

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455737	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Concho Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 613 Eaker St Eden, TX 76837	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources were reported immediately to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 5 Residents (Resident #1) reviewed for Abuse. The facility did not report an allegation of abuse per facility policy to the State Survey Agency (HHSC) when Resident #1 alleged abuse occurred during a recent hospital visit. This deficient practice could delay assessment and care of residents who report abuse. The findings were: Record review of Resident #1 's face sheet dated 10/17/25 revealed a [AGE] year-old female originally admitted to the facility on [DATE], readmitted on [DATE] after observation stay at Hospital #1 for delirium (a state of acute mental confusion and disorientation that can cause significant changes in a person's behavior, thinking, and perception) and readmitted [DATE] after a hospital stay at Hospital #2 with the diagnosis that included: altered mental status (a significant change in a person's level of consciousness, awareness, and cognitive function. Record review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated moderate cognitive impairment. Section G revealed Resident #1 required moderate to maximum assistance with dressing and toileting. MDS indicated no behaviors present. Record review of Resident #1's progress note dated 10/8/2025 at 3:00PM written by DON revealed she was sent to Hospital #1 emergency room at 1:00PM due to physically aggressive behavior. Record review of Resident #1's hospital records Hospital #1 revealed on 10/8/25 at 1:30PM upon arrival she was administered Ativan (a benzodiazepine medication that is used for anxiety, insomnia, and seizures) 1mg for agitation and Haldol (antipsychotic medication used to treat psychotic disorders) and placed in soft restraints. Resident #1 was discharged back to the nursing facility on 10/10/2025. Record review of Resident #1's progress note dated 10/12/2025 at 11:15AM written by RN C revealed Resident #1 reported an allegation of abuse that occurred during her hospital stay on 10/8/2025. Resident #1 stated while at Hospital #1 they took her to a back room and a very big, tall man began to repeatedly hit her with his hands on her private area and was repeatedly called her name. Record review of Resident #1's progress note dated 10/10/2025 by Nurse Practitioner indicated upon returning to facility reveals no wounds and generalized bruising to bilateral upper and lower extremities. Record review of Resident #1's progress notes on 10/12/2025 at 12:15PM written by RN C revealed there was no bruising to perineal/private area and posterior buttocks/anal area. There was an elongated bruise to the left upper anterior thigh and a circular bruise to the right upper anterior thigh. Further review of the progress note revealed resident does carry her wallet inside her brief. The progress note revealed this was reported to the Administrator. The progress note revealed Resident #1 has had a history of behaviors that have escalated in the last 2 weeks which included hallucinations, delusions, verbal and physical aggression and increased falls. Observation of Resident #1 on 10/17/2025 at 1:46PM revealed she was in bed with eyes closed lying on her back. An interview with the Administrator on 10/17/25 at 1:45 P.M. revealed she did not report the allegation from Resident #1, as the allegation occurred outside the facility. She stated RNC reported Resident #1's allegation to her. She stated she did call the ADO but did not follow up because the allegation occurred outside the facility. However, upon reviewing the abuse guidelines from HHSC, she stated she should have reported the incident. An interview with the ADO on 10/17/25 at 9:20 AM revealed they did not report this allegation to the State office when it was first reported to the Administrator on 10/12/2025. It was not reported to the State office until 10/16/2025 after ADO and Regional Compliance nurse read the progress notes. They were performing an audit of Resident #1's chart prior to readmission and read the residents allegations in the progress note. ADO stated they did not have a DON at the facility at this time and the DON reviewed all progress notes. She stated the Administrator attempted to call her on 10/12/2025 but they did not speak, and no messages were left. The ADO stated she was traveling at that time and unable to answer. She stated her expectations are for the Administrator to leave a message or continue to call. The ADO stated she did not follow up because she was traveling and forgot to return the phone call. On 10/17/2025 at 10:30AM the surveyor attempted to reach the RN C with no success. The surveyor left a message but did not receive a return call. An interview with DON on 10/17/2025 at 2:30PM revealed she was not employed on the date this allegation occurred. She was the current Interim DON and started on 10/15/2025 and does not have access to electronic health records as of this time. She stated her expectation is for and abuse neglect</p>		