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	11/21/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 3 (Resident #4, Resident #11, and Resident #13) of 10 residents reviewed for MDS assessment.Resident #4's quarterly MDS assessment dated [DATE] failed to indicate Resident #4 had falls on 07/28/25 that resulted in major injury, on 09/09/25 that resulted in minor injury, and on 10/02/25 that resulted with no injury.Resident #11's quarterly MDS assessment dated [DATE] failed to indicate Resident #11's behavior of physical aggression that occurred on 09/23/25.Resident #13's quarterly MDS assessment dated [DATE] failed to indicate Resident #13's behaviors of delusions and refusal of care that occurred on 09/16/25.Resident #13's quarterly MDS assessment dated [DATE] failed to indicate Resident #13 had a fall that resulted in minor injury that occurred on 10/13/25.This deficient practice could place residents at risk for inadequate care and services to meet their needs based on inaccurate assessments.

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
	455621	A. Building B. Wing	11/21/2025

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. (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	11/21/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (Resident #4) of 5 residents reviewed for care plans.The facility failed to develop a comprehensive person-centered care plan for Resident #4 to address the use of a fall mat.This failure could place the residents at risk of not receiving appropriate interventions and care to meet their current needs.Record review of Resident #4's face sheet dated 10/21/25 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: dementia (decline in cognitive abilities), generalized muscle weakness, other lack of coordination, mood disorder (impacts emotional state), type 2 diabetes (high levels of sugar in blood), and chronic kidney disease. Record review of Resident #4's fall risk evaluation dated 10/02/25 reflected a score of 13 which indicated a high risk. Record review of Resident #4's MDS assessment dated [DATE] reflected Resident #4 had a BIMS score of 2, which indicated severe cognitive impairment. Record review of Resident #4's care plan, dated 10/21/25, reflected, [Resident #4] was at risk for falls related to gait balance problems, incontinence, unaware of safety needs, and wandering. Date initiated: was 03/20/23. Interventions included: call light within reach, encourage the use of call light for assistance, and ensure resident was wearing appropriate footwear. [Resident #4] had an actual fall on 07/28/25 with a laceration to back of head. Date initiated: was 07/28/25. Interventions included: continue interventions on the at-risk plan, monitor for signs/symptoms of pain or new injury for 72 hours, and neuro checks as ordered. [Resident #4] had a witnessed fall on 09/09/25 with a minor skin tear to left elbow. Date initiated: was 09/09/25. Interventions included: monitor for signs/symptoms of pain or new injury for 72 hours, therapy to evaluate, and treatment per orders. [Resident #4] had an unwitnessed fall on 10/02/25 with no apparent injury. Date initiated: was 10/02/25. Interventions included: determine/address causative factors for fall, monitor signs/symptoms of pain or new injury for 72 hours, neuro checks as ordered, and offer activities to distract resident. Resident #4's care plan did not reflect the use of a fall mat. On 10/22/25 at 2:15 PM, an attempted interview and observation with Resident #4, revealed she was not interviewable. Resident #4 did not answer baseline questions or questions related to the incident. Resident #4 laid in bed with the call light within reach. Resident #1 was observed with good personal hygiene, no injury, and not in distress. The bed was at its lowest position. A fall mat was in place next to the right side of the bed. On 10/23/25 at 11:15 AM, in an interview with the ADON, she said Resident #4 had several falls and was at risk for falls. The ADON said she was not sure if Resident #4 had a fall mat or when it was implemented. The ADON said if it was part of the interventions for falls, the fall mat should have been care planned. The ADON said it was important to have the fall mat care planned so staff were aware of the intervention and ensured the fall mat was in place. The ADON said the team ensured the interventions were implemented and care planned. On 10/23/25 at 1:05 PM, in an interview with the DON, she said Resident #4 was at risk for falls. The DON said she did not know if Resident #4 had a fall mat. The DON said if Resident #4 had a fall mat, the fall mat should have been care planned. The DON said it was important to have the fall mat care planned so that staff were aware that Resident #4 needed to have it in place to possibly prevent injury or harm. Record review of Care Plans, Comprehensive Person-Centered Policy dated December 2016, reflected:Policy statement: A comprehensive, person-centered 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. 8. The comprehensive, person-centered care plan will:g. incorporate identified problem areas.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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	11/21/2025

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. (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	11/21/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 2 (Resident #4 and Resident #13) of 10 residents reviewed for accuracy of records.LVN E failed to document Resident #4's change of condition for a fall on 09/05/25.LVN F failed to document Resident #13's change of condition for aggressive behavior on 10/10/25.LVN D failed to document Resident #13's vital signs correctly on the change of condition form on 10/14/25 for a fall that occurred on 10/13/25.The DON failed to document Resident #13's vital signs correctly on the change of condition form on 10/21/25 for an incident of aggressive behavior that occurred on 10/10/25.These failures could place residents at risk for errors in care due to inaccurate or incomplete documentation and records. 1. Record review of Resident #4's face sheet dated 10/21/25 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: dementia (decline in cognitive abilities), generalized muscle weakness, other lack of coordination, mood disorder (impacts emotional state), type 2 diabetes (high levels of sugar in blood), and chronic kidney disease. Record review of Resident #4's MDS assessment dated [DATE] reflected Resident #4 had a BIMS score of 2, indicating severe cognitive impairment. Record review of Resident #4's care plan dated 10/21/25 reflected [Resident #4] was at risk for falls related to gait balance problems, incontinence, unaware of safety needs, and wandering. Date initiated: 03/20/23. Record review of Resident #4's progress note dated 09/05/25 at 6:54 PM, reflected LVN E was alerted that Resident #4 was on the floor. LVN E ran to the scene where LVN E observed Resident #4 on the floor laying down talking to herself. LVN E assessed Resident #4's vital signs which were within normal limits. RP aware. Resident #4 ate her dinner in the living area with RP by her side. LVN E will continue to monitor for behaviors. 2. Record review of Resident #13's admission record, dated 10/21/25, reflected an [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Her diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), dementia, mild, with mood disturbance (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities with marked disruptions in emotions), dementia, moderate, with agitation, and emotional lability (a rapid and intense change in a person's emotions or mood, typically inappropriate to the setting). Record review of Resident #13's quarterly MDS, dated [DATE], reflected a BIMS score of 00 which indicated severe cognitive impairment.Record review of Resident #13's assessments screen in PCC reflected the only assessment completed on 10/10/25 for Resident #13 was a skin observation tool completed and signed by the DON on 10/13/25. The change of condition form that documented Resident #13's aggressive behavior was in the miscellaneous forms screen and was a handwritten document completed and signed by the DON on 10/21/25 and scanned into Resident #13's EMR.Record review of Resident #13's change of condition form for the incident of aggressive behavior dated 10/10/25 and completed/signed by the DON on 10/21/25 reflected in section B-Vital Signs Evaluation:2. Most recent blood pressure: 133/68; Date: 10/21/253. Most recent pulse: 91; Pulse type: radial; Date: 10/21/254. Most recent respiration: 19; Date: 10/21/255. Most recent temperature: 98.0; Route: Forehead (no contact); Date: 10/21/256. Most recent weight: 129; Scale: Standing; Date: 10/21/257. Most recent O2 sats: 96%; Method: Room air; Date: 10/21/25Record review of Resident #13's change of condition form for her fall dated 10/13/25 at 9:35 PM and signed by LVN D reflected in section B- Vital Signs Evaluation:2. Most recent blood pressure: 142/58; Date: 10/13/25 at 9:35 PM3. Most recent pulse: 85; Pulse type: Regular; Date: 10/13/25 at 12:31 PM4. Most recent respiration: 20; Date: 10/13/25 at 12:31 PM5. Most recent temperature: 98.1; Route: Forehead (non- contact); Date: 10/13/25 at 12:31 PM6. Most recent weight: 129; Scale: Standing; Date: 10/21/257. Most recent O2 sats: 99%; Method: Room air; Date: 02/22/25 at 1:04 PM8. Most Recent Blood Glucose: Blood Glucose: 108; Date: 08/27/23 at 9:47 PMOn 10/22/25 at 2:15 PM, an attempted interview and observation with Resident #4, revealed she was not interviewable. Resident #4 did not answer baseline questions or questions related to the incident. Resident #4 laid in bed with the call light within reach. Resident #4 was observed with good personal hygiene, no injury, and not in distress. The bed was at its lowest position. A fall mat was in place next to the right side of the bed. On 10/22/25 at 4:15 PM, in an interview with LVN E, she said Resident #4 was on the floor on 09/05/25, but it was not considered a fall. LVN E said she was down the hall and heard a resident call out for help which was another resident. LVN E said she saw Resident #4 on the floor of another resident's room. LVN E said the other resident told