

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

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Form Approved OMB
No. 0938-0391

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 07/09/2026
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and facilitate resident self-determination through support of resident choice, for 1 of 3 residents (Resident #1) reviewed for resident rights. The facility failed to promote Resident #1's self-determination by not allowing him to choose when he wanted to go to bed. This failure could place residents at risk for their needs and preferences not being met. Findings included: Record review of Resident #1 face sheet dated 07/09/2026 the resident was admitted to the facility on [DATE] with diagnoses which included personal history of transient ischemic attack, and cerebral infraction (a medical classification indicating a patient has previously experienced a mini-stroke or a full stroke, but has fully recovered without ongoing, disabling symptoms), Alzheimer's disease (a progressive and irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks). Record review of Resident #1's MDS assessment dated [DATE] indicated his BIMS score was 00 which indicated severe cognitive impairment (a score of 0-7 indicated severe cognitive impairment). He was totally dependent for transfers. Record review of Resident #1's Care Plan dated 05/02/26 indicated he had an ADL self-care performance deficit r/t Alzheimer's. Interventions: Transfer, the resident requires assistance by 1 staff to move between surfaces. Record review of Resident #1's video footage provided by family member with a post date of 7/8/2026 at 04:17 a.m., revealed Resident #1 was on his wheel chair and CNA A and CNA B were trying to convince him to go to bed and Resident #1 was saying that he did not want to lay down. CNA A and CNA B proceeded to transfer Resident #1 against his will. During an observation and interview on 7/8/26 at 5:45 p.m., Resident #1 was in bed. Resident #1 stated he was not able to recall the transfer or was not able to recall if he was refusing going to bed. During an interview on 7/8/26 at 5:45 p.m., Resident 1's family member stated that Resident #1 was put in bed even when he was refusing to go to bed on 7/8/2026 at 4:20 a.m. She stated that it was not fair to put him to bed against his will. Family member said that she had not mentioned it to anyone. During an interview on 7/8/26 at 10:57 p.m., CNA A said Resident #1 was on contact precautions and he wanted to go outside his room. CNA A stated that Resident #1 wanted to go outside the facility. CNA A stated that she had to respect the residents' wishes but she thought it was not safe for him. During a telephone interview on 7/9/26 at 11:28 a.m., CNA B stated that she was not able to recall that resident was transferred without his will. CNA B stated that Resident #1 was confused and he wanted to go outside the facility. CNA B stated that she and CNA A transferred him to bed but she did not remember that Resident #1 was saying that he did not want to go to bed. CNA B stated that by transferring resident to bed after he refused, she was not respecting Resident #1 wishes. During a telephone interview on 7/9/26 at 11:27 a.m., LVN C stated that Resident #1 was confused and looking for an exit and Resident #1 was looking for his family member. LVN C (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she did not know that he was refusing going to bed. LVN C stated that staff needed to respect the residents' wishes. LVN C stated that the negative outcome could be that the resident could get more agitated and aggressive because we were not respecting his rights. During an interview on 7/9/26 at 8:00 p.m., DON stated that she was not aware of this allegation. DON stated that resident's wishes needed to be respected. DON stated that the negative outcome was that staff was not respecting the resident's rights. Record review of facility's policy titled Resident Rights with a revised date December 2016 reflected Employees shall treat all residents with kindness, respect, and dignity.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;.e. self-determination;.		