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	02/17/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to immediately consult with the resident's physician and notify the resident representative when there was a change in residents health status for 1 of 1 resident (Resident #1) reviewed for notification of changes. LVN B failed to immediately notify Resident #1's physician and Resident # 1's RP when CNA A reported to him that resident had skin tears to right hand and right elbow. This failure could place residents at risk of injury, hospitalization, and/or decreased quality of life. Findings included: Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included Parkinsonism (A set of movement symptoms associated with Parkinson's disease (PD) and other disorders, Unspecified Dementia (Condition which involves memory loss, affecting thinking, and social abilities which interfere with their daily lives.), Atherosclerosis (is a hardening of your arteries from plaque building up) and Heart Disease (is a broad term for conditions that affect the structure and function of the heart). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. He required assistance from staff with ADL care. Record review of Resident #1's care plan dated 01/31/2026, revealed the resident was at risk for falls related to unsteady gait. Interventions were to include low bed as ordered on 07/02/2025 and assist rails required as enabler to promote as much independence as possible as ordered on 6/22/2025 and the resident's call light is within reach and encourage the resident to use it for assistance as needed as ordered on 05/19/2025. Record review of Resident #1's Wound assessment dated [DATE] at 3:30 PM. Wound Care Treatment Nurse. Assessment of 2 new wounds with onset date of 02/10/2026. Description of wounds as Non-pressure- Skin Tear/ Abrasion/ Scratch. Wound # 1 location is on Right hand (back) length 7.5 CM, width 5 CM. Wound # 2 location is on Right elbow length 6 CM, width 2.5 CM. Notification for change in condition related to wounds was reported to Resident #1, RP and Physician on 02/10/2026 upon completion of the Wound Assessment at 3:30 p.m. Record Review of Resident # 1's Radiology report located in Progress notes dated 02/10/2026 at 7:04 p.m. Bilateral Hand X-ray results were Electronically signed and finding included no evidence of fracture or dislocation, typical soft tissue senescent changes, no aggressive osseous lesions. Conclusion: mild degenerative changes without acute findings. In an interview on 02/12/2026 at 6:46 p.m., CNA A said on 02/10/2026 at about 5:00 a.m. he was walking the hallway on rounds, and he found Resident #1's forearms tangled in the left side assist bars. CNA stated, I lifted his arms out of the assist rails, and I noticed skin tears on both of Resident #1's elbows and bruising on his hands and forearms. CNA A stated Resident # 1 had bruises on his forearms prior to this incident and now the bruises look worse than before. CNA A stated he immediately reported this incident to the Male Charge Nurse who looked at Resident # 1's arms and he cleaned them up. In an observation and interview on 02/12/2026 at 6:49 p.m., Resident #1, could not verbalize answers to the question of how he got (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruises and cuts to his arms. Observed resident sitting in his wheelchair using his left hand to point at his spilled coffee cup on the floor. Resident appeared well groomed. In an interview on 02/12/2026 at 7:27 p.m., LVN B said at around 5:30 a.m. CNA A came to the nurse's station, and he told me he noticed bruises on Resident # 1's arms. LVN B stated, {CNA A} just asked me to come and see, he didn't tell me that the resident fell or got tangled. LVN B stated, I looked at Resident #1 and I asked him what happened? Resident # 1 didn't answer. LVN B stated he found just bruises, no cuts and he put moisturizer cream on Resident #1's arms. He stated, I called the NP, and he said to just monitor, he didn't order x-rays because there was no fall. I was off for 2 days and when I came back to work, I noticed that x-rays had been ordered on 02/10/2026. LVN B stated on 02/10/2026 his shift was over at 6:00 a.m. and he left the facility at the end of his shift. LVN B said he returned to the facility approximately 8 hours after he was notified of Resident # 1's incident and on that date at 1:24 p.m. he made a late entry in the progress notes for Resident # 1. Per witness statement on 02/12/2026, LVN B wrote on 02/2026, {CNA A} on the hall called me into resident room, noted discoloration to bilateral arms, resident could not state how it happened. Incident report was completed RP/ NP notified. Signed and dated 02/12/2026. In an interview on 2/13/2026 at 11:56 a.m., TN revealed that the 24-hour report indicated that Resident # 1 needed to be assessed. Per statement on 02/12/2026, CNA A wrote: when I was doing my last walk thru on Tuesday morning 2/10/26 I found Resident # 1 between bed rail and mattress not on floor. I put him back in bed and reported it to nurse. Per record review of progress notes on 02/10/2026 at 1:24 p.m., LVN B noted Resident presented with decolorated area to bilateral arm, resident could not state how it happened. Notified RP/NP. Per Record review of Telehealth Visit dated 02/10/2026 at 11:29 a.m. and Telehealth Facilitator was DON. The date and time of visit with NP was 02/10/2026 9:43 a.m. In an interview on 02/13/2026 at 10:07 a.m., DON said CNA A reported the incident to the Charge Nurse (LVN B). DON stated, his expectation was that staff were to report immediately to the NP of any incidents or changes occurred to a resident. DON stated, LVN B did not enter progress notes in a timely manner and that notes were entered 8 hours after LVN B was notified of the incident. DON stated he had facilitated the call with the NP at 9:43 a.m. and that this was approximately 4 hours after the incident with Resident # 1. In an Interview on 02/13/2026 at 11:29 a.m., UD revealed that around 7:30 - 8:00 a.m. on 02/10/2026 Charge Nurse, (LVN C) asked if I knew anything about the bruises on Resident # 1's hands. UD placed call to CNA A to inquire about the bruises on Resident #1's hands. CNA A explained he found resident hands tangled in the assist bed rail during the early hours of the morning on 02/10/2026 and he had reported it to LVN B. UD stated she went to the dining room, and she observed Resident #1's sitting in the dining room eating breakfast, he was wearing a long sleeve shirt so she couldn't see his forearms or elbows, but his hands were visible, and she saw he had bruising on them. UD said occasionally, Resident # 1 will get a little discoloration but, the hand bruising she saw on 02/10/2026 was unusual for Resident # 1. In an interview on 02/13/2026 at 12:11 p.m., LVN C stated, on 02/10/2026 I arrived for work for my shift 6 a.m. to 6 p.m. I looked in PCC to see if there was a note about {Resident # 1's} bruising from the night shift. There were no notes entered by the night charge nurse. LVN C stated, the bruises were worse than what I usually saw so I reported it immediately to the ADM. In an interview on 02/17/2026 at 3:51 p.m., RD stated it was her expectation that if a Nurse has been notified of an injury or incident or fall, they are to immediately perform an assessment of the resident. RD stated LVN B should have assessed Resident # 1, documented the assessment, notified the NP, family, Administrator and the DON and that was not done. RD stated, LVN B should not have left the assessment to the Treatment Nurse. Policy Incident and Accidents. Dated 10/01/2025 reviewed / revised 12/1/2025 It is the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy of this facility for staff to utilize the risk management - incident report in the electronic health record to report, investigate, and review any accident of incident that occurred allegedly occurred, on facility property and may involve or allegedly involve a resident.Policy Explanation:The purpose of incident reporting can include:assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrence and improve the management of resident care.Conducting roof cause analysis to ascertain causative/ contributing to avoid further occurrences. Alert risk management and/ or administration of occurrences that could result in claims or further reporting requirements.Meeting regulatory requirements for analysis and reporting of incident and accidentCompliance Guidelines4. Any injuries will be assessed by the licensed nurse or practitioner, and the effect individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions.5- the supervisor or other designee will be notified of the incident/ accident. If necessary, law enforcement may be contacted for specific events.6. The Nure will contact the residents' practitioner to inform them of the incident/ accident, report any injury so other findings, and obtain orders if indicated which may include transportation to the hospital dependent upon the nature of the injury.8. The residents' family or representatives will be notified. (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)S483.10(g)(14) Notification of Changes.(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention.