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	07/25/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from were verbal and physical abuse by a resident for 6 of 6 residents (Residents #5, #71, #82, #88, #95, #99) reviewed for abuse, in that: 1.The facility failed to ensure Resident #71 was free abuse when Resident #88 hit Resident #71 on the head on 01/24/25. 2. The facility failed to ensure Resident #71 was free from abuse when Resident #88 had a physical altercation with Resident #71 on 04/05/25. 3. The facility failed to ensure Resident #82, and Resident #99 were free from abuse when Resident #88 had a physical altercation with Resident #82 and Resident #99 on 06/04/25. 4.The facility failed to ensure Resident #5 was free from abuse when Resident #88 entered Resident #5's room and attempted to pull Resident #5 from her wheelchair on 06/22/25. 5.The facility failed to ensure Resident #95 was free from abuse when Resident #88 went up to Resident #95 and attempted to remove her from her wheelchair. Resident #88 shook Resident #95 and then slapped her on the side of her head on 06/28/25. An IJ that occurred in the past was identified. The IJ began on 01/24/25 and removed on 06/28/25. The facility took action to remove the IJ before survey began. While the IJ was removed on 06/28/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm because all staff had not been trained on abuse/neglect. This failure has the potential to result in serious injury or death as a result of abuse and neglect. 1. Record review of Resident #88's Face Sheet dated 07/24/25 revealed she was a [AGE] year-old female admitted to facility on 10/24/24 with diagnoses of Alzheimer's disease (a progressive disease that destroys the memory and other important mental functions), anxiety disorder, unspecified psychosis (a mental health condition characterized by a loss of contact with reality, often involving symptoms like hallucinations and delusions), and major depressive disorder, recurrent, severe with psychotic symptoms. Record review of Resident #88's quarterly MDS dated [DATE] revealed Resident #88 was usually understood by others and usually was able to understand others. She had a BIMS score of 02 which indicated severe cognitive impairment. Resident had physical behavioral symptoms directed toward others (hitting, kicking, scratching, grabbing), verbal behavioral symptoms directed toward others (screaming at others, cursing at others) and other behavioral symptoms not directed toward others (physical symptoms such as hitting, pacing, rummaging or verbal symptoms like screaming, disruptive sounds). Record review of Resident #88's comprehensive care plan revised on 05/28/25 revealed Resident #88 has been physically aggressive (hitting staff or other resident) r/t dementia: 01/24/25 - Resident became physically aggressive toward another resident The care plan included the following interventions:-When resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk away calmly and approach later. Record review of Resident #88's Physician's Order Summary for July 2025 revealed orders for: --Gabapentin oral capsule 100 mg, give two capsules by mouth three times a day related to emotional lability, order date 06/09/25.Haldol Decanoate intramuscular solution 50 mg/ml, inject 50 mg intramuscularly monthly starting on the 10th and ending on the 10th every month for agitation, order date 07/06/25 and start date on 07/10/25.Latuda oral tablet 20 mg, give 1 tablet by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic symptoms, order date 06/11/25 and start date 06/12/25.Zyprexa oral tablet 5 mg (Olanzapine), give 5 mg by mouth two times a day related to unspecified psychosis, order date 06/13/14 and start date 06/14/25. Record review of Resident #88's progress notes dated from 06/28/25 to 07/25/25 revealed Resident #88 was put on a continuous one-to-one monitoring until Resident #88 was admitted to a facility in San [NAME]. Record review of Resident #71's Face Sheet dated 07/24/25 indicated she was [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.), anemia (a problem in which the blood does not have enough healthy blood cells to carry oxygen to throughout the body), and hypertension (when the blood pressure in the blood vessels is too high). Record review of Resident #71 quarterly MDS dated [DATE] indicated Resident #71 was understood by others, and was able to understand others, did not have any behaviors, and had a BIMS score of 05 which indicated she had moderate cognitive impairment. Record review of facility's Provider Investigation Report dated 01/24/25 revealed Incident date and time: 01/24/25 at 4:00 pm. Nurse Aide saw Resident #88 go hit Resident #71's in the back of the head and pull her hair. Record review of the Provider Action Taken Post Investigation dated 01/24/25: Head to toe assessment performed on 01/24/25 for