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	12/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 (Resident #1 & #2) of 16 residents reviewed for quality of care. The facility failed to ensure that the residents were cared for in a kind manner for Residents #1 and Residents #2 by walking away from the residents and not returning. The noncompliance was identified as PNC. The noncompliance began on 09/10/25 and ended on 09/17/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of not receiving necessary care. Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old woman who admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of cerebral infarction (a condition where blood flow to the brain was interrupted, leading to brain cell damage or death) with additional diagnoses of insomnia (sleep disorder where you have difficulty falling asleep) and unspecified generalized anxiety disorder (when a person experiences significant anxiety symptoms that do not fully meet the criteria for other specific anxiety disorders, such as panic disorder or social anxiety disorder).Review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS score of 15 which indicated Resident #1 was cognitively intact. Resident #1's Quarterly MDS also reflected she was frequently incontinent which means (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Review of Resident #1's care plan, dated 06/11/2025, reflected Resident #1 was care planned for required assistance x1 staff to move between surfaces during toileting needs. This care plan indicated this may fluctuate with weakness, fatigue, or weight bearing status.During an interview with Resident #1 on 09/25/2025 at 4:00PM, Resident #1 stated she felt a staff member had treated her unkindly. Resident #1 stated CNA A entered her room a while back, after Resident #1 pushed her call light for assistance to the bathroom. Resident #1 stated CNA A responded to the call light and stated, why didn't you get up and go to the bathroom? then proceeded to leave Resident #1's bedroom without helping her to the bathroom. Resident #1 stated CNA A came back approximately 30 minutes later and did not speak during the encounter. Resident #1 stated she had not experienced this type of behavior from a staff member again. Resident #1 stated that made her feel bad about asking for help. Review of Resident #2's undated face sheet reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction (complete paralysis on one side of the body, Weakness on one side of the body), type II diabetes mellitus with diabetic nephropathy (serious kidney complication caused by prolonged, poorly controlled high blood sugar and high blood pressure, leading to damage in the kidney's filtering blood vessels), and end stage renal disease (condition where the kidneys have deteriorated to the point where they can no longer function effectively). Review of Resident #2's Quarterly MDS, dated [DATE], reflected a BIMS score of 14 which indicated resident was cognitively intact. Resident #2's Quarterly MDS also reflected he required partial/moderate assistance for toileting needs which meant the helper less than half lifts, holds, or supports trunk or limbs, but provides less than half the effort.Review of Resident #2's care plan, dated 08/06/2025, reflected Resident #2 was care planned for an ADL self-care performance deficit r/t generalized weakness, amputation.During an interview with Resident #2 on 09/25/2025 at 4:30PM, Resident #2 stated he felt CNA A treated him unkindly. Resident #2 stated CNA A, during the night shift, had turned around and walked away from him when he needed to be clean him up. Resident #2 stated sometimes he could feel dizzy and would need help with going to the restroom. CNA A stated he reported the incident to the administrator. Resident #2 stated his care improved after the incident. Resident #2 stated it made him feel like he was not getting the care he needed. During an Interview with LVN A on 09/25/2025 at 4:30PM, LVN A stated they had been employed at the facility for 3 months. LVN A stated she had received training on both Resident Rights and Abuse/Neglect/Exploitation. LVN A stated that she had heard gossip about CNA A not treating residents fairly. LVN A confirmed that that CNA A had been placed on suspension during the investigation. During an interview with ADM on 09/25/2025 at 5:15PM, ADM stated they had been employed at the facility for 7 months. ADM stated he had received training on both Resident Rights and Abuse/Neglect/Exploitation. ADM stated the training included the residents have the right to be treated with dignity. ADM stated he had been made aware of the incident regarding Resident #1 and CNA A. He stated that Resident #1 had written a letter stating that CNA A had treated her unkindly during the night shift. Additionally in the written letter, she