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	06/08/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain good grooming and personal care for 1 of 5 residents (Resident #1) reviewed for ADL care. The facility failed to provide nail care to Resident #1, leaving the toenails thick, dirty, long, and discolored.This failure could place residents at risk of social embarrassment, isolation, infection, injury, pain, deterioration of health and a diminished quality of life.Findings included:Record review of Resident #1's face sheet, dated 06/08/26, reflected Resident #1 was admitted [DATE]. He was an [AGE] year-old male diagnosed with dementia, hypertension, insomnia, lack of coordination, muscle weakness, and cognitive communication deficit.Record review of Resident #1's initial MDS assessment, dated 05/28/26, reflected that an assessment for BIMS could not be completed as the resident was rarely/never understood. Further review revealed that for self-care he was fully dependent.Record review of Resident #1's care plan, dated 04/10/26 reflected that he required assistance for performing ADLs due to muscle weakness. The relevant intervention was checking nail length and trimming and cleaning on bath day and as necessary.During an observation and interview with RN A on 06/08/26 at 10:50 a.m., it was noted that all of Resident #1's fingernails were appropriately trimmed. However, an assessment of his feet revealed that his toenails were approximately half an inch long on both feet. The toenails were thick, dirty, yellow in color, and exhibited a yellow substance underneath. There was no sign of any infection or pain on the toes. RN A stated that she occasionally worked on Resident #1's hall as the charge nurse but had not paid attention to his feet. She stated that the toenails needed to be trimmed as soon as possible but expressed concern about her ability to perform the task, citing that it appeared more complicated and required specialized expertise. RN A indicated she would request a podiatrist to address this issue today, as untrimmed nails pose a risk of infection and injury.An attempt to interview Resident #1 at 11:00 a.m. on 06/08/26 was unsuccessful due to his cognitive deficits.During an interview on 06/08/26 at 2:35 p.m., the ADON stated that no staff reported the condition of Resident #1's toenails to her. She explained that, according to facility protocol, staff were responsible for reporting overgrown nails to the nurse-in-charge. She said if the resident was diabetic or if the nails appeared complicated, staff were expected to report the issue to the ADON so that a referral to a podiatrist can be made. The ADON stated that overgrown toenails could lead to injuries and infections, which was especially critical for residents with medical conditions such as diabetes.During an interview on 06/08/26 at 1:10 p.m., the DON stated that nail care should be performed appropriately and timely. She said that Resident #1's toenails had become overgrown and required evaluation by a podiatrist. She stated that the yellow substance beneath the nails was most likely fungal growth and that attempting to trim the nails by an RN would be risky. The DON explained that the Social Worker handled podiatry appointments and follow-ups. She also stated that Resident #1's toenail issue was discussed during the IDT meeting a few weeks prior; however, no referral had been made until this day. The DON stated she thought since the podiatrist visits once a month, there was no need for an earlier referral. She stated overgrown toenails posed infection control concerns because the nail bed could harbor germs that caused infectious diseases. The DON (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676471	A. Building B. Wing	06/08/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that long nails could cause scratches and injuries, which could have more serious consequences for residents with diabetes, peripheral vascular disease (a condition thta narrows, blocks, or spasms blood vessels outside the heart and brain) , or those taking blood thinners.Record review of the document Request for service/Consultation it was revealed that the request for podiatry service for Resident#1 was made on 06/08/26 by the ADON. Record review of the facility policy titled, Nail Care, dated 10/01/2025, reflected : Purpose: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health.Policy Explanation and Compliance Guidelines:1. Policy Explanation and Compliance Guidelines: Principles of nail care:a. Nails should be kept smooth to avoid skin injury.b. Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems shall be filed only.c. If a resident has a toe infection, diabetes mellitus, neurologic disorders, or renal failure, toenail trimming should be performed by a physician or practitioner.d. Resident without complicating disease processes, may have their toenails clipped by staff who have received education and training to provide this service within professional standards of practice and as per facility policy.