

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Vidor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 470 Moore Drive 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have sufficient nursing staff to assure resident safety and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 4 halls (500 Hall) reviewed for sufficient nursing staff. *The facility did not always have the secured unit (500 Hall) staffed with 2 CNAs as indicated in the facility assessment. This failure could place residents who reside on the 500 Hall at risk of diminished quality of life and quality of care, injuries, elopement risk, and delayed treatment. Findings included: Record review of the Facility assessment dated [DATE] indicated: .Staff AssignmentsDescribe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments. Resident-centered collaborative care is defined by the Agency for Healthcare Research and Quality as care that is relationship-based with an orientation toward the whole person, and that includes partnering with residents and their families to understand and respect each resident's unique needs, culture, values, and preferences. Care that is resident-centered also supports residents in learning to manage, organize, and participate in their own care at the level the resident chooses. Based on the information provided in this assessment, the facility's staffing needs per unit and per shift is on the following pages: .Unit-Hall 5006a-2p or 6a-6p Licensed Nurse 1 CMA CNA 2 2p-10p (blank if 12 hr shift) Licensed Nurse 1 CMA CNA 210p-6a or 6p-6a (blank if 12 hr shift) Licensed Nurse see below CMA CNA 1. During observations on 07/13/26 of the 06:00 a.m. to 02:00 p.m. shift indicated:-at 09:15 a.m. there was 1 LVN and 1 CNA (LVN A and CNA B) on the secured unit. LVN A had RN C orientating with her. -at 09:18 a.m. the nursing office on the secured unit had no CCTV monitoring of the hall, dining area, or sitting room. These areas were not visible from the nurse office. -at 10:37 a.m. CNA B left the dining room area, where there were 10 residents, to attend to a resident in their room. LVN A and RN C were in the nursing office at the opposite end of the hall.-at 10:41 a.m. a resident stood up out of his wheelchair and was trying to walk around. -at 10:42 a.m. CNA B returned to the dining room and assisted the resident back to his wheelchair to sit down. -at 12:15 p.m. CNA B left the dining room area where there were 14 residents to attend to a resident in their room. LVN A and RN C were in the nursing office at the opposite end of the hall.-at 12:18 p.m. CNA B returned to the dining room. LVN A and RN C were in the nursing office at the opposite end of the hall.-at 12:21 p.m. dietary staff brought the lunch trays on an open slotted cart to the unit. LVN A was not there to check the trays. -at 12:32 p.m. LVN A left the secured unit without checking the lunch trays on the cart. -at 12:34 p.m. RN C brought a resident to the dining room and sat them at one of the tables for lunch then left the dining room. Lunch trays remained on the cart untouched. -at 12:35 p.m. LVN A returned to the secured unit nurse office. Lunch trays remained on the cart unchecked.-at 12:36 p.m. RN C returned to the dining (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 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. Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 2 freezers (Freezer #2), 1 of 4 refrigerators (Refrigerator #4), and 1 of 1 kitchen reviewed for food and nutrition services. The facility failure to ensure food items in Freezer #2 were labeled, dated, and sealed. The facility failed to ensure Refrigerator #4 was clean and free of debris and spills. The facility failed to ensure the water and drainpipes under dish machine were free of leaks. The facility failed to ensure that the floor in the kitchen was clean and intact. The facility failed to ensure the kitchen ceiling was free of holes. The facility failed to ensure the garbage in the kitchen was in the receptacle with lid on the garbage barrel and away from food. The facility failed to store staff's personal drink away from food preparation area. This failure could place residents at risk for health complications, foodborne illnesses, and decreased quality of life. Findings included: During observations on 07/13/2026 from 8:30 to 9:15 a.m. *Freezer#2 had 2 unmarked and unsealed gallon bags which contain approximately 16 frozen cookies and approximately 20 frozen garlic bread rolls. *Refrigerator #4 had clear liquid on the bottom shelf and had spills and food debris. There were 2 cardboard boxes with 4 sealed bagged eggs and 8- 1 pound butter blocks not bagged on the bottom shelf with clear liquid, spills and food debris. The boxes were soaked with clear liquid. *Ceiling in the dish room had 3 holes around the air-conditioning vent approximately 3 by 4 inches and had black substance around the sheetrock with water damage. *The water pipes and drainpipes were leaking under the dish machine, and the floor was wet and 8 tiles were loose and the grout deteriorated. During an interview on 07/13/2026 at 9:20 a.m., the DM said all food items in the freezers and refrigerators should be dated, labeled and sealed to prevent contamination. The DM said the clear liquid had been there, and she was unaware why that happened. She said the refrigerators and freezers should be kept cleaned to prevent food related illnesses. She said she was new and would see why maintenance had not fixed issues in the kitchen. During an interview on 07/13/26 at 9:25 a.m., dietary staff K said the ceiling was like that when he hired on, one year ago. He said he put a bucket under the pipes and said the drain water still splashed and got on the floor and under the loose tiles. He said he had reported the leaking water and loose tiles. During an observation and interview on 7/15/26 at 11:45 a.m., approximately 1 cup of scrambled eggs was on the floor in front of the steam table as [NAME] L was placing items for lunch on the steam table. [NAME] L pureed the beef patties in the mechanical processor for the pureed diets. Next to the processor on the food preparation table was a personal drinking cup. [NAME] L said his coffee should not be there. He said each cook was responsible for cleaning up after each meal and he cooked breakfast and missed those eggs. He said his drink needed to be kept away from the food preparation area and cleaning after each meal prevents spread of germs. There was a rolling trash can 64 gallons without a lid 1/2 full of garbage next to the preparation table and a clean food rack which had clean trays and desserts. During an interview on 07/15/2026 at 12:30 p.m., Maintenance supervisor said he could not fix the ceiling in the kitchen until the roof was fixed, no one reported pipes were leaking again. He said he was unaware about the refrigerator having water in the bottom shelf. Record review of undated Inservice: Food Receiving and Storage indicated Specific procedures are required to maintain a safe food supply. The residents in our facility tend to be at a higher risk for infection and illness than the rest of the populations. floors needs to be kept clean.3. Date all food items with the date received it was received. Record review of undated Dietary Food Services Personnel policy and procedures indicated . dispose of food fallen on the floor .		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for kitchen reviewed for physical environment. The facility failed to ensure the kitchen was free from gnats. This failure could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life. Findings included: During an observation on 07/13/2026 at 9:05 a.m. there were 4 to 6 gnats in the kitchen in the dish room flying around the leaking pipes. During an interview on 7/13/2026 at 9:25 a.m., dietary staff K said there were gnats because of the drained water last 3 weeks. During an observation on 07/14/2026 at 11:50 a.m., approximately 5 to 6 gnats were flying around a box on the floor with garbage in it and over the preparation table where the [NAME] L was battering chicken. He said insects can cause spread of germs. During an interview on 7/15/26 at 3:30 p.m., the Maintenance supervisor said no one had reported pests in the kitchen and said the exterminator company was here a week ago, but no one reported the kitchen was having gnats. He said he would notify pest control company. Record review of the Texas Food Establishment Rules dated October 2015 indicated . (k) Controlling pests. The presence of insects, rodents, and other pests shall be control to eliminate their presence on the premises by: (1) routinely inspecting incoming shipments of food and supplies; .(2) routinely inspecting the premises for evidence of pests; .(3) using methods, if pests are found, such as trapping devices or other means of pest control as specified under S228.204(b) and S228.208(b) and (c) of this title; . and (4) eliminating harborage conditions. [34].		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the option he or she prefers for 1 of 5 residents (Resident #3) reviewed for resident rights. The facility failed to ensure Resident #3 had a completed Consent for Antipsychotic or Neuroleptic Medication Treatment (HHSC form 3713) form for Risperidone (an antipsychotic medication). This failure could place residents at risk for treatment or services provided without their informed consent. Findings included: Record review of a face sheet dated 07/15/26 indicated Resident #3 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs). She had a POA listed on the face sheet. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #3 had a BIMS score of 03 out of 15, which indicated she had severely impaired cognition. She had an active diagnosis of bipolar disorder. She received antipsychotic medication. Record review of a comprehensive care plan dated 05/24/26 indicated Resident #3 required anti-psychotic medications related to bipolar disorder with an intervention that read: .Educate the resident/family/caregivers about risks, benefits and the side effects. Record review of a physician's order summary report dated 07/15/26 indicated Resident #3 had a physician's order dated 03/28/25 which read .risperidONE Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth two times a day related to BIPOLAR DISORDER,. Record review of the MARs for May, June, and July 2026 indicated Resident #3 received Risperidone 0.5 mg twice daily every day. Record review of the EMR indicated Resident #3 had an HHSC form 3713 dated 04/07/24 uploaded into the EMR. Risperidone was the antipsychotic listed on the form. The form did not have:-a Vendor Number listed;-in Section I, the dosage and frequency for the medication; and-in Section I, the signature of the person prescribing the medication. Record review of the EMR indicated Resident #3 had an HHSC form 3713 dated 01/14/25 uploaded into the EMR. Risperidone was the antipsychotic listed on the form. The form did not have:-a Vendor Number listed;-the resident's SS number listed;-in Section I, the dosage and frequency for the medication;-in Section II, information as to who was giving the consent; -in Section II, information as to on behalf of who the consent was being given for; and-the signature of the Resident or Resident's Representative, it was signed by staff member with a verbal consent from the POA. During an interview on 07/15/26 at 04:10 p.m., the RCN/Former DON said the form should have been completed with all the missing information prior to being uploaded. She did not realize a verbal consent could not be obtained for the HHSC form 3713. She said she could not make out which staff member signed as receiving verbal consent for Resident #3. She said residents could be at risk for adverse side effects and families may not be made aware of the residents' condition if they were not informed and given the opportunity to consent to treatment. During an interview on 07/15/26 at 04:35 p.m., the Administrator said nursing staff were responsible for ensuring medication consents were signed and in place for psychotropic medications. She said not obtaining completed consents and signed prior to administering psychoactive medications could take away the residents right to being informed regarding their medications and could possibly take away their right to refuse treatment. Record review of a facility policy titled Psychotropic Medication revised 02/12/25 indicated: .Resident's Right to be InformedResidents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences) for 1 of 21 residents (Residents #9) reviewed for resident rights. The facility failed to ensure Resident #9's physician was notified of her insulin was held on 07/08/2026, 07/09/2026 and 07/10/2026. This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. Findings included: Record review of Resident #9's face sheet dated 04/21/2023 indicated Resident #9 was admitted on [DATE], was a [AGE] year-old female with diagnoses that included acute kidney failure (when kidneys stop working suddenly), and diabetes. Record review of Resident #9's physician's orders for July 2026 indicated she had an order for Tresiba FlexTouch Subcutaneous Solution 100 UNIT/ML (Insulin Degludec) Inject 20 unit subcutaneously one time a day related to diabetes mellitus without complications with a start date of 07/08/2024. The physician's orders contained no hold orders. Record review of Resident #9's MAR dated July 2026 indicated on 7/8 blood sugar was 80, 7/9 blood sugar was 90, 7/10 blood sugar was 97 and the insulin was held. The MAR for Resident #9's was marked a code of 11. (11=BS within Normal Limits no administration was required). Record review of Resident #9 nurse's notes from 06/26/2026 to 07/14/2026 indicated no documented evidence the physician was notified the insulin was held for 3 doses. No evidence of negative impacts of insulin being held. During an interview on 07/15/2026 at 1:00 p.m., the DON said her expectation was for the nurses to notify physicians of holding medications 3 times in a row. She said the physician needed to know if he needed to adjust the medication or to prevent negative outcomes. During an interview on 07/15/2026 at 3:15 p.m., LVN F said she held insulin for 3 days in a row. She said she should have called the NP or physician in case they needed to make med adjustments. She said Resident #9 blood sugar was below 100 on 07/08/2026, 07/09/2026 and 07/10/2026 which was consider within normal limits. Record review of the Medication Administration and General Guidelines dated 03/2025 indicated Policy . 12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. Resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of medication has not been given. If an electronic medical record is being utilized, then the caregiver administering the medication will enter the correct documentation that will then be electronically date / time stamped with their initials.		

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NAME OF PROVIDER OR SUPPLIER Vidor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 470 Moore Drive Vidor, TX 77662	
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior 2 of 10 rooms and for (Rooms 104A, and 112B) observed for homelike environment. The facility failed to ensure room [ROOM NUMBER]A was in good repair and did not have a hole and missing sheet rock exposing the wood frame and insulation on 07/13/26, 07/14/26 and 07/15/26. The facility failed to ensure room [ROOM NUMBER]B was in good repair and did not have a hole and missing sheet rock exposing the wood frame and insulation on 07/13/26, 07/14/26 and 07/15/26. This failure could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: During an observation on 07/13/2026 at 9:45 a.m. on hall 100: room [ROOM NUMBER]A, door wall had friction marks, torn and peeling paper of sheet rock exposing the white chalky core and a large hole in the sheet rock that exposed the brown wood frame and insulation. The hole was approximately 1.5 feet in length and 6 inches in width. On the floor was a build-up of chalky white dust. room [ROOM NUMBER]B, window wall had 4-5 linear abrasion grooves which were approximately 1-inch wide, 6-inches long and 1-2 inches deep and a large hole in the sheet rock that exposed the brown wood frame and insulation. There was a visible gap between the sheet rock and the insulation where the outside wall could be seen. The hole was approximately 2.5 feet in length and 1.5 feet in width. On the floor was a build-up of chalky white dust and torn paper. During an interview on 07/15/2026 at 3:00 p.m., CNA-J said he began employment in May of 2026 and was the person responsible for initially damaging the sheet rock in room [ROOM NUMBER]A but did not know about the wall in 112B. CNA-J said he was adjusting the head of the bed in room [ROOM NUMBER]A and the bed was too close to the wall and it scratched the sheet rock. CNA-J stated it was the responsibility of Maintenance Man to complete facility repairs. CNA-J said he reported room [ROOM NUMBER]A needing wall repairs verbally to the Maintenance man the day of the incident. CNA-J said over time it kept getting worse, but he did not report it again because he felt the Maintenance Man already knew about the hole since he was the one to report it. CNA-J said all staff could verbally report or enter issues in the maintenance log. CNA-J said not having the wall's sheet rock repaired could affect the facility's appearance and cleanliness. During an interview on 07/15/26 at 3:30 p.m. the Maintenance Supervisor said he had been employed at the facility since April 2026, and it was his expectation to try to complete repair issues the day they were submitted unless parts were required that needed to be ordered. The Maintenance Supervisor said if parts needed to be ordered then repairs were completed once the needed parts came in. The Maintenance Supervisor said he was in charge of repairs and scheduling repairs with outside vendors for facility maintenance and repairs. The Maintenance Supervisor said the facility (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff put any maintenance requests or needs in the maintenance log that was at each of the nurse's stations or could tell him verbally. The Maintenance Supervisor said he checked the logs daily if possible but at a minimum of several times a week. The Maintenance Supervisor said he was responsible for completing maintenance requests and building repairs. The Maintenance Supervisor said it could potentially negatively affect a resident if building repairs were not completed. The Maintenance Supervisor said when showed room [ROOM NUMBER]A and 112B wall that he was aware of the repairs needing to be made and none of these items had been logged into the maintenance log binder. The Maintenance Supervisor said he was aware of the damaged walls in room [ROOM NUMBER] and 112 since hired and had made plans to repair but survey started He said he had started in another room on the same hall making repairs and had not gotten to rooms 104 or 112 yet. He said he would repair the current issues found but was working on other environment areas in the facility that took priority. During an interview on 07/15/26 at 3:40 p.m. the Administrator said she had been employed with the facility for about a month or so. The Administrator said it was her expectation that any facility repair request be communicated via the maintenance log repair binder unless it was an emergency then to call the Maintenance Supervisor or the Administrator. The Administrator said repairs are completed the next day unless parts are needed to complete the repair then as soon as parts come in the repair is completed. The Administrator said Maintenance Supervisor is responsible for checking the maintenance log binder daily and completing facility repairs. She said she reported all the issues with the environment a couple of weeks ago to the corporate staff and was told the building had been full remodeled at the beginning of the year 2026 and facility was responsible for repairs. She said she knew the condition of the facility and the plan was to complete repairs and paint areas which needed painting, but it would take time. The Administrator said at this point there were other factors that took priority. The Administrator said she expected the facility to be homelike for the residents. The Administrator said she was responsible for ensuring the facility and resident rooms were homelike. The ADM said it could negatively impact the residents' quality of life and demeanor. The ADM said the facility was resolving environmental issues and had started on hall 100. Record review of Maintenance logs for the facility from 02/01/2026 through 07/13/2026 did not indicate wall in room [ROOM NUMBER]A or room [ROOM NUMBER]B had been reported needing repair. Review of the facility's policy Maintenance Services, revised December 2011, read in relevant part Maintenance services shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance in federal, state and local laws, regulations and guidelines. b. maintaining the building in good repair and free from hazards. Record review of a facility policy titled Resident Rights, dated November 2021, read, .Dignity and Respect: you have the right to: *Live in safe, decent and clean conditions.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 1 resident (Resident #54) reviewed for enteral devices. The facility failed to ensure RN G administered Resident #54's water flush by gravity instead of pushing it through his gastronomy tube (placement of a tube into the stomach used for nutrition and medication administration) with a syringe on 07/14/2026. This failure could affect residents receiving enteral nutrition, medications, and hydration by placing them at risk of health complications. Findings included: Record review of Resident #54's face sheet dated 07/14/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included cerebral infarction (stroke), gastronomy status (surgically placed soft flexible tube inserted through the abdomen into the stomach) and dysphagia (difficulty swallowing). Record review of Resident #54's Quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 2, indicated severely impaired cognition with diagnoses of cerebral infarct. Resident #54's MDS assessment indicated the resident had a feeding tube. Record review of Resident #54's Order Summary Report dated 07/15/2026 indicated enteral feeding order flush tube with 30 ml water before and after medication and feeding with a start dated 10/16/2025 and three times a day flush gastronomy tube with 300 ml of water with a start date of 04/08/2026. Record review of Resident #54's care plan with a target date of 07/30/2026 indicated he had a gastronomy tube related to dysphagia. During an observation and interview on 07/14/2026 at 9:11 a.m., indicated Resident #54 was sitting up in his wheelchair. He said the staff gave him his medication in the tube in his stomach. During an observation of medication administration with RN G on 07/14/2026 starting at 9:15 a.m., RN G said she was providing care for Resident #54 today. She administered his medication through the gastronomy tube by gravity flow. She called for LVN H to bring a cup of water to her. RN G then she drew up the water in the syringe. LVN H asked RN G if she was going to give the water by gravity flow and RN G said no. RN G then pushed the water through Resident #54's g-tube slowly. RN G said she should have inserted the water by gravity instead of pushing it with the syringe with the plunger. She said she was educated to give medication and water by gravity. She said she was using the syringe and plunger to measure the water. RN G said the risk of pushing the water and not giving by gravity flow was it could cause regurgitation by the resident. During an interview on 07/14/2026 at 4:45 p.m. the DON said RN G should not have pushed water into the gastronomy tube, it should have been given by gravity. She said RN G may have gotten nervous and pushed the water in the gastronomy tube, but she was educated on gastronomy tube medication administration. The DON said RN G was being onboarded by LVN H. She said the resident risk was potentially gastric upset. The DON said her expectation was nurses follow policy giving gastronomy tube medication. During an interview on 07/15/2026 at 12:45 p.m., LVN H said she was training RN G yesterday. She said she was monitoring her while giving medication. LVN H said she asked RN G if she was going to give water to the resident by gravity and RN G said no. She said RN G was educated on gastronomy tube medication administration. She said the resident risk of giving liquid through a gastronomy tube by a push instead of gravity was potential stomach problems. During an interview on 07/15/2026 at 1:25 p.m. the Administrator said the charge nurse was responsible for giving gastronomy tube medication properly. She said she was unsure of RN G's background, and she may not be used to working in long term care. She said RN G had a nursing license and was educated on gastronomy medication (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedures. The Administrator said RN G was being onboarded with another nurse. She said the resident risk of pushing fluid into the gastronomy tube instead of given by gravity was a potential contra indication such as nausea or vomiting. The Administrator said her expectation was gastronomy tube medication be given according to policy and procedure. Record review of the facility's policy titled, Enteral Tube Medication Administration, dated 3/2025, indicated, . The facility assures the safe and effective administration of enteral formulas and medication. 8. Flush the tube with 30 ml of water.10. allow medication to flow down tube via gravity. 11. Flush the tube with 30 ml of water and clamp. Prevents medication from clogging tube .		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and record review, the facility failed to follow menus for 1 of 2 meals reviewed for menus in that: The facility failed to follow the menu on 07/15/26 at the lunch meal service the pureed diets contained no rolls. This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss. The findings were:Record review of the menu dated 07/15/2026 indicated chicken, mashed potatoes, gravy, vegetables, honey kissed roll and pudding for lunch meal.Record review of the recipe for honey kissed rolls pureed dated 07/15/2026 indicated the pureed diet should have a pureed roll with chicken base. desired thickness should be mashed potatoes or pudding texture.During an observation on 07/15/26 at 11:40 a.m., [NAME] L pureed items for lunch which included meat, potatoes, vegetables and pudding for the pureed diet. [NAME] L did not pureed rolls or bread for the pureed diets.During an interview on 07/15/2026 at 11:50 a.m., [NAME] L said he was unable to make pureed rolls to the right consistency for pureed diets. He said it was too thin or too thick. He said he had been the cook, and he was unable to provide bread for the pureed diet. During an interview on 07/15/2026 at 2:25 p.m., the DM said she was new and was unaware [NAME] L was unable to process bread or rolls to the right consistency. She said she was unaware the pureed diet did not have the rolls today. DM said the pureed diet should include all items on the menu to prevent weight loss.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review the facility failed to serve each resident food prepared in a form to meet individual needs for one of one meal (lunch meal 07/14/2026) reviewed for pureed food preparation. The facility failed to ensure [NAME] L prepared puree meat to pudding consistency with no pieces. These failures could result in choking hazards, decreased nutrient intake and weight loss. Findings included: During an observation on 07/14/2026 at 11:45 a.m., [NAME] L pureed chicken, green beans and made mashed potatoes for pureed diets. During an observation and tasting of the pureed tray on 07/14/2026 at 1:30 p.m., the test pureed lunch meal had 2 solid pieces chicken was 1/4 by 1/4 inch of meat and there was a part of whole green bean approximately 1/2 inch in the pureed meat and the DM said her bite was smooth. The DM said the pureed food should be smooth and pudding consistency to prevent choking. She said the cook was responsible for ensuring no solid pieces were in the pureed food. Record review of the Diet Type Roster dated 07/13/2026 indicated 9 residents had pureed as their diet orders. Record review of the recipe for fried chicken for pureed diet dated 07/14/2026 indicated .Desired texture should be mashed potatoes, pudding, or applesauce texture. There should be no large lumps or particles.		

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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 review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #43 and #54) of 18 residents, reviewed for infection control. *RN G failed to don PPE prior to performing the high contact resident care activity on Resident #54 who was on enhanced barrier precaution. *The Wound Care Nurse failed to follow infection control procedures by dropping a gown on the floor then picking it up and wearing intending to perform direct patient care for Resident #43 on contact isolation. These failures placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Record review of Resident #43's face sheet dated 07/13/2026 indicated she was a [AGE] year-old female admitted [DATE] and readmitted [DATE] with diagnoses of diabetes mellitus (chronic metabolic disease characterized by persistently high blood sugar) with foot ulcer (open sore on the foot). Record review of Resident #43's quarterly MDS Assessment, dated 05/26/2026, indicated a BIMS score of 8 indicated moderately impaired cognition. The resident had diagnoses which included diabetes mellitus and ulcer to left foot. The assessment included other ulcers, wounds and skin problems of diabetic foot ulcer and application of dressing to feet. Record review of Resident #43's Comprehensive Care Plan, with a target date of 08/08/2026 indicated she had infection to left heel wound with interventions that included Contact isolation. Record review of Resident #43's physician order dated 07/13/2026 indicated Contact Isolation for wound with a start date of 06/29/2026. During an observation on 07/15/2026 at 12:02 p.m., Resident #43's room had a Contact Isolation sign on the door and a cabinet with PPE beside the door. The Wound Care Nurse prepared supplies on a cleaned rolling table outside Resident #43's room, and she performed hand hygiene. The Wound Care Nurse grabbed a gown out of a PPE drawer that was not sealed in a plastic wrap, dropped it on floor, picked up the gown off the floor and put it on. She then assisted CNA J to put his gown on. She grabbed her rolling table loaded with supplies and pushed it to the doorway of Resident #43's room. After Surveyor intervention she stopped and removed the gown, washed her hands and applied a new gown. She said she was responsible for wound care in the facility and was educated in infection control practices. The Wound Care Nurse said she should not have put on the gown that fell on the floor. She said she got nervous and was not thinking. The Wound Care Nurse said the resident risk of using a gown that fell on the floor during direct patient care was potentially carrying bacteria to the resident. 2. Record review of Resident #54's face sheet dated 07/14/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included cerebral infarction (stroke), gastronomy status (surgically placed soft flexible tube inserted through the abdomen into the stomach) and dysphagia (difficulty swallowing). Record review of Resident #54's Quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 2, indicated severely impaired cognition with diagnoses of cerebral infarct. Resident #54's MDS assessment indicated a feeding tube. Record review of Resident #54's Order Summary Report dated 07/15/2026 indicated enteral feeding order flush tube with 30 ml water before and after medication and feeding with a start dated 10/16/2025 and three times a day flush gastronomy tube with 300 ml of water with a start date of 04/08/2026 and enhanced barrier precautions. Record review of Resident #54's care plan with a target date of 07/30/2026 indicated he received enhanced barrier precautions with indications that included gloves and gown should be donned if the following activities occur enteral (gastrostomy) feeding care or (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other high-contact activity. During an observation and interview on 07/14/2026 at 9:11 a.m., the door to Resident #54's room had an Enhanced Barrier Precaution (EBP) sign on the door and a cabinet with PPE beside the door. Resident #54 was sitting up in his wheelchair. He said the staff gave him his medication in the tube in his stomach. During an interview and observation on 07/14/2026 at 9:15 a.m. RN G prepared Resident #54's gastrostomy tube medication. She performed hand hygiene with hand sanitizer and entered the resident's room. RN G gave Resident #54's gastrostomy tube medication without wearing proper PPE (gown). She said she was responsible for giving medication to Resident # 54 today. RN G said she should have worn a gown when she gave the medication. She said she was educated to wear a gown with direct patient care for Residents on EBP. RN G said she forgot to put on her gown. She said the Resident risk of not wearing a gown for a resident on EBP was a potential for infection. During an interview on 07/14/2026 at 4:35 a.m., the ADON said she was responsible for infection control training and in-services. She said all nurses were educated on infection control procedures and EBP. She said she went over EBP with RN G prior to working the floor. She said the resident risk of not wearing a gown for a resident on EBP was a potential for infection. She said RN G should have worn a gown for direct patient care for a resident on EBP. During an interview on 07/14/2026 at 4:45 p.m., the DON said RN G should have worn a gown to give gastrostomy medication. She said RN G may have gotten nervous and forgot to put on a gown, but she was educated on EBP and aware to wear a gown. The DON said RN G was being onboarded by LVN H. She said the resident risk of not wearing a gown for a resident on EBP was potential infection. The DON said the Wound Care Nurse was responsible for wound care in the facility, and the weekend RNs were the back up. She said the Wound Care Nurse was educated on infection control policies and should not have used a gown that touched the floor. The DON said the Wound Care Nurse was not thinking clearly when she used a gown that touched the floor. She said the resident risk of using a gown that fell on the floor for direct patient care was the potential to spreading infection. The DON said her expectation was all staff follow the infection control policy. During an interview on 07/15/2026 at 1:25 p.m. the Administrator said the charge nurses were responsible for giving gastrostomy tube medication properly. She said she was unsure of RN G's background, and she may not be used to working in long term care. She said RN G had a nursing license and was educated on gastrostomy tube medication procedures and EBP and was being onboarded by another nurse. The Administrator said the resident risk of not wearing a gown for an EBP resident was potential infection or cross contamination. She said her expectation was everyone abide by EBP and know the policy and procedure. The Administrator said the Wound Care Nurse was responsible for wound care in the facility and was educated on infection control policies. She said the ADON was the infection preventionist that educated all staff on infection control procedures. The Administrator said the Wound Care Nurse may have been nervous and not thinking clearly when she used a gown that fell on the floor. She said the resident risk of wearing a gown that fell on the floor was potential cross contamination. The Administrator said her expectation was all staff follow infection control procedures. She said anything that fell on the floor should be disposed of in the trash. Record review of the facility's policy titled Enhanced Barrier Precautions dated 04/01/2024, indicated: .(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. Resident Activity/ Assistance . device care or use: . central line, urinary catheter, feeding tube . [NAME] gloves and gown . yes . Resident Activity/ Assistance . any other high -contact activity that includes close bodily contact or coming into contact with the indwelling medical device . don gloves and gown . yes . Record review of an undated facility's policy titled, Fundamentals of Infection Control Precautions indicated, . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. 1. Gowns and protective apparel are worn to provide barrier protection to reduce the opportunity for transmission of microorganisms in the LTCF. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures. 2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity from transmission of pathogens from residents or items in their environment to other residents or environment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Vidor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 470 Moore Drive 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement an antibiotic stewardship program that included antibiotic use protocols. * The facility did not include the antibiotic time out protocol in their Antibiotic Stewardship policy in the Infection Control Tracking and Trending review. This failure could place residents with infections at risk for unnecessary antibiotic use and increased infections that are resistant to antibiotics. Findings included: Record review of an undated Antimicrobial Stewardship Policy indicated Facility Antimicrobial Stewardship Mission StatementOur facility embraces the importance of an infection prevention and control program that includes an antimicrobial stewardship program, providing antibiotic use protocols and monitoring to prevent antibiotic resistance. We are committed to the prudent use of antimicrobials on behalf of all residents we are privileged to serve through a sustainable antimicrobial stewardship program. There was no indication in the policy of a protocol addressing the 72-hour Antibiotic Time Out. Record review of the Infection Control Tracking and Trending Book for 2026 indicated the IP was not conducting a 72-hour Antibiotic Time Out on residents with antibiotics ordered for infections. Reviews were only done on residents who had specimen collected for a C&S. During an interview on 07/14/26 at 10:58 a.m. the IP said she did not realize she needed to conduct a 72-hour antibiotic time out on all residents on antibiotics for infections to ensure they were improving on the antibiotic they were prescribed. She said she did not remember seeing the protocol in the policy. She said she would review the residents if there was a C&S specimen obtained. During an interview on 07/15/26 at 04:46 p.m. the Administrator said she expected staff to follow protocol/policy for what they have been assigned. She said not following protocol/policy regarding antibiotics could cause resident infections not to be addressed appropriately. Record review of the CDC's Core Elements of Antibiotic Stewardship for Nursing Homes accessed on 07/14/26 at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-b-508.p Take Action through Policy and Practice Change to Improve Antibiotic Use: Broad interventions to improve antibiotic use: Standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 2 dining rooms and for Resident #4 and Resident #80 observed for reviewed for physical environment. The facility failed to ensure the main dining room was free of water leaks and free of a water-stained ceiling. This failure could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. Findings included:Record review of Resident #4's admission record indicated she was admitted on [DATE] and was [AGE] years old with diagnoses included blood in her urine and chronic kidney failure. Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated her BIMS was 12 which indicated she had moderate cognitive impairment. Record review of Resident #80's admission record dated 07/14/2026 indicated she was admitted on [DATE] and was [AGE] years old with diagnoses included stroke and heart disease. Record review of Resident #80's quarterly MDS assessment dated [DATE] indicated her BIMS was 13 which indicated she was cognitively intact. During an observation on 07/13/2026 at 11:00 a.m., revealed the main dining room's ceiling had 6 areas of discolored (tan) sheet rock. One of the discolored areas was oblong and was approximately 3 feet long and approximately 1 and 1/2 feet wide. The 5 others were round and approximately one foot to 6 inches. The areas were in the center of the dining room. During an observation on 07/14/2026 at 12:30 p.m., revealed the middle of the main dining room was blocked off with wet floor signs, a mop bucket and a blanket on the floor between 2 rows of tables. During an interview on 07/14/2026 at 12:40 p.m., Resident #4 and Resident #80 were sitting and were visiting. Resident #80 said she had to move to another table during lunch because of the roof leaking. They both said the ceiling had been leaking for a few months. During an interview on 07/15/2026 at 8:45 a.m., the Administrator said she wanted the dining room to be free of leaks and discolored ceiling. She said the facility had been trying to get it fixed. She said last April 2026 the facility had new air-conditioning installed. She said the facility had spent a lot of money on the new air-conditioning and the company had worked on duct work trying to get the leaks fixed. She every time they have new leaks when it rains rain. During an interview on 07/15/2026 at 9:30 a.m., the Maintenance Supervisor said the company was coming out Saturday (07/18/2025) to give an estimate to fix the leak. During an interview on 07/15/2026 at 2:00 p.m., the Housekeeping Supervisor said the housekeepers mopped the dining room several times a day if it rained. She said the ceiling leaked and the ceiling being discolored started 3 to 4 months ago. She said the company that had replaced the air-conditioning unit had come out and would patch around the duct work a couple of times, but when the rain started a new area would leak. She said when the leaking started, we had to shut the dining room down because the sheet rock ceiling was sagging so badly. She said the dining room only leaks in the middle of the room. Record review of the undated Resident Rights policy . Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must be provided- 1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.		