

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 11/18/2025
NAME OF PROVIDER OR SUPPLIER Park Valley Inn Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents were free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms for one of six residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse when Resident #2 physically assaulted her on 09/27/25. The noncompliance was identified as PNC. The noncompliance began on 09/27/25 and ended on 09/30/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for abuse. Findings included: Record review of Resident #1's face sheet dated 10/15/25 revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes, lack of coordination, muscle weakness, hypertension, heart failure, difficulty in walking, depression, anxiety disorder and chronic pain. Record review of Resident #1's quarterly MDS dated [DATE] revealed her BIMS score was 11 indicating her cognition was moderately impaired. Record review of Resident #1's care plan dated 07/26/25 revealed Resident #1 was at the risk for falls r/t decreased mobility. The relevant intervention was educating the resident/family/caregivers about safety reminders and what to do if a fall occurs. Record review of Resident #2's face sheet dated 10/15/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included parkinsonism, chronic obstructive pulmonary disease (difficulty in breathing), type 2 diabetes, chronic kidney disease, hypertension, schizoaffective disorder (a mental disorder), anxiety disorder and muscle weakness. Record review of Resident #2's quarterly MDS dated [DATE] revealed her BIMS score was 14 indicating her cognition was intact. She was not coded for any physical, verbal or other behavioral symptoms directed towards others. Record review of Resident #2's care plan dated 07/26/25 revealed Resident #2 had potential to be physically aggressive r/t schizoaffective disorder, anxiety, and depression. The relevant interventions were, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior and encourage seeking out of staff member when agitated. Record review of the Provider investigation report dated 09/30/25 reflected, on 09/27/25 charge nurse, LVN A responded to a scream from the room of Resident #2. Upon entering, she observed Resident #1 on the floor and Resident #1 alleged that Resident #2 pushed her and she lost her balance and fell. Resident #1 had a skin tear to the left elbow from the fall and that was cleansed and treated with triple antibiotic ointment. During an observation and interview on 10/15/25 at 10:50am Resident #2 was emerging out from her room and sat in the living room. She stated she had changed her room two days ago and the current roommate was okay. She stated her previous roommates were not good as she had arguments with them. Resident #2 stated her previous roommate called her names and litter the room with various things. Resident #2 said the SW was trying to find the most suitable placement in another facility with the right kind of people and she stated she was okay with it. She stated she had issues with depression and anxiety and the medications that she had were not fully effective. When the investigator asked about the incident that occurred on 09/27/25 with Resident #1, she stated Resident #1 was a frequent visitor in her room to meet her roommate and she did not like any other residents entering her room. Resident #2 stated she was angry at that time, shouted at her and tried to push her out of the room. She stated she felt sorry later about the incident and, she apologized to Resident #1. She stated she did not have any intention of hurting anyone. During an interview on 10/15/25 at 3:20pm Resident #1 stated she was visiting her friend who shared the room with Resident #2. She added, without any provocation, Resident #2 approached her screaming and shouting and pulled her hair and pushed her down to the ground. She stated it was a very traumatizing experience mentally and physically and had a skin tear on her elbow area from the fall. She stated she did not retaliate and shouted for help instead as she believed in nonviolence. Resident #1 stated she asked the staff to call the police as Resident #2 assaulted her. Resident #1 said, next day Resident #2 approached her and apologized, though she was not sure how genuine she was. During a phone interview on 10/15/25 at 2:30pm LVN A stated, on 09/27/25 at about 9:50am she heard a scream from Resident #2's room and upon entering the room she saw Resident #2 was sitting on her bed. LVN A said she was furious and yelled Get the hell out of my room and stop bothering me</p>		