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	05/19/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interviews, record reviews and the comprehensive assessment of a resident, the facility failed to ensure that a resident 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 four residents review for quality of care in that: The facility failed to ensure Resident #1 was wearing her Geri-sleeves as ordered to reduce the risk of injury. The facility failed to intervene appropriately when Resident #1 had a skin tear on her left lateral calf on 05/11/2026 which led to Resident #1 having another skin tear on her right posterior lower leg. The facility failed to ensure Resident #1's wound care was done as ordered when the dressing came off. These deficient practices placed Residents at risk for infection, injury and decreased quality of care. Findings included:Review of Resident #1's face sheet dated 05/19/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills. It is the most common form of dementia, primarily affecting adults aged 65 and older), Generalized Anxiety (involves persistent, excessive, and uncontrollable worry about everyday issues like health, money, or work. It is characterized by feeling constantly on edge on more days than not for at least six months), Type 2 Diabetes Mellitus without complication (indicates the presence of high blood glucose without systemic organ damage, difficulty walking, and other abnormalities of gait and mobility. Review of Resident #1's care plan initiated 06/11/2025 reflected Resident #1 had an ADL self-careperformance deficit r/t Alzheimer's, has impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's, risk for falls r/t muscle weakness & poor safety awareness. Initiated on 05/03/2026, Resident #1 had cellulitis and bruising to left hand. Resident #1's care plan did not address skin tears and interventions. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99 indicating Resident #1 was unable to complete the interview and staff assessment of mental status was conducted. It was also reflected Resident #1 had both long and short-term memory problems. Section GG-Functional Abilities reflected Resident #1's mobility device was a wheelchair. Section GG also reflected, Resident #1, Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) were coded as 2 indicating Resident #1 required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Review of Resident #1's wound assessment dated [DATE] reflected Resident #1 had non-pressure bruise on her left arm, non-pressure bruise on right arm and non-pressure-skin tear/abrasion/scratch on her right calf measuring 6.5 cm x 2.0 cm. Review of Resident #1's incident report dated 05/11/2026 at 8:00 pm written by LVN D reflected: This nurse observed a paper tower with dried blood in resident's trash. Inquired from CNA if she was aware of any injuries on resident and cna stated that she had noticed a skin tear on resident's Lt lateral leg while giving her a shower. Head to toe assessment done, Skin tear noted on Lt lateral leg. skin tear measures 3.8cm x 3cm with Skin flap still present. Area cleansed with wound cleanser, skin well approximated. Some bleeding noted at this (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time, border dressing applied. Incident report also reflected on 05/14/2026 the facility documented, Resident resides in facility's memory care unit LTC with diagnosis of Alzheimer's disease. Residents depend on staff to provide ADL care.Event - resident noted with skin tear to left shin.RCA - resident transferred by CNAs without removal of footrests causing her shin to bump against footrestIntervention - nurse educated staff on removing footrests prior to transfersANE ruled out based on RCA / event. Review of Resident #1's incident report dated 05/14/2026 at 08:30 am written by LVN C reflected: CNA was pushing resident in the w/c from dining area to living area and noted a skin tear to posterior right lower leg. complete assessment done. area cleansed, pat dry, non-adherent pad applied and wrapped with kerlex (a brand of medical gauze primarily used for bandaging, packing, and protecting wounds), resident tolerated well. NP at facility and notified. Rp notified. care ongoing. Resident Unable to give Description. Incident report also reflected on 05/19/2026 the facility documented, Resident resides in facility's memory care unit LTC with diagnosis of Alzheimer's disease. Residents depend on staff to provide ADL care.Event - resident noted with skin tear to left shin.RCA - resident transferred by CNAs without removal of footrests causing her shin to bump against footrestIntervention - nurse educated staff on removing footrests prior to transfersANE ruled out based on RCA / event. Review of Resident #1's physician orders reflected the following:Preventative Treatment - Geri Sleeves every shift Moisturize skin, then apply geri-sleeves to bilateral upper extremities to prevent skin breakdown. May take off occasionally for bathing and ADLs with start date of 06/03/2025 (Geri sleeves- specialized, non-compression tubular protectors designed to safeguard fragile, thin skin. They are commonly used by seniors, post-surgery patients, and those in wheelchairs to prevent skin tears, bruising, and abrasions caused by friction or minor impacts.) WOUND TREATMENT: Bruise to left arm, monitor for any changes and report to MD/NP. every day shift with start date of 05/07/2026 WOUND TREATMENT: Bruise to right arm, monitor for any changes and report to NP/MD. every day shift with start date of 05/07/2026WOUND TREATMENT: Skin tear to right shin. Clean with NS/WC, pat dry and apply xeroform and cover with dry dressing. every day shift every Mon, Wed, Fri for wound care with order date of 05/13/2026 and start date 05/15/2026WOUND TREATMENT: Skin tear to right posterior lower extremity. Clean with NS/WC, dap dry and apply xeroform and cover with dry dressing. every day shift every Mon, Wed, Fri for wound tx with order date of 05/14/2026 and start date of 05/15/2026 During an observation on 05/19/2026 at 10:53 am, Resident #1 was sitting in her wheelchair in the living area, no geri sleeves on, visible bruising and skin tear at left lateral lower extremity, no dressing present. Resident #1 was taken to her room by CNA B for skin assessment. While in Resident #1's room, it was observed that the skin tears at left lateral lower leg and right posterior lower leg skin tears were in line with the pointed metal piece on Resident #1's wheelchair from which Resident #1's footrest can be attached, footrest was not present while Resident #1 was in the wheelchair. Observation of Resident #1's skin revealed a partially opened skin tear to left lower extremity with serous (Clear, watery plasma. It is thin, slightly yellow, and normal during the initial inflammatory healing stage) drainage coming out, redness around skin tear on left lower extremity. Skin observation also revealed an open skin tear at right lower extremity, wetness within the wound, redness around the wound, 3 little skin tears with scab above major skin tear. Bruises noted on Resident #1's both arm. During an interview on 05/19/2026 at about 11:03 am, RN A stated Resident #1 used to ambulate, but she no longer ambulated but moved around in her wheelchair by moving her feet. RN A stated the bruises and skin tears on Resident #1 could be from her bumping herself into the wall or from her wheelchair. RN A stated the skin tears on Resident #1's lower extremities looked like they were from her wheelchair. RN A stated Resident #1 could have scratched her legs on the metal on her wheelchair. RN A stated the staff do not put the footrests on Resident #1's wheelchair. RN A stated the Wound Care Nurse handle wounds and dressing changes; he did not do wound care because he had lot going on as a nurse. RN A stated there were wound care orders and maybe the orders were stopped and he did not recall Resident #1 having wound dressing on her wounds. During an interview on 05/19/2026 at 11:13 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	am, CNA B stated she worked with Resident #1 on 05/15/2026 and there were no skin tears. CNA B stated Resident #1 would sometimes get agitated, try to get up from the wheelchair, turn in her wheelchair and the metal part of her wheelchair hurt her. CNA B stated sometimes Resident #1 would hit something and get bruised. CNA B stated Resident #1 was no longer able to get up from her wheelchair. During an interview on 05/19/2026 at 12:12 pm the Wound Care Nurse stated she worked from Monday through Friday from 8am to 5:00 pm. The Wound Care Nurse stated Resident #1 had some unknown bruises on her hands and skin tears on both legs. The Wound Care Nurse stated she did not know how Resident #1 got the skin tears but Resident #1 was supposed to have treatment done on her skin tears on her legs and the skin tears should be covered. The Wound Care Nurse stated Resident #1 was on the memory care unit and tends to remove wound dressings. The Wound Care Nurse stated she was not made aware by nursing staff that Resident #1's wound dressing was off. The Wound Care Nurse stated the charge nurse for the hall was supposed to perform wound care /treatment on Resident #1's wound when the previous dressing came off, the charges nurses were not supposed to wait for the Wound Care Nurse. The Wound Care Nurse stated Resident #1's wounds could get infected if left opened. During an interview on 05/19/2026 at 12:36 pm, the DON stated she was aware of Resident #1's skin tears but she had not seen the skin tears. The DON stated Resident #1 was prone to removing the bandage from her wound. The DON stated, if a resident removed their wound dressing, she expected the CNAs to notify the charge nurse so the charge nurse can re-dress the wound. The DON stated she expected the charge nurses to know if a resident's wound needed to be covered, the charge nurses do not have to wait for the Wound Care Nurse to come before wound care was done. The DON stated the Wound Care Nurse does staging of wounds, measurements and documentations and the charge nurses were expected to perform wound care in the absence of the Wound Care Nurse. The DON stated any wound that was left open, not covered or wrapped was at risk for infection. The DON stated Resident #1 got her wound from hitting her legs on the footrest and hit her foot on the footrest when trying to get up. The DON stated the facility would see if Resident #1's footrest was easy to remove when she was being transferred. The DON stated the facility would have the maintenance staff take a look at Resident #1's wheelchair footrest. The DON stated she would have to follow up with the Administrator on the intervention for the skin tear because he was the one that first assessed the situation. During a phone interview on 05/19/2026 at 1:03 pm, LVN C stated on 05/14/2026, right after breakfast, while Resident #1 was being pushed in her wheelchair from the dining area to the living area, she noticed a skin tear to Resident #1's right posterior lower leg and wound dressing on left lateral lower leg. LVN C stated she cleaned the skin tear at Resident #1's right posterior leg and applied non-adhesive pad due to the skin tear not being approximate (even edges). LVN C stated she notified the NP who was already in the facility making rounds and also the DON. LVN C stated she did not see how Resident #1 got the skin tears on her legs but there was a possibility that it came from Resident #1's wheelchair footrest. LVN C stated Resident #1's wound was supposed to be covered to prevent infection. LVN C stated if the Wound Care Nurse was not around, the charge nurse would initiate the wound orders, and the Wound Care Nurse could change the order at any time. LVN C stated she had seen Resident #1 pulling on her wound dressing but if a resident removed their wound dressing, the charges nurses were supposed to replace the dressing. LVN C stated she worked with Resident #1 on 05/17/2026 and there was dressing on Resident #1's wound. LVN C stated Resident #1 was supposed to wear Geri-sleeves to prevent bruises and skin tears on her hands. During an interview on 05/19/2026 at 1:23 pm, the Administrator stated Resident #1 was noted with bruises on her hands on 05/03/2026, head to toe assessment was completed and abuse and neglect were ruled out. The Administrator stated he was made aware of Resident #1's skin tears on 05/11/2026 and 05/14/2026. The Administrator stated for the incident on 05/11/2026 regarding Resident #1's skin tear to the left lateral leg, he went and looked at Resident #1's skin tear, the wheelchair, spoke with staff and tied the skin tear to Resident #1's wheelchair footrest because Resident #1 had the tendency to kick her feet off the leg rest. The Administrator stated Resident #1's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had done the wound care. The DON looked at a picture of Resident #1's skin tear on her right posterior leg and stated she had seen wounds like that left open to air. The DON described the wound on Resident #1's right posterior leg by saying the wound was red inside and around with bruising and the wound had wet tissues. The DON then looked at a picture of Resident #1's left lateral leg and described it as angry skin, opened wound with surrounding red tissues. The DON stated Resident #1's wounds needed to be covered but Resident #1 took off the dressing all the time. The DON stated there should be documentation if Resident #1 was removing her wound dressings. The DON stated that the wound needed to be covered to prevent infection. The DON stated Resident #1's skin tears were caused by her wheelchair, and the interventions were removing the footrest when transferring Resident #1. The DON stated the first skin tear on 05/11/2026 was from Resident #1 dropping her foot and hitting the footrest. The DON also stated she did not go to assess Resident #1 to know how the second skin tear happened, but she spoke with the Wound Care Nurse who stated it was from the footrest, and it was discussed to ensure the footrest was removed during transfers. The DON stated if Resident #1 had an order for Geri sleeves, Resident #1 should be wearing Geri sleeves. On 05/19/2026 at 3:35 pm, the DON stated the facility had a PIP on Pressure Ulcers, but she was not done with it yet. The DON stated she would complete the PIP, but it was never provided to the Surveyors upon request. Review of facility's policy titled Wound Treatment Management dated 11/01/2025 reflected: Policy:To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.Policy Explanation and Compliance Guidelines:Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.Dressing changes may be provided outside the frequency parameters in certain situations:Feces has seeped underneath the dressing.The dressing has dislodged.The dressing is soiled otherwise, or is wet.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident environment remains as free of accident hazards as is possible; and Each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #1) of one Resident reviewed for transfers RN A and CNA B failed to properly transfer Resident #1 with a gait belt on 5/19/2026, they used Resident #1's pants to transfer her from the wheelchair to the bed. This failure place resident at risk of fall, injury and hospitalization. Findings included:Review of Resident #1's face sheet dated 05/19/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills. It is the most common form of dementia, primarily affecting adults aged 65 and older), Generalized Anxiety (involves persistent, excessive, and uncontrollable worry about everyday issues like health, money, or work. It is characterized by feeling constantly on edge on more days than not for at least six months), Type 2 Diabetes Mellitus without complication (indicates the presence of high blood glucose without systemic organ damage, difficulty walking, and other abnormalities of gait and mobility. Review of Resident #1's care plan initiated 06/11/2025 reflected Resident #1 had an ADL self-careperformance deficit r/t Alzheimer's, has impaired cognitive function/dementia or impaired thought processes r/t Alzheimer's, risk for falls r/t muscle weakness & poor safety awareness. Initiated on 05/03/2026, Resident #1 had cellulitis and bruising to left hand. Resident #1's care plan did not address skin tears and interventions. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99 indicating Resident #1 was unable to complete the interview and staff assessment of mental status was conducted. It was also reflected Resident #1 had both long and short-term memory problems. Section GG-Functional Abilities reflected Resident #1's mobility device was a wheelchair. Section GG also reflected, Resident #1, Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) were coded as 2 indicating Resident #1 required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. During an observation on 05/19/2026 at 10:53 am, Resident #1 was sitting in her wheelchair in the living area, no geri sleeves on, visible bruising and skin tear at left lateral lower extremity, no dressing present. Resident #1 was taken to her room by CNA B for skin assessment. It was observed while RN A and CNA B were transferring Resident #1 from the wheelchair to the bed, both staff held unto Resident #1's pants, using Resident #1's pants to transfer her from the wheelchair to the bed without the use of a gait belt. During an interview on 05/19/2026 at about 11:03 am, RN A stated Resident #1 used to ambulate, but she no longer ambulated but moved around in her wheelchair by moving her feet. RN A stated he was hoping Resident #1 would stand during the transfer from her wheelchair to her bed, he and CNA B were just giving Resident #1 a boost by grabbing her by the pants to stand. RN A stated that even if a gait belt was used, they would still use the resident's pants to stand them up. RN A later stated a gait belt probably would have helped. RN A stated using a resident's pants for transfer was a dignity issue. During an interview on 05/19/2026 at 11:13 am, CNA B stated she worked with Resident #1 on 05/15/2026 and there were no skin tears. CNA B stated they were supposed to use a gait belt while transferring Resident #1 from the wheelchair to the bed to prevent falls and injury. CNA B stated they were not supposed to transfer Resident #1 using her pants. During an interview on 05/19/2026 at 1:47 pm, the ADON stated Resident #1 relied on staff to provide care, move her feet while in the wheelchair but relied on staff to take her from one location to the other. The ADON stated staff shouldn't be grabbing residents by the clothes to aid in transfers, it could cause pain or skin tears. During another (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the DON on 05/19/2026 at 3:12 pm, the DON stated she had not yet seen Resident #1's skin tears to BLE but the Wound Care Nurse told her she had done the wound care. The DON stated Resident #1 needed a gait belt for transfers, she would not lift Resident #1 by the pants. The DON stated, if the staff were transferring Resident #1, they needed a gait belt to help support the staff, using Resident #1's pants to transfer Resident #1 would cause injury, ruin her clothes and cause discomfort like a wedgie.Review of facility's policy titled Safe Handling/Transfer revised 12/01/2025 reflected: Policy:It is the policy of this facility to ensure that residents are handled and transferred safely to prevent orminimize risks for injury and provide and promote a safe, secure and comfortable experience for theresident while keeping the employees safe in accordance with current standards and guidelines.Policy Explanation:All residents require safe handling when transferred to prevent or minimize the risk for injury tothemselves and the employees that assist them.Compliance GuidelinesHandling aids may include gait belts, transfer boards, and other devicesStaff members are expected to maintain compliance with safe handling/transfer practices. Failure tomaintain compliance may lead to disciplinary action up to and including termination of employment. Resident lifting and transferring will be performed according to the resident's individual plan of care.