STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455621	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Grande Manor	1212 S Bridge Weslaco, TX 78596

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 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** 41761 Based on interview, and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 5 residents (Resident #4) reviewed for resident rights, in that: The facility failed to ensure consent forms were properly completed or signed by a responsible party prior to administration of an antipsychotic medication (Nuplazid) for Resident #4. This failure could place residents who received psychoactive medications without informed consents and placed additional 27 residents who received psychoactive medications at risk of receiving treatments without informed consent. Findings include: Record review of Resident #4's Admission Record dated 04/25/24, revealed a [AGE] year old female, admitted to facility on 01/11/24. Her diagnoses included: Dementia (a general term for a group of diseases that cause a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life) with other behavioral disturbance, Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), heart disease, type 2 diabetes mellitus, chronic kidney disease, macular degeneration, bilateral (an eye disease that slowly destroys sharp central vision). Record review of Resident #4's admission MDS dated [DATE] revealed a BIMS score of 00, indicating severe impaired cognition. Record review of Resident #4's Care Plan dated 04/12/24, revealed: FOCUS: The resident uses psychotropic medications (NUPLAZID) r/t Behavior management Date Initiated: 04/22/2024 GOALS: o The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Date Initiated: 04/22/2024 (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS/TASKS: o Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Date Initiated: 04/22/2024 LPN RN o Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. Date Initiated: 04/22/2024 LPN RN o Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, CNA LPN RN. (EPS - Extrapyramidal Symptoms - common adverse effect of dopamine-receptor blocking agents, also known as drug induced movement disorder) Record review of Resident #4's Order Summary dated 04/25/24 revealed, Resident #4 had the following orders: Start Date: 04/19/24 11:55 am ordered by NP H for MD I Nuplazid Oral Capsule 34 MG (Pimavanserin Tartrate) Give 1 capsule by mouth one time a day for Parkinson's associated delusions. Medication Class: Antipsychotic/Antimanic Agents Black Box Warning: Warning: Increased mortality in elderly patients with dementia-related psychosis Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Pimavanserin is not approved for the treatment of patients with dementia who experience psychosis unless their hallucinations and delusions are related to Parkinson disease. Record review on 04/25/24 revealed no consent for antipsychotic Nuplazid. Record review on 04/25/24 of April 2024 MAR revealed Resident #4 had received Nuplazid Oral Capsule 34mg once a day on 04/20/24 through 04/25/24 with no consent signed by RP. Record review of Resident #4's progress note written on 04/25/24 01:20 pm Health Status Note written by LVN J: Note Text: Followed up with RP regarding need to sign consent for new medication Nuplazid. RP stated he had not had time but offered to have it signed today 04/25/24 by end of day. Medication was again verbally reviewed with the RP and questions answered regarding potential side effects. In an observation on 04/26/24 at 07:10 pm Resident #4 sitting in wheelchair trying to move down the hallway. Resident smacking lips. In an interview on 04/30/24 at 01:58 pm LVN J stated Resident #4's left eye has had discharge since she started working here about a year ago. LVN J said has even Resident #4 had eye antibiotics and still had a discharge. LVN J stated Resident #4 had always smacked her lips since she started working here. LVN J said Resident #4 was served pureed food and had been seen by speech therapy for evaluation. LVN J stated she did not know if it were a habit or not. LVN J stated the provider was aware and following on it. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/30/24 at 06:00 pm, the DON stated things (signing of consent forms) does not happen immediately. She stated there was a time period from when the doctor writes the order for an antipsychotic and when the RP signed the consent. The DON stated they put a note in the computer on 04/25/24 showing they had spoken to the RP, and he was going to try to come in to sign the consent for Resident #4 but he had not made it in yet. Review of facility's policy Antipsychotic Medication Use 2001 MED-PASS, Inc. (Revised July 2022) revealed: Policy Statement Residents will not receive medications that are not are not clinically indicated to treat a specific condition. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Policy Interpretatin and Implementation 1.Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2.The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 4.The attending physician and facility staff will identify acute psychiatric episodes, and will differentiate them from enduring psychiatric conditions. 6.Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. 7.Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizoaffective disorder; Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g., bipolar disorder, depression with psychotic features, and treatment refractory major depression); f. Psychosis in the absence of dementia; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. 8.Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; AND: (1)the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2)Behavioral interventions have been attempted and included in the plan of care, except in and emergency (see below). 12.Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; or k. Uncooperativeness. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13.Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind. Review of facility's Resident Rights policy 2001 MED-PASS, Inc. (Revised December 2016) revealed: Policy Interpretation and Implementation 1.Federal and state law as guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: o. be notified of his or her medical condition and of any changes in his or her condition; p. be informed of, and participate in, his or her care planning and treatment;

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920 Based on observation, record review and interview the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for one resident (Resident #3) of five residents reviewed for abuse, neglect, and exploitation. The facility failed to conduct an investigation of Resident # 3's transfer by a mechanical life when the straps tore, and Resident #3 was placed at potential of injury. This deficient practice could place residents at risk for abuse, neglect, and not having their needs met. The findings included: Record review of Resident #3's Admission Record dated 04/25 /2024 revealed she was a [AGE] year-old female originally admitted to the facility 03/19/20 with a most recent admitted [DATE]. Resident #3's diagnosis included benign neoplasm of the brain (non-cancerous tumor), diabetes, hyperaldosteronism (endocrine disorder that causes high blood pressure), morbid obesity (body mass index of 40 or higher), major depressive disorder, anxiety disorder, drug induced polyneuropathy (damage or disease affecting peripheral nerves), and lymphedema (condition of localized swelling.) Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected. -BMIS score was 15 (independent-decisions consistent/reasonable) -had impairment on both sides of the lower extremity (hip, knee, ankle, foot) -required maximal assistance for toileting hygiene, shower, upper and lower body dressing, putting on and off footwear. -dependent on assistance for all transfers by two persons. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 10:09 am with Resident #3 revealed on 04/17/24 CNA C and CNA D provided her with a transfer from her bed to the shower chair using a Hoyer lift. Resident #3 said CNA C and CNA D placed the sling under her body and then attached the sling to the Hoyer lift (assistive device for transfers) on the four corners using the first of four loops on the straps. She said the shower chair was close to her bed and CNA D was managing the Hoyer lift remote to lift her and CNA C was away from her, close to the shower chair. Resident #3 said as CNA D began to lift her off her bed about a foot and away from her bed about half a foot where her body was still over the bed, the four loops on each of the three straps tore and she was left dangling above her bed and partially away sideways from her bed. CNA D using her own body weight pushed Resident #3 directly above her bed and then using the remote on the Hoyer lift she lowered Resident #3 into her bed as the fourth strap tore the four loops. Resident #3 said she was very frightened that she could have fallen onto the floor or on top of CNA D. Resident #3 said she asked both CNAs if they were going to report the incident and both CNAs replied they were not going to report the incident. Resident #3 was asked by both CNAs if she still wanted to go to shower room using another sling for the Hoyer lift and Resident #3 replied she did not because she was frightened. Resident #3 said she received a bed bath that day. Resident #3 said the day Activity Director came and told her they were going to get someone to check all slings used on the Hoyer lift for wear and tear and were going to date them when they were checked. Record review of the facility incident report files revealed no evidence of an investigation of an incident on 04/17/24 involving Resident #3. Observation on 04/25/24 at 10:30 am revealed a sling that appeared new, with Resident #3's name on bathroom. The sling indicated it was good for a maximum of 600 pounds. Interview on 04/25/24 at 11:15 am with the Administrator revealed the incident had been reported to the charge nurse and to the DON. The incident was not further investigated or reported as neglect because the incident occurred rapidly and no injuries had occurred, and it was witnessed by the staff. Interview on 04/25/24 at 1:17 pm with ADON E revealed CNA C and CNA D informed her that on 04/17/24 they had attempted to transfer Resident #3 from her bed to shower chair and that a loop on one strap of the hoyer sling tore and they moved her back over the bed and one more loop on another strap tore as she was placed on her bed. ADON E said Resident #3 was assessed and no injuries were noted. The incident was reported to the DON first by the CNAs. Interview on 04/25/24 at 2:04 pm with CNA D revealed on the day of the incident with Resident #3 she and CNA C were preparing to take Resident #3 to her shower using a Hoyer lift. Resident #3 told them to check the Hoyer lift sling to make sure the sling was not torn. CNA D said they both checked the sling for Resident #3 in front of her and then placed the sling under resident's body while she laid in bed. CNA D said as they lifted Resident #3 with the Hoyer lift, two loops on one strap tore and Resident #3 was immediately placed back on her bed. CNA D said there was no injury to the resident. CNA D said the incident was reported to LVN F. Interview on 04/25/24 at 2:15 pm with Central Supply G revealed she would order the slings for the Hoyer lift and was not involved in assessing the slings. The slings used for each resident was based on the maximum weight needed. Central Supply G said she did not remember the sling that was returned for a new one for Resident #3. The torn sling was thrown away. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 2:25 pm with the DON revealed she was informed of the incident with Resident #3's sling loops being torn when she was transferred. The DON said she did not know why that had occurred. The correct sling for 600-pound maximum weight was used. Resident #3 did talk to her and told her two loops for two straps had torn. Resident #3 did not tell her all three straps had torn. Resident #3 was more concerned she was not going to get showered. The DON said she interviewed CNA D that day and CNA D told her only loops had torn from two different straps and only one complete strap tore. The DON said she reported the incident to the Administrator and an in-service was provided to direct care staff to check the slings before placing on Hoyer lift. Interview on 04/25/24 at 3:31 pm with the Activity Director revealed she was not aware of the incident with Hoyer lift for Resident #3. Interview and observation on 04/25/24 at 4:07 pm with Resident #3 and the DON revealed Resident #3 demonstrated how she thought the loops and straps had torn. Observation of sling revealed four straps on each corner of the sling. Each strap had four loops, different colored loops. Resident #3 said she was lifted halfway up off her bed and all four loops on two straps tore. CNA C and CNA D guided her completely back to her bed and when she was over her bed, the third strap tore all four loops. The DON said she was not sure what ADON E and the Administrator understood of the extent of the torn loops or straps. The DON said she was sure the torn sling had been thrown away. Interview on 04/26/24 at 9:41 am with CNA C revealed on the day of the incident, the sling had been checked before placing it on Resident #3. CNA C said two loops tore on one strap and then when the resident was placed on the bed another loop tore from another strap. The straps with torn loops were holding Resident #3 from the shoulders. At no time did the straps tear from the lift. CNA C said they immediately pushed Resident #3 back into bed with no injury. Observation on 04/26/24 at 3:02 pm revealed CNA F and CNA G transferred Resident #3 from her bed to her wheelchair using the Hoyer lift. The CNAs inspected the sling for wear and tear, placed the sling under the resident and lifted Resident #3 into her wheelchair. Resident #3 appeared calm and in no concern. Interview on 04/26/24 at 5:22 pm with the DON revealed failure to investigate a possible incident of neglect placed a potential risk of a similar incident to occur with other slings used for Hoyer lift. Record review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated April 2022, reflected; Investigating Allegations, all investigations are thoroughly investigated. The administrator initiates investigations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761 Based on interview and record review, the facility failed to ensure that all alleged violations involving neglect, were reported immediately to the State Survey Agency, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 of 6 residents (Resident #4) reviewed for abuse/neglect. The facility failed to report Resident #4 had an unwitnessed fall on 09/03/23. Resident #4 sustained a laceration to right eyebrow and acute fifth metacarpal neck fracture (little finger fracture). The facility failed to report Resident #4 was observed on 09/28/23 with redness to right forehead and right eyelid with no mention of how the redness occurred. The facility failed to report Intake #477220 to State Survey Agency within 24 hours for Resident #4's injury of unknown origin. Incident occured on 01/10/2024 at 7:30 p.m. Facility emailed report on 01/16/2024. This failure could place all residents at increased risk for potential abuse to unreported allegations of abuse and neglect. The findings included: Record review of Resident #4's Admission Record dated 04/25/24, revealed a [AGE] year-old female, admitted to facility on 01/11/24. Her diagnoses included: Dementia (a general term for a group of diseases that cause a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life) with other behavioral disturbance, Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), heart disease, type 2 diabetes mellitus, chronic kidney disease, macular degeneration, bilateral (an eye disease that slowly destroys sharp central vision). Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS score of 00, indicating severe impaired cognition. Resident #4 was a total dependent for transfer, toileting, and shower. Record review of Resident #4's Care Plan dated 04/12/24, revealed: FOCUS: o (Resident #4) is at risk for falls r/t impaired mobility and incontinence. Date Initiated: 07/29/2020 GOALS: o Will have minimal to no falls through next review date. Date Initiated: 07/29/2020 Target Date: 04/30/2024 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS/TASKS: o Anticipate and meet The resident's needs. Date Initiated: 07/29/2020 CNA LPN RN o Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 07/29/2020 CNA LPN RN to Ensure proper footwear is worn at all times while out of bed. Date Initiated: 07/29/2020 Revision on: 07/29/2020 ACTA CNA o Follow facility protocol in the event of a fall. Date Initiated: 07/29/2020 Revision on: 07/29/2020 RN o Resident attempts to get out of bed on a regular basis. Bed in lowest position. Resident attempts to get out of bed and moves herself onto floor. Date Initiated: 01/15/2024 ADON. Record review of Resident #4's progress note written on 09/03/23 at 01:22 am Incident Note written by LVN L reflected; Note Text: Patient [Resident #4] found in floor by CNA. Patient [Resident #4] had a fall was on right side of body, right arm under. Patient noted with right eyebrow laceration about 3cm x 0.2cm and right-hand swelling. Incident reported to NP K/MD I knew orders for wound care cleanse with wound cleanser, pat dry apply Steris trips and TAO QD and prn, Tylenol 325mg 2 tabs (650mg) PO Q6H x 2 days. Xray of right hand. RP called no answer, left voicemail. Wound care performed, patient tolerated well with minimal pain, Tylenol administered. Patient continues awake agitated wanting to leave. Reported to [NP K] with no new orders. Neuro checks initiated, Will continue to monitor. Record review of Resident #4's progress notes written on 09/03/23 at 03:22 pm Health Status Note written by LVN J reflected Note Text: Xray results received and reviewed by [NP K]. New orders received to place Ice Pack Q Shift X 3 days, Immobilize/ Splint 5th digit to right hand, and Referral for Consult to Hand Specialist. Record review of Resident #4's progress notes written on 09/27/23 at 11:07 pm Incident Note written by RN M reflected: Note Text: Informed [NP K] at 2252 (10:22 pm). Pending call back. neuro v/s initiated. Resident is calm and asleep at this time. Bed kept at lowest position. call light within reach. Record review of Resident #4's progress notes written on 09/28/23 at 11:02 pm Incident Note written by RN M reflected, Note Text: Redness to right forehead and right eyelid are fading away. No untoward signs and symptoms noted. No evidence of pain noted. Bed kept at lowest position. Call light within reach. Record review of facility self-report for Resident #4 report #477220 dated 01/16/24 reflected, the Administrator wrote on the incident submission, Hello, I sent this the wrong address. This should have been submitted on 1/10/2024. Report #477220 brief summary reflected; Nurse Aide noticed discoloration on resident's head along hairline. Aide took resident to Nurse to access. Nurse Practitioner was called, she recommended a CT scan. Resident was sent out to local hospital for CT scan. Record review of Resident #4's 01/10/24 at 01:00 pm Health Status Note written by LVN N reflected, Note Text: Received call from MD at ER O (emergency room) to report resident had CT of Head done. CT clear. Resident will be admitted with Dx: bradycardia. Called RP to inform. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's progress notes written on 01/11/2024 at 07:50 a.m., Incident Note written by LVN N reflected, Resident brought to nurse's station by CNA show large area of purple and red discoloration to rt eye extending from hairline to temple to zygomatic bone (help give structure to the face and are connected to the jaw and bones near the ears, forehead, and skull). Area noted with moderate swelling, measuring approx 9x9 cm. Received order to transfer to local hospital for possible CT due to discoloration and swelling to right side of face. 911 activated. Record review of Resident #4's progress notes dated 01/11/2024 at 4:40 p.m. Incident Noted written by LVN Q reflected resident readmitted from [NAME] medical center via Ems stretcher. v/s within normal limits. assessments performed. MD reviewed medication list, resident to continue on medications. resident presents with right orbital ecchymosis and edema. redness to the left wrist, discoloration to right side of forehead and right antecubital. In an interview on 04/30/24 at 04:11 pm the DON stated allegation of abuse or neglect, injuries of unknown origin, certain resident-to resident altercations, misappropriation of property, and elopement were reportable. The DON stated the Administrator always took the lead and reported to State. The DON stated she was notified of all falls (witnessed and unwitnessed). The DON stated she would go over all falls or incidences with the administrator and he would decide whether it was reportable or not. In an interview on 04/30/24 at 04:25 pm the Administrator stated abuse, neglect, injury of unknown origin, and those types of things were reported. The Administrator was notified by surveyor of unreported incidences. The Administrator stated he would look into them. Review of facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating 2001 MED-PASS, Inc. (Revised April 2022) revealed: Record review of TULIP (a state database where intakes are tracked) on 04/29/2024 reflected no records of Resident #4's incidents for 09/03/2023 and 09/28/2023. Resident #4's Intake #477220 reflected a report date of 01/16/2024. Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 3. Immediately is defined as: a. within two hours of an allegation involving abuses or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455621	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Grande Manor	1212 S Bridge Weslaco, TX 78596

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920 Based on observation, record reviews and interviews, the facility failed to thoroughly investigate allegations of abuse and neglect for 1 of 5 residents (Resident #3) reviewed. The facility did not have evidence a thorough investigation was completed for Resident #3 who had an incident during a transfer with the use of a mechanical lift. This failure could place residents at risk of incidents not being thoroughly investigated. The findings included: Record review of Resident #3's Admission Record dated 04/25 /2024 revealed she was a [AGE] year-old female originally admitted to the facility 03/19/20 with a most recent admitted [DATE]. Resident #3's diagnosis included benign neoplasm of the brain (non-cancerous tumor), diabetes, hyperaldosteronism (endocrine disorder that causes high blood pressure), morbid obesity (body mass index of 40 or higher), major depressive disorder, anxiety disorder, drug induced polyneuropathy (damage or disease affecting peripheral nerves), and lymphedema (condition of localized swelling.) Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected. -BMIS score was 15 (independent-decisions consistent/reasonable) -had impairment on both sides of the lower extremity (hip, knee, ankle, foot) -required maximal assistance for toileting hygiene, shower, upper and lower body dressing, putting on and off footwear. -dependent on assistance for all transfers by two persons. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 10:09 am with Resident #3 revealed on 04/17/24 CNA C and CNA D provided her with a transfer from her bed to the shower chair using a Hoyer lift. Resident #3 said CNA C and CNA D placed the sling under her body and then attached the sling to the Hoyer lift (asssitive device for transfers) on the four corners using the first of four loops on the straps. She said the shower chair was close to her bed and CNA D was managing the Hoyer lift remote to lift her and CNA C was away from her, close to the shower chair. Resident #3 said as CNA D began to lift her off her bed about a foot and away from her bed about half a foot where her body was still over the bed, the four loops on each of the three straps tore and she was left dangling above her bed and partially away sideways from her bed. CNA D using her own body weight pushed Resident #3 directly above her bed and then using the remote on the Hoyer lift she lowered Resident #3 into her bed as the fourth strap tore the four loops. Resident #3 said she was very frightened that she could have fallen onto the floor or on top of CNA D. Resident #3 said she asked both CNAs if they were going to report the incident and both CNAs replied they were not going to report the incident. Resident #3 was asked by both CNAs if she still wanted to go to shower room using another sling for the Hoyer lift and Resident #3 replied she did not because she was frightened. Resident #3 said she received a bed bath that day. Resident #3 said the day Activity Director came and told her they were going to get someone to check all slings used on the Hoyer lift for wear and tear and were going to date them when they were checked. Record review of the facility incident report files revealed no evidence of an investigation of an incident on 04/17/24 involving Resident #3. Observation on 04/25/24 at 10:30 am revealed a sling that appeared new, with Resident #3's name on bathroom. The sling indicated it was good for a maximum of 600 pounds. Interview on 04/25/24 at 11:15 am with the Administrator revealed the incident had been reported to the charge nurse and to the DON. The incident was not further investigated or reported as neglect because the incident occurred rapidly and no injuries had occurred, and it was witnessed by the staff. Interview on 04/25/24 at 1:17 pm with ADON E revealed CNA C and CNA D informed her that on 04/17/24 they had attempted to transfer Resident #3 from her bed to shower chair and that a loop on one strap of the hoyer sling tore and they moved her back over the bed and one more loop on another strap tore as she was placed on her bed. ADON E said Resident #3 was assessed and no injuries were noted. The incident was reported to the DON first by the CNAs. Interview on 04/25/24 at 2:04 pm with CNA D revealed on the day of the incident with Resident #3 she and CNA C were preparing to take Resident #3 to her shower using a Hoyer lift. Resident #3 told them to check the Hoyer lift sling to make sure the sling was not torn. CNA D said they both checked the sling for Resident #3 in front of her and then placed the sling under resident's body while she laid in bed. CNA D said as they lifted Resident #3 with the Hoyer lift, two loops on one strap tore and Resident #3 was immediately placed back on her bed. CNA D said there was no injury to the resident. CNA D said the incident was reported to LVN F. Interview on 04/25/24 at 2:15 pm with Central Supply G revealed she would order the slings for the Hoyer lift and was not involved in assessing the slings. The slings used for each resident was based on the maximum weight needed. Central Supply G said she did not remember the sling that was returned for a new one for Resident #3. The torn sling was thrown away. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 2:25 pm with the DON revealed she was informed of the incident with Resident #3's sling loops being torn when she was transferred. The DON said she did not know why that had occurred. The correct sling for 600-pound maximum weight was used. Resident #3 did talk to her and told her two loops for two straps had torn. Resident #3 did not tell her all three straps had torn. Resident #3 was more concerned she was not going to get showered. The DON said she interviewed CNA D that day and CNA D told her only loops had torn from two different straps and only one complete strap tore. The DON said she reported the incident to the Administrator and an in-service was provided to direct care staff to check the slings before placing on Hoyer lift. Interview on 04/25/24 at 3:31 pm with the Activity Director revealed she was not aware of the incident with Hoyer lift for Resident #3. Interview and observation on 04/25/24 at 4:07 pm with Resident #3 and the DON revealed Resident #3 demonstrated how she thought the loops and straps had torn. Observation of sling revealed four straps on each corner of the sling. Each strap had four loops, different colored loops. Resident #3 said she was lifted halfway up off her bed and all four loops on two straps tore. CNA C and CNA D guided her completely back to her bed and when she was over her bed, the third strap tore all four loops. The DON said she was not sure what ADON E and the Administrator understood of the extent of the torn loops or straps. The DON said she was sure the torn sling had been thrown away. Interview on 04/26/24 at 9:41 am with CNA C revealed on the day of the incident, the sling had been checked before placing it on Resident #3. CNA C said two loops tore on one strap and then when the resident was placed on the bed another loop tore from another strap. The straps with torn loops were holding Resident #3 from the shoulders. At no time did the straps tear from the lift. CNA C said they immediately pushed Resident #3 back into bed with no injury. Observation on 04/26/24 at 3:02 pm revealed CNA F and CNA G transferred Resident #3 from her bed to her wheelchair using the Hoyer lift. The CNAs inspected the sling for wear and tear, placed the sling under the resident and lifted Resident #3 into her wheelchair. Resident #3 appeared calm and in no concern. Interview on 04/26/24 at 5:22 pm with the DON revealed failure to investigate a possible incident of neglect placed a potential risk of a similar incident to occur with other slings used for Hoyer lift. Record review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated April 2022, reflected; Investigating Allegations, all investigations are thoroughly investigated. The administrator initiates investigations. 47828

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 2 residents (Resident #1) reviewed for accidents and supervision, in that: 1. The facility failed to ensure Resident #1 received supervision to prevent Resident #1 from eloping from the facility undetected on 04/29/2023. The non-compliance for Resident #1 was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 04/29/2023 and ended on 05/01/2023. The facility corrected the non-compliance before the investigation began. This failure could place the residents with exit seeking behaviors and repeated falls at risk for injury or death. The findings were: Record review of Resident #1's face sheet dated 04/24/2023 revealed the resident was a [AGE] year-old male with an admitted [DATE] and a discharge date of [DATE]. The resident's diagnoses included Alzheimer's disease, and dementia. Record review of Resident #1's entry MDS assessment dated [DATE] reflected only section A (identification information) was completed. Record review of Resident #1's initial assessment dated conducted by nursing staff on 04/29/2023 reflected he required limited assistance with bed mobility, and with transfer. For mobility, he required limited assistance with walk in room/self-performance. For mobility walk in corridor, activity did not occur. Record review of Resident #1's incident report dated 04/29/2023 completed by LVN A at 11:40 p.m. reflected: Incident Description: New admission unknown type of behavior. [Resident #1] was seen walking back and forth in B wing north, resident was calm and relax in no distress, no signs of exit seeking. Immediate action: Started checking each room, closet, restrooms, called ADON informed him of situation went outside the building and started searching for resident. All Managers alerted to report to facility. Area searched, 911 notified, police department arrived and provided canine support, family here. Patient found adjacent to facility in church property. Patient taken to hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital records dated 04/30/2023 reflected [AGE] year-old male with worsening dementia and mood disorder who comes here brought because he actually walked out of the skilled unit he was discharged too yesterday [04/29/2023]. Apparently he spent the night outside of the nursing home. The patient apparently found on the grass where he apparently slept all night. He appears to be definitely much more lethargic then yesterday when he left. He appeared to be shivering a lot and having some dry cough. He was unable to provide history. He was brought here for evaluation after being found. Hospital notes also revealed family refused to allow Resident #1 go back to facility. Hospital records were only from the emergency department, they did not reveal any treatment received or if resident was admitted . Record review of a police report dated 04/30/2023 reflected the police were dispatched to the facility at 1:01 a.m. in reference to a missing person. At approximately 11:00 p.m. to 11:20 p.m., a resident identified as Resident #1 had left the facility. Resident #1 was last seen wearing a black sweater and blue jeans and he suffered from Alzheimer's and dementia. On Sunday April 30, 2023, at 7:47 a.m., the police officer was searching the back parking lot of a local church located next to the facility. The report reflected when I noticed an elderly male subject trapped behind a chain link fence. I then made contact with the male subject and noticed that it was [Resident #1] who had been reported missing. I then had one of the officers cut the chain to the gate and we were able to get [Resident #1] out. An interview on 04/23/2024 at 9:45 a.m., the SW said Resident #1 had been admitted to the facility the evening of 04/29/2023 (Friday) from a local hospital. She said the only assessment done on that day was the initial screening by chare nurse. The SW said the facility did not know if Resident #1 had any exit seeking behaviors at the time he was admitted . She said she received a text at about 3:30 a.m. on 04/30/2023 from the facility's Administrator who requested for her to report to the facility to assist with the search for Resident #1. The SW said she did not see the text message until 04/30/2023 at 5:00 a.m. and at that time called the Administrator who told her she was not needed anymore. The SW said Resident #1 was found in the back yard of a church next to the facility on [DATE] (not sure of the time). An interview on 04/24/23 at 10:21 a.m., the Administrator said he was not able to comment on Resident #1's elopement because he was not employed at the facility at the time. He referred the surveyor to the facility's Regional Director of Operations who he said was more familiar with the incident. In an interview on 04/24/2024 at 10:15 a.m., the Regional Director of Operations said Resident #1 was admitted (did not give date) without a warning that he was an exit seeker. She said Resident #1 was found in the backyard of a church next to the facility the next day. She stated Resident #1 had spent the night outside. She said Resident #1 had not sustain any injuries but was taken to hospital to be evaluated. She said the facility investigated the incident and determined Resident #1 must have exited the building by a side exit door that led to the patio because it was the only door that did not have an alarm. She said that staff and resident used door to go out to the patio. She said what might have happened was one of the residents messed with the door and did not close it right allowing Resident #1 to exit the building. She said they removed the dead bolt and installed magnetic lock/keypad on 05/01/23. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation/interview on 04/24/2024 at 3:00 pm, the Maintenance Director said after Resident #1's elopement the side door lock was changed. He said the dead bolt was removed and replaced with a keypad, and a code alert was installed. He said if a resident with a wander guard would try to open the side door an alarm would go off and lock the door. The Maintenance Director took a wander guard and attempted to exit the facility's doors and an alarm was activated and doors locked. LVN A said Resident #1 was admitted on the evening (not sure what time) of 04/29/2023 and eloped before 11:00 p.m., on the same day. LVN A said CNA B advised him between 10:45 p.m. and 11:00 p.m. that while she was doing her rounds, she noticed Resident #1 was not in his room. He said he had immediately activated the facility's elopement code (code silver) and the search ensued. LVN A said he advised the CNA's to search every room in the facility while he and other male staff searched outside the building. LVN A said he also called his ADON to let him know Resident #1 was missing and the local police department to report Resident #1 as a missing person. He said he also notified Resident #1's RP. LVN A said at some point all department heads were also called to report to the facility to assist in the search for Resident #1. LVN A said the facility's staff, Resident #1's family, and police department search all night for him city wide. He said his shift ended at 6:00 a.m. and by that time Resident #1 had still not been found. LVN A said he was told by other staff members; Resident #1 was found in the backyard of a church next to the facility. LVN A said all staff were in-serviced on the topic of elopement the next day. An interview on 04/24/2024 at 3:54 pm, CNA B said when she clocked in at 10:00 pm on 04/29/2023, she was given the report by the outgoing CNA that Resident #1 did not walk and that his bed needed to be kept at the lowest position. CNA B said she started doing her rounds and when she got to his room (around 11:00 p.m.) she noticed Resident #1 was not there. CNA B said she started looking for him and also informed LVN A. She said another CNA (did not remember name) told her she had seen a man that she did not recognize walking towards the kitchen. CNA B said she headed towards the kitchen but did not see anybody. She said the facility's staff searched all night but were not able to locate Resident #1 until the next day. CNA B said all staff were in-serviced on their elopement procedures on 04/30/2023. CNA B said the in-service covered what to do when a resident went missing, who they need to notify, and the code used over the intercom to alert all staff a resident is missing. Record review of facility's Elopements policy revised on December 2007 reflected: Policy Statement: Staff shall investigate and report all cases of missing residents. Policy Interpretation: 1 Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. 4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.); d. Provide search teams with resident identification information; and e. Initiate an extensive search of the surrounds area. Record review of facility in-services revealed the following in-services were conducted with staff from all three shifts after the incident: Topic: 04/30/2023 Elopement-staff shall promptly report any resident who tried to leave premises or is suspected of leaving to the charge nurse. Topic: 04/30/2023 and 05/01/2023: all new admissions with diagnosis of dementia will need a wander guard for 72 hours. Topic: 04/30/2023 and 05/01/2023: Nurse's and CNA's are to do a walking round at start and at the end of their shifts. Record review of facility's purchase order dated 05/01/2023 reflected: The only door without an alarm was replaced with a magnetic lock with power supply, an all-weather keypad, and a 24V supply with back-up battery port. Record review of facility's elopement binder reflected all 11 residents who were at risk of wandering had a current face sheet and demographic information in binder. An observation on 04/25/2024 at 11:00 a.m., the surveyor accompanied the DON who verified all 11 residents who were at risk of wandering had their wander guard on. An observation on 04/25/2024 at 3:30 p.m., revealed the Maintenance Director tested all exit doors and ensured the alarm was activated if a resident with a wander guard tried to exit. An interview on 04/24/24 CNA T, B, C, U, V, and G said they had been in-serviced said they had been in serviced on the topics of facility policy and procedure related to identifying residents with exit seeking tendencies, redirecting, and the facility's code used for elopements. They said she was aware of the elopement binder kept in the nurse's station and knew all residents listed on the binder had a wander guard. An interview on 04/23/24 LVN W, X, Y, J, S and ADON E said they had been in-serviced said they had been in serviced on the topics of facility policy and procedure related to identifying residents with exit seeking tendencies, redirecting, and the facility's code used for elopements. They said she was aware of the elopement binder kept in the nurse's station and knew all residents listed on the binder had a wander guard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 04/25/24 DON said she had been in-serviced said she had been in serviced on the topics of facility policy and procedure related to identifying residents with exit seeking tendencies, redirecting, and the facility's code used for elopements. She said she was aware of the elopement binder kept in the nurse's station and knew all residents listed on the binder had a wander guard. Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 3. Immediately is defined as: a. within two hours of an allegation involving abuses or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Record review of Resident #4's 01/10/24 at 01:00 pm Health Status Note written by LVN N reflected, Note Text: Received call from MD at ER O (emergency room) to report resident had CT of Head done. CT clear. Resident will be admitted with Dx: bradycardia. Called RP to inform.