated Resident #5 should have had EBP in place and it was important to protect the resident from acquiring an infection that could be life threatening. In an interview on 02/26/26 at 3:03 pm, the DON stated EBP was used for residents with PICCs, Midlines, external dialysis catheters, urinary catheters, gastric (feeding) tubes, and some chronic wounds to ensure residents did not get infections that were inadvertently carried into the room by staff members. She stated Resident #5 should have had EBP in place. Record review of the facility's Enhanced Barrier Precautions policy dated 04/01/24 reflected in part: Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient. EBP are indicated for residents with any of the following:Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.Implementing Contact versus Enhanced Barrier Precautions Resident Status: Has a chronic wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO.Use EBP: YesThe facility will ensure PPE and alcohol-based hand rub are readily accessible to staff prior (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to entry to their room.Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.Communication to Staff The facility will utilize postings outside the room and Point Click Care to communicate to staff if a resident requires EBP.