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 03/23/2026
NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the resident's right to be informed, in advance, of the care to be furnished for 1 of 3 residents (Resident #1) reviewed for consent for secured unit placement.Resident #1 was placed in the secured unit (a unit that is designed to provide specialized, dementia-specific skilled nursing care to adults with Alzheimer's disease or related disorders) without prior consent based on information of the benefits, risks, and options available.This failure could affect residents by placing them at risk of not being informed of treatment options.The findings included:Record review of Resident #1's admission Record dated 03/20/26 revealed a [AGE] year-old-female, having had an original admission date of 12/06/22 and readmission date of 08/01/25 with diagnoses of liver cirrhosis (late stage of chronic liver disease), history of Transient Ischemic Attack (a temporary blockage of blood flow to the brain AKA a mini stroke), dementia, schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), depression, anxiety and hypertension (high blood pressure).Record review of Resident #1's medical record on 03/20/26, did not reveal a consent for placement into the secured unit.Record review of Resident #1's progress note dated 03/11/26 revealed a change in condition for shortness of breath.In an interview on 03/20/26 at 12:05 pm, LVN B stated she was the usual nurse for the secured unit. LVN B stated Resident #1 was placed in the secured unit last week because the resident needed to be closely monitored. Resident #1 had an episode of shortness of breath and required oxygen. LVN B stated she was not working at the time Resident #1 was placed on the secured unit however, the DON was the one that handled the placement. LVN B stated that when a resident was placed in the secured unit, a consent was required.In an interview on 03/23/26 at 2:53 pm the DON stated Resident #1 had been placed in the secured unit on the night of 03/11/26 because she had a change in condition. Resident #1 had an episode of shortness of breath and needed to be monitored closely. DON stated there were more staff in the secured unit to monitor Resident #1. DON stated a consent was required to place any resident in the secured unit however one was not obtained for Resident #1. DON stated Resident #1 was in the secured unit overnight on 03/11/26 and was returned to her regular room the following morning. DON stated a consent was still required even though Resident #1 was in the secured unit for a few hours. The DON stated she did not know why consent was not obtained. DON stated not having consent was against the right of the resident.Record review of the facility's Secured Unit admission Criteria dated 3/2026 revealed:4. There will be a consent received for placement in the secured/locked area.

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 03/23/2026
NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 S Bridge Weslaco, TX 78596	

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure a resident was free from involuntary seclusion for 1 of 3 residents (Resident #1) reviewed for involuntary seclusion.The facility failed to ensure Resident #1 met criteria to be placed in the secured unit per secured unit criteria on 03/11/26.This failure could place residents at risk of isolation, decreased quality of life, and psychosocial harm.The findings included:Record review of Resident #1's admission Record dated 03/20/26 revealed a [AGE] year-old-female, having had an original admission date of 12/06/22 and readmission date of 08/01/25 with diagnoses of liver cirrhosis (late stage of chronic liver disease), history of Transient Ischemic Attack (a temporary blockage of blood flow to the brain AKA a mini stroke), dementia, schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), depression, anxiety and hypertension (high blood pressure).Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS of 04 indicating her cognition was severely impaired. MDS revealed Resident #1 did not exhibit potential indicators of psychosis such as hallucinations nor delusions. MDS also revealed Resident #1 had a score of 0 for behavioral symptoms directed towards others and a score of 0 for verbal behavioral systems directed toward others. 0 indicated behavior not exhibited.Record review of Resident #1's Order Summary Report dated 03/20/26 revealed there was no order placed on 03/11/26 for resident to be placed in the secured unit.In an interview on 03/20/26 at 12:05 pm, LVN B stated she was the usual nurse for the secured unit. LVN B stated Resident #1 was placed in the secured unit last week because the resident needed to be closely monitored. Resident #1 had an episode of shortness of breath and required oxygen. LVN B stated she was not working at the time Resident #1 was placed on the secured unit however, the DON was the one that handled the placement.In an interview on 03/23/26 at 2:30 pm, LVN D stated she had worked with Resident #1 for two days, 03/11/26 and 03/12/26. LVN D stated she worked the morning shift of 6:00 am - 2:00 pm on both days. LVN D stated that on 03/11/26, Resident #1 had been in her assigned room with no issues. On 03/12/26, Resident #1 was in the secured unit. LVN D stated she received report in the morning when she arrived to work, that Resident #1 had an episode of shortness of breath overnight and was placed in the unit for closer observation. LVN D stated she was directed by the DON to get Resident #1 from the secured unit and take her back to her room. LVN D stated she took Resident #1 back to her room around 9:00 am on 03/12/26.In an interview on 03/23/26 at 2:53 pm the DON stated Resident #1 was placed in the secured unit because she was having shortness of breath. DON stated there were more staff in the secured unit to monitor the resident. DON stated Resident #1 was placed in the unit around 11:00 pm on 03/11/26 and returned to her assigned room the following morning. DON stated that shortness of breath is not a criteria for a resident to be placed in the secured unit however she thought Resident #1 would be better monitored there. DON stated that a criteria for a resident to be in the secured unit was to have behavioral issues. DON stated Resident #1 did not have behavioral issues.Record review of the facility's Secured Unit admission Criteria dated 3/2026 revealed:admission criteria: The individual must have cognitive impairment. Behavioral assessment: Assessing high risk behaviors; self-harm, harm to others; frequency of behavior

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NAME OF PROVIDER OR SUPPLIER Valley Grande Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 S Bridge Weslaco, TX 78596	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for comprehensive person-centered care plans.1. The facility failed to ensure Resident #1 was care planned for the use of Lorazepam (a psychotropic medication used to treat anxiety).2. The facility failed to ensure Resident #1 was care planned for the use of the Wander Guard (A discreet wearable device that tracks movement and triggers automated security responses when a resident nears a restricted area).3. The facility failed to ensure Resident #1 was care planned for being placed in the secured unit (a unit that is designed to provide specialized, dementia-specific skilled nursing care to adults with Alzheimer's disease or related disorders).These deficient practices could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs.Findings included:Record review of Resident #1's admission Record dated 03/20/26 revealed a [AGE] year-old-female, having had an original admission date of 12/06/22 and readmission date of 08/01/25 with diagnoses of liver cirrhosis (late stage of chronic liver disease), history of Transient Ischemic Attack (a temporary blockage of blood flow to the brain AKA a mini stroke), dementia, schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), depression, anxiety and hypertension (high blood pressure).Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS of 04 indicating her cognition was severely impaired. MDS revealed an active diagnosis of anxiety disorder along with Resident #1 taking an antianxiety medication for this diagnosis. MDS revealed the presence of a Wander/elopement alarm on Resident #1's self. Record review of Resident #1's Order Summary Report dated 03/20/26 revealed resident had an order for Lorazepam 0.5mg, Give 1 tablet by mouth two times a day for anxiety with an effective date of 02/17/26. Record review of Resident #1's care plan initiated 11/18/24, did not reveal a Focus, Goal, or Interventions for Lorazepam, Wander Guard or for the placement of Resident #1 in the secured unit.An observation on 03/20/26 at 9:16 am, Resident #1 was in her assigned room, and a Wander Guard was noted on her right wrist.In an interview on 3/20/26 at 11:21 am, MDS Nurse A stated she was aware Resident #1 was taking Lorazepam but failed to add the medication to the care plan. MDS Nurse A stated she was aware Resident #1 had the Wander Guard on her right wrist. MDS Nurse A stated she had added the use of the Wander Guard on resident's quarterly MDS but failed to add it to the care plan. MDS Nurse A stated Lorazepam and the use of the Wander Guard should have been implemented into Resident #1's care plan but failed to do so. MDS Nurse A stated the DON was also responsible for implementing or revising care plans.In an interview on 03/20/26 at 12:05 pm, LVN B stated she was the usual nurse for the secured unit. Resident #1 had been in the secured unit last week because the resident needed to be monitored closely. Resident had an episode of shortness of breath and required oxygen. LVN B stated the DON was aware Resident #1 was in the secured unit. LVN B stated she was not responsible for updating care plans. LVN B stated what when there was a new order or a change in condition, the MDS nurse or the DON updated the care plans.In an interview on 03/23/26 at 2:53 pm the DON stated she and the MDS nurse were responsible for implementing and revising care plans. The DON stated she was aware Resident #1 was on Lorazepam for anxiety. The DON stated she was aware Resident #1 had the Wonder Guard in place. The DON stated Resident #1 was in the secured unit last week to be closely monitored. DON stated Resident had an episode of shortness of breath and would be better monitored in the secured unit. The DON stated she was aware the placement of Resident #1 into the secured unit should have been added to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Grande Manor	1212 S Bridge Weslaco, TX 78596

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's care plan. The DON stated she checked care plans weekly to ensure they were up to date but she did not know why these changes were not added. DON stated not updating care plans could result in Resident #1 not receiving the correct interventions to certain health problems.Record review of the facility's Care Plans, Comprehensive Person-Centered Policy dated December 2016 revealed:8. The comprehensive, person-centered care plan will: a. Include measurable objective and timeframes. b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, [NAME], and psychosocial well-being. k. Reflect treatment goal, timetables, and objectives in measurable outcomes13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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	455621	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a written, signed and dated order from the attending physician for 1 of 3 residents (Resident #1) whose records were reviewed for physician services.The facility failed to obtain a physician's order for Resident #1 to be in the secured unit.This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information records.The findings included:Record review of Resident #1's admission Record dated 03/20/26 revealed a [AGE] year-old-female, having had an original admission date of 12/06/22 and readmission date of 08/01/25 with diagnoses of liver cirrhosis (late stage of chronic liver disease), history of Transient Ischemic Attack (a temporary blockage of blood flow to the brain AKA a mini stroke), dementia, schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), depression, anxiety and hypertension (high blood pressure).Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS of 04 indicating her cognition was severely impaired.Record review of Resident #1's Order Summary Report dated 03/20/26 revealed there was no order placed on 03/11/26 for resident to be placed in the secured unit.In an interview on 03/20/26 at 12:05 pm, LVN B stated she was the usual nurse for the secured unit. LVN B stated Resident #1 was placed in the secured unit last week because the resident needed to be closely monitored. Resident #1 had an episode of shortness of breath and required oxygen. LVN B stated she was not working at the time Resident #1 was placed on the secured unit however, the DON was the one that handled the placement. LVN B stated she was unsure if an order was required for a Wander Guard and that she would need to ask the DON.In an interview on 03/23/26 at 2:30 pm, LVN D stated she had worked with Resident #1 for two days, 03/11/26 and 03/12/26. LVN D stated she worked the morning shift of 6:00 am - 2:00 pm on both days. LVN D stated that on 03/11/26, Resident #1 had been in her assigned room with no issues. On 03/12/26, Resident #1 was in the secured unit. LVN D stated she received report in the morning when she arrived to work, that Resident #1 had an episode of shortness of breath overnight and was placed in the unit for closer observation. LVN D stated she was directed by the DON to get Resident #1 from the secured unit and take her back to her room. LVN D stated she took Resident #1 back to her room around 9:00 am on 03/12/26.In an interview on 03/23/26 at 2:53 pm the DON stated Resident #1 was placed in the secured unit because she was having shortness of breath. DON stated there were more staff in the secured unit to monitor the resident. DON stated Resident #1 was placed in the unit around 11:00 pm on 03/11/26 and returned to her assigned room the following morning. DON stated there was no order for Resident #1 to be placed in the unit. DON stated a doctor's order is required for a resident to be placed in the secured unit. DON stated she did not know why she did not obtain a doctor's order. DON stated it was not required to obtain a doctor's order for a Wander Guard. Record review of the facility's Secured Unit admission Criteria dated 3/2026 revealed:3. A physician order for placement will be obtained for secured unit placement.Record review of the facility's Wandering and Elopements Policy dated March 2019, did not have any information regarding criteria or implementations of the Wander Guard.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices. The facility must maintain medical records on each resident that are complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for clinical records.The facility failed to document a change in condition or progress note to reflect the placement of the Wander Guard (A discreet wearable device that tracks movement and triggers automated security responses when a resident nears a restricted area) on Resident #1. The facility failed to document a change in condition or progress note to reflect the placement of Resident #1 in the secured unit (a unit that is designed to provide specialized, dementia-specific skilled nursing care to adults with Alzheimer's disease or related disorders).These failures could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records.The findings included:Record review of Resident #1's admission Record dated 03/20/26 revealed a [AGE] year-old-female, having had an original admission date of 12/06/22 and readmission date of 08/01/25 with diagnoses of liver cirrhosis (late stage of chronic liver disease), history of Transient Ischemic Attack (a temporary blockage of blood flow to the brain AKA a mini stroke), dementia, schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), depression, anxiety and hypertension (high blood pressure).Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS of 04 indicating her cognition was severely impaired. MDS revealed the presence of a Wander/elopement alarm on Resident #1's self. Record review of Resident #1's medical chart revealed there was no progress note or change in condition to indicate the resident was placed in the secured unit.An observation on 03/20/26 at 9:16 am, Resident #1 was in her assigned room, and a Wander Guard was noted on her right wrist.In an interview on 03/20/26 at 9:20 am, LVN C revealed she was aware Resident #1 had a Wander Guard on her right wrist. LVN C stated she did not know when the Wander Guard was first placed. LVN C stated she was documenting the assessment of the Wander Guard in the TAR every shift. LVN C stated the DON was the one who initiated the Wander Guard on Resident #1 and therefore the progress notes and change in condition should have been initiated by the DON.In an interview on 03/20/26 at 12:05 pm, LVN B stated she was the usual nurse for the secured unit. LVN B stated Resident #1 was placed in the secured unit last week because the resident needed to be closely monitored. Resident #1 had an episode of shortness of breath and required oxygen. LVN B stated she was not working at the time Resident #1 was placed on the secured unit however, the DON was the one that handled the placement.In an interview on 03/23/26 at 2:53 pm the DON stated she was aware that Resident #1 had a Wander Guard to her right wrist but was unaware who had placed it or when it was placed. The DON stated the change in condition or a progress note should have been documented to reflect the placement of the Wander Guard but did not know why it was not documented. The DON stated that Resident #1 had been placed in the secured unit last week because she had an episode of shortness of breath and needed to be monitored closely. DON stated there were more staff in the secured unit to monitor Resident #1. The DON stated that all nurses should be updating Resident #1's medical chart to reflect anything new in her condition. It was important to document because it ensured that all skilled nurses were aware of Resident #1's health status.Record review of the facility's Charting and Documentation policy dated July 2017 revealed:2. The following information is to be documented in the resident medical record: d. Changes in the resident's condition6. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment date and/or any unusual findings obtained during the procedure/treatment