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	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Grande Manor	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 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 residents right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 1 of 5 residents (Resident #3) reviewed for consent for antipsychotic medications in that: Resident #3 was prescribed and administered Risperidone (an antipsychotic) without prior consent based on information of the benefits, risks, and options available. This failure could affect the right to self-determination of all facility residents who receive medication by allowing them to receive medication without their prior knowledge or consent, or that of their responsible party or emergency contacts. The findings included: Record review of Resident #3's admission record dated 07/01/2026, revealed a [AGE] year-old male with an admission date of 06/25/2026. Resident #3's diagnoses included bipolar disorder (a lifelong mental health condition that causes extreme shifts in mood, energy, and activity levels) and autistic disorder (a lifelong neurodevelopmental condition that affects how a person communicates, interacts with others, perceives the world, and learns). Record review of Resident #3's Entry MDS, dated [DATE], was not completed. Record review of Resident #3's Physician's orders and start date 06/26/2026 revealed risperiDONE Oral Tablet 2 MG (Risperidone). Give 1tablet by mouth two times a day for bipolar disorder. Record review of Resident #3's care plan, revealed it was not completed. Record review of Resident #3's June 2026 MAR revealed Resident #3 was administered risperiDONE Oral Tablet 2 MG (Risperidone) Give 1 tablet by mouth two times a day for bipolar disorder from 06/26/2026 at 04:00 p.m. through 08:00 a.m. on 07/02/2026. Record review of Resident #3's medical record on 07/02/2026, revealed there was no signed consent for the antipsychotic risperidone. During an interview on 07/02/2026 at 04:54 p.m., LVN C said for antipsychotics they needed the RP signature consent. He said the antipsychotic could not be administered before consent was given. During an interview on 07/02/2026 at 05:27 p.m., LVN D stated before they would put in an order for an antipsychotic, they had to have the consent signed. LVN D stated she would not give the antipsychotic before the consent was signed. She stated she had never given an antipsychotic without the consent being signed and would not know the negative effect. During an interview on 07/02/26 at 07:05 p.m., the DON stated antipsychotics needed signature consent. She said there was no RP signature on Resident #3's consent for the antipsychotic. The DON stated she had verbal consent from the RP. There was no documentation in the electronic medical record that RP verbal consent was given. She said it was very difficult to get the RP's signature because RPs were not at the facility every day. Record review of facility's Resident Rights policy (2001 MED-PASS, Inc. Revised December 2016) revealed: Policy Interpretation and Implementation1.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: p. be informed of, and participate in, his or her care planning and treatment.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care of 1 (Resident #3) of 3 residents reviewed for baseline care plan completion.The facility failed to complete a baseline care plan for Resident #3 within 48 hours of his admission.This failure could place newly admitted residents at risk of not receiving effective, person-centered care.Findings included:Record review of Resident #3's admission Record dated 06/30/26 revealed a [AGE] year-old male with an admission date of 06/25/26. Resident #3 had a diagnoses of Type 2 Diabetes Mellitus (high blood sugar levels in body) without complications, and Dependence on Renal Dialysis (filtering waste and excess fluid from blood).Record review on 06/30/26 at 8:45am of Resident #3's electronic medical record under assessment tabs revealed no baseline care plan was initiated.During an interview on 06/30/26 at 10:25am, Resident #3 said he had just been at the facility a few days and did not remember having a meeting with the staff since he had been admitted .During an interview on 06/30/26 at 6:04pm the DON said the IDT was responsible for completing care plans for residents. She said the base line care plans were supposed to have been done within 48 hours of when a resident was admitted to the facility. She said a baseline care plan was supposed to have been done for Resident #3. She said it was an oversite. The DON said there was no negative impact on Resident #3 because all residents care was discussed during morning meetings.Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, date revised December 2016 revealed:Policy StatementA 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of (Resident #1) of 5 residents reviewed for respiratory care. The facility failed to ensure Resident #1's oxygen was administered at the correct setting of 2 liters per minute on 06/30/2026 and at 4 liters on 07/01/2026 as ordered by the physician. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #1's admission record dated 06/30/2026 reflected a [AGE] year-old female with an initial admission date of 03/19/2020. Diagnoses included chronic obstructive pulmonary disease (a progressive lung condition that causes obstructed airflow and breathing difficulties), chronic respiratory failure (a long-term medical condition in which the lungs cannot properly oxygenate the blood or remove carbon dioxide), and functional quadriplegia (the complete inability to move all four limbs due to extreme physical frailty or a severe medical condition, entirely without physical injury or damage to the brain or spinal cord). Record review of Resident #1's 05/25/2026 Quarterly MDS revealed a BIMS score of 13 which indicated her cognitive function was intact. Record review of Resident #1's person-centered care plan, initiated date 04/27/2026 reflected Resident #1 used oxygen therapy related to ineffective gas exchange, COPD. Date Initiated: 03/08/2024. Give medications as ordered by physician. Monitor/document side effects and effectiveness. Date Initiated: 05/07/2026 LVN RN. OXYGEN SETTINGS: O2 @ 2L/min via Nasal Canula continuously to maintain SPO2 > 90% Date Initiated: 03/08/2024 Revision on: 06/30/2026 LVN RN. Record review of Resident #1's order summary dated 06/30/2026, reflected oxygen at 2 Lpm via nasal cannula continuously to maintain O2 above 90% for shortness of breath every shift with an order date of 04/08/2026. During an observation and interview on 06/30/2026 at 05:00 p.m., Resident #1's oxygen level on the oxygen concentration machine was at 3 Lpm via nasal cannula. Observation of Resident #1 revealed the resident was in bed with the head of the bed elevated. No signs of respiratory distress were noted. Resident #1 stated her O2 was supposed to be set on 4 Lpm. During an interview and observation on 06/30/2026 at 05:15 p.m., LVN E stated Resident #1 was supposed to be on 4 Lpm O2. LVN E adjusted the O2 to 3.5 Lpm. During an interview on 06/30/2026 at 05:30 p.m., the DON stated Resident #1 was to be getting 4 Lpm of oxygen via nasal cannula. She stated the O2 was set on 3.5 Lpm and she adjusted the setting to 4 Lpm. She stated that if the O2 was not at the correct setting, the doctor's order was not being followed. She said that the resident could become short of breath. She said they did in-services on O2 but did not remember when the last one was. Record review of Resident #1's physician order dated 07/01/2026 revealed RESPIRATORY: O2 at 4 L/MIN VIA N/C TO MAINTAIN SPO2 ABOVE 90%.During an observation on 07/02/2026 at 03:00 p.m., revealed Resident #1's O2 set at 3.5 Lpm. Resident #1 had no signs of respiratory distress noted. During an observation and interview on 07/02/2026 at 03:05 p.m., LVN F was in Resident #1's room to check the O2 setting. LVN F said the O2 setting was at 3.5 Lpm. She said if the physician's orders were not followed, the resident could become short of breath, and they would not be following the doctor's orders. During an interview on 07/02/2026 at 05:57 p.m., ADON G said O2 machines were set with the ball meter being in the middle of the line. He said they should be eye level with the ball meter when setting the machine. He said the negative effect of an incorrect setting on the O2 machine could be that a resident may have their oxygen levels drop and have hypoxia (low oxygen). He said if the order said 4 Lpm, it should be set on 4 Lpm. He said 3.5 Lpm was not good enough. Record review of the facility's Oxygen Administration Policy 2001 MED-PASS, Inc., Revised October 2010 revealed, PurposeThe purpose of this procedure is to provide guidelines for safe oxygen administration.Preparation1.Verify that there is a physician's order for this procedure. Review the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's orders or facility protocol for oxygen administration. Steps in the Procedure 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident by failing to ensure the timely acquisition and administration of prescribed medications for 1 (Resident #3's) of 3 residents reviewed for pharmacy services.The facility failed to timely acquire and administer an ordered central nervous system (CNS) stimulant medication, Ritalin 20 mg twice daily for Attention-Deficit/Hyperactivity Disorder (ADHD), resulting in an unapproved treatment delay.This failure has the potential to leave residents without critical prescribed therapies to manage their clinical and behavioral symptoms. Record review of Resident #3's admission record, dated 06/30/2026, reflected a [AGE] year-old male admitted on [DATE]. His diagnoses included Type 2 Diabetes (a chronic condition that affects the way the body processes blood sugar), End Stage Renal Disease (the final, permanent stage of chronic kidney disease where the kidneys no longer function on their own), Bipolar Disorder (a mental health condition that causes extreme mood swings), and Autistic Disorder (a developmental disorder that affects communication, behavior, and social interaction). Record review of Resident #3's electronic health record initial MDS assessment dated [DATE] revealed it was still in progress. Record review of Resident #3's initial care plan assessment revealed it had not been completed.Record review of Resident #3's physician order summary report dated 06/30/2026 revealed an active order entered with a start date of 06/26/2026 for: 'Ritalin Oral Tablet 20 MG (Methylphenidate HCl) Controlled Drug Give 1 tablet by mouth two times a day for ADHD.' A review of the resident's clinical record confirmed that as of 06/30/2026, the medication had not been administered, resulting in a five-day treatment delay of nine consecutive scheduled doses.Record review of Resident #3's June 2026 Medication Administration Record (MAR) revealed that from 06/26/2026 through 06/30/2026, the facility failed to execute the signed physician's order. Each of the nine scheduled doses of Ritalin 20 mg was signed off by nursing staff with a Code 9, indicating other, see progress notes, confirming that zero doses were administered to Resident #3.Record review of Resident #3's Orders - Administration Note on 06/26/2026 at 09:06 a.m., written by LVN I, revealed Ritalin Oral Tablet 20 MG pend delivery. [sic]Record review of Resident #3's Orders - Administration Note on 06/26/2026 at 04:01 p.m., written by LVN I, revealed Ritalin Oral Tablet 20 MG pend delivery. [sic]Record review of Resident #3's Orders - Administration Note dated 06/27/2026 at 10:26 a.m., written by LVN I, revealed Ritalin Oral Tablet 20 MG pend delivery. [sic]Record review of Resident #3's Orders - Administration Note dated 06/27/2026 at 07:56 a.m. written by LVN I, revealed Ritalin Oral Tablet 20 MG pending approval. Record review of Resident #3's Orders - Administration Note dated 06/28/2026 at 09:06 a.m., written by LVN I, revealed Ritalin Oral Tablet 20 MG pend delivery. [sic] Record review of Resident #3's Orders - Administration Note on 06/28/2026 at 04:00 p.m., written by LVN K, indicated Ritalin Oral Tablet 20 MG pend delivery. [sic] Record review of Resident #3's Orders - Administration Note on 06/29/2026 at 08:55 a.m., written by LVN J, revealed Ritalin Oral Tablet 20 MG pend delivery. [sic] Record review of Resident #3's Orders - Administration Note on 06/29/2026 at 09:06 a.m., written by LVN C, revealed Ritalin Oral Tablet 20 MG Resident out for dialysis. Record review of Resident #3's Orders - Administration Note on 06/29/2026 at 17:37 p.m., written by LVN C, revealed Ritalin Oral Tablet 20 MG Pending script.Record review of Resident #3's Orders - Administration Note on 06/30/2026 at 10:52 a.m., written by LVN J, revealed Ritalin Oral Tablet 20 MG pend delivery. [sic]Record review of Resident #3's June 2026 MAR revealed Ritalin 20 mg was not administered twice daily from 06/26/2026 through 06/30/2026.During a phone interview on 07/02/2026 at 02:18 p.m., with Resident #3's physician stated he was not aware that Resident #3 had not received his Ritalin due to its pending from pharmacy. He said the negative effect of Resident #3 not receiving his Ritalin would be he would not be able to concentrate. During an interview on 07/02/2026 at 05:00 p.m., LVN C stated if an ordered medication was unavailable, the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protocol was to call the physician for a prescription. He stated that if he needed further assistance, he would contact the ADON or DON. He stated that if a resident missed a medication dose, he would call the physician and notify the DON. During an interview on 07/02/2026 at 06:00 p.m., ADON G stated that floor nurses must contact the PCP to verify all admission orders. He stated if an ordered medication was not immediately available from the pharmacy, staff were required to check the automated medication dispensing system, obtain a retrieval code from the pharmacy, and have two nurses pull the medication. ADON G stated if the medication was unavailable in the automated medication dispensing system, staff must immediately notify the physician to obtain a hold or alternative order. He stated that an order for twice-daily Ritalin was written on 06/26/2026 for Resident #3, but there had been miscommunication with the pharmacy regarding the Ritalin order and the resident had not received the medication for five days. ADON G stated the facility protocol required staff to document physician notification whenever medication was unavailable or doses were not administered. During an interview on 07/02/2026 at 07:01 p.m., the DON stated she was responsible for reviewing new admissions and ensuring that newly admitted residents' orders were correct. She stated that facility nurses were trained to input admission medication orders directly into the electronic health record. She stated the nurses updated and verified all medication orders with the attending physician when a resident was admitted to the facility. The DON stated if a scheduled/controlled medication was ordered, staff must notify her and the physician to obtain explicit approval. The DON stated there was a five-day delay in obtaining the scheduled Ritalin order for Resident #3 because the facility had to fax the prescription hard copy to the pharmacy. The DON stated that there was no negative clinical outcome for Resident #3 not receiving the medication for five days.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to follow their policy regarding storage of foods brought to the residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption of the food and beverages for 1 of 1 Residents (Resident #1) reviewed for personal food storage. The facility did not have completed documentation of temperature checks for Resident #1's personal refrigerator from November 2025 through June 2026. This failure could place residents with personal refrigerators at risk of food borne illness.The findings included: Record review of Resident #1's admission record dated 06/30/2026 reflected a [AGE] year-old female with an initial admission date of 03/19/2020. Diagnoses included chronic obstructive pulmonary disease (a progressive lung condition that causes obstructed airflow and breathing difficulties), chronic respiratory failure (a long-term medical condition in which the lungs cannot properly oxygenate the blood or remove carbon dioxide), and functional quadriplegia (the complete inability to move all four limbs due to extreme physical frailty or a severe medical condition, entirely without physical injury or damage to the brain or spinal cord). Record review of Resident #1's 05/25/2026 Quarterly MDS revealed a BIMS score of 13 which indicated her cognitive function was intact. During an observation on 06/30/2026 at 05:00 p.m., Resident #1's personal refrigerator log revealed the refrigerator's temperature had not been checked since November 2025. During an interview on 06/30/2026 at 05:15 p.m., LVN E stated management checked the Resident #1's refrigerator temperatures. LVN E stated not checking the refrigerator could cause the residents to get sick. During an interview on 06/30/2026 at 05:30 p.m., the DON stated Resident #1's refrigerator temperature should be checked daily. She said per the log sheet, it had not been checked off since November 2025. She said management was responsible for checking the refrigerator temperature daily during their rounds. She said she was the one responsible for checking the refrigerator. She said if the refrigerator temperature was not checked every day, food could spoil and the resident could get sick. During an interview on 07/02/2026 at 04:29 p.m., CNA B stated the nurses were responsible for checking refrigerators in the residents' rooms. He said he did not check them. During an interview on 07/02/2026 at 05:57 p.m., ADON G stated refrigerators were checked by management and nurses. ADON G stated the nurse was the one who logged the temperature of the refrigerator and management was to verify it was done. During an interview on 07/02/2026 at 07:05 p.m., the DON stated the refrigerator logs are done during the room rounds. She said right now she was doing the refrigerator check daily. She said Resident #1's refrigerator was the only resident refrigerator in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish 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 2 (Resident #1 and #3) of 5 residents observed for infection control issues in that: 1. The facility failed to ensure LVN E performed hand hygiene before and after medication administration for Resident #1. 2. There was no signage observed outside of Resident #3's room indicating enhanced barrier precautions prior to entering room. These failure could place residents, employees, and visitors at risk of communicable diseases. Findings included: 1. Record review of Resident #1's admission record dated 06/30/2026 reflected a [AGE] year-old female with an initial admission date of 03/19/2020. Diagnoses included chronic obstructive pulmonary disease (a progressive lung condition that causes obstructed airflow and breathing difficulties), chronic respiratory failure (a long-term medical condition in which the lungs cannot properly oxygenate the blood or remove carbon dioxide), and functional quadriplegia (the complete inability to move all four limbs due to extreme physical frailty or a severe medical condition, entirely without physical injury or damage to the brain or spinal cord), and type 2 diabetes mellitus (a chronic condition where the body cannot use insulin properly or make enough of it). Record review of Resident #1's 05/25/2026 Quarterly MDS revealed a BIMS score of 13 which indicated her cognitive function was intact. Resident #1 was dependent on a helper performing all the effort for toileting, showers, and personal hygiene. Record review of Resident #1's Care Plan dated 04/27/2026 revealed, FOCUS: (Resident #1) has Diabetes Mellitus at risk for hypo/hyperglycemia. Date Initiated: 01/12/2026. INTERVENTIONS/TASKS: Administer Tirzepatide subcutaneous (into the fat under the skin) solution as ordered. Monitor for side effects and effectiveness. Date Initiated: 06/30/2026 Revision on: 06/30/2026 LVN RN Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 01/12/2026 LPN RN. Record review of Resident #1's Order Summary dated 06/30/2026 revealed, Tirzepatide Subcutaneous Solution Auto-injector 2.5 MG/0.5ML (Tirzepatide) Inject 2.5 mg subcutaneously in the afternoon every Tue for TYPE 2 DIABETES MELLITUS related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA. During observation on 06/30/2026 at 05:44 p.m., LVN E administered an injectable medication to Resident #1 without washing her hands or using hand sanitizer before putting on gloves and did not wash her hands or use hand sanitizer after administration of the medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/30/2026 at 05:49 p.m., LVN E said she did not perform hand hygiene before or after administering the medication to Resident #1. LVN E stated she should have performed hand hygiene before and after administering injectable medication to Resident #1. LVN E said the importance of hand hygiene was to prevent contamination and infection. She said they were in-serviced monthly on infection control which included handwashing and the use of hand sanitizer. During an interview on 06/30/2026 at 05:30 p.m., the DON stated handwashing or hand sanitizer should occur before and after administration of medications. She said a negative effect of not using hand sanitizer or washing of hands before and after medication administration could cause infection or cross-contamination of either the resident or the staff. During an interview on 07/02/2026 at 05:56 p.m., ADON G, stated staff are provided with in-service trainings every two weeks on infection control. ADON G stated the last infection control training was held a few weeks ago and the in-services are usually conducted by himself or by the DON. ADON G stated that the most effective technique for infection control was to practice hand washing. ADON states it is also very important for employees to use enhanced barrier protection. This includes the use of gowns, gloves and face masks. ADON states that donning and doffing are also very important. ADON states that employees are to wash their hands for 20 seconds. ADON G stated if the facility did not practice infection control it could affect the staff as well as the residents. ADON G stated diseases like scabies could be spread if infection control such as hand hygiene was not practiced. During an interview on 07/02/2026 at 07:06 p.m., the DON stated staff are provided with monthly in-service trainings on infection control. The DON stated that the staff were directed to practice proper hand hygiene. The DON stated that staff must demonstrate to DON and ADON how to properly wash their hands, which included washing their hands for 20 seconds or longer. The DON stated situations which required proper hand hygiene include before and after providing care to a resident. The DON stated staff are also expected to wash their hands prior to going into a resident's room and after exiting room. The DON stated a negative outcome of not practicing hand hygiene included the spread of infection through germs. 2. Record review of Resident #3's admission Record dated 06/30/26 revealed a [AGE] year-old male with an admission date of 06/25/26. Resident #3 had a diagnoses of Acquired Absence of other Genital Organ(s) (loss of reproductive organs due to surgical removal or disease), Type 2 Diabetes Mellitus (high blood sugar levels in body) without complications, and Dependence on Renal Dialysis (filtering waste and excess fluid from blood). Record review of Resident #3's care plan dated 06/30/26 revealed resident #3 had a potential/actual impairment to the skin integrity of the penis r/t surgical wound due to history of penectomy. Resident #3 also had potential/actual impairment to skin integrity of the heel r/t DFU initiated date 06/30/26. Record review of Resident #3's medication administration record revealed Resident #3 had active orders for Gentamicin Sulfate External Ointment 0.1%, apply daily for penile wound and Muplrocin External Ointment 2% apply daily for left heel wound. Observation on 06/30/26 at 9:37am of Resident #3's room revealed no signage indicating Resident #3 was on Enhanced Barrier Precautions (EBP). During an interview on 06/30/26 at 2:30pm LVN C said Resident #3 was on EPB due to wounds. LVN C said there was supposed to be signs posted on Resident #3's door so anyone who had entered his (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	07/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room would have known to practice EBP. He said he didn't know why there was nothing posted, he said Resident #3 was admitted to the facility a few days ago. LVN C said if the residents have something contagious the staff or anyone can pass it on to someone else if they don't use proper precautions or the residents can be at risk of also getting a disease, getting sick. During an interview on06/30/26 at 4:54pm the DON said Resident #3 was supposed to have signage of EBP outside his room. She said Resident #3 was receiving dialysis weekly and also had wounds. The DON said they needed to do a better job to make sure signage was in place for anyone on EBP. She said nothing could have happened to the resident because his wounds were covered and staff uses standard precautions for wound care. Observation on 06/30/2026 at 05:44 p.m., LVN E administered an injectable medication to Resident #1 without washing her hands or using hand sanitizer before putting on gloves and did not wash her hands or use hand sanitizer after administration of the medication. During an interview on 06/30/2026 at 05:49 p.m., LVN E said she did not perform hand hygiene before or after administering the medication to Resident #1. LVN E stated she should have performed hand hygiene before and after administering injectable medication to Resident #1. LVN E said the importance of hand hygiene was to prevent contamination and infection. She said they were in-serviced monthly on infection control which included handwashing and the use of hand sanitizer. During an interview on 06/30/2026 at 05:30 p.m., the DON stated handwashing or hand sanitizer should occur before and after administration of medications. She said a negative effect of not using hand sanitizer or washing of hands before and after medication administration could cause infection or cross-contamination of either the resident or the staff. During an interview on 07/02/2026 at 05:56 p.m., ADON G, stated staff are provided with in-service trainings every two weeks on infection control. ADON G stated the last infection control training was held a few weeks ago and the in-services are usually conducted by himself or by the DON. ADON G stated that the most effective technique for infection control was to practice hand washing. ADON states it is also very important for employees to use enhanced barrier protection. This includes the use of gowns, gloves and face masks. ADON states that donning and doffing are also very important. ADON states that employees are to wash their hands for 20 seconds. ADON G stated if the facility did not practice infection control it could affect the staff as well as the residents. ADON G stated diseases like scabies could be spread if infection control such as hand hygiene was not practiced. During an interview on 07/02/2026 at 07:06 p.m., the DON stated staff are provided with monthly in-service trainings on infection control. The DON stated that the staff were directed to practice proper hand hygiene. The DON stated that staff must demonstrate to DON and ADON how to properly wash their hands, which included washing their hands for 20 seconds or longer. The DON stated situations which required proper hand hygiene include before and after providing care to a resident. The DON stated staff are also expected to wash their hands prior to going into a resident's room and after exiting room. The DON stated a negative outcome of not practicing hand hygiene included the spread of infection through germs. 2. Record review of Resident #3's admission Record dated 06/30/26 revealed a [AGE] year-old male with an admission date of 06/25/26. Resident #3 had a diagnoses of Acquired Absence of other Genital Organ(s) (loss of reproductive organs due to surgical removal or disease), Type 2 Diabetes Mellitus (high blood sugar levels in body) without complications, and Dependence on Renal Dialysis (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	07/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(filtering waste and excess fluid from blood). Record review of Resident #3's care plan dated 06/30/26 revealed resident #3 had a potential/actual impairment to the skin integrity of the penis r/t surgical wound. Resident #3 also had potential/actual impairment to skin integrity of the heel r/t DFU initiated date 06/30/26. Record review of Resident #3's medication administration record revealed Resident #3 had active orders for Gentamicin Sulfate External Ointment 0.1%, apply daily for penile wound and Muplrocin External Ointment 2% apply daily for left heel wound. Observation on 06/30/26 at 9:37am of Resident #3's room revealed no signage indicating Resident #3 was on enhanced barrier precautions (EBP). During an interview on 06/30/26 at 2:30pm LVN C said Resident #3 was on EPB due to wounds. LVN C said there was supposed to be signs posted on Resident #3's door so anyone who had entered his room would have known to practice EBP. He said he didn't know why there was nothing posted. He said Resident #3 was admitted to the facility a few days ago. LVN C said if the residents had something contagious the staff or anyone could pass it on to someone else if they did not use proper precautions or the residents could be at risk of also getting a disease, getting sick. During an interview on06/30/26 at 4:54pm the DON said Resident #3 was supposed to have signage of EBP outside his room. She said Resident #3 was receiving dialysis weekly and also had wounds. The DON said they needed to do a better job to make sure signage was in place for anyone on EBP. She said nothing could have happened to the resident because his wounds were covered and staff uses standard precautions for wound care. 1. Record review of the facility's Handwashing/Hand Hygiene Policy (MED-PASS, Inc Revised August 2019) revealed, Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation 2 .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 6. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: c. Before preparing or handling medications. i. After contact with a resident's intact skin. m. After removing gloves. 2. Record review of facility's policy titled Enhanced Barrier Precautions date revised 04/2024 revealed; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.