STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676471	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Valley Inn Health Center	17751 Park Valley Drive Round Rock, TX 78681

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interview and record review, the facility failed to ensure residents had the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, for 1 (Resident #1) of 4 residents reviewed for resident rights, in that: The facility failed to include Resident #1's HSP (Hospice) services in Resident #1's care planning process . The facility held an IDT meeting between 03/22/24 and 06/24/24 to discuss Resident #1's behaviors and alternative placement and did not invite and include Resident #1's HSP in the meeting. This failure could place residents at risk of not receiving appropriate interventions, treatments, and care. Findings included: Record review of Resident #1's undated Patient Information revealed he was an [AGE] year-old male. Resident #1 also had a POA (FAM) and Hospice services. Record review of Resident #1's undated Admission Information revealed he was admitted to the facility on [DATE], discharged on [DATE], and had diagnoses including senile degeneration of the brain (a decrease in the ability to think, concentrate, or remember.) and unspecified Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of Resident #1's undated Discharge MDS Assessment revealed he had a BIMS of 3, which indicated he had severe cognitive impairment. Record review of Resident #1's Care Plan Report, dated 03/07/24, revealed he required HSP as evidenced by his terminal illness of senile Dementia of the brain and elected to use a hospice agency. Staff were required to report to Resident #1's HSP whenever he had a decline in condition. Record review of Resident #1's Clinical Notes Report, from 03/22/24 through 06/24/24, revealed there were no notes related to Resident #1's HSP's involvement in Resident #1's care planning process. There were also no notes related to Resident #1's HSP being notified, invited, nor attending Resident #1's IDT meeting to discuss Resident #1's increase in aggressive behaviors and interfering or not allowing staff to provide care to some female residents at the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Park Valley Inn Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 17751 Park Valley Drive Round Rock, TX 78681	

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/24 at 9:01 a.m., FAM revealed HSP SW told her that the facility was supposed to invite and notify HSP about Resident #1's care plan meetings. During an interview on 06/24/24 at 9:21 a.m., ADM revealed the facility had their own care plan meetings they invited HSP too. When asked who and how HSP was notified and invited to residents' care plan meetings, ADM stated he would have to ask the SW if she invited HSP to care plan meetings by phone or email. ADM also stated the facility had a care plan meeting with Resident #1's family. During an interview on 06/24/24 at 9:51 a.m., SW revealed she could not remember when Resident #1's last care plan meeting was held, but she believed it might have been the end of April 2024. SW explained Resident #1's meeting held at the end of April 2024 was actually an IDT meeting to discuss Resident #1's issues and a plan with Resident #1's family. SW stated the ADON documented Resident #1's IDT meeting in Resident #1's care plan. SW also stated Resident #1's HSP SW or HSP visited Resident #1 once a week. SW stated Resident #1's HSP SW was not invited to Resident #1's IDT meeting because she did not believe it was necessary and did not feel Resident #1's HSP SW needed to be at Resident #1's IDT meeting. SW explained HSP was responsible for residents' care, medications, and services. During an interview on 06/24/24 at 10:23 a.m., HSP Nurse B revealed Resident #1 was receiving HSP services, nurse visits, and medication management, changes and refills from HSP. During an interview on 06/24/24 at 10:23 a.m., HSP Nurse C revealed the facility normally worked with HSP when it came to residents' medication mediations and behaviors. HSP Nurse C stated the facility did not work with HSP when it came to Resident #1. HSP Nurse C explained the facility did not notify or invite Resident #1's HSP to Resident #1's care plan meetings. During an interview on 06/24/24 at 10:40 a.m., HSP SW revealed the facility held an IDT meeting for Resident #1 without her and HSP knowledge. HSP SW stated there was little communication between herself and the facility's SW. HSP SW also stated the facility's ADM admitted to her that Resident #1's HSP should have been included in Resident #1's IDT meeting. HSP SW stated Resident #1's family had a right to attend Resident #1's IDT meeting and have HSP attend Resident #1's IDT meeting. During an interview on 06/24/24 at 10:52 a.m., HSP Nurse D revealed he visited Resident #1 at the facility twice a week. HSP Nurse D stated he and HSP SW were not notified about Resident #1's care plan meeting. During an interview on 06/24/24 at 1:36 p.m., ADM revealed he would see if the facility had a policy on notifying HSP. ADM stated residents' health and well-being could be affected if their HSP was not invited or a part of residents' IDT and care plan meetings. ADM also stated the facility's SW arranged the IDT and care plan meetings. ADM stated the SW arranged Resident #1's IDT meeting. ADM also stated he was not sure if Resident #1's HSP was invited or notified of Resident #1's IDT meeting or care plan meeting. ADM stated HSP was not always involved with conversations between the facility and residents' families. During an interview on 06/24/24 at 2:22 p.m., SW revealed she arranged Resident #1's IDT meeting. SW stated residents' health and well-being could not be affected if HSP was not notified or invited to IDT or care plan meetings because HSP did not deal with psychosocial issues. SW explained HSP managed residents' pain, medications, and gave residents showers. SW stated HSP did not need to be invited to residents' IDT meeting because it was not necessary. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Respite/General Inpatient Hospice Agreement, dated 09/13/22, revealed the following, Now therefore in consideration of the Agreement set forth herein, the parties do agree to the following terms and conditions: Notify Hospice for changes in patient condition, patient or family needs, requests for additional tests or services, need for changes in physician orders or pain/symptom management, or requests for Hospice staff visits. The Administrator or designee is the party responsible for the implementation of the provisions of this contract. Record review of the facility's Resident Rights policy and procedure, revised February 2021, revealed the following, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .be informed of, and participate in, his or her care planning and treatment. Record review of the facility's Care Plans, Comprehensive Person-Centered, policy and procedure, revised March 2022, revealed the following, Policy Statement: 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. Policy Interpretation and Implementation: 1. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process and b. identify individuals or roles to be included. 5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. Record review of the facility's Hospice Services policy and procedure, dated November 2016, revealed the following, 4. The facility immediately notifies the hospice about the following: a. A significant change in the resident's physical, mental, social, or emotional status. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Clinical complications that suggest a need to alter the plan of care. c. A need to transfer the Patient/Resident from the facility for any condition. 11. The facility must arrange for the provision of hospice care with the interdisciplinary team who is responsible for working with hospice representatives. 12. The designated interdisciplinary team member is responsible for the following: a. Collaborate with hospice representatives and coordinate facility staff participation in the hospice care planning process for those residents receiving these services. b. Communicate with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. c. The facility communicates with the hospice medical director, the patient's/resident's attending physician, and other practitioners participating in the provision of care to the patient/resident as needed to coordinate the hospice care with the medical care provided by other physicians.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 (Resident #1) of 4 residents reviewed for hospice services, in that: The facility failed to immediately notify Resident #1's HSP about Resident #1's increase in aggressive behaviors and interfering or not allowing staff to provide care to some female residents behaviors and a need to transfer Resident #1 from the facility to due his behaviors from 03/22/24 through 06/24/24. This failure could place residents at risk of not receiving appropriate interventions, treatments, and care. Findings included: Record review of Resident #1's undated Patient Information revealed he was an [AGE] year-old male. Resident #1 also had a POA (FAM) and Hospice services. Record review of Resident #1's undated Admission Information revealed he was admitted to the facility on [DATE], discharged on [DATE] to home health, and had diagnoses including senile degeneration of the brain (a decrease in the ability to think, concentrate, or remember.) and unspecified Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of Resident #1's undated Discharge MDS Assessment revealed he had a BIMS of 3, which indicated he had severe cognitive impairment. Resident #1 had a planned discharge on 05/13/24 to another nursing home, active discharge planning was already occurring for Resident #1 to return to the community and return to the facility was not anticipated. Record review of Resident #1's Care Plan Report, dated 03/07/24, revealed he required HSP as evidenced by his terminal illness of senile Dementia of the brain and elected to use a hospice agency. Staff were required to report to Resident #1's HSP whenever he had a change or decline in condition. Resident #1 was also noted to have physical behavioral symptoms directed at others and would become physically aggressive with staff at times. Resident #1 was also noted to have verbal behavioral symptoms directed at others and usually walked alongside female residents closely, attempted to hold their hand or arm redirection needed. Resident #1 was also noted to have affectionate, non-sexual touching and interaction behaviors. No interventions for any of the previously mentioned behavior notes indicated to notify HSP. Record review of Resident #1's Clinical Notes Report, from 03/22/24 through 06/24/24, revealed the following notes: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note created by LVN E on 04/12/24 at 5:10 a.m., Resident was constantly going into the room with a female resident at the female resident request saying they lived together. Staff was able to separate the residents X 3 times. Resident then took his medication on the 3rd separation of him and the female resident and went into his own room and went to bed. Monitored throughout the night without further issues. A note created by LVN A on 04/14/24 at 7:00 p.m., Resident have increased confusion and aggressively trying to fight staff. Pacing down the hallways and exit seeking. At 3:00 p.m. resident is kissing another resident. Aggressively yelling at staff & will not let go of resident wheelchair. Separate both residents. Administer PRN Ativan. Redirect to bedroom. Call light at reach. At 6:20 p.m. PER Hospice nurse [NAME]. New lab order: UA Notified RP Aware. A note created by LVN F on 04/18/24 at 6:16 a.m., Patient started Antibiotics yesterday for UTI . Incontinent of urine. No adverse reactions noted to antibiotic therapy. Patient was anxious early evening. He was observed approaching female patients trying to hold their hands. He was observed putting his arms around a female and trying to lift her off her feet. Staff redirection not effective. PRN Ativan was given and was effective to calm residents anxiety. He is in bed at this time resting with eyes closed. Wass observed in bed resting during routine checks. A note created by LVN A on 04/24/24 at 8:19 p.m., Resident is aggressively controlling another resident. Grab resident and would not let her go. Difficult to redirect. Skilled nurse told resident that his wife was at door. Let other resident hand go. Administer PRN Ativan. At 4:30 p.m., resident exit seeking and setting door alarms off. Cussing resident. Resident states, 'That she is my wife.' Difficult to redirect. He continues to follow the other resident. Skilled nurse took other resident to bedroom and sat with her for about 20 minutes. Resident continues pacing hallways and exit seeking. A note created by LVN F on 04/25/24 at 2:25 p.m., Patient up pacing most of morning. Was given Ativan at 9:30 a.m. this morning for signs of anxiety. He was walking with female patient and would not allow staff to approach her for care. Ativan was effective. Patient walking with a different female patient at this time, no signs of aggression or possessiveness toward staff or resident. Calm and compliant with ADL care. A note created by LVN F on 05/08/24 at 3:13 p.m., No adverse reaction noted to increased Depakote dose. Ambulates with no gait changes noted, steady gait. Intrusiveness behavior noted with other female residents. Holding hands and attempting to kiss them. Unable to redirect his behaviors. PRN Ativan given. Effective to direct patient away from female residents. A note created by SW on 05/13/24 at 10:45 a.m., (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[SW] spoke with [FAM] of [Resident #1], who requested resident's clinicals, citing she needed to have a copy of the progress notes that documented resident's behaviors as well as medication given and times. [SW] noted the [FAM] appeared agitated as today is the day of [Resident #1's] move to another facility due to his behaviors. This was previously discussed during [Resident #1's] IDT meeting which was agreed by the [FAM]. It was stated and made clear to [FAM] that this was not a 30-day discharge notice and only a recommendation that [Resident #1] be placed into another facility as the facility did not feel he was a good fit due to his negative behaviors. It was explained that [Resident #1] would remain at current facility until the [FAM] agreed with a facility with the assistance of [SW]. [FAM] acknowledged and verbalized understanding. [SW] located a facility and informed the [FAM], who went to the facility for a walk-through. Days later, the [FAM] telephoned [SW] to advise of the acceptance by the facility, citing [FAM] satisfaction, and informed [SW] the date/time the [FAM] would be picking [Resident #1] up to take to new facility, as well as an email citing instructions of expectation for pick-up. There were no notes related to Resident #1's HSP's involvement in Resident #1's care planning process. There were also no notes related to Resident #1's HSP being notified, invited, nor attending Resident #1's IDT meeting to discuss Resident #1's behaviors at the facility. During an interview on 06/24/24 at 9:21 a.m., ADM revealed the facility notified Resident #1's HSP and providers about Resident #1's behaviors, incidents, and accidents. ADM stated if a resident were not a good fit for the facility, the facility would have a care plan meeting to discuss alternative placement. ADM also stated HSP had their own meetings with residents' families. ADM stated the facility also had their own meetings with residents' families and invited residents' HSP to the meetings. When asked how residents' HSP were invited to meetings, ADM stated he did not know and would have to ask the SW if communications were by phone or email. ADM also stated Resident #1 had behaviors that were not a good fit at the facility. ADM stated the facility offered to help Resident #1's family with alternative placement for Resident #1 during a meeting. During an interview on 06/24/24 at 9:51 a.m., SW revealed Resident #1 was aggressive at times, would claim women as objects, and would not allow nursing staff to care for other residents. SW stated on one occasion she witnessed Resident #1 swat away a medication cup from a nurse who was trying to administer medication to a female resident. SW explained Resident #1 was aggressive and protective over female residents. SW stated she could not remember when the facility and Resident #1's family had a care plan meeting and believed it might have been at the end of April 2024. SW clarified that the meeting was an IDT meeting with Resident #1's family to discuss Resident #1's issues and plan. SW stated the ADON documented the meeting in Resident #1's care plan. SW also stated Resident #1's HSP was notified of all incidents involving Resident #1. SW stated Resident #1's HSP SW or nurse visited Resident #1 once a week. SW also stated the facility notified Resident #1's HSP SW of Resident #1's incident. SW stated Resident #1's HSP was responsible for Resident #1's care, medications, and services. During an interview on 06/24/24 at 10:23 a.m., HSP Nurse B revealed Resident #1 was receiving hospice services, nurse visits, medication management, and medication changes and refills. HSP Nurse B revealed she was not notified of Resident #1's incidents and behaviors. HSP Nurse B stated the facility notified her that Resident #1 would get frustrated, but not hurt anyone. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/24 at 10:23 a.m., HSP Nurse C revealed she was not notified of any incidents or behaviors involving Resident #1. HSP Nurse C stated Resident #1 came off her HSP services and was assigned to another nurse who was his case manager, which was when facility reports about his aggression started. HSP Nurse C also stated Resident #1 never been known to be an aggressive person and was redirectable. HSP Nurse C explained Resident #1 only became agitated when he hyperventilated. HSP Nurse C stated she heard about alternative placement from the facility SW. HSP Nurse C also stated the facility normally worked with HSP for medication mediation and behaviors. HSP Nurse C stated the facility did not work with HSP. HSP Nurse C stated HSP Nurse D attempted to make adjustments for Resident #1's medications. HSP Nurse C also stated the facility did not include Resident #1's HSP in monthly care plan meetings and did not notify or invite Resident #1's HSP to care plan meetings. HSP Nurse C stated the HSP was supposed to be given a notice of transfer because HSP provided services to Resident #1. HSP Nurse C stated she knew Resident #1's transfer or discharge was facility initiated because they inquired with FAM about Resident #1's alternative placement. During an interview on 06/24/24 at 10:40 a.m., HSP SW revealed she was not notified of Resident #1's incidents. HSP SW stated the facility held IDT team meetings without her and HSP's knowledge about Resident #1's behaviors. HSP SW stated Resident #1's HSP reviewed inappropriate behaviors reported by the facility SW. HSP SW also stated inappropriate behaviors were due to Resident #1's protectiveness over female residents. HSP SW stated the facility did not contact HSP Nurse D about Resident #1's behaviors. HSP SW also stated they learned from FAM that they were informed about facility seeking out alternative placement for Resident #1. HSP SW stated there was little communication between the facility SW and her. HSP SW also stated she spoke with the facility SW, who told her that the facility was discharging Resident #1. HSP SW stated she asked the facility SW about Resident #1's 30-day notice, to which the facility SW said there was none because the facility was avoiding a 30-day notice . HSP SW stated the facility's ADM admitted HSP should have been included in Resident #1's IDT team meeting. HSP SW also stated FAM had a right to be attendance and have Resident #1's HSP in attendance at Resident #1's IDT meeting. During an interview on 06/24/24 at 10:52 a.m., HSP Nurse D revealed he was not notified of Resident #1's behaviors. HSP Nurse D stated he spoke with the facility and staff anytime he visited the facility and they never mentioned anything about Resident #1 being aggressive. HSP Nurse D also stated he was shocked that Resident #1 was being transferred because of his behaviors. HSP Nurse D stated the facility wanted Resident #1 out quickly. HSP Nurse D also stated he visited Resident #1 at the facility two times a week. HSP Nurse D stated he was not notified nor was HSP SW notified of Resident #1's care plan meeting. During an interview on 06/24/24 at 11:42 a.m., CNA G revealed she worked with Resident #1. CNA G stated Resident #1 was aggressive with not wanting to put on clothes, tried to let people out of doors, pressed on exit doors, and staff could not redirect him. CNA G also stated she tried to redirect Resident #1 despite him often trying to get out and press on exit doors. CNA G stated she thought FAM notified of Resident #1's behaviors during Resident #1's care plan meeting. CNA G also stated Resident #1's HSP would immediately be notified whenever incidents and behaviors happened with Resident #1. CNA G stated Resident #1's HSP was aware of Resident #1's behaviors and incidents because they would come and give him showers and he would refuse care. CNA G also stated Resident #1's HSP was aware that Resident #1 was pressing against exit doors. CNA G stated Resident #1's HSP would try to redirect Resident #1. CNA G also stated nurses notified HSP of any incidents involving Resident #1. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/24 at 12:11 p.m., RN H revealed she worked with Resident #1. RN H stated Resident #1 helped a lot with residents and was calm. RN H also stated on one occasion, she observed Resident #1 was walking with a female resident and another male resident took him. RN H stated Resident #1 tried to pick a fight, but the staff separated and redirected him. RN H also stated nurses notified Resident #1's HSP of incidents and documented communications. RN H stated staff must inform family, NP, HSP, and the ADM of incidents. During an interview on 06/24/24 at 12:19 p.m., LVN I revealed she worked with Resident #1. LVN I described Resident #1 was nice. LVN I stated she was told Resident #1 was aggressive and fought a lot by other staff. LVN I also stated on her shift, Resident #1 walked a lot. LVN I also stated the ADON told her to observe, assess, and give PRN if Resident #1 became aggressive. LVN I stated Resident #1's HSP was notified of behaviors or incidents. LVN I also stated Resident #1's HSP used to come often to the facility. LVN I stated nurses notified HSP of any behaviors or incidents. During an interview on 06/24/24 at 1:36 p.m., ADM revealed he would see if there was a policy on notifying HSP. ADM stated residents' health and wellbeing could be affected if HSP was not notified and did not participate in care, but it depended on a resident's condition. ADM also stated the facility's SW arranged residents' IDT and care plan meetings. ADM stated the SW arranged Resident #1's IDT meeting. ADM also stated he was not sure if Resident #1's HSP was notified or invited to Resident #1's care plan/IDT team meeting. ADM stated HSP would not always be involved with the facility's conversations with residents' families. ADM also stated residents' health and wellbeing could be affected if HSP was not invited or a part of residents' IDT and care plan meetings. Interview attempt to contact LVN F was made on 06/24/24 at 1:52 p.m. An attempt to leave a voicemail and call back number was made, but the wireless customer was unavailable. During an interview on 06/24/24 at 1:56 p.m., ADM revealed not every IDT meeting the facility held would follow the facility's care plan policy. During an interview on 06/24/24 at 2:22 p.m., SW revealed she arranged Resident #1's IDT team meeting. SW stated residents' health and wellbeing could not be affected if HSP was not notified of behaviors because HSP does not deal with residents' psychosocial issues. SW explained HSP managed residents' pain, medications, and showers. SW stated she did not know if Resident #1's HSP was notified to adjust Resident #1's medications. SW also stated Resident #1's HSP did not need to be invited to Resident #1's IDT team meeting because it not necessary. Record review of the facility's incidents and accidents log, 03/24/24-06/24/24, revealed Resident #1 was not listed. Record review of the facility's Care Plans, Comprehensive Person-Centered, policy and procedure, revised March 2022, revealed the following, Policy Statement: 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. Policy Interpretation and Implementation: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Valley Inn Health Center	17751 Park Valley Drive Round Rock, TX 78681

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process and b. identify individuals or roles to be included. 5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. Record review of the facility's Hospice Services policy and procedure, dated November 2016, revealed the following, 4. The facility immediately notifies the hospice about the following: a. A significant change in the resident's physical, mental, social, or emotional status. b. Clinical complications that suggest a need to alter the plan of care. c. A need to transfer the Patient/Resident from the facility for any condition. 11. The facility must arrange for the provision of hospice care with the interdisciplinary team who is responsible for working with hospice representatives. 12. The designated interdisciplinary team member is responsible for the following: a. Collaborate with hospice representatives and coordinate facility staff participation in the hospice care planning process for those residents receiving these services. b. Communicate with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. c. The facility communicates with the hospice medical director, the patient's/resident's attending physician, and other practitioners participating in the provision of care to the patient/resident as needed to coordinate the hospice care with the medical care provided by other physicians.