STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455621	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY GRANDE MANOR	**1212 S BRIDGE WESLACO, TX 78596**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve resident grievances, for one resident (R#1) of four residents reviewed for grievance resolution, in that: The facility did not document receipt of a grievance or efforts to resolve a grievance and did not notify the responsible party of the outcome of the investigation regarding R#1 being sent to the Optometrist without shoes or a mask. This failure could place residents at risk for unresolved grievances. The findings were: Record review of R#1's Admission Record, dated 06/12/20, revealed R#1 was [AGE] years-old, was admitted to the facility on [DATE] and was re-admitted on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's quarterly MDS assessment, dated 04/20/20, revealed R#1 had severely impaired cognition and required extensive assistance for activities of daily living. Record review of R#1's care plans revealed R#1 had ADL care self-care performance deficits related to dementia. Intervention included resident requiring extensive two staff assistance for dressing. Record review of Nurse's Notes for R#1, dated 05/27/20 and signed by ADON B revealed: Met with resident's (family member) regarding some concerns at her optometry visit this a.m. (R#1's RP) reports that (R#1) arrived at her optometry visit wearing socks and no shoes. He also reports that (R#1) appeared to have some discolorations to her BUE that look 'like bruises.' He verbalized concern on how the staff is conducting resident transfers and worries that they are grabbing her arms during transfers. Pt arrived via EMS in wheelchair shortly after speaking to (R#1's RP). She was assessed for injuries and nonverbal s/sx of pain. She is calm, affect is flat. Resident had head to toe skin assessment to verify any injuries or skin discolorations. No abnormalities noted, skin dry, and intact. Residents skin is fair and almost pale looking. She prefers to wear long sleeves through any temperature. Staff inquired on method of transfer. As per designated SN and staff, a gait belt and x2 assist for all transfers from bed to chair and vice versa. SN to follow up with (R#1's RP) on shoes and to inform that no skin abnormalities/injuries have been noted/reported. No new orders noted from optometry appointment. Resident transferred to low bed, call light within reach. Interview with R#1's RP on 06/11/20 at 12:02 p.m. revealed R#1 was transferred by the facility's transportation services to her optometry visit on 05/27/20. R#1's RP met R#1 at the optometrist's office. R#1's RP said he noticed R#1 was only wearing socks and no shoes. Staff at the optometry's office told him R#1 had been taken into the office by someone from the facility and they noticed R#1 had not been wearing a mask as per to COVID guidelines. R#1's RP said staff told him another patient sitting in the optometrist's office had an extra mask and this person gave R#1 a mask so R#1 could come into the waiting room and see the doctor. RP said he spoke to the facility Administrator and voiced his concerns of R#1 not wearing shoes and a mask. R#1's RP said they met outside the building since the RP could not go into the facility. The RP said the Administrator just replied, yes, yes and never got back to him about his concerns. Record review of the facility's Grievance Logs, dated between 04/01/20 and 06/12/20, revealed no grievance reports for R#1. In an interview on 06/11/20 at 1:23 p.m., the Administrator said a facility grievance form was used by staff to document all grievances voiced by family, residents, etc . The Administrator said R#1's RP had come to facility and voiced that R#1's glasses had been missing more than once and R#1 had been sent to the optometrist without shoes or a mask. The Administrator said he asked LVN A and the Receptionist who took R#1 out to the transport van about the concerns voiced by R#1's RP. The Administrator said he also informed the DON of the RP's concerns. The Administrator said he did not document the grievance by R#1's RP on a grievance form. In an interview on 06/12/20 at 9:28 a.m., the facility Social Worker said she was not informed of the grievance by R#1's RP. The Social Worker said she was not the Grievance Officer, and that responsibility was mainly the Administrator's. In an interview on 06/12/20 at 11:50 a.m., R#1's RP said the Administrator, DON, and ADON never contacted him to explain the concerns he had voiced. R#1's RP said LVN A did call him and told him he checked R#1 for bruising and there was no evidence of injury. The RP said he expected the Administrator to inform him of the results of the investigation of all his concerns. The RP said he never received feedback from the Administrator. In an interview on 06/12/20 at 12:16 p.m., LVN A said he was informed by the DON and ADON B about R#1's RP's concerns. LVN A said he asked his CNAs if they had dressed R#1 with shoes for her optometry visit on 05/27/20 and CNAs voiced R#1 had left her room without any shoes on the day of visit. LVN A said he did not know if R#1 had been wearing a mask when she left the facility because he had not been able to check on her before she left for her appointment. LVN A said, a few days later, he called R#1's RP to inform him about some lab work results for R#1 and to inform the RP of R#1's skin assessment and alleged bruising. LVN A said he told R#1's RP just had some skin discolorations. In an interview on 06/12/20 at 12:20 p.m., the DON said the Administrator gave her some information about R#1's RP's concerns. The DON said R#1's RP came outside of the facility and voiced his concerns to her (DON) and to ADON B. The DON said she spoke to staff about the concerns and she thought ADON B had called R#1's RP to inform him of the results of their investigation. In an interview on 06/15/20 at 4:12 p.m., ADON B said she spoke to R#1's RP via telephone call to inform him that R#1's shoes were in her room. ADON B said the RP had been upset that R#1 had been sent to the optometrist's office without shoes or a mask. Record review of the facility policy titled, Grievances/Complaints, Filing, dated April 2017 revealed: All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including rationale for the response. Grievances and/or complaints may be submitted orally or in writing and maybe filed anonymously. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The Administrator will review the findings with Grievance Officer to determine what corrective actions, if any, need to be taken. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. Record review of the facility policy titled, Resident Rights, dated December 2016, revealed: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -have the facility respond to his or her grievances.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.