STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676108	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vidor Health & Rehabilitation Center	470 Moore Dr Vidor, TX 77662

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, which included injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials, which included the State Survey Agency, in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to report the sexual abuse allegation, after the allegation was made by Resident #1 and CNA A did not report to the abuse coordinator for approximately 2 weeks. The allegation of sexual abuse was not reported to HHSC, investigated timely, and no interventions were initiated to prevent further sexual abuse for Resident #1. This failure could place residents at risk for sexual abuse due to not reporting, investigating and protecting when there was an allegation of abuse within the allocated timeframes. Findings included: 1.Record review of an admission record, dated 10/06/25, indicated Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Alzheimer disease (progress disorder that affects memory, thinking and behavior), high blood pressure (a condition where the force of the blood against the artery walls is consistently too high) and insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep). Record review of Resident #1's physician's orders dated October 2025 indicated an order to admit to the secure unit related to elopement risk with a start date of 04/21/2025. Record review of the quarterly assessment MDS dated [DATE] indicated Resident #1 had a BIMS score of 02 which indicated she was severely impaired cognitively. She had no verbal, physical or sexual behaviors indicated during the last 7 days prior to this assessment. The MDS indicated she wandered 1 to 3 days in the past 7 days prior to the assessment. Record review of Resident #1's care plan dated 08/22/25 indicated she had impaired cognitive function/dementia or impaired thought processes related to dementia. 2. Record review of an admission record, dated 10/06/25, indicated Resident #2 was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of which included dementia (a group of conditions that causes decline in memory, thinking reasoning and problems solving), high blood pressure (a condition where the force of the blood against the artery walls is consistently too high) and insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep). Record review of Resident #2's physician's orders dated October 2025 indicated an order to admit to the secure unit related to elopement risk with a start date of 07/31/2025. Record review of the quarterly assessment MDS dated [DATE] indicated Resident #2 had a BIMS score of 04 which indicated he was severely impaired cognition. He had no verbal, physical or sexual behaviors indicated during the last 7 days prior to this assessment. The MDS indicated he wandered every day in the past 7 days prior to the assessment. Record review of Resident #2's care plan dated 09/30/2025 indicated he had a potential to demonstrate physical behaviors related to his dementia and poor impulse control. Resident #2 was hit by another resident. During a confidential phone interview on 10/06/25, a non-staff person said wished to remain anonymous. The anonymous non-staff person said Resident #1 said that a man touched her breast and pointed at Resident #2 in front of the nurses. The anonymous non-staff person was unable to say exactly when this happened, unable to name staff and denied witnessing the event. The anonymous non-staff person denied reporting to the Administrator or the DON, said he didn't report that to the Administrator. The anonymous non-staff person said they just talked about the food being late and needing more staff in the kitchen that day. During an observation and interview during initial rounds on 10/06/25 at 9:30 a.m., Resident #1 was in the dining room, and she said she was ok. Her speech was clear and easy to understand. During an interview on 10/06/25 at 11:00 a.m., Resident #1 said some man touched her breast, but she pushed him away and he left her alone after that. She then pointed to Resident #2 across the dining room and said it was him. She said she got mad but was not afraid. She said he never did anything else to her. She was unable to say when this happened. She was unable to say what staff knew about it. During an interview on 10/06/25 at 2:15 p.m., CNA A said she overheard Resident #1 tell her family member that another resident touched her breast and said she pushed him away. CNA A said she had been trained on abuse and reporting abuse to the administrator and DON immediately. She denied knowing what date this happened, what date she overheard the conversation or if it happened. She stated, I reported to my charge nurse and the surveyor