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	02/27/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of three residents reviewed for quality of care related to subtherapeutic lab levels. The facility failed to follow up after notifying the NP twice regarding Resident #1's phenytoin (anti-seizure medication) lab value of 5.6 (therapeutic range 10.0 - 20.0) on [DATE] and no intervention or assessments were put in place. Resident #1 was hospitalized on [DATE] due to subtherapeutic serum Dilantin (phenytoin- anti-seizure medication) level and status epilepticus. On [DATE] an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm that was not Immediate Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility Administrator received and signed the IJ template on [DATE] at 11:20 a.m. These failures could place residents at risk for a delay in treatment or diagnosis of new symptoms, a decline in the resident's condition, the need for hospitalization, or death. Findings included: Record review of Resident #1's face sheet, printed [DATE], reflected he was a [AGE] year-old male re-admitted to the facility on [DATE]. His active diagnoses included anoxic brain damage (when the brain is completely deprived of oxygen, causing cell death within minutes) and epilepsy with status epilepticus (seizures lasting longer than 5 minutes or multiple seizures without regaining consciousness in between). Record review of Resident #1's Minimum Data Set (MDS) Comprehensive Resident Assessment, dated [DATE], reflected his BIMS summary score was 05 indicating severe cognitive impairment. The active diagnoses included seizure disorder or epilepsy. Record review of Resident #1's comprehensive care plan, date initiated [DATE], reflected The resident has seizure disorder.The resident will be free from injury from seizure activity through the review date.Give seizure medication as ordered by doctor. Monitor/document side effects and Effectiveness. Monitor labs and report any sub therapeutic or toxic results to MD. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Record review of Resident #1's order summary report, printed [DATE], reflected .DILANTIN (phenytoin) LEVEL Q 3 MONTHS (MARCH JUNE SEPT DEC) Prescriber Written Active [DATE].Phenytoin Oral Tablet Chewable 50 MG (Phenytoin) Give 250 mg by mouth one time a day. (Give 5 tabs to equal 250mg) Phone start date [DATE]. Record review of Resident #1's progress notes written by LVN A, dated [DATE] related to Resident #1, reflected, MD B here n/o decreases Dilantin (anti-seizure medication - same as phenytoin) to 200mg once daily. Repeat BMP, CBC, Dilantin every 2 months. Record review of Resident #1's order summary report, printed [DATE], reflected .Dilantin Oral Capsule 100 MG (Phenytoin Sodium Extended) Give 2 capsule by mouth one time a day for Seizures.start date [DATE]. Record review of Resident #1's Lab Result Report, dated [DATE], reflected .Phenytoin 5.6 ug/ml 10.0 to 20.0 (reference range) L (low) Final. This document had No New (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Orders handwritten on it and what looked to be initials or a signature. Record review of Resident #1's progress notes written by ADON C, dated [DATE], reflected .Resident bmp CBC and phenytoin labs reviewed by NP NNO given at this time. Record review of Resident #1's Medication Regimen Review, dated [DATE], reflected .Routine lab monitoring.order Dilantin oral capsule 100 mg (phenytoin sodium extended) give 2 capsules by mouth one time a day for seizures. Order date [DATE]. Level 5.6 on [DATE], 23.4 on [DATE] (reference range 10.0 to 20.0 ug/ml). Recommendation: Dose was decreased from 250 mg to 200 mg after the elevated level but is now low can we redraw and if still off adjust dose? . Physician Response Section: (the box was checked next to the following statement) I agree with this recommendation.physician signature present and dated [DATE]. Record review of Resident #1's order summary report, printed [DATE], reflected .Phenytoin | CBC w/Auto Diff | Basic Metabolic Panel ** SCHEDULED [DATE]; Auto-Send [DATE] 2:00 AM ** one time only Phone Active order date [DATE], start date [DATE]. Record review of Resident #1's progress notes between [DATE] and [DATE] did not reveal any other documentation related to this hospitalization and lab value. No documentation of any signs or symptoms of seizures. Record review of Resident #1's medication administration record for February 2026 reflected .Dilantin Oral Capsule 100 MG (Phenytoin Sodium Extended) Give 2 capsule by mouth one time a day for Seizures. There was a check mark showing the medication was given February 1st through February 23rd of 2026. Record review of Resident #1's progress notes written by LVN D, dated [DATE], reflected .Transfer notification.Resident #1 was transferred to a hospital on [DATE] 12:00 AM related to Screaming in severe pain. Record review or Resident #1's hospital records, printed [DATE], reflected [DATE] - ED to Hosp-admission (Current).Chief complaint Altered Mental Status.Hospital Problems.Status epilepticus.epilepsy.History.anoxic brain injury seizures apparently noncompliant with his Dilantin (phenytoin) checked out to me to load with Dilantin DC back to group home.Medical Decision Making.with seizures and apparent noncompliance with Dilantin as level was undetectable loaded with Dilantin here patient had another seizure gave Ativan (acute seizure medication). Diagnoses.subtherapeutic serum Dilantin level.his Dilantin level was low very low.positive for seizures.labs phenytoin less than 1.8. During an observation on [DATE] at 10:30 a.m., Resident #1 was at the hospital in his bed. An attempt to interview was made, but he was not interviewable and continued to fall asleep off and on. During an interview with FM #1 on [DATE] at 10:40 a.m., she stated the hospital neurologist told her he can't be taken off medications like that in that way. The hospitalization was all caused by the decrease in his medication. This was preventable. She stated he seemed to be doing better and was no longer having seizures. During an interview with FM #2 on [DATE] at 11:27 a.m., she stated the neurologist said this was preventable. She said the phenytoin levels were too low, critical level in December. She stated he was sent out in the middle of the night screaming. The ER said his levels were less than 1.8. She stated he hadn't had a seizure in 12 years. She stated she was told when he had these kinds of seizures brain cells died and did damage to his heart. She stated his phenytoin level was 5.6 in December, and they did nothing at that point. During an interview with the DON on [DATE] at 1:01 p.m., she stated Resident #1's [DATE] labs had 23.4 for his phenytoin level. MD B decreased his dosage from 250 mg to 200 mg in [DATE] and increased lab draws from every three months to every two months. She stated the next set of labs had a level of 5.6 and that was low. The NP reviewed the labs and gave no new orders. She stated it was a little behind because of the holidays. During an interview with the NP on [DATE] at 1:41 p.m., she stated I am at a loss I don't know what happened. I looked yesterday when I heard about it. She was unable to recall everything exactly. She stated she knew she signed it, but she missed it somehow. She stated if she had caught it, for labs sensitive like that, normally she would ask for a replacement lab that day. By that time, the lab (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	value was two weeks old. Then adjust medications and redraw them two weeks later. She stated with his history of seizures and his levels being low like that, she definitely would have ordered to redraw labs. She stated the seizures could have been prevented. During an interview with MD B on [DATE] at 2:36 p.m., he stated he lowered the dosage due to a critically high phenytoin level. He stated he did not decrease it that much. He changed phenytoin from 250 mg to 200 mg which is 1/3 of the dosage and he stated it should have minimal change. He increased lab draws from every three months to every two months. He stated, The first recheck was 5 something. He stated it was on the low side. It should be somewhere around 10. He stated the NP missed the lab; he was not sure how that happened. MD B stated the seizures could have any other cause such as stress or a urinary tract infection. He did not recall if he was notified about this specific lab value. He stated the levels could be off due to timing of the labs. He stated there was no reason to do anything else at the time because there were no symptoms. He stated he wouldn't just chase the numbers. During an interview on [DATE] at 3:19 p.m., ADON C stated when the NP came to the building, she rounded at that time. She pulled all the labs that have not been reviewed. She stated she did not specifically look at each lab herself. She printed them and gave them to the NP. The NP read through them while she was standing there, signed them, and gave them back to her. ADON C documented any orders or if there were no orders in the EHR, then the signed labs were given to medical records to be scanned and uploaded into the EHR. This was part of the normal lab practice for all the labs that came into the entire facility. During an interview on [DATE] at 3:26 p.m., LVN D stated she notified the NP of the lab results. She did not confirm or deny that she informed the NP specifically about the phenytoin level. She stated she knew she would notify the doctor if any lab values were off. She stated she received a text back, no new orders from the NP. She stated she knew she put in the progress notes that she contacted the NP regarding the labs. During an interview on [DATE] at 9:15 a.m., the DON stated the lab value was low, not critical. The DON stated the NP was contacted twice regarding the labs. The Administrator was present during this interview, she added the NP was contacted twice, what else are we supposed to do? The Administrator asked, Isn't it the NP's responsibility to let the doctor know? She stated, the NP was under his license, so she should do that. The DON stated it was beyond the nurse's scope to question the NP's response. She stated we followed the orders, drew the labs, and contacted the NP and followed her recommendations. She stated she would not answer any other questions until she contacted her VP. An attempt to interview the hospital neurologist on [DATE] at 9:26 a.m. was made, no return call was received. During an interview on [DATE] at 1:08 p.m., MD F stated the phenytoin lab was at 5.6, which is low, it can change quickly. He stated all doctors should probably schedule labs monthly if they are changing something (like medication dosages) or if the lab value was changing rapidly, the labs should be drawn weekly. He stated, oh no, can't make changes based off old labs. He stated new labs should have been done, before changes to the medications were made, lab draws should be within a couple days. He stated the lab values were subtherapeutic, you can't say for sure. (it caused seizures) but it didn't help. The DON was emailed regarding a related lab policy on [DATE], she replied at 1:30 p.m., there was no specific policy for labs, they followed the doctor's orders. Review of the facility's policy, Notifying the Physician of Changes in Status, no date, reflected The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. This facility utilizes the INTERACT tool, Change in Condition - When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Work day notification of the (continued on next page)

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