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	05/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #1), reviewed for pharmaceutical services, in that: LVN C failed to verify Resident #1's morphine was accounted for when completing a narcotic count on 12/06/24. Resident #1's Morphine Sulfate Oral Solution 20mg/5ml was missing and not found. This failure could place residents at risk for not receiving medication as ordered. The findings included: Record review of Resident #1's face sheet, dated 05/22/25, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: Poly osteoarthritis (when 5 or more joints have arthritis),unspecified, adult osteomalacia (softening of bones), unspecified, osteophyte (bony lumps that grow on the bones in the spine or around joints), unspecified joint, and unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #1's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 had a BIMS score of 03 indicating severe cognitive impairment. Record review of Resident #1's care plan, with an initiation date of 07/13/23 had a focus that stated Resident #1 had a terminal prognosis related to senile degeneration of brain with a goal of The residents comfort will be maintained through the review date and a intervention stating, Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Resident #1's focus, goal and intervention all had an initiation date of 06/26/24. Resident #1's care plan included a focus stating Resident #1 was at risk for pain related to polyosteoarthritis and osteomalacia with an intervention to anticipate the resident's need for pain relief and respond immediately to any complaint of pain, both Resident #1's focus and intervention had an initiation date of 09/03/23. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician's orders, retrieved on 05/22/25, revealed an order for Morphine Sulfate Oral Solution 20MG/5ML to be provided as needed (PRN) every 4 hours with a dose of 0.1 ML for pain with start date on 06/25/24 and an end date of indefinite. Record review of Resident #1's November 2024 Medication Administration Record (MAR) revealed Resident #1 was last provided her order for Morphine Sulfate Oral solution on 11/25/24 at 9:57am by LVN G. Record review of Resident #1's pain tool with an effective date of 12/06/24 indicated the resident had no pain based on the use of face scale where face with No Hurt underneath was selected. Record review of document titled, NARACOTICS AND DACA [Anticancer Agent]DRUGS Eight - Hour Verification Record at Nurses Station with December 2024 written on top of document revealed the following nurses signed for the narcotic counts. On 12/05/24 the off-going nurse who signed for the 6am-2pm shift was LVN B and the oncoming nurse who signed was LVN C. On 12/05/24 the off-going nurse who signed for the 2pm-10pm shift was LVN C and the oncoming nurse who signed was LVN D. On 12/05/24 the off-going nurse who signed for the 10pm-6am shift was LVN D and the oncoming nurse who signed was LVN B. On 12/06/24 the off-going nurse who signed for the 6am - 2pm shift was LVN B and the oncoming nurse who signed was LVN C. On 12/06/24 the off-going nurse who signed for the 2pm-10pm shift was LVN C and the oncoming nurse spot was left unsigned. Record review of undated statement written by LVN D stated she counted narcotics on 12/05/24 with the 10pm-6am nurse (LVN B) and stated the count was accurate at that time. On 12/06/24 while doing narcotic count with LVN C, LVN C told LVN D that LVN B told her the morphine was in the fridge. LVN C and LVN B went to the fridge to check if morphine was in there and it was not in the fridge. Record review of statement written by LVN B on 12/06/24 stated on 12/05/24 she took shift over from LVN D and completed narcotic count and stated morphine was in the cart. Statement stated at 6:00am (12/06/24) she completed narcotic count with LVN C who was at the box while LVN B called out the medications. LVN B stated she signed narcotic count and LVN C took over shift. Record review of a statement written by LVN C and dated 12/06/24 stated, This morning while counting narcotics with LVN B I asked her are [Residents #1's] narcs [narcotics] in the fridge she replied yes. I did not physically go check narc box in fridge before signing narcotic book. Observation of facility staff nurses, LVN H and LVN I completing a narcotic count on 05/22/25 at 3:55pm revealed they followed appropriate procedures and had no discrepancies, LVN C was attempted to be reached via telephone call on 05/21/25 at 9:34am, 10:12am and 3:26pm on 05/22/25 at 2:06pm and 2:42pm with all attempts unsuccessful. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B on 05/21/25 at 2:40pm she stated the process to complete a narcotic count was when getting to their shift they to go over all the medication and narcotic record by name and amount left and to look in the cart to ensure it was accurate and would then sign the narcotic sheet. LVN B stated narcotic counts were completed at start and end of all shifts with 2 nurses. LVN B stated narcotics were stored in the locked medication cart inside another locked area. LVN B stated if medication needed to be refrigerator, they also had a lock box in the fridge. LVN B stated only the nurses and ADON and DON had the keys to access the medications. LVN B denied any occurrence of the locks/securements not functioning as they should. LVN B stated if the narcotic count was ever inaccurate, they would get the ADON and DON so they could figure out what was missing and why. LVN B stated morphine was included in the narcotic count and stated it would not be stored in the refrigerator and would be stored in the narcotic box in the nurse's cart. LVN B stated she did not recall Resident #1 and when asked if she worked on 12/05/24 from 10:00pm-6:00AM she stated, Yes, I work at night, LVN B stated it had been a while, but she had probably done a narcotic count at start and end of her shift and then stated, usually yes. LVN B then stated she did not remember if she accounted for all the narcotics but stated more than likely yes, she did. LVN B stated again that she did not recall Resident #1, did not recall who completed the narcotic count and stated she did not recall any morphine, LVN B stated she did not recall anyone telling her morphine was in the fridge and did not recall looking through the fridge on 12/05/24 during narcotic count. LVN B stated she was asked if she had put the morphine in the fridge but did not remember and stated she would not put the morphine in the fridge. LVN B stated it had been a while and was unable to remember the last time she saw Resident #1's morphine during a narcotic count. LVN B stated she had been trained over narcotic counts and had demonstrated competency on narcotic counts but did not recall when or who provided her with the education or competency. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN D on 05/21/25 at 4:40pm she stated the process to complete a narcotic count was when she was coming to work she would be counting medication while another nurse was on the binder and they would confirm the patient, the medication, dosage and amount of it, and stated they would count the medication, check the boxes or patches and check the fridge to make sure everything was in order and accurate. LVN D stated narcotic counts were completed at start and end shift and was completed by the nurses. LVN D stated narcotics were stored in a metal lock box in the nurses cart and a lock box that was in the fridge. LVN D stated the nurses had the keys to access the medications. LVN D denied any occurrence of the locks/securements not functioning as they should. LVN D stated if the narcotic count was ever inaccurate, they would report to the DON and ask the nurse and see what happened. LVN D stated morphine was included in the narcotic count and stated it would not be stored in the refrigerator and would be stored in the nurse's cart. LVN D stated Resident #1 had morphine at the facility and still had one but stated it was rare that she would take it. LVN D stated Residents #1's morphine was stored in the narcotic box in the nurses cart. LVN D said she worked on 12/05/24 and 12/06/24 from 2:00pm-10:00pm and stated she completed a narcotic count on both days at start and end of her shift. LVN D stated on 12/05/24 her and LVN B did a narcotic count at around 10:30/10:40pm when LVN B came in and stated Resident #1's morphine was there. LVN D stated on 12/06/24 when she came in her and LVN C started a narcotic count but the morphine was missing. LVN D stated LVN B had said LVN C told her the morphine was in the fridge however when LVN D and LVN C went to check it was not there. LVN D stated she did not recall if LVN C said she had checked for the morphine at the start of her shift. LVN D stated they made the DON E and the previous ADON, ADON F aware and started to search for the morphine but stated nothing was found. LVN D stated the last time she had seen Resident #1's morphine was on 12/05/24 when she did narcotic count with LVN B and LVN B was coming in and LVN D was leaving. LVN D stated she had been trained over narcotic counts and had demonstrated competency on narcotic counts, LVN D stated education and competencies were completed provided by the DON and ADON, but she did not recall the last time. LVN D stated signing off but not verifying all mediation were accounted for during a narcotic count could negatively impact the residents because the count could be wrong and residents may not have their medication or not have enough. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/25 at 2:25pm with the previous DON, DON E she stated narcotic counts were completed at start and end of all nursing shifts with the nurse who was on coming and the nurse who is leaving with 1 on the book and 1 opening the box and counting. DON E stated narcotics were under double lock in the medication carts and in the fridge and stated only the nurses had access to the medications. DON E stated she was not aware of any occurrences of the locks no functioning as they should. DON E stated if the count was not accurate, they had to report to their immediate supervisor either the DON or the ADON. DON E stated morphine was included in the narcotic count and stated Resident #1 did have morphine. DON E stated on 12/06/24 LVN D was doing a narcotic count with LVN C during change of shift between 2:30pm and 3:00pm when they went to check and the morphine was not found. DON E stated on 12/06/24 LVN C told her she took LVN B's word who had said the morphine was in the fridge and stated LVN C stated she should have been more careful and checked but did not. DON E stated LVN C should have checked the fridge for the morphine. DON E stated they looked everywhere and did not find it but hospice replaced the medication. The DON stated Resident #1 did not go without any pain medication and stated during that time she had not requested anything for pain. DON E stated the facility policy stated narcotics had to be accounted for at the beginning and end of the shift and had to be confirmed by both nurses that the medication was there, and any discrepancy had to be reported DON E stated by LVN C signing the narcotic sheet but not physically seeing the medication she had no followed the policy. The DON was not sure if trainings had been done prior to the incident with missing morphine but she stated they did do one after and stated staff had demonstrated competency with narcotic count but did not say when but stated the ADON or DON would be the ones who would check that. DON E was asked how signing off but not verifying all medications were account for during a narcotic count could negatively impact the resident and she stated, Resident #1 was not affected due to the medication not being routine and not having any pain. During an interview the facility DON on 05/22/25 at 5:07pm, the DON stated she started working at the facility on 04/07/25 and was not working at time of this incident. The DON stated narcotic counts should be completed at start and end of each shift with 2 nurses, with 1 with the book and the other looking at the medication. The DON stated staff should read out the name, medication and amount of medication and confirm before moving on to the next one. The DON stated narcotics were stored under double lock in the fridge and nurses cart and are accessed with a key that the nurses have. The DON stated if the narcotic count was off staff should report to the DON right away. The DON stated morphine was included in the narcotic count and should be placed in the nursing cart at room temperature and should not be in the fridge. The DON stated LVN C should have physically checked and verified amount of morphine. The DON stated signing off but not verifying all medications were account for during a narcotic count could negatively impact the resident if the resident was in pain and that was the only pain medication they had then they would be in pain. LVN G was attempted to be reached via telephone on 05/22/25 at 5:37pm, attempt was unsuccessful. Record review of inservice training covering controlled substances, narcotic count and security of med [medication] carts, dated 12/06/24 revealed LVN G, LVN B, LVN C and LVN D had received the training. Record review of facility policy titled Controlled Substances with a revised date of April 2019 stated, 12. At the End of Each Shift: a. Controlled medications are counted at end of each shift. The nursing coming on duty and the nurse going off duty determine the count together. B. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prepare, store, distribute, and serve foods in accordance with professional standards for food service safety in the facility's only kitchen. Dietary Aide A failed to effectively restrain her hair while getting snacks in the kitchen. This failure placed the 92 residents, who received their meals from the facility's only kitchen, at risk for food contamination and food borne illness. Findings included: Observation on 5/20/25 at 4:10 p.m. revealed Dietary Aide A was getting snacks from the kitchen and was not wearing a hairnet. During an interview on 5/20/25 at 4:20 p.m. Dietary Aide A stated that she was late, and she entered the kitchen through the back door and forgot to use a hair net. Dietary Aide A stated that she knew she had to use a hair net when entering the kitchen. Dietary Aide A stated that by not using the hair net the food could get infected or a hair could fall into the food. During an interview on 5/20/25 at 4:30 p.m. the DM stated that all staff knew that a hair net was required when entering the kitchen. The DM stated that hair net was used to prevent the contamination of the food. The DM stated that a hair could fall into the food. DM stated he reminded staff on using hair nets during the monthly meetings. During an interview on 5/20/25 at 5:35 p.m. The ADM stated that all staff should wear a hair net while in the kitchen. The ADM stated that the food could get contaminated if a hair touches the food. The ADM stated that the DM was in charge to monitor and inservice the staff regarding using hair nets to prevent food contamination. Record review of the facility's policy named Food Preparation and Service with a revised date April 2019, revealed Food and nutrition services employees prepare and serve food in a manner that complies with safe and food handling practices. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraints, etc.) so that hair does not contact food.