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	12/10/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of five residents reviewed for quality of care. The facility failed to ensure LVN A documented Resident #1's unwitnessed fall, conducted neuros, and informed the oncoming nurse on 11/28/24. The aides continued to notify the nurses of Resident #1's pain and was not sent to the ER until the late evening on 11/29/24, where she was diagnosed with a hip fracture. The noncompliance was identified as PNC. The IJ began on 11/28/24 and ended on 12/05/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of not receiving necessary medical care, increased pain, injury, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, pain, muscle weakness, and generalized anxiety disorder. Review of Resident #1's quarterly MDS assessment, dated 10/09/24, reflected a BIMS could not be conducted due to rarely/never being understood. Section E (Behavior) reflected she wandered daily. Section J (Health Conditions) reflected she had falls since the prior MDS assessment with one resulting in injury. Review of Resident #1's quarterly care plan, dated 11/28/24, reflected she was at risk of falls related to dementia, fatigue related to constant pacing, and quick movement with an intervention of supervising her ambulation to prevent falls or other injuries when she was unsteady. It further reflected She had the potential risk for injury due to quick pacing with an intervention of educating patient/responsible party on the risks. Review of Resident #1's incident report, dated 11/28/24 at 5:20 PM (completed on 12/05/24 at 1:16 PM) and documented by LVN A, reflected the following: (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 12/10/2024
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fall - Unwitnessed [Resident #1] was noted sitting on the floor in the hallway playing with a box . [Resident #1] was assessed on suspicion of fall. [Resident #1] displayed no signs of pain/discomforts. No changes to skin. Review of Resident #1's progress note, dated 11/28/24 at 5:30 PM (documented on 12/05/24 at 12:23 PM) and documented by LVN A, reflected the following: [Resident #1] noted sitting on the floor. [Resident #1] taken to room for evaluation. Active nosebleed noted. Nostril cleaned and skin is intact with no discoloration. Nose care provided and bleeding subsided. Review of Resident #1's progress note, dated 11/29/24 at 11:25 PM and documented by LVN B, reflected the following: AM an PM CNAs reported that [Resident #1] has been in bed all day and is unable to stand up or walk. I assessed [Resident #1] and she has no bruising, swelling, no abrasions, or other visual signs of fall or injury. I attempted to sit [Resident #1] up to assist with standing. [Resident #1] grabbed her right hip area and yelled. She is shaking and appears to be in discomfort when I assessed her and when I checked her v/s. Her b/p is 160/90, pulse 100. Resp 22 . [Resident #1] left to (hospital ER) at 10:18 PM. Review of Resident #1's hospital paperwork, dated 11/29/24, reflected the following: .presents to ED for right hip pain from nursing home. Unsure if she fell but has been unwilling to stand today and has an abrasion to her cheek and dried blood in bilateral nares. Work up showed: right intertrochanteric femur fracture. .[Resident #1]'s RP stated she was not sure if she would want [Resident #1] to have hip surgery. Review of witness statements obtained by the ADM, on 12/10/24, reflected the following: [CNA D] Worked Thursday (11/28/24) & Friday (11/29/24) with [Resident #1]. Thursday [Resident #1] was up as usual ambulating on the unit. Mid morning she saw [Resident #1] sit on the floor near the windows at the end of the 300 hallway, she spoke to [Resident #1] and [Resident #1] got up on her own and walked back to the common area. Later in the day she also noted that [Resident #1] was sitting on the floor apparently in the living room area by the large armchair and sofa. [CNA D] assisted [Resident #1] to get up without incident. Did not report these instances of [Resident #1] on the floor. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Thursday approaching 6:00 PM [CNA D] states she went to assist charge nurse [LVN A] with [Resident #1] who was on the floor just outside the door to her room. [CNA D] says that she and [LVN A] helped [Resident #1] get off the floor and brought her into her room and bed. [CNA D] states it appeared [Resident #1] had difficulty bearing weight on her right side. They noticed blood on her pants so they checked [Resident #1] while changing her brief and noted no source of blood on her body. However [Resident #1] had dried blood on her nostrils from an apparent nose bleed. She noticed a healing abrasion on [Resident #1]'s right cheek. [CNA D] states she finished changing [Resident #1] then stayed in the room and continued to make [Resident #1] 's bed and clean up and that [Resident #1] left the room walking on her own when [LVN A] did. On Friday, [CNA D] again worked with [Resident #1] and that [Resident #1] stayed in bed for breakfast but that was not unusual for [Resident #1]. She fed [Resident #1] and she ate well. She got [Resident #1] dressed but [Resident #1] did not want to get up and leave the room. [CNA D] reported to ADON that [Resident #1] was not getting out of bed. When nearing lunch time [CNA D] again tried to get [Resident #1] up for lunch but she refused and did not want to be repositioned in bed. [CNA D] brought [Resident #1] her lunch which she ate well. On Friday around dinner time [CNA D] again went to check and change [Resident #1] who still did not want to get out of bed and appeared tired. [CNA D] reported to oncoming [CNA E] that [Resident #1] had not been up that day and was sleeping at dinner time and did not yet eat dinner. [LVN A] On Thursday she noted [Resident #1] was up and active and ate well through the day. In the afternoon [Resident #1] was sitting on the floor near her room and had a cardboard box left by another resident's family, it appeared to [LVN A] this was purposefully sitting on the floor. [LVN A] reports that [Resident #1] didn't want to get up off the floor and let the box be taken to be discarded and verbally objected in her native language. [LVN A] noted that [Resident #1] enjoyed playing with the box and considered it safe and let her continue. Around 5:30 PM [LVN A] came to assist [CNA D] who was walking with [Resident #1] to her room. [Resident #1] was agitated and [LVN A] assisted her to bring [Resident #1] to get her cleaned and changed. At this time she noticed dried blood in her nostrils, and what appeared to be blood spots on her pants. She did a head to toe body check and noted no blood, scratches, bruising or discoloration. [LVN A] saw the healing abrasion on cheek. [LVN A] states that [CNA D] cleaned, changed and got [Resident #1] dressed at this time. [LVN A] then left [Resident #1]'s room. Subsequently [LVN A] and on-coming nurse [RN F] went to [Resident #1]'s room. [LVN A] informed [RN F] that [Resident #1] had a nosebleed earlier in the day but had resolved . [CNA E] Worked Thursday evening with [Resident #1]. [Resident #1] was already in bed when she started her shift. She noted [Resident #1] was laying in bed diagonally, provided peri-care to [Resident #1] around 1:30 AM and [Resident #1] indicated pain to her right hip. She informed charge nurse [LVN C]. In the morning around 4:30 AM [CNA E] says she checked and provided peri-care to [Resident #1] who indicated pain to her hip and reported that to oncoming charge nurse [ADON]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Friday evening [CNA E] noted [Resident #1] in bed and changed her brief with charge nurse [LVN B]. [Resident #1] indicated pain to her right hip to [CNA E] and [LVN B]. [LVN B] [LVN B] states that she came in to work around 6:10 PM on Thursday. She says [CNA E] reported to her that [Resident #1] had not been out of bed overnight Thursday into Friday, and [CNA D] told her that she not gotten out of bed on Friday. [LVN B] assessed [Resident #1] and though she had no bruising or swelling to indicate a fall, that [Resident #1] complained of pain to right hip, and was unwilling/ unable to stand . [ADON] On Friday November 29th this nurse worked as a charge nurse on hall 100/200, taking care of [Resident #1]. At 6am I received report from 10-6am nurse coming off shift with no reports of change in report of said patient. I did my own rounds checking on patients starting around 6:10 am and when I went into patient [Resident #1]'s room she was sitting on the side of her bed, AOx1-2 at baseline, talking in her language with no apparent distress noted at that time. I then returned to [Resident #1]'s room to give her medication between 7am-8am and taking her vitals, which were WNL. [CNA D] came up to me around about 8-9am telling me that the pt was not walking around as her usual baseline, and that it had been going on. I stated to her that I noticed pt wasn't walking around as well and that I had assessed her and noted no bruising of any sort and that the pt was sitting up for me and no c/o pain, so I then monitored her throughout my shift. I also checked her chart and noticed there was no documentation regarding any falls or change in her condition. At 10:18 am the DON called my phone and being that she usually covers the MC I asked her about any changes to said patient, and I let her know that since no one else made any documented notes, that I would. My note is in the patient's chart for 11/29/2024. [LVN C] [LVN C] states that [Resident #1] was in bed during her shift and that [CNA E] reported to her that [Resident #1] had difficulty standing when she cleaned and changed her brief. [LVN C] states she went to check on [Resident #1] after that and that she was sleeping, and she decided not to wake her as [Resident #1] usually sleeps through the time. She says she had no other interaction with [Resident #1] during the remainder of her shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/10/24 at 10:12 AM, the ADON stated she worked the floor on the MCU (where Resident #1 resided) on 11/29/24. She stated she relieved the night nurse at 6:00 AM (LVN C) and she did not relay any changes regarding Resident #1. She stated she did her initial rounds and Resident #1 did not appear to be in pain. She stated she ate breakfast in bed that morning and she typically walked around throughout the day, but thought she just needed the rest. She stated because her vitals were stable and she noted no abnormal changes, she had no reason to think anything was wrong with her wanting to rest. She stated around 9:00 AM, CNA D came to her and told her Resident #1 still did not want to get out of bed. She stated there were no notes in her chart that anything had happened the day before so she figured she would continue to monitor her since nothing was out-of-whack. She stated around 10:18 AM, she called the DON because she knew she had worked the day prior (11/28/24) and asked her if she knew if anything had happened with Resident #1 because she was not walking around that day. The DON told her she had not been aware of anything. She stated Resident #1 had a history of sitting down on the floor. She stated if an aide found her sitting on the floor, they should get a nurse so an assessment could be done as it should be seen as an unwitnessed fall. She stated if LVN C was notified by the aide during the night of 11/28/24 that Resident #1 was in pain, she should have assessed her no matter what, even if she was sleeping. She stated LVN C should have also documented that. She stated she did notice some dry blood to Resident #1's nose as if she had a nosebleed. She stated because nothing from the day before had been documented, she did not know anything about it (the fall). She stated it would have been important for this to have been documented so that she could have followed up. During an interview on 12/10/24 at 10:40 AM, LVN B stated she came in on 11/29/24 just to assist with medication pass from 6:00 PM - 10:00 PM. She stated CNAs D and E approached her and asked her to go check on Resident #1 as something was very wrong. She stated CNA D told her she had been in bed all day, had not been out of bed since the day before, did not think she could walk, and insinuated she could not get out of bed due to pain. She stated CNA D told her she had told the nurse about her pain and felt like something needed to be done. She stated she immediately went and assessed Resident #1 and she was shaking in excruciating pain while her vitals were elevated. She stated she gave her Tylenol until she could get ahold of the doctor, but it did not seem to alleviate her pain. She stated she still could not get ahold of the doctor, so she called the DON and notified her she was sending her out to the ER because she had been in bed since the day before and that was not normal for her. She stated Resident #1 did not have a history of sitting on the ground but did have a history of squatting to poop on the floor. She stated an aide should never pick her up if she was found on the ground before getting a nurse for an assessment. She stated she had recently been in-serviced on change in condition, reporting incidents, abuse and neglect, and unwitnessed falls by the DON. She stated everything regarding the resident (incidents, falls, changes in condition) should always be documented in residents' progress notes to ensure all staff knew what was going on with the resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 12/10/24 at 11:01 AM, CNA D stated Resident #1 was found three times on the ground on 11/28/24. She stated she helped her up each time because she was her resident. She stated she normally walked around the unit really fast, almost like she was running. She stated she was slow on 11/28/24 and she thought something had happened. She stated the first time she was on the floor she picked her up and Resident #1 ran away. She stated the second time she found her on the floor in the living room around 2:00 PM. She stated the third time she was in the activity room on the ground, so she picked her up and put her in a chair. She stated after her break, she heard Resident #1 screaming in pain. She stated she went to her room where LVN A was and told the nurse she was not normal. She stated between the both of them, they tried to help her stand, but she could not because of weakness and pain to her right side . She stated the next day, 11/29/24, she ate breakfast in bed, which was not abnormal for her. She stated she did not want to get up after breakfast or for lunch. She stated that was when she told the ADON she normally got up for lunch, but she refused. She stated she told her Resident #1 was shaking and had pain to her right side. She stated she left her in bed the whole day because she was in pain, and she felt bad. She stated she told the ADON several times throughout the day. She stated when the night CNA (CNA E) arrived that evening, they talked about how something was wrong with Resident #1 as she was shaking and in pain. She stated they notified LVN B who assessed her. She stated she had recently been in-serviced by the DON on notifying a nurse when a resident was on the ground, falls, pain management, and abuse and neglect . She stated she should never pick up a resident off the floor without notifying a nurse first to ensure they were not injured. During an interview on 12/10/24 at 12:10 PM, the DON stated she went to the MCU on 11/28/24 between 3:00 - 3:15 PM and physically saw Resident #1 sit herself down on the floor. She stated if an aide ever found a resident on the ground, they needed to treat it as an unwitnessed fall. She stated the nurses would need to complete an assessment and start neuro checks prior to getting the resident off the floor. She stated after interviewing staff, she was informed of two other instances where she was found sitting on the ground that day. She stated LVN A told her she found her sitting on the ground, she assessed her, and cleaned her bloody nose from having dry nostril membranes. She stated the reason LVN A documented in Resident #1's EMR seven days later was because she asked her to. She stated LVN A verbally told her she assessed the resident but did not document it, so she verbally asked her to put it in later. She stated that did not meet her expectations as it needed to be documented the same day . She stated she did not hear about anything abnormal with Resident #1 until 11/29/24 at 10:30 AM when the ADON called to ask her if anything had happened. She stated nobody informed her of any falls, being in pain, or not being able to be repositioned. She stated she did not find out about the pain she was in or her not being able to stand until later that night (11/29/24) by LVN B. She stated her expectations were that she be notified of any change of condition . She stated neuro checks should have been completed by LVN A. She stated the nursing team really dropped the ball. She stated she immediately began in-servicing all nursing staff and they did not work their next shift until they were in-serviced. She stated they were just notified that morning (12/10/24) that Resident #1 was discharged to another facility and would not be returning. During an interview on 12/10/24 at 12:51 PM, CNA G stated she had recently been in-serviced on abuse and neglect, change of condition, notifying a nurse when a resident was on the ground, and pain management. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 12/10/24 at 12:57 PM, LVN A stated on 11/28/24 Resident #1 was very active throughout the day. She stated closer to the evening time she saw her sitting on the floor playing with a box. She stated a little bit later, she saw a CNA walking her to her room and she was fighting her. She stated she noticed blood coming out of her nose, so she went and did a full skin assessment and took her vitals. She stated she had just forgotten to document anything from that shift. She stated she could not remember if she told the on-coming nurse about her sitting on the floor as she did not think it was a big deal. She stated she saw Resident #1 at the end of her shift (around 10:00 PM) and she was sleeping peacefully. During a telephone interview on 12/10/24 at 1:10 PM, LVN C stated she worked overnight on 11/28/24. She told her CNA E did not tell her Resident #1 was in pain, but that she had trouble standing up. She said she went to assess her, but she was sleeping. She stated in the morning she told LVN A she was not able to walk. She stated when she came back that evening (11/29/24), LVN B told her she was still not getting out of bed. She stated she told LVN B she told LVN A that morning that something was wrong, and it had to have been from a fall or something. She stated if she would have known Resident #1 had a fall when CNA E told her she was having trouble standing, she would have notified the NP immediately, tried to get her up, and sent her to the hospital. She stated she had recently been in-serviced by the DON on change in condition, pain management, abuse and neglect and documentation. She stated it was important to document all incidents and resident change of condition to ensure all staff were aware of what was going on with the resident. She stated neuros were important after an unwitnessed fall to ensure the resident did not have a change in their mental status. During a telephone interview on 12/10/24 at 1:20 PM, CNA F stated during the night shift on 11/28/24, Resident #1 was in a lot of pain. She stated when she tried to change her brief and turned her on her right side she started moaning in pain. She stated she immediately notified LVN C and asked her if anything had happened to her. She stated when she changed her before the end of her shift (at 6:00 AM on 11/29/24), she reacted the same way. She stated she told LVN C and the ADON of the pain she was experiencing. She stated she had recently been in-serviced by the DON on pain management, change in condition, and abuse and neglect . She stated she should never get a resident off the floor before notifying a nurse so they could assess for injury. Review of a PIP created by the DON, dated 12/05/24, reflected the following: Problem Area Identified: Inconsistency documenting and following the Accident/Incident process Changes Implemented to reach baseline: 1. Identify all patients with accident/incident reports 2. After morning report, ensure accident/incident process is opened and if not have, have nurse open before returning to the floor. 3. Accidents and incidents discussed daily at stand up and stand down - ongoing. 4. Ensure accident/incident process is opened, reports are completed, treatments are documented, process for unwitnessed falls have neuro checks initiated, and investigations are completed accordingly - ongoing (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Charting and Documentation Policy, revised July of 2017, reflected the following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Review of the facility's Accidents/Incidents Policy, dated May of 2016, reflected the following: 1. An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence an accident/incident . Review of the facility's Abuse and Neglect Policy, dated April of 2019, reflected the following: 1. The patient has the right to be free from abuse, neglect, mistreatment of resident property, and exploitation . The noncompliance was identified as PNC. The IJ began on 11/28/24 and ended on 12/05/24. The facility had corrected the noncompliance before the survey began.