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	11/06/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45070 Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for one (Resident #1) of four residents reviewed for abuse. The facility failed on 11/04/24 during breakfast time to protect Resident #1 from physical and emotional abuse by CNA B, who threw a cup on him with agitation. This failure could place residents at risk of serious injury and harm. Findings included: Record review of Resident #1's face sheet on 11/06/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were hypertension, abnormal weight loss, dementia, cognitive communication deficit, lack of coordination, age-related physical debility, muscle weakness, abnormalities of gait and mobility, anxiety disorder, schizophrenia, anemia, and pain. Record review on 10/16/24 of Resident #1's quarterly MDS assessment, dated 10/28/24 revealed a BIMS score of 05 indicating his cognition was severely impaired. Record review on 10/16/24 of Resident #1's care plan dated 01/06/24 reflected the resident was at the risk of dehydration and the relevant intervention was offering additional fluids with meals. Record review of the facility's incident report to HHSC dated 11/05/24 stated, on 11/4/2024 at 8:15am CNA A reported to the DON that CNA B threw an empty juice cup on Resident #1's lap. During an observation and interview on 11/06/24 at 1:05pm the resident was in bed preparing for an afternoon nap. He stated he remembered someone threw a white glass on him. He stated he did not remember the day and the exact time the incident had occurred. He said he also was not remembering if it hit his shoulder or hand, however, he was sure it was painful for a while at that time. He stated one of the staff members rubbed the area with alcohol and the pain was relieved after some time. He stated there was no pain or issues at the time of the interview. Observation of his right and left hands revealed no marks, discoloration, or swelling. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 11/06/24 at 11:03am CNA B stated she had experience as a CNA for about [AGE] years and started working at the facility about 6 months ago. She stated she did throw an empty plastic cup on 11/04/24 during the breakfast time in the dining area of the memory care unit in the facility, aiming towards the floor however it ended up on Resident #1's lap. CNA B explained, on 11/04/24 at about 8:00am the breakfast was served in the dining room, and she was passing breakfast to residents. She said she served breakfast and two glasses of orange juice to the Resident #1, however he went and grabbed another resident's juice, drank it entirely, and then placed the empty glass in the tray of that resident. CNA B stated she was concerned about the cross contamination and with that frustration threw the glass on the floor. However, it fell on the resident's lap instead, who was sitting on his wheelchair. CNA B said she had no intention to throw it on Resident #1 and harm him. She said she felt very bad after the incident and sorry for her action. CNA B stated a PO called her twice on 11/05/24 and asked her about the incident and later told her there were no charges pressed against her for the incident. During an interview on 11/06/24 at 11:55am CNA A stated she started working at the facility since May 2024 and witnessed an incident of CNA B throwing a plastic cup to Resident #1. She said, on 11/04/26 at about 8:10am while passing the breakfast trays to residents, she saw Resident #1 grabbing a glass of orange juice from another resident's tray, drank the entire juice, and put back the glass into that resident's tray. She said CNA B got annoyed seeing it, took the glass, and threw it to Resident #1. The plastic cup hit the resident on his right hand and then ended up on Resident #1's lap. She said the resident screamed Ouch out of pain and stated it was painful. CNA A stated she rubbed the area of the hand where the glass hit, to relieve the pain. She said the skin at that area was reddish in color at that time. CNA A stated she then went and reported it to the DON and the DON escorted CNA B to her office. CNA A said the AD also was present and witnessed the incident. She said she encouraged the AD to report to the DON about what she had seen at the time of the incident. During an interview on 11/06/24 at 12:10pm the AD stated she was present in the dining room when the incident between Resident #1 and CNA B occurred. She said the resident had the habit of taking food from other resident's plates and at that time he took a glass of orange juice from another resident's tray though he was already served with 2 glasses by CNA B. He then drank all of it and kept the empty glass on the other resident's plate. CNA B got frustrated after seeing this incident, threw the glass most likely aimlessly, however the glass ended up on the resident's lap. She stated she was not sure if the glass hit any part of the resident's body. The AD stated she did not believe the resident was hurt from the incident. Observation on 11/06/24 at 11:30am of the reusable juice glass used at the facility revealed it was a transparent acrylic glass weighed approx. 2 oz. During a telephone interview on 11/06/24 at 1:25pm the PC stated she was the psychology consultant and visit the facility weekly. She stated she visited the resident the next day after the incident. The PC stated during that time Resident #1 stated that everything was going well with him without any stress factors. She said nothing bothered him at that time and did not make any reference of the incident that occurred on 11/04/24 in the dining room. During a telephone interview on 11/06/24 at 1:20pm RN C stated she had not witnessed the incident however she was the RN who did the head-to-toe assessment on Resident #1, about one hour after the incident, as requested by the DON. RN C stated she had observed no bruises, swelling, or redness on him or any part of his body at that time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 9:40am the DON stated on 11/04/24 in the morning at about 8:20am CNA A reported to her that at about 8:10am, during the breakfast in the memory care unit, CNA B threw a glass on Resident #1 because Resident #1 was taking juice from another resident's plate. The DON stated CNA B was taken into her office at 8:18am for an interview. The DON reported, during the interview can B appeared remorseful, stated she threw the glass out of frustration from resident's behavior, and stated what she did was wrong. The DON stated as CNA B's behavior was not acceptable at the facility and against the facility's abuse policy, she was reported to the police and sent home on suspension with immediate effect. Record review of the facility's Abuse, Neglect, Exploitation, and Misappropriation prevention Program revised in April 2021, reflected, Policy statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: l. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observations, interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 2 of 4 residents (Residents #2 and Resident # 3) reviewed for quality of care. The facility failed to ensure Resident #2 and Resident #3's nebulizing mask and tubing, that were observed on 11/06/24, were not bagged for sanitation when not in use per the facility's policy. This failure could affect residents who received nebulizing treatment and place them at risk for respiratory infections. The findings included: Record review of Resident #2's face sheet on 11/06/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were hypertension, dementia, cognitive communication deficit, muscle weakness, heart failure, type 2 diabetes, cough, and seasonal allergic rhinitis (allergy). Record review on 10/16/24 of Resident #2's quarterly MDS assessment, dated 10/13/24 revealed a BIMS score of 06 indicating his cognition was severely impaired. Record review on 10/16/24 of Resident #2's care plan dated 09/19/24 had not indicated any respiratory issues and the need for medication using a nebulizer for Resident #1. Record review of Resident #2's November 2024 MAR revealed he received: Albuterol sulfate 2.5 mg/3 ml (0.083 %) solution for nebulization (1) vial, nebulizer (ml) inhalation as needed every four hours starting 09/19/2023. Record review of Resident #3's face sheet on 11/06/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were chronic respiratory failure, insomnia, COPD (difficulty to breath), pneumonitis (inflammation in the lungs) due to inhalation of food and vomit, UTI, pulmonary embolism (blood clot in the blood vessels in lungs), restlessness, and agitation. Record review on 10/16/24 of Resident #3's quarterly MDS assessment, dated 10/13/24 revealed a BIMS score of 06 indicating his cognition was severely impaired. Record review on 10/16/24 of Resident #3's care plan dated 10/11/24 revealed the resident was on oxygen therapy and relevant interventions were checking and filling the humidifier and changing the tubing. There was no care plan for the use of the nebulizer. Record review of Resident #3's November 2024 MAR revealed he received: 1. Budesonide 0.5 mgl2 ml suspension for nebulization (1 vial) ampul for nebulization (ml) inhalation two times daily starting 10/10/2024 for chronic respiratory failure with hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. AR formoterol 15 mcg/2 ml solution for nebulization (1 vial) vial, nebulizer (ml) inhalation two times daily starting 10/17/2024 for chronic obstructive pulmonary disease with (acute) exacerbation. Observation and interview on 11/06/24 at 10:45am of Resident #2 and Resident #3's room revealed there were nebulizers on the side table. The mask and tubing of the nebulizers were exposed to the environment as they were not stored in a protective bag. A closer observation of the mask revealed it was 'foggy' and dirty. LVN D who witnessed the nebulizer masks stated they were supposed to be sanitized before and after use and should have been stored in a protective bag whenever not in use. She stated this was necessary to avoid infections. During an interview on 11/06/24 at 2:00pm the DON stated all staff were supposed to be compliant with the facility policy for using the oxygen cannula and nebulizers. She stated the nebulizer masks were to be cleaned and safely stored in the protective bags provided. She stated there was a potential for respiratory infectious diseases due to this deficiency. Record review of the facility's policy, titled Protocol for Oxygen administration revised on March,2019 reflected: Oxygen tubing, cannulas, nebulizer tubing, and face masks will be changed weekly and as needed. When not in use, oxygen cannulas and facemasks will be stored in plastic bags attached to oxygen concentrator or tank .