

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 07/25/2025
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse by a resident for 6 of 6 residents (Residents #5, #71, #82, #88, #95, #99) reviewed for abuse, in that: 1. The facility failed to ensure Resident #71 was free abuse when Resident #88 hit Resident #71 on the head on 01/24/25. 2. The facility failed to ensure Resident #71 was free from abuse when Resident #88 had a physical altercation with Resident #71 on 04/05/25. 3. The facility failed to ensure Resident #82, and Resident #99 were free from abuse when Resident #88 had a physical altercation with Resident #82 and Resident #99 on 06/04/25. 4. The facility failed to ensure Resident #5 was free from abuse when Resident #88 entered Resident #5's room and attempted to pull Resident #5 from her wheelchair on 06/22/25. 5. The facility failed to ensure Resident #95 was free from abuse when Resident #88 went up to Resident #95 and attempted to remove her from her wheelchair. Resident #88 shook Resident #95 and then slapped her on the side of her head on 06/28/25. An IJ that occurred in the past was identified. The IJ began on 01/24/25 and removed on 06/28/25. The facility took action to remove the IJ before survey began. While the IJ was removed on 06/28/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm because all staff had not been trained on abuse/neglect. This failure has the potential to result in serious injury or death as a result of abuse and neglect. 1. Record review of Resident #88's Face Sheet dated 07/24/25 revealed she was a [AGE] year-old female admitted to facility on 10/24/24 with diagnoses of Alzheimer's disease (a progressive disease that destroys the memory and other important mental functions), anxiety disorder, unspecified psychosis (a mental health condition characterized by a loss of contact with reality, often involving symptoms like hallucinations and delusions), and major depressive disorder, recurrent, severe with psychotic symptoms. Record review of Resident #88's quarterly MDS dated [DATE] revealed Resident #88 was usually understood by others and usually was able to understand others. She had a BIMS score of 02 which indicated severe cognitive impairment. Resident had physical behavioral symptoms directed toward others (hitting, kicking, scratching, grabbing), verbal behavioral symptoms directed toward others (screaming at others, cursing at others) and other behavioral symptoms not directed toward others (physical symptoms such as hitting, pacing, rummaging or verbal symptoms like screaming, disruptive sounds). Record review of Resident #88's comprehensive care plan revised on 05/28/25 revealed Resident #88 has been physically aggressive (hitting staff or other resident) r/t dementia: 01/24/25 - Resident became physically aggressive toward another resident The care plan included the following interventions:-When resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk away calmly and approach later. Record review of Resident #88's Physician's Order Summary for July 2025 revealed orders for: --Gabapentin oral capsule 100 mg, give two capsules by mouth three times a day related to emotional lability, order date 06/09/25. Haldol Decanoate intramuscular solution 50 mg/ml, inject 50 mg intramuscularly monthly starting on the 10th and ending on the 10th every month for agitation, order date 07/06/25 and start (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455621	Facility ID: 455621 If continuation sheet Page 1 of 26

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	date on 07/10/25. Latuda oral tablet 20 mg, give 1 tablet by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic symptoms, order date 06/11/25 and start date 06/12/25. Zyprexa oral tablet 5 mg (Olanzapine), give 5 mg by mouth two times a day related to unspecified psychosis, order date 06/13/14 and start date 06/14/25. Record review of Resident #88's progress notes dated from 06/28/25 to 07/25/25 revealed Resident #88 was put on a continuous one-to-one monitoring until Resident #88 was admitted to a facility in San [NAME]. Record review of Resident #71's Face Sheet dated 07/24/25 indicated she was [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.), anemia (a problem in which the blood does not have enough healthy blood cells to carry oxygen to throughout the body), and hypertension (when the blood pressure in the blood vessels is too high). Record review of Resident #71 quarterly MDS dated [DATE] indicated Resident #71 was understood by others, and was able to understand others, did not have any behaviors, and had a BIMS score of 05 which indicated she had moderate cognitive impairment. Record review of facility's Provider Investigation Report dated 01/24/25 revealed Incident date and time: 01/24/25 at 4:00 pm. Nurse Aide saw Resident #88 go hit Resident #71's in the back of the head and pull her hair. Record review of the Provider Action Taken Post Investigation dated 01/24/25: Head to toe assessment performed on 01/24/25 for Resident #71 revealed no other visible injuries noted. Employees were in-serviced on resident-to-resident abuse and resident de-escalation techniques. Social Services did resident safe interviews. Resident behaviors care planned. Staff will keep both residents apart when in close proximity or when doing social activities. Care Plans for both residents updated. Observation of 07/21/25 at 9:32 am revealed Resident #88 in bed on her side with the lights off and a CNA in the room. Resident #88 was still in her pajamas and shoes on. Resident #88 did not respond to greeting and questions regarding incident with Resident #71. In an interview on 07/21/25 9:57 am CNA K said Resident #88 was able to walk and wandered throughout the building, but they had to shadow her to prevent aggressive behaviors toward other residents. If resident was on her own, she would fight with other residents. CNA K said Resident #88 cried a lot and the other residents became impatient with her and then she became aggressive. CNA K said when resident was on her own in her room, she was ok. CNA K said if they gave her colors and pages to color, she would do it. 2. Record review of Incident Report dated 04/05/25 revealed Resident #88 hit Resident #71 on her back and took some coloring pages from her. Resident #88 was separated from Resident #71. Head to toe evaluation of both residents by LVN revealed no injuries to either resident. Record review of Resident #88's care plan was revised on 04/08/25 to include incident on 04/05/25 with aggressive behavior with interventions to monitor for sundowning behavior, continue sertraline 100 mg daily (antidepressant), follow up counseling and psych recommendations and monitor behavior. Record review of Psychiatric Progress Note dated 04/24/25 by NP revealed Resident #88 was tearful, confused and wanted to go home to see her mother and father. Patient has many altercations with female residents. The NP last saw Resident #88 on 04/24/25. 3. Record review of Resident #82's Face Sheet dated 07/24/24 revealed Resident #82 was a [AGE] year-old female admitted to facility on 10/24/24 with diagnoses of unspecified dementia (progressive or persistent loss of intellectual functioning), muscle wasting and atrophy, and muscle weakness. Record review of Resident #82's Quarterly MDS dated [DATE] revealed Resident #82 was usually understood by others, and usually understands others, BIMS of 03, and does not have behaviors and was able to ambulate independently. Record review of Resident #82's care plan dated 06/05/25 revealed Resident #82 has a behavior problem (labile moods) r/t dementia. On 06/04/25 Resident had altercation with another female resident (#88) and grabbed the other female (88) by her shirt and other resident (#88) lost her balance and fell. Interventions included administer medications as ordered, monitor/document for side effects and effectiveness. Explain/reinforce why behaviors are inappropriate and/or unacceptable. Record review of Resident #99's Face Sheet dated 06/10/25 revealed Resident #99 was an [AGE] year-old female admitted to the facility on [DATE] with (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	diagnoses of muscle wasting and atrophy, anxiety disorder, and major depressive disorder. Record review of facility's Provider Investigation Report revealed Incident Date/Time: 06/04/24 at 7:45 pm. Resident #88 was attempting to grab another female resident (#99) and Resident #82 started yelling at Resident #88 to stop harassing the other resident. Resident #88 then went towards Resident #82. Resident #82 grabbed Resident #88 by her shirt and Resident #88 was not able to keep her balance and fell landing on her right lateral side. Nurse aide ran toward altercation but was not able to stop Resident #88 from falling. Resident #88 suffered a small cut to her right eyebrow, no other visible injuries noted. Resident #88 sent to ER for further evaluation per physician's orders. Record review of Health Status Note dated 06/04/25 at 11:09 pm revealed Resident #88 returned from the ER with swelling to right eye and light purple discoloration due to fall. Dermabond was applied to laceration for closure. CT was negative. Resident will be on neuro checks due to fall. Bed at lowest position with call light within reach. Record review of facility's Provider Investigation Report revealed Incident Date/Time: 06/07/25 at 8:29 am. Resident #88 was in the dining room and attempted to assist Resident #5 in the wheelchair. Resident #5 said she did not want the assistance. Resident #88 became aggressive and pulled Resident #5's hair. The residents were separated and both Residents were taken to their rooms. Both Residents were assessed by LVN N. After the altercation Resident #88 was taken to the nurse's station for the remainder of the shift. Investigation Summary: After investigation it was determined Resident #82 attempted to stop Resident #88 from harassing another resident and Resident #88 lunged at Resident #82. Resident #82 grabbed Resident #88 by the shirt and Resident #88 lost her balance. The NP, family and the police were notified of the incident. Provider action taken post-investigation: Performed resident interviews and Follow-up with the psych NP as needed. In an interview on 07/21/25 at 12:54 pm Resident #82 said she did not fight with anyone, and she did not recall any incidents when another Resident tried to hit her. Resident #82 said she kept to herself and participated in her own activities. In an interview on 07/22/25 at 4:28 pm CNA J said she was walking toward the nurse's station when she saw Resident #82 pull Resident #88's shirt and push her toward the floor. CNA said Resident #88 must have done something to Resident #82 because Resident #82 did not usually fight. CNA J said the CNA in front of her ran toward Resident #88 and then asked her to get the nurse. CNA J said she went to look for the nurse, but he was providing care to a resident, and he asked CNA J to get the nurse from the back hall. CNA J said she went to get LVN N and then LVN N went and attended to Resident #88. Observation on 07/23/25 at 12:55 pm revealed Resident #88 was walking up A [NAME] Wing. CNA S was holding Resident #88's hand as they ambulated through the hallway. 07/23/25 1:25 pm CNA S said he had been on a one to one with Resident #88 since 07/22/25 through 07/25/25. CNA S said Resident #88 was on a one-to-one monitoring for the 2-10 shift. CNA S said he went everywhere Resident #88 went. CNA S said if Resident #88 became aggressive with another resident, he would intervene and if necessary, would get between the two residents so she would not hit the other resident. He would redirect Resident #88 toward another direction and keep walking with her. 4. Record review of Resident #5 Face Sheet dated 06/10/25 revealed Resident #5 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hemiplegia (weakness to one side of the body) and hemiparesis (weakness to one side of the body), muscle wasting and atrophy, and unspecified dementia. Record review of Resident #5's quarterly MDS dated [DATE] revealed Resident #5 was sometimes understood by others, usually understood others, had a BIMS of 08 indicating she had moderate cognitive impairment and did not have any behaviors and required substantial/maximal assistance with her ADLs. Record review of facility's Provider Investigation Report dated 06/22/25 revealed Incident date and time: 06/22/25 at 7:20 pm. Nurse Aide saw Resident #88 go into Resident #5's room. Nurse Aide followed her into the room. Nurse Aide saw that Resident #88 was attempting to get Resident #5 out of her wheelchair while she was in it. Resident #5 shoved/pushed Resident #88 with her right hand (arm in splint) causing Resident #88 to re-open her wound to her right eyebrow. Nurse Aide immediately separated residents. Head to toe assessments performed by LVN R for both residents. Resident #88 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	re-opened wound to right eyebrow, no other visible injuries noted. Notified MD/RP/Administrator. Reported to police. Self-report to HHSC. Resident #88 had Latuda (aggression) increased on 06/12/25 to BID and Zyprexa (antipsychotic) 5mg BID on 06/14/25. Provider Action Taken Post-investigation: 06/22/25 Charge nurse placed her WOW in front of resident's room throughout the rest of shift and 10-6 shift. 5. Record review of Resident #95's Face Sheet dated 07/24/25 revealed Resident #95 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unspecified dementia, muscle wasting and atrophy, muscle weakness, and Parkinson's Disease (a progressive neurodegenerative disorder that primarily affects movement). Record review of Resident #95's quarterly MDS dated [DATE] revealed Resident #95 is usually understood by others, usually able to understand others, has a BIMS of 00 meaning she has severe cognitive impairment and does not have any behaviors. Record review of Resident #95's comprehensive care plan dated 07/29/20 revealed Resident #95 requires staff assistance with ADLs due to diagnosis of Parkinson's at risk for decline in ADL function. Record review of Resident #95's progress note dated 06/28/25 at 10:50 am revealed late entry: Resident A came up to resident during service, shook this resident, and slapped resident on the side of the head. Resident A was immediately stopped and separated was sent to her room. Record review of facility's Provider Investigation Report revealed Resident #88 came up to Resident #95 who was sitting in her wheelchair during service, shook resident and slapped resident on the side of her head. Resident #88 was immediately stopped and separated, went back to her room with nurse. Head to toe assessment performed by nurse (Resident #95). Provider Response: Resident (#88) was placed on a one-to-one, family came to stay with her for 1-2 hours. Labs ordered UA to rule out UTI, and CBC, CMP to rule out any infection. Reported it to police with case number 25-16894. Started abuse and neglect in-service. Resident continues on psych services with medication adjustments. Provider Action Taken Post-investigation Started looking for other facility placement for resident. Given 30-day notice. Safety survey done, continue with 1 to 1 monitoring. Record review of Resident #88's electronic medical record dated 06/28/25 through 07/25/25 revealed Resident #88 was on a one-to-one monitoring all three shifts. A CNA is with Resident #88 at all times. Observation on 07/21/25 at 9:07 am revealed Resident #95 was in her room sitting in her wheelchair. Resident #95 had tremors in her head and hands. Resident #95 was talking to herself. Surveyor attempted to interview Resident #95, but she has garbled speech and was difficult to understand. In an interview on 07/22/25 at 3:25 pm Resident #60 said she was in the dining room when she saw Resident #88 approach Resident #95. Resident #88 was yelling at Resident #95 and then she shook Resident #95. Resident #60 said then she saw Resident #88 slap Resident #95 on the face. Resident #60 said the staff intervened and took Resident #88 to her room. Resident #60 said the police were called and interviewed her, but nothing was done because the police said Resident #88 had dementia. In an interview on 07/22/25 at 5:28 pm CNA L said Resident #88 would walk around the facility. CNA L said Resident #88 was currently on a one-to-one because she was in an altercation with another resident. Resident #88 slapped another resident and was put on a one to one. Before being on a one-to-one Resident #88 would wander into different rooms and they would have to redirect her before she got upset and started a fight with a resident. They have in-services on ANE every month. CNA L said if she witnessed any person abusing a resident she would intervene and then make sure resident was safe. CNA said she would report it to her supervisor. The Abuse Coordinator was the Administrator. In an interview on 07/22/25 at 5:41 pm LVN E said he worked PRN for 2 or 3 months. LVN said he was familiar with Resident #88. LVN said Resident #88 needed a lot of redirections. LVN E said if someone got in her way, she became upset. If it was a person in a wheelchair, Resident #88 would try to push them around because she thought she was helping them. LVN E said they tried to verbally deescalate the situation and redirect Resident #88. Usually if they offered food, drink, or candy it would help redirect Resident #88 from the situation. LVN E said they also had her at the nurse's station with the nurse. Resident would stay a while then would get up again. Resident #88 was currently on a one to one in her room. Resident was allowed to come out and walk around the facility with the sitter (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	following Resident #88. LVN E said they have in-services on abuse/neglect monthly. In an interview on 07/23/25 at 5:00 pm, the Psychiatric NP said she had not seen Resident #88 since April. The NP said she did not know that Resident #88 was on more than one antipsychotic. Surveyor asked NP what the behavioral plan for Resident #88 was and she said they had to rule out medical issues, see if something physiologically was causing the behaviors. The NP said then they could prescribe medications at a medium dose and see how the resident was doing on them. Then they needed to see if the resident's family was supportive of resident taking the medications. The NP said the resident could benefit with psychological counseling. In an interview on 07/24/25 at 4:40 pm the Administrator said his responsibility was to know what was going on in the facility. The Administrator said they had morning meetings, and, in the afternoon, they had stand down meetings. They discussed any concerns regarding resident care or grievances from families. The Administrator said they educated staff on the need to report any and all abuse. They tell staff that they needed to report abuse and if they did not report it then they were just as guilty as the person abusing a resident. They would investigate all incidents and reported any incident that could be considered abuse, neglect, or misappropriation. The Administrator said Resident #88 had been getting aggressive more often and that was the reason they had provided a 30-day discharge notice to the family. Resident #88 has been seen by a psychiatric NP and was put on a one-to-one monitoring since 06/28/25. Record review of Resident #88's 30-day notice of discharge revealed the Notice of Involuntary Transfer or Discharge and Opportunity for Appeal was provided to Resident #88's Responsible Party on 07/07/25. The notice indicated the reason for the notice was This discharge, or transfer is necessary for your welfare because your needs can not be met in this facility, as documented in your clinical record by your physician. 42C.F.R.S483.15(C)(1)(A); 40 Tex. Admin. Code 19.502(b)(1). In an interview on 07/07/25 at 8:56 am LVN A has been employed about three months. LVN A said her responsibilities were to make sure the residents were safe, and their needs were met. LVN A said she would report to the physician any change of condition to the residents and make sure the labs were done and results sent to physician. LVN A said she also supervises the CNAs to make sure they were treating residents kindly and interacting with them gently. They have in-services on abuse/neglect frequently and there was a resident on the other side of the hall that has behaviors and would fight with other residents. They would have an in-service on abuse/neglect after each incident. They had an in-service on abuse/neglect last week. The abuse Coordinator was the Administrator. LVN A said if a resident hit another resident that was considered abuse. LVN A said the residents needed to be separated and assessed for injuries. Then she would document and would report any change in condition to the RP, physician, DON and the Administrator. LVN A said an aggressive resident needs to be monitored frequently. LVN A said she would contact the physician, and they might give orders for an antipsychotic medication, call the RP to inform of the incident and request consent before administering the medication. In an interview on 07/25/25 at 9:56 am CNA M said her responsibilities were to attend to the resident's needs. Whatever the resident needs she would attend to them. CNA M said they would check on a resident with aggressive behavior or wandering into other resident room often. CNA M said they would offer snacks or give Resident #88 activities to do. CNA M said Resident #88 liked to push the residents in the wheelchairs but when resident would refuse the help Resident #88 would get mad. CNA M said they would redirect her by telling her Let's go to the dining room for coffee or let's go do an activity then the resident would go with her. Resident #88 liked coloring, and they would provide coloring pages and crayons. Resident #88 would be taken to the Activity room, and she would sit there to color pages. The nurses also kept her at the nurse's station with them. CNA M said the types of abuse were physical verbal, sexual and when a resident asked them to be showered, or for water and the staff ignored the resident then that was neglect. CNA M said if she saw a resident being abused, she would separate the resident from that person and then she would report it to her supervisor. The Administrator was the Abuse Coordinator. CNA M said she would report the abuse right away. In an interview on 07/25/25 at 10:12 am the SW said Resident #88 needed (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	redirection by distracting resident to do something else. The SW said she would take Resident #88 to her office and gave her a pen, notebook, and a snack. Resident #88 would finish eating the cookie and she would want to get up and leave. The SW said she tried to get resident to write in a notebook, but she would only write for a few seconds and then would get up and walk away. The SW said it was constant redirections. SW said Resident #88 had a short attention span of a few seconds. Resident #88 had difficulty focusing on a task and following directions. Directions had to be broken down in small steps. The SW said the family did attend the care plan meeting via phone and lately in the facility. The last care plan meeting was at the facility. The daughter came in with the Ombudsman. The SW said the daughter was informed of the incidents Resident #88 had with other residents. The family was fine with whatever medications the doctor prescribed. The facility asked that the family to come more often to stay with resident, but they did not come very often. The SW said the DON made a power point in-service on dementia. It addressed the medical and personal effects of dementia and the different types of behaviors. The SW said Resident #88 was sent to the hospital on [DATE] to be cleared medically and then sent to the behavioral center to be stabilized. Resident #88 would then be sent to a long-term care facility in San [NAME] with a memory unit. In an interview on 07/25/25 at 10:54 am the DON said when a resident was identified with behaviors, they would monitor the resident by keeping her close to a nurse or with the DON in her office. They encouraged the resident to be taken to activities and for the family to visit her. The DON said they would ask resident if she wanted to go color. Redirection was used for the resident to do tasks or activities that she liked doing. Maybe make a bed, fold clothes, or color pages. The DON said they needed to be able to find the triggers that sets Resident #88 off. DON said she asked the daughter, but the daughter said Resident #88 did not have any triggers. DON said the daughter was not able to help them find what caused the resident's aggression. She would do an in-service on whatever the incident was about. If it was abuse/neglect or misappropriation she would train staff on it. The DON said she had conducted a presentation earlier this year on dementia and behaviors. The DON said they did train on abuse/neglect monthly and whenever there was an incident. The DON said Resident #88 was discharged to the hospital to clear her medically before she was sent to the Behavioral Center. Record review of her Immediate Discharge Notice dated 07/24/25 with Effective Date of Discharge 07/24/25 and the reason was for the health and safety of resident or others and the location was to a local hospital. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from were verbal and physical abuse by a resident for 6 of 6 residents (Residents #5, #71, #82, #88, #95, #99) reviewed for abuse, in that: 1.The facility failed to ensure Resident #71 was free abuse when Resident #88 hit Resident #71 on the head on 01/24/25. 2. The facility failed to ensure Resident #71 was free from abuse when Resident #88 had a physical altercation with Resident #71 on 04/05/25. 3. The facility failed to ensure Resident #82, and Resident #99 were free from abuse when Resident #88 had a physical altercation with Resident #82 and Resident #99 on 06/04/25. 4.The facility failed to ensure Resident #5 was free from abuse when Resident #88 entered Resident #5's room and attempted to pull Resident #5 from her wheelchair on 06/22/25. 5.The facility failed to ensure Resident #95 was free from abuse when Resident #88 went up to Resident #95 and attempted to remove her from her wheelchair. Resident #88 shook Resident #95 and then slapped her on the side of her head on 06/28/25. An IJ that occurred in the past was identified. The IJ began on 01/24/25 and removed on 06/28/25. The facility took action to remove the IJ before survey began. While the IJ was removed on 06/28/25, the facility remained out of compliance at a scope of K and a severity level of no actual harm with a potential for more than minimal harm because all staff had not been trained on abuse/neglect. This failure has the potential to result in serious injury or death as a result of abuse and neglect. The findings were: 1. Record review of Resident #88's Face Sheet dated 07/24/25 revealed she was a [AGE] year-old female admitted to facility on 10/24/24 with diagnoses of Alzheimer's disease (a progressive disease that destroys the memory and other important mental functions), anxiety disorder, unspecified psychosis (a mental health condition characterized by a loss (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of contact with reality, often involving symptoms like hallucinations and delusions), and major depressive disorder, recurrent, severe with psychotic symptoms. Record review of Resident #88's quarterly MDS dated [DATE] revealed Resident #88 was usually understood by others and usually was able to understand others. She had a BIMS score of 02 which indicated severe cognitive impairment. Resident had physical behavioral symptoms directed toward others (hitting, kicking, scratching, grabbing), verbal behavioral symptoms directed toward others (screaming at others, cursing at others) and other behavioral symptoms not directed toward others (physical symptoms such as hitting, pacing, rummaging or verbal symptoms like screaming, disruptive sounds). Record review of Resident #88's comprehensive care plan revised on 05/28/25 revealed Resident #88 has been physically aggressive (hitting staff or other resident) r/t dementia: 01/24/25 - Resident became physically aggressive toward another resident The care plan included the following interventions:-When resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk away calmly and approach later. Record review of Resident #88's Physician's Order Summary for July 2025 revealed orders for: --Gabapentin oral capsule 100 mg, give two capsules by mouth three times a day related to emotional lability, order date 06/09/25.Haldol Decanoate intramuscular solution 50 mg/ml, inject 50 mg intramuscularly monthly starting on the 10th and ending on the 10th every month for agitation, order date 07/06/25 and start date on 07/10/25.Latuda oral tablet 20 mg, give 1 tablet by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic symptoms, order date 06/11/25 and start date 06/12/25.Zyprexa oral tablet 5 mg (Olanzapine), give 5 mg by mouth two times a day related to unspecified psychosis, order date 06/13/14 and start date 06/14/25. Record review of Resident #88's progress notes dated from 06/28/25 to 07/25/25 revealed Resident #88 was put on a continuous one-to-one monitoring until Resident #88 was admitted to a facility in San [NAME]. Record review of Resident #71's Face Sheet dated 07/24/25 indicated she was [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.), anemia (a problem in which the blood does not have enough healthy blood cells to carry oxygen to throughout the body), and hypertension (when the blood pressure in the blood vessels is too high). Record review of Resident #71 quarterly MDS dated [DATE] indicated Resident #71 was understood by others, and was able to understand others, did not have any behaviors, and had a BIMS score of 05 which indicated she had moderate cognitive impairment. Record review of facility's Provider Investigation Report dated 01/24/25 revealed Incident date and time: 01/24/25 at 4:00 pm. Nurse Aide saw Resident #88 go hit Resident #71's in the back of the head and pull her hair. Record review of the Provider Action Taken Post Investigation dated 01/24/25: Head to toe assessment performed on 01/24/25 for Resident #71 revealed no other visible injuries noted. Employees were in-serviced on resident-to-resident abuse and resident de-escalation techniques. Social Services did resident safe interviews. Resident behaviors care planned. Staff will keep both residents apart when in close proximity or when doing social activities. Care Plans for both residents updated. Observation of 07/21/25 at 9:32 am revealed Resident #88 in bed on her side with the lights off and a CNA in the room. Resident #88 was still in her pajamas and shoes on. Resident #88 did not respond to greeting and questions regarding incident with Resident #71. In an interview on 07/21/25 9:57 am CNA K said Resident #88 was able to walk and wandered throughout the building, but they had to shadow her to prevent aggressive behaviors toward other residents. If resident was on her own, she would fight with other residents. CNA K said Resident #88 cried a lot and the other residents became impatient with her and then she became aggressive. CNA K said when resident was on her own in her room, she was ok. CNA K said if they gave her colors and pages to color, she would do it. 2. Record review of Incident Report dated 04/05/25 revealed Resident #88 hit Resident #71 on her back and took some coloring pages from her. Resident #88 was separated from Resident #71. Head to toe evaluation of both residents by LVN revealed no injuries to either resident. Record review of Resident #88's care (continued on next page)		

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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 07/25/2025
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	plan was revised on 04/08/25 to include incident on 04/05/25 with aggressive behavior with interventions to monitor for sundowning behavior, continue sertraline100 mg daily (antidepressant), follow up counseling and psych recom		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that described the services to be provided to attain or maintain the residents' highest practicable physical, mental, and psychosocial needs, for 1 (Resident #88) of 4 residents reviewed for care plans in that: The facility failed to implement individualized interventions to address Resident #88's behaviors of aggression toward other residents from 01/24/25 through 06/28/25. This failure could place residents at risk of injuries and their medical, physical and psychosocial needs not being met. Record review of Resident #88 Face Sheet dated 07/24/25 revealed she was a [AGE] year-old female admitted to facility on 10/24/24 with diagnoses of Alzheimer's disease, anxiety disorder, unspecified psychosis and major depressive disorder, recurrent, severe with psychotic symptoms. Record review of Resident #88's quarterly MDS dated [DATE] revealed Resident #88 was usually understood by others and usually was able to understand others. She had a BIMS of 02 which indicated Resident #88 had severe cognitive impairment. Resident #88 had physical behavioral symptoms directed toward others (hitting, kicking, pushing, grabbing), verbal behavioral symptoms directed toward others (screaming, cursing at others), and other behavioral symptoms not directed toward others (physical symptoms such as hitting, scratching self, pacing, rummaging or verbal symptoms like screaming). Record review of Resident #88's comprehensive care plan revised on 05/28/25 revealed Resident #88 has been physically aggressive (hitting staff or other resident) r/t dementia: 01/24/25 - Resident became physically aggressive toward another resident 04/05/25 - resident had a physical aggression 05/31/25 - Resident wanted another female's wheelchair 06/01/25 - resident hit another resident 06/04/25 - got into altercation with another female resident 06/07/25 - Resident went into another female resident's room attempting to take her wheelchair 06/28/25 - Resident went up to another female resident and shook her/slapped her on the side of the head. The care plan included the following interventions: -When resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk away calmly and approach later. -05/31/25 Resident's RP came to stay with resident. NP gave order for Haldol IM x1. Pending UA results. Record review of -06/04/25 Resident seen by psych nurse on 06/03/25 had Hydroxyzine d/c. Started on Latuda and Trazodone 500mg BID for 14 days. Sent to ER for further evaluation and treatment. -06/07/25 Resident stayed with nurses at nurses' station for remainder of shift. Resident would be taken for brief change and brought back to nurse's station. -Administer medications as ordered, Monitor/document for side effects and effectiveness. -Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. -Assess and address for contributing sensory deficits. -Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level body positioning, pain, etc. -Give the resident as many choices as possible about care and activities. -06/22/25 Charge nurse sat at the entrance of hallway throughout the rest of shift and 10-6, -06/28/25 Resident redirected to her room, given food, checked for soiled brief. Resident was placed on a one-to-one. Record review of Resident #88's comprehensive care plan revised on 05/28/25 revealed Resident #88 has been physically aggressive (hitting staff or other residents) r/t dementia but did not reveal any individualized interventions to prevent Resident #88's aggression toward other residents. Record review of Resident #88's Physician's Order Summary for July 2025 revealed orders for: gabapentin oral capsule 100 mg, give two capsules by mouth three times a day related to emotional lability, order date 06/09/25. Haldol Decanoate intramuscular solution 50 mg/ml, inject 50 mg intramuscularly monthly starting on the 10th and ending on the 10th every month for agitation, order date 07/06/25 and start date on 07/10/25. Latuda oral tablet 20 mg, give 1 tablet by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms, order date 06/11/25 and start date 06/12/25. Zyprexa oral tablet 5 mg (Olanzapine), give 5 mg by mouth two times a day related to unspecified psychosis, order date 06/13/14 and start date 06/14/25. Record review of Psychiatric Progress Note dated 04/24/25 by NP revealed Resident #88 was tearful, confused and wanted to go home to see her mother and father. Patient has many altercations with female residents. The NP last saw Resident #88 on 04/24/25. Observation on 07/21/25 at 9:32 am revealed Resident #88 was in bed with her eyes closed, she was wearing pink and white pajamas and white and pink shoes. Resident #88 had her hair up. The lights were off. There was a CNA in the room with the resident. Resident #88 was asking for water. The CNA gave the resident some water. Resident #88 was on a one-to-one supervision. In an interview on 07/21/25 at 9:57 am CNA K said Resident #88 had been crying. CNA K said she asked Resident if she wanted to go walking outside but she did not want to go. CNA K said Resident #88 was able to walk and wandered throughout the building, but they had to shadow her. If resident was on her own, she would get into a fight with other residents, so she was on a one-to-one around the clock. CNA K said Resident #88 cries a lot and the other residents got impatient with her and then she got aggressive. CNA K said when resident was on her own, she was ok. CNA K said if they gave her colors and pages to color, she would do it. Resident #88 was a librarian, and she recalled being there and wanted the door to be opened because the children were coming. Resident #88 also recalled her family members and cried because she missed them. In an interview on 07/22/25 at 5:28 pm CNA L said Resident #88 would cry constantly. Resident #88 would walk around the facility. CNA L said Resident #88 was currently on a one-to-one because she was in an altercation with another resident. Resident #88 slapped another resident and was put on a one to one. CNA L said today Resident #88 was in a good mood. CNA L said Resident #88 saw CNA and came and hugged her. Before being on a one-to-one Resident #88 would go into different rooms and they would have to redirect her before she got upset and started a fight with a resident. In an interview on 07/22/25 at 5:41 pm LVN E said he was familiar with Resident #88. LVN E said Resident #88 needed a lot of redirections. LVN E said he was not aware that Resident #88 had a trigger that would lead her to become aggressive. LVN E said if someone got in her way she got upset. If it was a person in a wheelchair, she would try to push them around because she thought she was helping them. LVN E said they tried to verbally deescalate the situation and redirect Resident #88. He would call the physician if the situation became serious. Usually if they offered food, drink, or candy it would help redirect Resident #88 from the situation. LVN E said they also had her at the nurse's station with the nurse. Resident #88 would stay a while then would get up again. Resident #88 was currently on a one to one in her room. Resident #88 was allowed to come out and walk around the facility with the sitter following Resident #88. In an interview on 07/23/25 at 5:00 pm, the NP said she had not seen Resident #88 since April. NP said she would never prescribe 2 or 3 antipsychotics to a patient with dementia. NP said she did not know that Resident #99 was on more than one antipsychotic. Surveyor asked NP what the behavioral plan for Resident #88 was and she said they had to rule out medical issues, see if something physiologically was causing the behaviors. The NP said then they could prescribe medications at a medium dose and see how the resident was doing on them. Then they needed to see if the resident's family was supportive of the resident taking the medications. The NP said the resident could benefit with psychological counseling. In an interview on 07/24/25 at 2:15 pm MDS O and MDS P said they do not develop the care plans for residents when there was a change in condition. They develop the care plans that were triggered by the MDS at admission, quarterly or annually. The DON or the nurses do the care plans for change of condition such as falls, infections, and behaviors. In an interview on 05/25/25 at 10:54 am the DON said when they had identified Resident #88 with behaviors, they would monitor resident by keeping her close to a nurse or with her in her office. They encouraged Resident #88 to be taken to activities and for the family to visit her. Redirection was used for the resident to do tasks or activities that she liked doing. Maybe have her make a bed, fold clothes, or color pages. The DON said they would ask resident if she wanted to go color. The DON said they needed to be able to find the triggers that set Resident #88 off. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said she asked the family member, but the family member said Resident #88 did not have any triggers. The DON said the family member was not able to help them find what caused the resident's aggression. Record review of facility's policy for Care Plans, Comprehensive Person-Centered revised December 2016 revealed: 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. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: a. include measurable objectives and time frames. b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 9. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to maintain 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 3 (Resident #6, Resident #96, and Resident #66) of 7 residents reviewed for infection control, in that:1) The facility failed to ensure that LVN D performed hand hygiene for at least 20 seconds prior to and after medication administration for resident #6. 2) The facility failed to ensure that CNA H and CNA I followed the Enhanced Barrier Precautions (EBP) when they did not wear a gown while providing perineal/foley care to Resident #96.3) The facility failed to ensure that LVN G and LVN J put on PPE when they entered Resident #66's room who was on isolation precautions. These failures could place residents at risk for healthcare associated cross-contamination and infections. Findings included: Record review of Resident #6's face sheet 07/23/25 reflected a [AGE] year-old-female with an initial admission date of 12/06/22. Diagnoses included Encephalopathy (damage or disease that affect the brain), dysphasia (difficulty swallowing) following cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), chronic obstructive pulmonary disease (lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants), and gastrostomy status (medical condition of a patient with a gastrostomy tube). Record review of Resident #6's Quarterly MDS assessment, dated 06/20/2025 revealed a BIMS score of 2, which indicated Resident #6's had severe cognitive impairment. Further review revealed nutritional status was a feeding tube. During an observation of medication administration on 07/22/25 at 7:20 AM, LVN D performed hand hygiene for 11 seconds prior to Resident #6's medication administration. After medication administration, LVN performed hand hygiene for 13 seconds. In an interview on 07/22/25 at 11:55 AM, LVN D was able to recall the steps for proper handwashing. LVN D stated that rubbing soap on hands should have been for at least 15 seconds. LVN D stated she was aware she did not rub her hands with soap long enough. LVN D stated it was important to rub hands with soap for at least 15 seconds to reduce bacteria. LVN D stated that the negative outcome to not having washed hands properly would have led to passing infections. LVN D stated, Somebody could have had something, and it could have been transmitted to someone else. LVN D could not recall when the last infection control in-service (training) was but stated it was some time this past month. LVN D stated hand hygiene was one of the topics discussed in the last in-service. In an interview on 07/25/25 at 9:20 AM, the DON stated staff should wash their hands for more than 20 seconds because that was the recommended time to remove pathogens from the hands according to CDC. The DON stated it was important to wash hands thoroughly because germs and infections can be transmitted from person to person whether being a resident, staff, or a visitor. The DON stated that staff were in-serviced almost weekly on infection control which included teachings on proper hand hygiene. The DON stated random spot checks were done to ensure staff and nurses were washing their hands according to the policy. Record review of the facility's Handwashing/ Hand Hygiene policy dated August 2019 revealed: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy statement: This facility considers hand hygiene the primary means to prevent the spread of infections. The Policy Interpretation and Implementation: All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Procedure for Washing Hands: 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 5. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis. The following resource was found on the CDC website at https://www.cdc.gov/clean-hands/about/index.html reflected: The CDC handwashing guidelines recommend the following steps for effective handwashing: 1. Wet your hands with clean, running water (warm or cold), and turn off the tap. 2. Apply soap and lather your hands by rubbing them together, including the backs of your hands, between your fingers, and under your nails. 3. Scrub your hands for at least 20 seconds. 4. Rinse your hands well under clean, running water. 5. Dry your hands using a clean towel or air dry them. Use hand sanitizer when you can't use soap and water. 2) Record review of Resident #96's electronic face sheet dated 07/23/2025 reflected the resident was a 93 -year-old male admitted to the facility on [DATE] with an original admission date of 01/19/2022. Resident #96 pertinent diagnoses which included the following: Obstructive and Reflux Uropathy (a condition in which urine was blocked or functional impediment of urine flow), Retention of Urine (a condition in which urine cannot empty from the bladder), Atrophy of Kidney (the kidney was smaller than average), Dementia, and Heart Failure. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #96's Quarterly MDS assessment, dated 06/19/2025, reflected she scored a 3 on her BIMS which reflected severely cognitively impaired. Resident #96 had an indwelling catheter and was dependent on personal hygiene. During an observation on 07/22/2025 at 2:15 p.m. revealed that CNA H and CNA I did not wear a gown, only gloves to provide perineal care to Resident #96 who had a foley catheter. There was an Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of drug-resistant organisms) sign posted on Resident #96 's door. In an interview on 07/22/2025 at 3:07 p.m. CNA H stated that she has had in services for enhanced based precautions upon hire. She stated that staff were to wear gloves and gowns when providing patient care to residents who were on EBP. These residents were identified by an EBP sign posted on the outside of their door. CNA H stated that she forgot to put on a gown because she did not see any nearby. She stated that it was important to put on proper PPE to prevent infection. In an interview on 07/22/2025 at 3:15 p.m. CNA I stated that staff were to wear gloves and gowns when providing patient care to residents who were on EBP. These residents were identified by an EBP sign posted on the outside of their door. He stated that he forgot to put on a gown. He stated that it was important to put on proper PPE to prevent the spread of infection. He stated that he has had in services for enhanced based precautions about a month ago. 3) Record review of Resident #66's electronic face sheet dated 07/21/2025 reflected the resident was a 93 -year-old female admitted to the facility on [DATE]. Resident #66 pertinent diagnoses which included the following: COVID-19, Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out simple tasks), Type 2 Diabetes Mellitus (high blood sugar levels), Heart Failure, Chronic Kidney Disease, stage 3 (kidneys were damaged and cannot filter blood properly). Record review of Resident #66's MDS BIMS, dated 07/21/2025, reflected she scored a 0 on her BIMS which reflected severely cognitively impaired. Record review of the Physician's Order Summary reflected Resident #66 May be on Isolation/Quarantine precautions d/t covid positive every shift COVID 19 protocol Start Date: 07/15/2025. During an observation on 07/21/2025 at 10:50 a.m. revealed LVN G and LVN J entered Resident #66's room without donning (to put something on) gown, gloves, or mask. A droplet precaution (extra steps taken to prevent the spread of germs that travel in tiny droplets from a sick person's cough, sneeze, or even talking) sign was posted on the door. No PPE was available on the outside of the room. Family members in the room were only wearing face masks. In an interview on 07/21/2025 at 10:55 a.m., family members stated that they were not informed of having to wear a gown or gloves when visiting Resident #66 and that they visited her every day since she was admitted on [DATE]. In an interview on 07/21/2025 at 10:58 a.m., LVN G stated she was the floor nurse for Resident #66. She was not sure who was responsible for setting up PPE outside of isolation rooms. She stated that she did educate family members on using PPE, which includes gloves and gowns, when entering Resident #66's room but she does not think they understood the concept. LVN G stated that she (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	forgot to use PPE when entering Resident #66's room. She said isolation precautions required staff to wear a mask, gown, and gloves every time prior to entering the room. LVN G stated if they did not follow the instructions on the precaution signs located outside of resident's rooms, they could spread infection to other residents and themselves. In an interview on 07/21/2025 at 11:04 a.m., LVN J stated that she was responsible for placing PPE outside the resident's isolation rooms. She stated she was the infection preventionist and wound care nurse for the facility. She stated the staff was required to wear a gown, gloves, and face mask whenever they go into Resident #66's room. LVN J stated that she forgot to put on a gown and gloves when she entered the room. She stated it was important for staff and families to use the proper PPE to avoid the spread of infection. In an interview on 07/21/2025 at 4:09 p.m. the DON stated that the IP, LVN J, trains infection control and she assists. She stated in the training, they go over EBP and isolation transmission-based precautions. She stated staff were to wear PPE, gloves and gowns, when providing patient care for EBP residents. The DON stated there were three types of transmission-based precautions, airborne, droplet, and contact. She stated that LVN J was responsible for placing PPE on the outside of the isolation rooms. The DON stated if a resident was in isolation precautions for COVID-19, staff and family members must wear a gown, gloves, and face mask prior to entering the resident's room and the resident's door was to be kept closed. She stated that this was important to prevent infection from spreading. In an interview on 07/24/2025 at 3:39 p.m. the ADM stated that the DON and the infection preventionist were responsible for in-service training for infection control. He stated they do admit residents with an array of infections and follow protocols for them. He stated that he has been here since April 2025, and they have had several infection control trainings. He does attend these trainings. He was aware that for residents on isolation precautions they must use appropriate PPE when providing care and remove PPE before exiting the rooms. He said for residents on EBP, they must gown up and wear gloves while providing direct care. He said for residents on isolation precautions for COVID-19, they do have to wear a face mask, gowns, and gloves before entering the room. The ADM stated that this was important to not spread infection. Record review of the facility In- Service Sign in Sheet reflected, Topic: EBP Precautions, Contact, Droplet. Dated 06/10/2025. Record review of the facility policy, titled Enhanced Barrier Precautions, revised 04/2024, reflected Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions: b. indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes) Record review of the facility policy, titled Isolation-Categories of Transmission-Based Precautions, (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised October 2018, reflected Policy Statement: Transmission based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Explanation and Compliance Guidelines: 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of of transmission-based precautions are contact, droplet, and airborne. Droplet Precautions: 3. Mask will be worn when entering the room. 4. Gloves, gown and goggles should be worn if there is risk for spraying respiratory secretions. Record review of the facility policy, titled Infection Control Guidelines for All Nursing Procedures, revised August 2012, reflected Purpose: To provide guidelines for general infection control while caring for residents. General Guidelines: 2. Transmission Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. 5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infected materials.		

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 07/25/2025
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for 1 (Resident #6) of 9 residents reviewed for call lights. The facility failed to ensure Resident #6 had the call light within reach in the morning while in bed. This failure could place residents at risk of being unable to obtain assistance or help when needed and in the event of an emergency. Record review of Resident #6's face sheet dated 07/23/25 reflected a [AGE] year-old-female with an initial admission date of 12/06/22. Diagnoses included Encephalopathy (damage or disease that affect the brain), dysphasia (difficulty swallowing) following cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), muscle wasting and atrophy (a decrease in muscle size and strength, often resulting from disuse, nerve damage, or certain diseases), history of falling, and lack of coordination. Record review of Resident #6's Quarterly MDS assessment, dated 06/20/2025 revealed a BIMS score of 2, which indicated Resident #6's had severe cognitive impairment. Resident #6 used a wheelchair. Observation on 07/21/25 at 9:45 AM revealed Resident #6's call light was pinned to the bed sheet at the top edge of the bed. Resident #6 was unable to reach the call light. During an interview on 07/21/2025 9:53 AM, LVN B observed Resident #6's call light device pinned at the top edge of the bed and that Resident #6 was not able to reach it. LVN B stated that Resident #6 was supposed to have the call light close to call for help. LVN B stated that Resident #6 does not like to use the call light at times, but he knows that all residents were to have their call lights accessible. LVN B stated that a negative outcome for the resident having not having her call light near could have resulted in an unnecessary fall or injury. During an interview on 07/25/25 at 9:20 AM, the DON stated that all nurses and CNAs must check on residents frequently. Part of those checks were to ensure that the call lights were within residents' reach. The DON stated that a negative outcome of the resident not having her call light within reach could have resulted in an unnecessary fall. Record review of facility's policy titled Answering the Call Light dated March 2021 stated; Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #100) of 8 residents reviewed for Advance Directives. The facility failed to ensure Resident #100's OOH-DNR was completed. The OOH-DNR form did not have the physician's signature. This failure could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: Record review of Resident #100's electronic face sheet dated [DATE] reflected the resident was a [AGE] year-old male originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. His diagnoses included: Respiratory Failure, Metabolic Encephalopathy (any disease or disorder of the brain, characterized by changes in brain function or structure), Type 2 Diabetes Mellitus, Hypertension (high blood pressure), Acute Kidney Failure. Resident #100's electronic face sheet reflected Code Status: DNR. Record review of Resident #100's MDS assessment dated [DATE] reflected he scored a 7 on his BIMS which reflected severely cognitively impaired. Record review of Resident #100's undated comprehensive care plan reflected, Resident #100's Advanced Directives: Code Status: Full Code Date Initiated: [DATE]. Goal: Resident/Family Wishes will be honored through next review. Interventions: Initiate CPR as indicated. Record review of Resident #100's physician order dated [DATE] reflected ***Code Status: ***DNR*** Record review of Resident #100's OOH-DNR form undated reflected the form was signed in section B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication: agent in a medical power of attorney The OOH-DNR revealed the form was not signed by the attending physician below section E, Physician's Statement: I am the attending physician of the above noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in our-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. It also revealed the physician did not sign section F, All persons who have signed above must sign below, acknowledging that this document has been properly completed. In an interview on [DATE] at 12:30 p.m., LVN A stated that the DNR form was discussed upon admission. She stated residents who were DNR should have a completed and signed by all parties, the OOH DNR. She stated all parties were residents or family, witnesses, and the doctor. LVN A stated that until they have completed signed OOH DNR, the resident was considered a full code. They would have to provide CPR causing the resident harm. She stated that the DNR status of a resident was located on PCC. LVN A stated if it showed DNR on PCC that meant the OOH DNR form had been verified and completed. In an interview on [DATE] at 2:50 p.m., Social Services stated that she was the one responsible for completing the OOH DNR form. She stated that upon admission, she informed the resident and/or family of their rights regarding the DNR status. If it was confirmed for the resident to be DNR, she provided them with the form, and obtained their signatures, and the doctor 's signature. She stated that the OOH DNR form should be signed by the doctor as soon as possible. She called the hospice 's office to notify her of needing a signature. She stated that it was important for the OOH DNR form to be signed by the doctor because it makes the document official, a legal document that all parties signs. The Social Services stated the DNR was not complete until the doctor signed it. In an interview on [DATE] at 2:20 p.m., DON stated that the social worker was responsible for completing the OOH DNR form. She stated the facility explains the document and if they say yes that they want to be DNR, the facility would obtain the resident/RP and witnesses signatures. They then call MD for an order and change the DNR status in PCC. The DON stated that it was important for the MD to sign the OOH DNR form to verify that they agree to the process. She stated that it was an (continued on next page)		

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Form Approved OMB
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	official legal form. She stated that form and the order had to match, along with the care plan. Record review of the facility's Do Not Resuscitate Order policy date reviewed/revised [DATE], revealed the Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a do not resuscitate order in effect. 1. Do not resuscitate orders must be signed by the resident's attending physician in the resident's medical record.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency for 1 of 2 Residents (Resident #1) who were reviewed for misappropriation of property in that: The facility failed to report when Resident #1 gave CNA T money to buy gift cards. This failure could place residents at risk for potential abuse/misappropriation of property/exploitation due to not having allegations reported as required. Findings were: Record review of Resident #1's admission Record dated 07/24/25 reflected a [AGE] year-old female admitted on [DATE] with a readmission date of 08/08/24. Her diagnoses included Generalized Anxiety (mental health condition, excessive, persistent worry about everyday things), Essential (Primary) Hypertension (persistently high blood pressure) and Type 2 Diabetes Mellitus with Diabetic nephropathy (kidney complication of type 1 and 2 diabetes). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected her BIMS score was 14, which reflected her cognition as intact. In an interview on 07/22/25 at 5:30 pm the BOM said she had been trying to assist Resident #1 in applying for Medicaid services and requested Resident #1's bank statements. She said at first Resident #1 had been hesitant to provide them but had eventually done so. She said she noticed a few large amounts of transactions along with a name that she had thought might have been an employee working at the facility so she had asked HR if that was a current employee. She said HR looked into and reported it to the Administrator. In an interview on 07/22/25 at 5:30pm HR said the BOM brought to her attention the withdrawals to Resident #1's bank account. BOM said she spoke to Resident #1 who said she had been giving CNA T money to buy her gift cards. She then said she and the Administrator H spoke with CNA T who confirmed that Resident #1 was giving her money to buy the gift card sfor her. The BOM said staff were not supposed to be accepting or taking money from residents for any reason. She said they terminated CNA T's employment. In an interview on 07/24/25 at 5:42 pm CNA T said Resident #1 had given her money on several occasions so she could buy gift cards for Resident #1. She said Resident #1 wanted them so she could give them to her boyfriend. She said Resident #1 trusted her. CNA T said she knew she was not supposed to accept or take money from any resident even if it was to buy something for the resident. She said the facility had in serviced her on that before. CNA T said she never told anyone what she was doing. She said when the facility found out, they terminated her employment immediately. In an interview on 07/24/25 at 5:53 pm the Administrator said he was not employed at the facility at the time of the incident involving Resident #1. He said he only recently found out about it and was told the reason it was not reported was because Resident #1 said she gave CNA T the money. He said this incident should have been reported because staff were not supposed to accept or ask Resident's for money for any reason. At the time of the investigation, Resident #1 had a planned discharge and was no longer residing at the facility. Resident #1 was her own Responsible Party and her telephone number listed was not a working number. Neither the Administrator at the time nor the DON were employed at the facility at the time of the investigation. Record review of the facility's policy titled; Abuse Prevention Program revised date December 2016 states; Policy Statement Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and ImplementationAs part of the resident abuse prevention, the administration will: . 6. Identify and assess all possible incidents of abuse;7. Investigate and report any allegations of abuse within timeframes as required by federal requirements;		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move for 1 of 4 (Resident #105) reviewed for notifying the LTC Ombudsman of the residents' discharge, in that: Resident #105 was discharged to family member who was traveling to [NAME] and was planning to admit to another LTC facility on 05/15/2025 without a notice to the LTC state ombudsman. This failure could place residents at risk of not knowing their rights and receiving the services of the state LTC Ombudsman. Record review of Resident #105's electronic face sheet dated 07/24/2025 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and a discharge date of 05/15/2025. His diagnoses included Osteoarthritis (a condition that causes joint pain and stiffness due to the breakdown of cartilage), Major Depressive Disorder, Muscle Wasting and Atrophy (muscles shrinking and getting weaker), Type 2 Diabetes Mellitus (high blood sugar levels), Schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), Bipolar Disorder (a mental health condition that causes extreme shifts in mood, energy, and ability to function), Anxiety Disorder, and Acute Kidney Failure (the sudden loss of your kidneys' ability to remove waste and help balance fluids and electrolytes in your body). Record review of Resident #105's comprehensive MDS dated [DATE] reflected a BIMS score of 12 indicating moderately impaired cognition. Record review of Resident #105's electronic medical record reflected a progress note dated 05/15/2025 stating Resident #105 had been picked up by family member upon discharged from current facility to admit a local nursing facility in [NAME]. Traveling via private vehicle. Record review of Resident #105's electronic medical record from 05/05/2025 to 05/21/2025 reflected no evidence of notice given to the LTC Ombudsman pertaining to Resident #105's discharge. Record review of the ombudsman email that was sent to the surveyor on 07/23/2025 at 7:11pm reflected that she reviewed the monthly discharge log for June 2025 that the facility emailed. She was not made aware of Resident #105 discharge on [DATE]. During an interview on 07/23/2025 at 4:17 p.m. the Social Worker stated that she submits a list of discharges every first day of the month to the ombudsman with the discharges from the month prior. She stated that a copy of this list was sent to the administrator and corporate office. She stated that for residents that were discharged in May 2025, she sent the list to the ombudsman on 06/1/2025. The Social Worker confirmed that Resident #105 was not on the list that was submitted to the ombudsmen on 06/01/2025. She stated that it was an oversight. The Social Worker stated that it was important to notify the ombudsman of discharges that were unexpected, unfavorable, and unsafe for her to keep track. She stated Resident #105 slipped through the cracks. During an interview on 07/24/2025 at 3:39 p.m. the ADM stated that he looked up the new regulation regarding notifying the ombudsman on the facility's discharges. He stated that he has been doing this for over twenty years and had not heard of it until now. The Social Worker sends him and the ombudsman a monthly list for the discharges of the month prior via email. The ADM stated that unfortunately, Resident #105 was left off the list for the May 2025 discharges. He stated that it was important for the ombudsman to be notified because she confirms that it was a safe discharge and if she has any other questions. He stated that it was important for them to keep an open line communication with the ombudsman. Record review of the facilities policy titled Transfer or Discharge Notice, date revised: December 2016 revealed: Policy Statement: Our facility shall provide resident and/or the residents representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge. Policy Interpretation and Implementation: 1. A resident, and/or his or her representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge. 4. A copy of the notice will be sent to the Office of the State Long Care Ombudsman.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was given medications by enteral means received appropriate treatment and services to prevent complications for 1 of 2 residents (Resident #90) reviewed for gastrostomy tubes in that: LVN C did not check for residual of Resident #90's gastrostomy tube (G-Tube) prior to administering medications. This failure could place residents with G-tube at risk of medical complications, or a decline in health due to inappropriate G-tube management and not following appropriate procedures. Record review of Resident #90's face sheet dated 07/23/25 revealed the resident had an original admission date to the facility on [DATE], with diagnoses that included Metabolic encephalopathy (brain dysfunction caused by an underlying condition that affects your metabolism), anemia (when your blood doesn't carry enough oxygen to the rest of your body), dysphagia (difficulty swallowing), severe protein-calorie malnutrition (serious health condition stemming from an insufficient intake or absorption of protein and energy), and gastrostomy status (feeding tube which goes directly into the stomach). Record review of Resident #90's annual MDS dated [DATE] revealed a BIMS score of 6 which indicated severely impaired cognition. Resident #90's nutritional status for eating was total dependence of one person per gastrostomy tube. Record review of Resident #90's care plan updated on 07/16/25 revealed the resident needs total care with tube feeding and water flushes. Record review of Resident #90's physician's orders dated 05/22/25 revealed an order to check G-tube residuals prior to meds and feedings. In an observation and interview during med pass on 07/22/25 at 11:32 AM, LVN C did not check for residual of the G-Tube prior to administering medications for Resident #90. When asked about residuals, LVN C stated she forgot to check, but knew the procedure to check for residual after the resident's G-tube placement was checked. During an interview on 07/22/25 at 11:45 AM, LVN C stated she was aware she forgot to check for residuals but knew how important it was to check. LVN C stated not checking for residuals could have led to over contents in the stomach which in turn could have led to aspiration. LVN C stated she had been in-serviced (trained) on how and why to check for residuals prior to giving nutrition or medications. LVN C stated she could not remember when the last in-service was. During an interview on 07/25/25 at 9:20 AM, the DON stated that the facility had in-serviced nursing staff regarding G-tube care which included checking for residuals prior to feedings or medications. The DON stated LVN C should have checked for residuals prior to administration of medications but did not know why she did not. The DON stated all nursing staff would be getting an in-service on G-tube care soon to avoid further errors. Record review of the facility's policy titled Enteral Nutrition dated November 2018, revealed: 12. The provider will consider the need for supplemental orders, including: g. checks for gastric residual volume (GRV). 15. Staff caring for residents with feeding tubes are trained on how to recognize and report complications relating to the administration of enteral nutrition products, such as: d. interactions between feeding formula and medications; and e. aspiration		

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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 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 a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 2 of 4 residents (Resident#100 and Resident#52) reviewed for oxygen in that: 1. Resident #100 received oxygen at 2.5 LPM via nasal cannula without a physician's order. 2. The facility failed to ensure that Resident #52 received oxygen as prescribed. These deficient practices could affect the residents who received oxygen continuously and could result in residents receiving incorrect or inadequate oxygen support and could result in a decline in health. The findings were: 1. Review of Resident #100's face sheet, dated 8/15/18, revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, pneumonia, and hypoxia. Review of Resident #100's electronic chart and paper chart revealed there was no physician order for oxygen. Observation on 07/21/25 at 11:22 AM revealed Resident #100 was laying on bed with a nasal cannula on and oxygen was administered at 2.5 LPM (Liters Per Minute). During an interview on 07/21/25 at 11:35 PM with LVN A, after she looked at Resident #'s physician orders, confirmed there were no orders for oxygen. LVN A reported Resident #100 required the oxygen because without it, her blood oxygen saturations would drop, and she wanted to keep the oxygen saturations above 90%. LVN A said that it was important to have a physician's order in place to administer the adequate amount of oxygen to Resident #100. During an interview on 7/21/25 at 11:50 AM, DON said that it was important to have a physician's order in place because nurses had to follow physician's orders. DON said that a negative outcome by not having the physician's order in place, Resident #100 could get hypoxic (low level of oxygen in the blood), or get too much oxygen leading to oxygen toxicity. DON said that without the physician's order, staff would not know how much oxygen needed to be given to the resident. 2. Record review of Resident #52's electronic face sheet dated 07/22/2025 reflected the resident was a 76 -year-old female admitted to the facility on [DATE] with an original admission date of 04/07/2023. Resident #52 had diagnoses which included the following: Acute (rapid onset) and Chronic (persistent and long-lasting) Congestive Heart Failure, Acute Respiratory Failure with Hypoxia (the body is not getting enough oxygen), Muscle Wasting and Atrophy (muscles shrinking and getting weaker), Unspecified Dementia, Type 2 Diabetes Mellitus (high blood sugar levels), Rhabdomyolysis (condition where damaged muscle tissue breaks down and releases its contents into the bloodstream), and Hypertension (high blood pressure). Record review of Resident #52's Quarterly MDS assessment, dated 07/14/2025, reflected she scored a 3 on her BIMS which reflected severely cognitively impaired. Special treatments, procedures, and programs reflected resident received oxygen therapy. Record review of the Physician's Order Summary dated 07/21/2025 reflected Resident #52 was (continued on next page)		

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 07/25/2025
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed O2 at 2-4L via nasal cannula continuously every shift for SOB start date 07/18/2025. Record review of the most recent Care Plan for Resident #52, reflected the resident had Congestive Heart Failure. Interventions reflected: Oxygen Settings: O2 via NC @0.5-5LPM for saturations below 90% as needed. Observation on 07/18/2025 at 9:41 a.m. Resident #52 observed in room lying in bed with her eyes closed and the head of the bed was slightly elevated. Resident #52 did not respond to the State Surveyor when knocked on door. Resident #52 was not interviewable. She was well dressed and appeared with good personal hygiene. Resident #52 was not receiving oxygen and did not have a concentrator in the room. She did not have symptoms of respiratory distress. LVN G checked Resident #52 O2 saturation and read 84%. During an interview on 07/21/2025 at 9:53 a.m. LVN G stated she was the nurse for Resident #52. She stated that she was not sure if Resident #52 was on oxygen. She verified that Resident#52 had a physician order for continuous oxygen. LVN G stated that she was not aware of the physician order regarding her oxygen needs. She stated the admitting nurse was the one responsible for following through with the physician order. She stated that this information was not provided to her in the bedside report. LVN G stated the negative outcome was that Resident #52 oxygen can desaturate (low levels of oxygen in the blood). During an interview on 07/21/2025 at 10:08 a.m. with the DON stated that the nurses were responsible for following physician orders. She stated that the nurses should be checking the physician orders. She stated that she does not know how long Resident #52 has been without oxygen. She stated that training was provided for respiratory care this past weekend. The DON stated that the negative outcome was that Resident #52 can have shortness of breath. Review of the policy titled Oxygen Administration, with revised date 10/2010, revealed, the Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 3. Assemble the equipment and supplies as needed.		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 observation, interviews, and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete, accurately documented, readily accessible, and systematically organized for 2 of 7 residents (Resident #48 and Resident #93) reviewed for resident records. 1. The facility failed to ensure a physician order was written for isolation precautions for Resident #48 on 07/15/2025. 2. The facility failed to ensure a physician order was written for dietary diet for Resident #93 on 07/19/2025. 1. Record review of Resident #48's electronic face sheet dated 07/22/2025 reflected the resident was a 77 -year-old female admitted to the facility on [DATE] with an original admission date of 11/27/2020. Resident #48 had diagnoses which included the following: COVID-19, Unspecified Dementia, Muscle Weakness, Type 2 Diabetes Mellitus (high blood sugar levels), Immunodeficiency due Conditions Classified Elsewhere (the decreased ability of the body to fight infections and other diseases), Chronic Kidney Disease stage 2 (your kidneys were damaged and can't filter blood properly). Record review of Resident #48's Comprehensive MDS assessment, dated 06/20/2025, reflected she scored a 2 on her BIMS which reflected severely cognitively impaired. Record review of Resident #48 Physician's Order Summary dated 07/21/2025 did not reflect isolation precaution order on 07/15/2025 when Resident#48 tested positive for COVID-19. Record review of the most recent Care Plan for Resident #48, reflected the resident had tested positive for COVID-19 on 07/15/2025. Interventions reflected: Place resident on isolation/quarantine as per protocol. Allow resident to express fears and concerns, offer comfort and support. Encourage to use of clean hygiene techniques to avoid cross-contamination. Lab as ordered with results to MD. Monitor for presence or absence of symptoms: -Fever -Cough SOB Sore throat. Notify Transport personnel or receiving healthcare facility to Dx and precaution needs. Offer and encourage fluids (if appropriate for medical Dx). Assess the need for dietary modification and consult RD as indicated. Observation on 07/21/2025 at 10:45 a.m. Resident #48 had Droplet Precaution (extra steps taken to prevent the spread of germs that travel in tiny droplets from a sick person's cough, sneeze, or even talking) sign on the door. PPE hanging on the outside of the door. Resident sitting in room, well dressed and appeared to be well groomed. During an interview on 07/21/2025 at 3:52 p.m. with LVN E, stated that the nurse who puts up the isolation precaution sign was the person responsible for checking that there was a physician order in place. He verified that there was no isolation precaution physician order for Resident #48. He stated it was important to have a physician order in place to make sure that the order was followed through for safety and to not cross contaminate. During an interview on 07/21/2025 at 4:09 p.m. with the DON stated that Resident #48 was on isolation precautions due to COVID-19. She stated that a physician order needs to be in place to prevent COVID-19 from spreading to others. The DON stated the physician order needs to be in place as soon as the resident tests positive for COVID-19. 2. Record review of Resident #93's electronic face sheet dated 07/23/2025 reflected the resident was a 65 -year-old female admitted to the facility on [DATE] with an original admission date of 05/22/2025. Resident #93 had diagnoses which included the following: Metabolic Encephalopathy (the brain was not working properly because something was wrong with your body's chemistry), Unspecified Dementia, Muscle Wasting and Atrophy (muscles shrinking and getting weaker), Dysphagia (difficulty swallowing), Muscle Weakness, Neurocognitive Disorder with Lewy bodies (decreased mental function due a medical disease), Bipolar Disorder (a mental health condition that causes extreme shifts in mood, energy, and ability to function), Type 2 Diabetes Mellitus (high blood sugar levels), Anxiety Disorder. Record review of Resident #93's Discharge MDS assessment, dated 07/15/2025, reflected she scored a 10 on her BIMS which reflected moderately cognitively impaired. Nutritional Approaches has Mechanically altered diet while a resident and at discharge. Record review of (continued on next page)		

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Centers for Medicare & Medicaid Services

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93 Physician's Order Summary dated 07/21/2025 did not reflect a dietary order on 07/19/2025 when Resident#93 was re-admitted from the hospital. Record review of the most recent Care Plan for Resident #93, reflected the resident has potential nutritional problem r/t dementia, diet restrictions. Interventions: Provide, serve diet as ordered. Monitor intake and record every meal. LCS diet Mechanical Soft texture, Regular Liquids consistency. Revision on: 07/07/2025. Observation on 07/21/2025 at 1:05 p.m. LVN G was reviewing diet orders as she was assisting with handing out lunch trays. The residents in hall A got their trays except for Resident #93. Resident #93's lunch tray was kept on the tray cart in the hallway. Meal ticket on tray reflected, Diet: LCS. Diet Txtr: Dental Soft (Mech Soft) Liquid Consist: Thin. During an interview on 7/21/25 at 1:26 pm with LVN G, stated that there was no diet order for Resident #93, and this was why they did not give her the lunch tray. She stated the nurse that admitted Resident #93 was responsible for obtaining the diet order. She stated this was important for Resident #93 to get the nutritional needs. LVN G stated the negative outcome would be that Resident #93 could aspirate if not given the proper dietary food texture. During an interview on 07/21/2025 at 1:35 p.m. with the DON stated that Resident #93 had returned from the hospital on [DATE]. She stated that she was not aware of Resident #93 not having an active dietary physician order on file. The DON stated that it was important for the physician's order to be in place so that they know what to give her. She stated the nurses were responsible for entering the physician order. The DON stated the negative outcome would be that she can aspirate. Record review of policy titled, Physician Services revised February 2021, reflected Policy Statement: The medical care of each resident is supervised by a licensed physician. Policy Interpretation and Implementation: 2. Once a resident is admitted , orders for the resident's immediate care and needs can be provided by a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). 6. Physician orders and progress notes are maintained in accordance with current OBRA regulations and facility policy. Record review of policy titled, Medication Therapy revised April 2007, reflected 1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Policy Interpretation and Implementation: 1. The residents clinical record must contain a written order for all prescriptions and over counter medications taken by the resident.		