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	11/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #1) reviewed for infection control practices, in that: CNA A used cleansing wipe multiple times when performing incontinent care for Resident #1.This failure place residents who use cleansing wipes during incontinent care at-risk for urinary tract infections due to cross contamination. The findings were: Record review of Resident #1's electronic face sheet dated 11/20/25 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnosis included type 2 diabetes mellitus (a chronic disease in which glucose levels in the blood were higher than normal because the body does not make enough insulin or use it the way it should), muscle weakness, muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), dementia (loss of cognitive functioning, such as thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities).Record review of Resident #1's undated comprehensive person-centered care plan, reflected Resident #1 had an ADL self-care performance deficit r/t generalized body weaknessDate Initiated: 04/05/2022. PERSONAL HYGIENE: The resident requires assistance by (1) staff with personal hygiene and oral care. Date Initiated: 04/05/2022. Revision on: 10/16/2023. TOILET USE: The resident requires assistance by (2) staff for toileting. Date Initiated: 04/05/2022. Revision on: 10/16/2023.Record review of Resident #1's Quarterly MDS dated [DATE] reflected Resident #1 had a BIMS of 03 which indicated a severe impairment of mental status. Resident #1 required substantial/maximal assistance for self-care in toileting hygiene. Resident #1 had bowel incontinence and an indwelling catheter. During an incontinent care observation on 11/19/25 at 1:45 PM., CNA A and CNA B performed incontinent care on Resident #1. CNA A grabbed a wipe and wiped the tip of the penis, crumpled the wipe in his hand, and wiped the tip of the penis again using the same wipe. CNA performed the same technique 2 more times. CNA A cleansed the remainder of the front genital area. CNA A grabbed a wipe and wiped one side, crumpled the wipe in his hand and reused the wipe. CNA performed the same technique to the other side. When the front area was completed, CNA B assisted Resident # 1 to his left side. CNA A grabbed a wipe, wiped between the buttocks, crumpled the wipe in his hand and wiped again using the same wipe. CNA A grabbed another wipe and cleansed one side of the buttocks, crumpled the wipe in his hand and wiped again using same wipe. CNA A performed the exact same technique to the other side of buttocks. CNA A did not use one wipe per swipe throughout the whole procedure.In an interview on 11/19/25 at 2:00 pm, CNA A said the facility had infection control training at least once a month and the training included incontinent care for residents. CNA A said during incontinent care they used disposable wipes, they wiped once, folded the wipe and wiped again using the same wipe but could not use the contaminated site of the wipe. CNA A said that was what they taught at the facility training. CNA A said that was the way to prevent infections for residents.In an interview on 11/19/25 at 2:15 pm CNA B said they always had in-services on peri-care and infection control. CNA B said they received training at every meeting. CNA B said they were not supposed to reuse a wipe. CNA B said they just used a wipe once, disposed and used another wipe. CNA B said she saw CNA A use one wipe per swipe. CNA B then said CNA A did use the same wipe, but he turned it around. CNA B said sometimes they did that with washcloths. CNA B said she had never been instructed to fold over disposable wipes and reused them. CNA B said they swiped once with a wipe and threw it away. She said in-services and trainings enforce this was best way for infection control. In an interview on 11/19/25 at 3:34 pm LPN C said they went over infection control during monthly meetings. This investigator asked LPN C if during incontinent care, CNAs wiped with a disposable wipe, folded over the wipe, then reused the wipe. LPN C said she hoped they did not. LPN C said CNAs should not reuse or fold used disposable wipes and use again. LPN C said CNAs should wipe once and throw the disposable wipe away. She said it would be against infection control. In an interview on 11/20/25 at 2:20 pm ADON D said they went over infection prevention and control information with staff monthly to quarterly and upon hire. ADON D said they checked off skills upon hire and quarterly. ADON D said she believed infection prevention and control training was required once a year, but she also liked to complete if she saw any trends. ADON D said disposable wipes use was a gray area. ADON D said it depended on the condition of the wipe, during incontinent care CNAs could wipe once with a disposable wipe then dispose of the wipe or they could wipe