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	01/30/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from misappropriation and exploitation of property for 1 of 6 residents reviewed for misappropriation of property. (Resident #2) The facility failed to protect Resident #2 from misappropriation/exploitation by allowing housekeeping to take money from Resident #2 for housekeeping's own well-being and personal expenses, exact date unknown. This failure could place residents who resided in this facility at risk of misappropriation of property. Findings included: Record review of a face sheet dated 1/30/26 reflected Resident #2 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included vascular dementia (a decline in thinking, memory, and reasoning skills caused by reduced blood flow to the brain, which damages or kills brain cells), and muscle wasting and atrophy (when muscles waste away). Record review of the MDS assessment dated [DATE] reflected Resident #2 had a BIMS score of 4 which indicated Resident #2 had severe cognitive impairment. The MDS assessment reflected Resident #2 required supervision or touching assistance with eating and needed substantial/maximal assistance with staff for toileting, and bathing. Record review of the care plan dated 11/6/19 indicated Resident #2 had impaired cognitive function and impaired thought processes related to dementia. During an interview on 01/29/2026 at 3:00 PM, Resident #2 stated he stated the staff here were all alright and they treated him well. He stated no staff had ever stolen anything from him, but he had given one guy $40.00 recently and he had paid him back only $10.00. He stated it was the housekeeping guy that he gave the money to. He stated he gave the money from his safe. He stated he felt safe in the facility, and he had no concerns. He stated he did get his money back and that the administrator paid him back. Attempts to interview housekeeping person were unsuccessful, two attempts were made to reach him by telephone on 01/30/26 at 10:47 AM and 2:16 PM. No return call was received. In an interview on 01/30/2026 at 7:00 PM, the DON stated that she was not working in the facility when the incident happened. During an interview on 01/30/26 at 7:50 PM, the ADM stated in the case of the self-report for misappropriation of property, on 09/6/25, Resident #2 had informed him that he lent $40 dollars to the housekeeping person, and he had paid him only $10.00 dollars back. He stated he immediately began the investigation and upon interviewing. He stated when he asked the housekeeping person about the money, he admitted to receiving the money. He stated the housekeeping person was suspended immediately and would be terminated. He stated that the facility paid back the $30.00 dollars to Resident #2. He stated they performed safe surveys for other residents. He stated he in-serviced staff on abuse and reporting. He stated that law enforcement was called. Review of the Facility Policy on Abuse Prevention Program with revised date December 2016 revealed: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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 01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from chemical restraints that were not required to treat the residents' medical symptoms for 1 (Resident #1) of 3 residents reviewed for unnecessary medications. The facility failed to have an adequate indication for the use of the medication Zyprexa (Olanzapine- atypical antipsychotic) for Resident #1. This failure could put residents at risks of receiving unnecessary psychotropic medications.Findings include: Record review of Resident #1's admission Record dated 01/29/26 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. The admission record revealed Resident #1 had diagnoses of Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks), vascular dementia (a decline in thinking, memory, and reasoning skills caused by reduced blood flow to the brain, which damages or kills brain cells). Record review of Resident #6's MDS Resident Assessment and Care Screening dated 1/6/26 revealed Resident #1 had a BIMS score of 3 which indicated Resident #1 had severely impaired cognition. The MDS assessment also revealed Resident #1 was on a high-risk drug, an antipsychotic. Record review of Resident #1's care plan dated 1/1/26 revealed that Resident #1 used antipsychotic medications related to Alzheimer's disease. The interventions were to monitor for side effects and effectiveness every shift, and monitor/document/report PRN any adverse reactions to antipsychotic medications. Record review of Resident #1's Physician's Orders revealed an order dated 1/1/26 for Olanzapine Oral Tablet 10 mg, give one tablet by mouth two times per day related to Alzheimer's disease, unspecified. The order did not indicate an end date. Side effect monitoring for Olanzapine every shift with start date of 12/31/25 and behavior monitoring for Olanzapine every shift with start date of 12/31/25. Record review of Resident #1's e-MAR dated revealed the medication Olanzapine oral tablet 10 mg was administered to Resident #1 1/06/2026 through 1/05/2026. During a phone interview on 1/30/26 at 1:00 p.m., Pharmacist stated Alzheimer's disease was not an appropriate diagnosis for an antipsychotic medication. Pharmacist stated that antipsychotic for a resident with Alzheimer's disease could cause death. During an interview on 1/30/26 at 6:02 p.m., ADON stated the negative outcome for ordering an antipsychotic medication for Alzheimer's disease on Resident #1 could cause death, that was why was not recommended on residents with Alzheimer's or Dementia. During an interview on 01/30/26 at 7:50 pm, the DON stated Resident #1 was on olanzapine medication. While the DON looked at her computer screen, the DON read out loud Resident #1's Olanzapine order. The DON stated the indication of Alzheimer's disease was allowed due to Resident#1 came with that order from the hospital. Record review of Facility's policy titled Antipsychotic Medication Use with a revised date December, 2016 revealed: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 (wound care cart) of 7 medication carts. The facility failed to ensure that the wound care cart was secured and lock when it was left unattended by LVN A. These failures could place residents at risk of injury to other residents if medication left unsecured were consumed. Findings included: During an observation on 01/29/2026 at 02:20 PM revealed the wound care medication cart was left unlocked outside room [ROOM NUMBER]. During the observation LVN A came out of the room and surveyor informed her wound care medication cart was unlocked and LVN A secured the cart by locking it. During an interview on 01/29/2026 at 02:25 PM with LVN A revealed she was responsible for the wound care medication cart that was left unlocked. She stated she was expected to lock the wound care medication cart when she walked away from it. She stated if it was left unlocked then a resident could open a drawer and take anything that was not for them. She stated he had left the cart unlocked because she just forgot. During an interview on 01/30/2026 at 04:18 PM with the DON stated her expectation was for staff to lock it when they walk away from the medication cart . DON stated that the negative outcome for leaving the cart unlocked was that a resident or visitor could grab the medication from the cart, and it could harm them. Record review of undated facility policy Storage of Medications: revealed the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.