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	02/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interviews and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 4 residents (Resident #1 and Resident #3) reviewed for comprehensive care plans. 1. The facility did not include Resident #1's rash on her care plan. 2. The facility did not include Resident #3's rash on her care plan. This failure could place residents at risk for not receiving appropriate treatment and services. The findings included: 1. Record review of Resident #1's face sheet, dated 02/21/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (memory loss, cognitive decline, language problems, behavioral changes and difficulty with daily tasks), unspecified, Anxiety disorder, unspecified (intense, excessive, and persistent worry and fear about everyday situations), dysphagia (difficulty swallowing) and polyneuropathy, (a condition affecting multiple peripheral nerves, causing damage and dysfunction), unspecified. Record review of Resident #1's quarterly Minimum Data Set assessment, dated 12/09/24, revealed Resident #1 had a BIMS score of 00, indicating her cognition was severely impaired. Section M - skin conditions reflected Resident #1 was at risk for developing pressure ulcers/injuries, had 0 unhealed pressure ulcers/injuries, 0 venous and arterial ulcers present and had application of ointments/medications other than to feet. Record review of Resident #1's physician's orders revealed orders for weekly skin assessment, with a frequency of every day shift every Thu (Thursday) for skin integrity with a start date of 12/05/24 and end date of indefinite. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 12/31/24 stated, Skin: generalized scattered rash. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 01/03/24 stated, Skin: generalized scattered rash. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 01/16/25 stated, Skin: generalized scattered rash. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 01/27/24 stated, Noted to have diffuse psoriatic rash all over body and circular for [SIC] rashes with central clearing all over the back. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 01/30/25 stated, Skin: generalized scattered rash. Record review of Resident #1's care plan with a closed date of 02/05/25 did not include verbiage of rash. 2. Record review of Resident #3's face sheet, dated 02/18/25, revealed the resident was an [AGE] year-old female who was originally admitted to the facility on [DATE] with diagnoses that included: parkinsonism (motor symptoms found in Parkinson's disease; tremor, bradykinesia (slowed movements), rigidity and postural instability), unspecified, peripheral vascular disease (narrowed or blocked arteries or veins that reduce blood flow to the extremities), unspecified, chronic kidney disease, stage 3, (moderate kidney damage, where the kidneys are not functioning optimally) unspecified, vascular dementia (changes to memory, thinking and behavior resulting from condition that affect the blood vessels in the brain), unspecified severity, with other behavioral disturbance, type 2 diabetes mellitus (high blood sugars) with unspecified complication and hemiplegia (paralysis to one side of body) and hemiparesis (weakness on one side of body) following cerebral infarction (stroke) affecting left non-dominant side. Record review of Resident #3's quarterly minimum data set assessment (MDS), dated [DATE], revealed Resident #3 had a BIMS score of 10, indicating the resident's cognition was moderately impaired. Resident #3's section M - skin conditions reflected Resident #3 was at risk for developing pressure ulcers/injuries, had 0 unhealed pressure ulcers/injuries, 0 venous and arterial ulcers present and had skin problem of skin tears and had application of ointments/medications other than to feet. Record review of Resident #3's physician's orders revealed orders for weekly skin assessment on: Thursday, with a frequency of every day shift every Thu (Thursday) with a start date of 07/11/24 and an end date of indefinite. Record review of Resident #3's change in condition dated 01/21/25 was completed by the wound care nurse, LVN B stated, new onset rash noted to upper and lower back. Record review of Resident #3's NP note with an effective date of 01/22/25 stated, Skin .generalized scattered pruritic rash. Record review of Resident #3's care plan with an initiated date of 03/28/22 and next review date of 02/11/25 revealed no verbiage regarding Resident #3 rash. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review with the MDS nurse on 02/21/25 at 2:34 p.m., he stated he had just started working at the facility recently on 01/27/25. The MDS nurse stated was responsible for completing and updating the care plans and stated they should be updated on the same day a resident had a change. The MDS nurse stated rashes should be on the care plans. The MDS nurse stated he would get notified of any changes by the wound care department during their morning meetings and stated he also reviewed wound care notes daily. The MDS nurse reviewed Resident #1's chart and stated there was documentation indicating she had rash in-between November 2024 - January 2025. The MDS nurse stated he was not aware of Resident #1 having a rash. The MDS nurse reviewed Resident #3's chart and stated there was an unspecified rash indicated in January 2025 and stated he did not know of any rashes Resident #3 had. The MDS nurse reviewed both Resident #1 and Resident #3's care plan and stated their [NAME] were not mentioned on their care plans. The MDS nurse stated they must have not been updated properly and stated rashes should be reflected on the care plans because it helped involved the whole team and so they could have the proper care. The MDS nurse stated he was currently being trained by the regional MDS nurse. The MDS nurse did not know the facility care plan policy. The MDS nurse stated the DON monitored the care plans daily to ensure they accurately reflected the residents skin changes, conditions, and rashes. The MDS nurse added that not accurately reflecting a resident's skin changes, condition or rashes on the care plan could negatively impact residents because the resident's health and healing can be delayed due to not getting the proper care that is needed in a timely manner. During an interview and record review with the ADON on 02/21/25 at 6:38 p.m., she stated the MDS nurse was responsible for completing and updating the care plan and LVN B was responsible for anything related to resident's skin on their care plan. The ADON stated care plans were updated any time a resident had a change. The ADON stated rashes should be on the care plans. The ADON reviewed Resident #1's chart and stated it seemed she had rash on and off during November 2024 - January 2025 and stated she was aware that Resident #1 had a rash. The ADON reviewed Resident #3's chart and stated she had a change in condition in January 2025 that noted a rash. The ADON stated she was sure she was made aware of Resident #3's rash but did not know when she was told. The ADON reviewed both Resident #1 and #3's care plan and sated there was no verbiage related to their rash. The ADON did not know why the care plans did not reflect resident's rash and stated it should be reflected in the care plan because it was to show they were making a plan for the patient and to set a goal. The ADON stated the DON had trained both her and the MDS nurse over completing and updating care plans. The ADON Stated she did not know the facility exact policy regarding accurate and updated care plans but stated she knew they should be updated as things changed, and new things come about. The ADON stated she and staff had followed the care plan policy. The ADON stated the DON monitored the care plans to ensure they accurately reflected the residents skin changes, conditions, and rashes. The ADON stated the DON would complete quarterly reviews. The ADON added that not accurately reflecting a resident's skin changes, condition or rashes on the care plan could negatively impact residents because the facility may not be meeting their needs or doing what they are supposed to do. (continued on next page)

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	02/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review with LVN B on 02/21/25 at 7:25 p.m, she stated she was responsible for completing and updating anything related to resident's skin which included rashes on their care plan. LVN B stated care plans were updated whenever residents had anything new. LVN B stated rashes should be on the care plans and stated she was aware that Resident #1 had a rash between November 2024 and January 2025. LVN B reviewed Resident #1's care plan and stated there was no mention of a rash. LVN B reviewed Resident #3's care plan and stated it also did not mention any rash. LVN B reviewed a change in condition that she completed for Resident #3 dated 01/21/25 that indicated at that time Resident #3 had a new onset of a rash. LVN B did not know why Resident #1 and Resident #3's rash was not reflected on their care plans and stated rashes should be on the care plan and was important so they could carry out the treatment and the effectiveness of the treatment. LVN B stated she had previously been trained on resident care plans but a previous employee. LVN B stated she did not know the facility policy regarding accurate and updated care plans. LVN B stated she was responsible for monitoring the care plans to ensure they accurately reflected the resident's skin changes and conditions and stated she tried to complete it weekly. LVN B stated there was treatment in place for the residents and was not sure how the care plan not reflecting a resident's skin changes, condition or rash could negatively impact them. During an interview with the ADON on 02/21/25 at 7:40 p.m., the MDS nurse did not have any training over care plans documented and stated everything had been on the job training. Record review of facility policy titled Care Plans, Comprehensive Person - Centered with a revised date of December 2016 included a section titled, Policy Statement that included the following verbiage: A comprehensive, person - center care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .12. Assessments of residents are ongoing and care plans are revised as information about the resident sand the residents' conditions change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

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 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 45737

Based on interview and record review the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal pharyngeal ulcers for 1 of 1 resident (Resident #2) reviewed for gastrostomy feedings in that:

The facility did not transcribe and initiate Resident #2's enteral feeding order of 65ml for 22 hours, leading to 6 pound weight loss between 10/11/24 and 12/09/24.

This failure placed resident at risk for not receiving their required daily nutritional intake placing the resident at risk for weight loss.

The findings included:

Record review of Resident #2's face sheet dated 02/18/25 revealed a [AGE] year-old- female who was initially admitted to the facility on [DATE]. Resident diagnoses included the following: cerebral infarction (decreased blood flow to the brain), dysphagia (difficulty in swallowing) following cerebral infarction (stroke), gastrostomy status (surgical procedure that creates an opening in the abdominal wall and into the stomach) and type 2 diabetes mellitus (high blood sugar) with out complications.

Record review of Resident #2's quarterly MDS dated [DATE] revealed Resident #2 had a BIMS score of 03 indicating Resident #2's cognition was severely impaired. Record review of section K - Swallowing/Nutritional Status reflected that Resident #2 had a feeding tube while a resident at the facility.

Record review of Resident #2's care plan retrieved 02/18/25 revealed Resident #2 had a focus of The resident required tube feeding) [SIC] r/t dysphagia, with an initiation date of 01/10/24 and focus of The resident has unplanned weight loss r/t dependent on staff for nutrition, with an initiation date of 12/05/24.

Record review of Resident #2's notes dated 12/11/24 revealed the following weight change note: Resident receiving continuous feedings of diabetasource [SIC] @ 65cc/hr x 22 hours to provide 1430ml/1716kcal in 24 hours .Formula increased in November per dietary recommendation d/t initial trigger for weight loss.

Record review of Resident #2's dietary consult dated 10/10/24 revealed a recommendation to discharge diabetisource at 50ml for 20 hours and begin diabetisource at 65ml for 22 hours to provide 1430 ML VTBD, 1716kcal, 86 GM protein and 1167ML fluid. On 10/11/24 this recommendation was agreed on by the PA (physician assistant).

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's physician order dated 10/11/24 revealed the ADON had entered an enteral feed order for diabetisource [SIC] AC continuous feeding 65ML/HR x 20 HRS to provide 1430ML VTBS, 1716KCALS, 86GM protein and 1167ML fluids. Physician order had an end date of 12/09/24. Resident #2's physician order dated for enteral feedings did not accurately reflect previous dietary recommendations that were agreed on 10/11/24. Record review of Resident #2's physician order dated 12/09/24 revealed the DON had entered an enteral feed order for diabetisource [SIC] AC continuous feeding 65ML/HR x 22 HRS to provide 1430ML VTBS, 1716KCALS, 86GM protein and 1167ML fluids. Physician order had an end date of 02/13/25. Record review of Resident #2's MAR for the months of October, November and December 2024 reflected Resident #2 was receiving continuous feedings of 65ml/hr for 20 hours from 10/11/24 till 12/09/24. Record review of Resident #2's weights revealed the following: 08/01/24 - 143lbs 09/01/24 -137lbs 10/01/24 - 133lbs (*weight loss triggered) 11/06/24 - 130lbs 11/19/24 - 126lbs 11/26/24 - 126lbs 12/01/24 - 127lbs 12/10/24 - 127lbs 12/17/24 - 127lbs 12/31/24 - 127lbs 01/07/25 - 127lbs 02/05/25 - 128lbs 02/12/25 - 128lbs Record review of Resident #2's weights revealed Resident #2 continued to lose 6lbs between 10/01/24 and 12/10/24 while receiving enteral feedings for 20 hours instead of the recommendation and agreed on 22 hours. Record review of Resident #2's weights from 12/10/24 until 02/12/25 reflected a 1-pound weight gain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/21/25 at 3:53 p.m., the RD (registered dietician) stated she was unable to recall Resident #2 and did not have access to resident records unless she was on site. The RD stated if a resident did not receive their feedings for the right amount of time the resident would not get their calories and if were not meeting their nutritional needs there could be weight loss. During an interview and record review with the ADON on 02/21/25 at 7:02 p.m., she stated Resident #2 had a feeding tube in place and did not eat anything by mouth. The ADON stated dietary consultations occurred 2 to 3 times a month and stated Resident #2 was being seen by the dietitian. The ADON stated on 10/11/24 Resident #2 was identified to have weight loss and stated in response they changed the rate ad hours of feedings. The ADON stated the dietary recommendation was for 65ml for 22 hours and stated the doctor had agreed to the recommendation. The ADON stated after a recommendation is agreed by the doctor it will then be given to herself or the nurses. The ADON reviewed Residents #2's physician orders and stated she input the order on 10/11/24 for 65ml an hour for 20 hours and stated It should have been said 22 hours, the ADON Stated the hours input were incorrect. The ADON Stated it was important to ensure the recommendation and orders were reflected accurately so that residents would get enough calories and everything they needed. The ADON she input the order incorrectly because she did it too fast and stated she should have double checked. The ADON was not sure if staff was providing only 20 hours of feeding as stated in the order. The ADON stated the DON brought it to her attention in December and that was when they corrected the physician order to reflect the dietary recommendations agreed on. The ADON stated between the time of the original order on 10/11/24 and when the order was corrected on 12/17/24 Resident #2 had a 6lb weight loss. The ADON stated since the correction to Resident #2's enteral feeding order she had gained 1 lb. The ADON stated both the DON and her were responsible for monitoring and ensuring orders were correctly input and stated they completed this daily. The ADON was not able to recall the facility policy related to inputting accurate orders. The ADON stated she had been trained on inputting order accurately and monitoring and maintaining weights by the DON. The ADON stated not accurately inputting enteral feed orders could cause residents to not get the calories and protein they need. During an interview with the ADON on 02/21/25 at 7:40 p.m., she stated she did not have any training over weights and accurate orders documented and stated everything had been on the job training. Record review of facility policy titled, Charting and Documentation with a revised date of July 2017 included verbiage that reflected, 3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for medical records accuracy, in that: The facility failed to ensure Resident #1's skin observation tool documentation accurately reflected Resident #1's rash. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: Record review of Resident #1's face sheet, dated 02/21/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (memory loss, cognitive decline, language problems, behavioral changes and difficulty with daily tasks), unspecified, Anxiety disorder, unspecified (intense, excessive, and persistent worry and fear about everyday situations), dysphagia (difficulty swallowing) and polyneuropathy, (a condition affecting multiple peripheral nerves, causing damage and dysfunction), unspecified. Record review of Resident #1's quarterly MDS assessment, dated 12/09/24, revealed Resident #1 had a BIMS score of 00, indicating her cognition was severely impaired. Resident #1's section M - skin conditions reflected Resident #1 was at risk for developing pressure ulcers/injuries, had 0 unhealed pressure ulcers/injuries, 0 venous and arterial ulcers present and had application of ointments/medications other than to feet. Record review of Resident #1's physician's orders revealed orders for weekly skin assessment, with a frequency of every day shift every Thu (Thursday) for skin integrity with a start date of 12/05/24 and end date of indefinite. Record review of Resident #1's skin observation tool dated 01/02/25, 01/04/25, 01/09/25 and 01/16/25 revealed no verbiage of a rash. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 12/31/24 stated, Skin: generalized scattered rash. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 01/03/24 stated, Skin: generalized scattered rash. Record review of Resident #1's NP (Nurse Practitioner) note with an effective date of 01/16/25 stated, Skin: generalized scattered rash. Record review of Resident #1's care plan with a closed date of 02/05/25 did not include verbiage of rash. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review with LVN A on 02/21/25 at 1:20 p.m., she stated the nurses were responsible for completing skin assessments. LVN A stated she completed the skin assessments for Resident #1 on 01/02/25 and 01/04/25. LVN A reviewed both skin assessments and stated neither included any documentation regarding a rash on Resident #1. LVN A stated on 01/02/25 and 01/04/25 she was not notified of any rash and did not recall observing any rash on Resident #1. LVN A reviewed the NPs note dated 12/31/24 and 01/03/25 and stated they had both identified a rash on Resident #1. LVN A did not know why the NP notes identified a rash and her skin assessments did not. LVN A stated she may have overlooked it but did not recall a rash on Resident #1. LVN A stated when completing a skin assessment, they needed to observe the resident's entire body and should include any rash. LVN A stated the facility policy over skin assessments stated to include any rashes, LVN A stated she felt like she did follow the policy. LVN A stated she had been trained over completing accurate skin assessments by the DON. LVN A stated the ADON and DON both monitored and oversaw the skin assessments to ensure accuracy. LVN A stated not documenting complete and accurate skin assessments could cause residents discomfort or further complications. During an interview and record review on 02/21/25 at 6:27 p.m., with the ADON she stated the floor nurses were responsible for completing skin assessments. The ADON reviewed Resident #1's skin observation tools from 01/09/25 and 01/16/25 and stated she completed them and did not include any documentation of a rash on Resident #1. The ADON stated she did not remember if Resident #1 had a rash at the time her skin assessments. The ADON reviewed Resident #1 skin observation tool from 01/02/25 and 01/04/25 and stated they were both completed by LVN A and did not include verbiage of a rash on Resident #1. The ADON reviewed NP noted from 12/31/24, 01/03/25, and 01/16/25 and stated all included verbiage of a rash on Resident #1. The ADON stated she did not know why the NP noted mentioned a rash with the nurse's skin observations did not. The ADON stated its possible they copied and pasted from previous skin assessments or were focused on something more acute because the rash was being treated. The ADON stated she could not visually recall if Resident #1 had a rash between 12/21/24 and 01/03/25 but stated she wanted to say yes because she was being treated. The ADON stated when nurses completed a skin assessment, they should observe the resident's entire body and any rashes should be documentation on their skin assessments. The ADON stated accurate skin assessments were important because they had to document the truth and what was going on and for the NP to know that they are doing things accurately. The ADON stated the facility policy over skin assessments stated a skin assessment had to be completed from head to toe, front and back. The ADON stated her and LVN A had not followed the policy due to not mentioning Resident #1's rash. The ADON stated both her and LVN A had been trained over completing accurate skin assessments by LVN B. The ADON stated both the DON and LVN B both monitored and oversaw the skin assessments to ensure accuracy. The ADON stated not documenting complete and accurate skin assessments could cause residents to not get the treatment they needed and stated it could get worse before they got treatment. The NP was attempted to be reached via phone call on 02/21/25 at 5:16 p.m. but was unsuccessful. Record review of facility in-service dated 09/03/24 revealed the training covered daily skin assessments and was completed by LVN A Record review of facility in-service dated 11/14/24 revealed the training covered daily skin assessments and was completed by the ADON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Charting and Documentation with a revised date of July 2017 included verbiage that reflected, 3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.