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	01/18/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Based on observations, interviews, and record review, the facility failed to ensure each resident was treated with respect and dignity in an environment that promotes maintenance or enhancement of his or her quality of life for 4 of 31 residents (Resident #3, Resident #59, Resident #97, and Resident #15) reviewed for resident rights. 1. The facility failed to ensure Resident #3, Resident #59 and Resident #97 clothing were changed daily on (01/14/2025 through 01/17/2025). 2. The facility failed to ensure Resident #15's room was free of odors and cleaned daily or as needed on 01/14/2025. This failure placed all residents at risk for not receiving adequate care and diminished quality of life and embarrassment. Findings included: 1. Review of Resident #3 face sheet revealed an [AGE] year-old female admitted on [DATE] with diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss and a decline in thinking skills), unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), other lack of coordination (a condition that causes uncoordinated movement), and need for assistance with personal care. Review of Resident #3 quarterly MDS dated [DATE] revealed Resident #3 required supervision or touching assistance (verbal cutes and/or touching/steadying) as the resident completed the activity for upper body and lower body dressing and putting on and taking off footwear. Observation on 01/14/2025 at 8:00 AM revealed Resident #3 ambulating around secured unit. Observation on 01/15/2025 at 2:01 PM revealed Resident #3 ambulated in secured unit in same clothing as on 01/14/2025. Review of Resident #3's progress notes dated 01/14/2025 through 01/17/2025 revealed no information regarding attempts to assist Resident #3 with changing clothing. (continued on next page)

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	Review of Resident #3's medical chart revealed had no care plan in place. Review of Resident #59 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnosis of Alzheimer's disease (a progressive brain disorder that causes memory loss and a decline in thinking skills), dementia (a decline in mental abilities that affects a person's ability to perform everyday activities), other lack of coordination (a condition that causes uncoordinated movement), and depression (a mental health condition that involves a long period of feeling sad or hopeless, and a loss of interest in activities). Review of Resident #59 quarterly MDS dated [DATE] revealed resident required set up assistance (staff help set up and resident completed the activity) for upper and lower body dressing and putting on and taking off footwear. Review of undated care plan for Resident #59 revealed Resident was short-term memory impaired and unable to recall after 5 minutes. Goals included that Resident #59 will participate in ADLs and facility routines. Interventions included maintain a consistent routine and to provide direct guidance when Resident #59 was unable to follow through with instructions. Further review revealed Resident #59's ADL functions were supervision and set up with all ADLs. Goal included that Resident would maintain a sense of dignity by being clean, dry, odor free, and well groomed. Review of Resident #59's care plan also revealed Resident rejects or resists care and had a history of refusal of hygiene care, and showers. Review of shower sheets for Resident #59 revealed she refused her shower on 01/14/2025 with a note will try again. Review of Resident #59 progress notes dated 01/14/2025 through 01/17/2025 revealed no information regarding attempts to assist Resident #59 with changing clothing. Observation of Resident #59 on 01/15/2025 at 9:50 AM revealed resident sat in common are with pajamas on. Observation of Resident #59 on 01/15/2025 at 2:42 PM revealed Resident sat in common are and had same pajamas on. Observation of Resident #59 on 01/16/2025 at 9:48 AM revealed Resident ambulated up and down hall with same pajamas as 01/15/2025. Observation of Resident #59 on 01/16/2025 at 3:37 PM revealed Resident had same pajamas on from 01/15/2025. Observation of Resident #59 on 01/17/2025 at 9:51 AM revealed Resident #59 had same pajamas on from 01/15/2025. Review of Resident #97 face sheet revealed an [AGE] year-old woman admitted on [DATE] with diagnoses of cerebral infarction, unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels), other lack of coordination (a condition that causes uncoordinated movement), and cognitive communication deficit (a difficulty with communication caused by a cognitive impairment). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #97 quarterly MDS dated [DATE] required supervision or touching assistance and required verbal cues or steading as Resident completed the activity for upper and lower body dressing. Resident required set up assistance for putting on and taking off footwear. Review of Resident #97's undated care plan revealed no interventions for ADL assistance. Review of Resident #97's progress notes dated 01/14/2025 to 01/17/2025 revealed no information regarding attempts to assist Resident #97 with changing clothing. Observation on 01/14/2025 at 8:47 AM revealed Resident #97 sitting in dining room eating breakfast. Observation on 01/15/2025 at 9:36 AM revealed resident standing in her room. Resident was observed in same clothing as 01/14/2025. Observation on 01/16/2025 at 9:44 Am revealed Resident in hallway and wearing same clothing as 01/14/2025. Observation on 01/16/2025 at 3:36 PM, revealed Resident wearing different pants but same top as 01/14/2025. During an interview on 01/17/25 at 09:59 AM CNA A stated that when she assisted residents in the morning to get up, she started by greeting them and bringing a warm washcloth to wipe their face. She stated that she then assisted the resident to the bathroom and assisted with oral hygiene. CNA A stated she then typically assisted the resident with getting dressed so they could feel ready for the day. She stated Resident #59 does have a history of refusing to get dressed and may hit while getting dressed. She stated she will offer Resident #59 to help her get up. CNA A stated that if a resident refused to get dressed or refused oral care, she would allow them to refuse and try again later. CNA A stated she would also ask other aides working so they could try. CNA A stated if the resident continued to refuse, she would tell the nurse. She stated usually when the nurse intervenes the resident would get dressed or shower. CNA A stated Resident #97 has no issues getting dressed daily but she does usually take her clothes off. During an interview on 01/17/2025 at 10:48 AM, CNA B stated that when she assisted residents to get up and ready for the day, she usually brought them a washcloth with warm water to wipe their face, combed their hair and brushed their teeth. She stated she would then help the resident get dressed so they could eat breakfast. CNA B stated that Resident #59 does refuse to get changed to get dressed and it may take a few staff to get her changed or showered. CNA B stated Resident #97 does not have issues with getting dressed if you explained what you are doing. She stated Resident #3 also does not have any issues getting dressed and will assist in the process. CNA B stated she does not know why Resident #3 and Resident #97 would be wearing the same clothing more than one day. She stated it Resident #59 refused they could redirect her and call her daughter so her daughter may assist with her getting showered or changed. She stated she would let the nurse know so the nurse could call Resident #59's family. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/2025 at 11:06 AM, LVN C stated that residents should get dressed every day. She stated that if a resident refused with a CNA they should tell the nurse, so the nurse could try and document if they refuse. She stated that with Resident #59 you had to try a few times, but she would usually get dressed. LVN C stated Resident #97 would get dressed but often does not keep her clothes on. LVN C stated that no staff has reported that Resident #97 refused to get dressed today. LVN C stated staff should try and help Resident #97 change their clothes and get Resident #97's family involved. She stated that if her clothes were not changed, she may have issues with her skin that staff do not see. During an interview on 01/17/2025 at 3:11 PM, LVN D stated that the CNA was supposed to report any refusals of care and then the nurse would try to encourage them and may even try a third time. LVN D stated she would document if the resident continued to refuse. LVN D stated that it was important to document so that it could show the care was offered. She stated she would also ask other staff to assist and may care plan it and come up with a plan to help. LVN D stated that residents should have their clothing changed every day. She stated staff should try other ways to encourage residents to change their clothes or any refused care. During an interview on 01/17/25 at 05:02 PM, DON stated that she expected residents clothing to be changed daily or asked needed if their clothing was soiled. She stated that if residents have behaviors for refusing care, she expected it to be care planned. DON stated she expected that staff document any attempt to offer a resident to change clothing. DON stated in the secured unit they have to approach the resident three times before it is considered a refusal. DON stated if a resident went for days without clothing being change, they could become uncomfortable, have skin break down and not have good hygiene. During an interview on 01/17/25 at 05:36 PM SW stated that she promoted residents' dignity by ensuring they are treated with respect. SW stated she ensured resident gets clean clothing every day. SW stated it was her responsibility to ensure residents' rights are not violated and that she advocated for the residents. SW stated if residents clothing was not changed daily, it could make them feel dirty, unkept, and have their rights violated. SW stated she had not received any complaints from family residents clothing not being changed. SW stated if residents have behaviors of refusing care it should be on their care plan. SW stated nursing would be responsible for care planning those behaviors. During an interview on 01/17/2025 at 5:57 PM, ADM stated that he expected residents' clothing to be changed daily unless they had a different preference. ADM stated he expected behaviors of refusing showers or clothing changes to be care planned or documented. ADM stated if a resident went for days without clothing being changed, they could be in dirty clothing, or it could affect their dignity if it was not their preference or choice or previous habit. ADM stated that if it was documented previously that a resident had a habit of refusing it may not necessarily need to be care planned but it could be updated in the care plan. 2. Review of Resident #15's chart reflected that a [AGE] year-old female was admitted to the facility on [DATE] with a diagnosis of vascular dementia. During an observation on 1/14/2025 at 7:22 am revealed that when the door was opened to Resident #1's room Resident #1 was standing in her room pacing. The room had a strong odor of urine in the room. Resident #1 was not able to answer questions at the time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/14/25 at 11:17 AM DA was coming to Resident #1's room and the room still smelled like urine. DA said that yesterday Resident #1 was different than she is acting today. DA said that she has never came to the facility and the room smelled like urine. DA told the nurse, and someone came to clean the room. During an interview with CNA A on 01/17/25 10:30 AM, she said that residents are check on in their rooms every 2 hours or even more depending on their need. CNA A said that if they check on a resident and there is a urine smell in the room, then they change the resident immediately. CNA A said that if the room and resident are not cleaned then resident could get bed sores, or a UTI if left soiled. During an interview with Nurse A on 01/17/25 10:29 AM, she said that residents at the facility are checked on every two hours sometimes more. Nurse A said that she will find out where why there is a smell and taken care of it. Nurse A said that a resident could get a UTI bedsores or skin break down if they are left in a soil clothes or briefs. During an interview with CNA 3 on 01/17/25 10:50 AM, CNA B, she said that residents are checked on every 2 hours or more often. CNA B said that if there is a smell in the room then she reports it to the Nurse and the nurse will tell housekeeping. CNA B said that if a resident is left in that situation, then resident could get a UTI and bed sores. CNA B said that when there is a smell in the room, then she will report this to the nurse then they tell housekeeping. During an interview with DON on 01/17/25 11:01 AM, DON said that residents are checked on every two hours or more often. If a room smells like urine, then the resident's room and resident are checked. DON said that sometimes residents will put soiled clothes in the closet, and that is why they check the whole room. DON said that if resident is not cleaned then they can have skin beak down. During an interview with ADM on 01/17/25 05:49 PM, ADM said that residents should be checked on every two hours. If there is was a urine smell in the room, then staff are expected to find the source of the smell and get it cleaned. ADM said that the smell would be unpleasant for the resident. ADM said that the strong urine smell could mean that the resident is was incontinent. Review of facility in-service dated 01/06/2025 with topic Hygiene- ADLs revealed, assist residents with hygiene care, comb or brush hair, and wipe face. Review of facility policy dated February 2021 titled Resident Rights revealed residents shall be treated with respect and dignity. Residents have the right to a dignified existence.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Based on observations, interviews, and record review the facility failed to accommodate the needs and preferences for 5 of 10 residents reviewed for accommodations. The facility failed to ensure that Residents #17, #39, #159, #80, and #94 had call lights in reach while lying in bed. This deficient practice could place residents at risk of injury, for not receiving timely care, and for not receiving nursing interventions. Findings Included: Resident #39 Record review of Resident #39's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic pain due to trauma, a contusion of head, wedge compression fracture 3rd lumbar vertebrae, rheumatoid arthritis, fracture of left femur and nasal bones, repeated falls, severe protein-calorie malnutrition, hypotension, and nausea. Record review of Resident #39's Quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating her cognition was intact. Further review of the MDS revealed Resident #39 required moderate to substantial assistance for her activities of daily living. Record review of Resident #39's Care Plan dated 12/10/24 reflected she had a fractured hip and had limited ambulation. The care plan stated the resident was non weight bearing status and changed status as healing progressed. Assist with ADL's and repositioning every two hours. Observed Resident #39 on 01/14/2025 at 9:15 am lying in bed talking with family, the call light was on the floor. In an interview with Resident #39 on 01/17/2025 at 3:35 pm she stated that her call light was falling out of reach often. She said it was hard to get care even with her call light in reach. She said she was sick on Sunday morning and her call light was out of reach. She was not able to put weight on her legs and waited 2 hours for someone to come in and check on her. It made her feel less than human because she had to wait so long. Resident #159 Record review of Resident #159's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included a fracture of right femur and orthopedic aftercare, hypertension, congestive heart failure, mild intermittent asthma, vascular dementia, repeated falls, presence of an implantable cardiac defibrillator, non-Hodgkin lymphoma, coronary atherosclerosis due to calcified coronary lesion, pneumonia, urinary tract infection, depression, and anxiety. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #159's MDS dated [DATE] reflected a BIMS score of 3, indicating severe cognitive impairment, and a complete dependence for ADL's. Record review of Resident #159's Care Plan dated 12/10/24 reflected: o At risk for fall related to a history of frequent falls. Interventions include place call bell within easy reach. o At risk for falls related to a history of syncope with interventions including placing call light within reach. Observed Resident #159 on 01/14/2025 at 7:20 am lying in bed sleeping with the call light hanging down out of reach. Observed Resident #159 on 01/14/2025 at 9:35 am sitting in wheelchair eating breakfast. Her call light was sitting in the middle of the bed. Interview with RP on 01/17/2025 at 3:45 pm revealed he had concerns about her condition in general and that no one was coming to feed her. He stated that with her condition even if she had a call light, he was unsure if she would call for help. Resident #80 Record review of Resident #80's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included syncope and collapse, urinary tract infection, diabetes mellitus type 2, seizures, encephalopathy (brain disease that affects mental alertness) , altered mental status, legal blindness, hyperlipidemia, hypertensive heart disease, cerebrovascular disease, and personal history of malignant neoplasm of organs and systems (widespread cancer). Record review of Resident #80's 5-day MDS assessment, dated 12/22/24 reflected a BIMS score of 10, indicating her cognition mildly to moderately affected. Further review of the MDS revealed Resident #80 required partial/moderate assistance for her activities of daily living, and she used a walker and a wheelchair. Record review of Resident #80's Care Plan dated 01/16/25 reflected Resident #80 required extensive assistance with bed mobility, bathing, hygiene, dressing, and grooming. The goals were for Resident #80 to be odor free, dressed and out of bed daily over the next 90 days, and Resident #80 would assist with her activities of daily living to the highest degree possible. The interventions included transfer status with gait belt with one staff assist and set up assist with her meals. Observed Resident #80 on 01/14/2025 at 7:15 am lying in bed crying without the call light in reach. Observed Resident #80 on 01/16/2025 12:36 PM lying in bed while the call light was on the ground. In an interview with Resident #80 on 01/14/2025 at 7:15 am she stated she had a fall in the middle of the night and had pulled herself back into bed. She stated she didn't know where her call light was and just went back to sleep after the fall. She stated she had just woken up and was in pain. She wanted to find her call light to call for the nurse. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the RP on 01/16/2025 at 1:15 pm she stated that she didn't think Resident #80 knew to call for help at times. She stated sometimes she got confused. Although she would like for the call light to be always available. Resident #94 Record review of Resident #94's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included status post left hip fracture, hypertension (high blood pressure), diabetes mellitus type 2, dementia, dysphagia (a condition that impacts the ability to swallow), muscle wasting and atrophy, pneumonia, and a cognitive communication deficit. Record review of Resident #94 's Quarterly MDS assessment, dated 01/14/25 reflected a BIMS score of 0, indicating her cognition was moderately to severely affected. Further review of the MDS revealed Resident #94 required total assistance for her activities of daily living, and she used a wheelchair. Resident #94's MDS also reflected she had a Foley catheter and two stage one pressure ulcers. Record review of Resident #94 's Care Plan dated 01/17/25 reflected Resident #94 had a left non-displaced hip fracture and was at risk for increased pain and limited ambulation. Further review of Resident #94's Care Plan reflected she was at risk for unintended weight loss related to malnutrition, with a goal of eating 50% of her meal three times per day over the next 90 days. Interventions included a weekly weight and for nursing to notify the physician of significant weight variances, lab work as ordered and notify physician of all findings, a liberalized diet and record meal intake, and a hospice evaluation. Observed Resident #94 on 01/14/2025 at 7:20 am lying in bed sleeping with the call light on the floor. Observed Resident #94 on 01/14/2025 at 9:36 am asleep in bed with the call light hanging over the bottom bedrail and the button near the ground. An interview was attempted with the resident on 01/14/2025 at 9:35 am, but the resident was unresponsive. Resident #17 Record review of Resident #17's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included spastic quadriplegic cerebral palsy (neurological disorder characterized by the permanent stiffness of all four limbs, which can lead to a loss of motor function and mobility), microcephaly (neurological condition where a child has a smaller head and brain than normal), anemia, muscle weakness, dysphagia (difficulty swallowing), epilepsy (seizure disorder), aphasia (a communication disorder caused by brain damage that affects verbal and written language), gastroparesis (a condition that affects the normal muscle movements of the stomach), and gastrostomy status (creation of an artificial external opening into the stomach for nutritional support or gastric decompression). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's Annual MDS assessment, dated 11/15/24 did not have a BIMS Score, indicating her cognition was moderately impaired. The MDS indicated Resident #17 had a diagnosis of cerebral palsy and received nutrition and medication via a gastrostomy tube. Further review of the MDS revealed Resident #17 required substantial/maximal assistance for her activities of daily living, and she used a modified wheelchair. Record review of Resident #17's Care Plan dated 01/17/25 reflected Resident #17 was transferred to and from her bed, chair, and wheelchair and was totally dependent on staff. Observed resident #17 on 01/14/2025 at 7:21 am lying in bed with the door open and the call light was tucked up behind the resident's mattress. Observed Resident #17 on 01/17/2025 at 2:45 pm lying in bed watching TV. No call light was visible when the state surveyor approached the bed. Observed Resident #17 on 01/17/2025 at 2:55 pm lying in bed watching TV. The call light was in the same place as 10 minutes ago. In an interview with CMA R on 01/16/25 at 5:27 pm she stated that residents were supposed to always have call lights. If she did not see a resident's call lights, she would pin the light to them . In an interview with RN U on 01/17/25 at 3:55 pm, he stated that residents should have had call lights available always. He stated there's no reason for them to be without access to help. He stated that they could have a serious issue and not be able to get help if the staff did not place the call lights correctly . In an interview with LVN W on 01/17/25 at 4:22 pm she stated that she knew she was supposed to always put call lights within reach. She stated it was expected that if they didn't see it, they needed to find it and place it within reach. She stated if the resident did not have a call light they could have a possible fall, choke on food, or even die from an incident. In an interview with the DON on 01/17/25 at 5:30 pm she stated that call lights should have been available always. There were no acceptable times for a call light to be out of reach. She expected the nurses and aids to place the call lights within reach while they were performing care or when leaving the room. IF they did not have access to the call lights they could get hurt or they could have missed an important incident. In an interview with the Administrator on 01/17/25 at 6:05 pm he stated the call lights should have been always available. He expected the direct care staff to put them within reach and should have looked for them before they left a room. He stated the call lights were a part of their rights as a reasonable accommodation and if they weren't able to get them, they would not have been able to get their needs met. Review of facility policy titles Call Lights dated 2001 stated: The purpose of this procedure is to respond to resident's requests and needs . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Based on observations, interviews, and record review, the facility failed to ensure that the resident had a right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms and to use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints for Resident #2 whose care was reviewed. in that: Resident #2 was in a wheelchair against the nurse's desk and a table in the dining room with the wheels locked prevented her from getting out of the wheelchair. These deficient practices affected 1 resident and had the potential to affect other residents who may be placed in restraints by contributing to restricted movement, a decline in ADL's function, and psychological distress. The findings include: A Record review of Resident #2's face sheet, care plan, and MDS was completed. Resident #2 revealed a [AGE] year-old female admitted on [DATE]. Resident #2's diagnoses include: Alzheimer's , and resident had a BIM score of 3. Resident has a history of wondering, Observation on 01/15/25 at 11:15 AM Resident #2 was in her wheelchair with the wheels locked at the nurse's station against the desk eating a snack. Resident #2 was trying to get out of the wheelchair at the nurse's station and almost fell . A facility staff was told that Resident #2 was falling, and staff came to assist Resident #2. Observation on 01/16/25 at 3:45 PM Resident #2 was alone in the dining room at a table in her wheelchair with the wheels locked. Resident #2's wheelchair was between the wall and the table in the dining room. Resident #2 was trying to stand up from the wheelchair and almost fell . Facility staff came to get Resident #2 before she fell . Interview on 01/17/25 at 10:30 AM CNA C has been at the facility for 3 Weeks. CNA C said residents should not be restrained at any time. CNA C said that if residents were being restrained, they could fall and injure themselves. CNA C said if she sees a resident being restrained, she will put them into a regular chair. CNS C said that she had not seen Resident #2 being restrained in the wheelchair, and if she had seen this then she would have moved Resident #2 from being restrained. CNA C said that she had been trained on restraints . Interview on 01/17/25 at 10:49 AM Nurse B has been at the facility for a week. Nurse B said there was no reason for a resident to be restrained in a wheelchair. Nurse B said that if a resident were restrained then they could injure themselves. Nurse B said that residents are not to be restrained at the facility. Nurse B stated that she did not know that. Resident #2 was being restrained in the wheelchair. Nurse B said that if someone is locked in the wheelchair that would be a restraint. Nurse B had been trained on restraints (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/17/25 at 10:59 a.m.: Resident #2 was in her wheelchair against the table in the dining room with other residents, the wheels locked. The other residents sitting at the table were not restrained. Interview on 01/17/25 at 11:20 AM. DON is aware that Resident #2 was in the wheelchair with the wheels locked. DON said Resident #2 was not being restrained but was a reminder for Resident #2 not to stand. DON was informed that while this was going on Resident#2 almost fell two other times. DON said that if residents were to fall, they could injure themselves. DON said that they did activities on busy boards. DON stated that they have not had any training on restraints because they did not use restraints. I01-17-25 at 05:49 PM interview with the ADM. ADM states that there should not be a reason for a resident to be restrained in a wheelchair. ADM stated that a resident being locked in a wheelchair against a desk, or a table would be a restraint. Residents would not be able to move if they were restrained. ADM said that there is no restraint policy in the facility so there has not been any training .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to ensure their written policies and procedures were implemented regarding prohibiting and preventing abuse and neglect for 1 (Resident #95) of 6 residents reviewed for developing and implemented abuse and neglect policies. LVN T failed to report that Resident #95 was slapped on the shoulder by Resident #97 and failed follow incident procedures after she received report of incident on 01/14/2025. This deficient practice could place residents at risk of continued abuse, injury, trauma, and psychosocial harm. Findings included: Review of Resident #95 face sheet revealed a [AGE] year-old man admitted on [DATE] with diagnoses of peripheral vascular dementia (a type of dementia that's caused by reduced blood flow to the brain), restlessness and agitation (feelings of inner tension and severe restlessness that can manifest in a variety of ways) and cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked). Review of Resident #95 initial MDS assessment dated [DATE] revealed BIMS of 04 which indicated severe cognitive impairment. Further reviewed revealed resident presented mild symptoms of depression indicated by score of 06 on PHQ-9. Review of undated care plan for Resident #95 revealed resident had ineffective coping related to inability to manage internal and external stressors secondary to anxiety. Interventions included to protect from injury to self and others, redirect from source of increased stimuli. Review of nursing progress notes dated 01/12/2025 revealed Resident #95 had another resident coming into his room frequently and Resident #95 was upsent and requested resident to stay out of his room. Resident #95 was provided safety device to prevent other residents from entering room. Other resident made several attempts to enter door but was not successful. Resident #95 reminded to request assistance if other another resident is was irritating him. Review of Resident #97 face sheet revealed an [AGE] year-old woman admitted on [DATE] with diagnoses of cerebral infarction, unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels), other lack of coordination (a condition that causes uncoordinated movement), and cognitive communication deficit (a difficulty with communication caused by a cognitive impairment). Review of Resident #97 quarterly MDS dated [DATE] revealed Resident #97 had a BIMS of 12 at time of assessment which indicated mild cognitive impairment. Review of Resident #97 care plan revealed resident was taking psychotropic medication as evidence by anxiety, cognitive impairment, insomnia and bipolar disorder with interventions to protect Resident #97 from self and others. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #97 nursing progress notes dated 01/12/2025 revealed Resident #97 had been irritable all day with manic behavior. Resident #97 continuously went to another resident's door and attempted to enter. Review of nursing note dated 01/15/2025 revealed reported to nursing that resident went into another resident's room and he told her to leave, Resident #97 hit him on the back and left. Nursing questioned the resident that was hit, and he said he was fine, and Resident #97 didn't hurt him. During an interview on 01/14/2025 at 7:28 AM, CNA U stated Resident #95 doorknob cover because another resident was going into his room. Observation on 01/14/25 at 01:03 PM revealed Resident #97 entered Resident #95's room. Resident #95 pulled resident on shirt near her shoulder and told her to get out and stated she takes and steals things. Resident #97 was observed slapping Resident #95 on his left shoulder and then exited the room. Surveyor notified LVN T of observation on 01/14/2025 at 1:05 PM. LVN T left common area and walked to Resident #95's room. During an interview on 01/17/2025 at 10:07 AM CNA A stated if she got a report that a resident slapped another resident she would report to the nurse and if the nurse didn't do anything she would tell DON and ADM. She stated she would report it right away. She stated that Resident #97 does not usually hit other residents. CNA A stated she usually got training on abuse and neglect when there is was an incident. She stated she knew she is was supposed to report it right away. She stated she is was new and she received abuse and neglect training when she got hired and stated the facility kept reminding her of what to do when there is was an incident. During an interview on 01/17/2025 at 10:48 AM CNA B stated she had received training on abuse and neglect but was not sure how often. CNA B stated she started back at the facility about two weeks ago and received the training. CNA B stated if she received a report of a resident slapping another resident, she would separate the residents and report to nurse, chart about it and report it to ADM. She stated she would report it immediately. CNA B stated if she didn't report that she could lose her license. She stated Resident #97 typically just undressed and wandered around and she did not know of her hitting other residents. During an interview 01/17/2025 on 11:06 AM LVN C she stated she got training frequently on abuse and neglect and they review who the abuse coordinator was. LVN C stated she is required to report anything that is unsafe for residents. She stated for resident to resident incidents she would do an incident report, let family know, NP and, DON. LVN C stated she would do an head to toe assessment and begin monitoring protocol. She stated she would report it as soon as it happened after she separated the residents. LVN C stated if she did not see it but someone told her she would still report it. LVN C stated if it was not reported sometimes there could have been an injury or the abuse may continue. LVN C stated to her knowledge Resident #97 does not have any issues with getting physical altercations with other residents. (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/25 at 03:11 PM LVN D stated that if there is was an incident, they get updated training on abuse an neglect but she is unsure how often training is received. LVN D stated if she observed or received a report of a resident-to-resident incident then she would notify ADM, complete an incident report, and notify family and DON. LVN D stated incident report included a head-to-toe assessment. LVN D stated if it was not reported it could be considered neglect and you may not know what could happen to the residents. She stated she is supposed to report it right away. LVN D she stated even if she checked on resident she would still report it to the ADM. During an incident on 01/17/2025 at 4:55 PM, DON stated abuse and neglect training is provided periodically through staff online training and in-servicing on abuse and neglect is done whenever the is something to report. DON stated she expected staff to report resident-to-resident altercations. DON stated the process for altercation between two residents depended on how hard the slap was. DON stated it would be investigated and determine if was done to cause harm and if so facility would self-report. If nurses or CNAs got a report a resident slapped another resident, she would want them to report it to the ADM. DON stated ADM and DON involve their regional support to determine if it should be investigated and reported to HHSC . DON stated it altercation is wa considered abuse and neglect it should be reported within two hours of being notified. She stated if it was not reported, the resident could be hurt and may not know it because there was no follow-up. During an interview on 01/17/2025 at 5:50 PM, ADM stated training on abuse and neglect is was provided at least annually and as needed, but it was usually done frequently. He stated he expected staff to report resident-to-resident altercations to him. ADM stated the process for when altercations happen is to complete and incident report, investigate to determine what happened and compare it to provider letter to determine if it would be reportable to HHSC. ADM stated that altercations should be reported immediately. ADM stated if he was not made aware he could not investigation the situation to see if it was reportable or not. Review of facility policy titled Accidents/Incidents dated May 2016 revealed an accident/incident report must be completed immediately upon facility staff becoming aware of occurrence involved a patient and if necessary to update a care plan. A psychosocial well-being care area assessment must be completed on all patients with potential for psychosocial changes resulting from an incident. The administrator serves as the abuse coordinator and when an allegation of abuse or actual abuse is identified, the abuse protocol must be implemented. Review of facility in-service dated 01/02/2024 revealed topic of abuse protocol was reviewed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Based on observation, interviews and record review , the facility failed to develop and implement a comprehensive person-centered care plan with resident rights, which included measurable objectives and time frames to meet the resident's mental and psychosocial need for three (Resident #3, Resident #73, and Resident #97) of six residents reviewed for care plans. The facility failed to update Resident #97's activity preferences were not updated after the quarterly assessment. The facility failed to update Resident #73's dental status and activity preferences were not updated after the quarterly assessment. The facility failed to implement a comprehensive care plan for Resident #3 within 21 days of admission on 12/04/2024. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met. Findings included: Review of Resident #73 face sheet revealed an [AGE] year-old female admitted on [DATE] with diagnosis of Alzheimer's disease (a progressive brain disorder that causes memory loss and a decline in thinking skills), generalized anxiety disorder (a condition that causes people to feel excessive and uncontrollable worry about everyday things), restlessness and agitation (feelings of inner tension and severe restlessness that can manifest in a variety of ways) and cognitive communication deficit (a difficulty with communication caused by a cognitive impairment). Review of Resident #73 quarterly MDS dated [DATE] revealed Resident #73 denied having littler interest or pleasure in doing things or feeling down, depressed, or hopeless. Further review revealed none of the above were present for oral/dental status which included loosely fitting dentures. Review of Resident #73 undated care plan revealed there were no preferences for activities for Resident #73 and no information regarding her dental status. During observation an interview on 01/14/2025 at 12:51 PM, Resident #73 stated her bottom teeth were permanent dentures and did not fit well. Observation of Resident #73 revealed her dentures were loose. Resident #73 stated she did not wear her top denture. During an interview on 01/15/2025 at 10:31 AM, Resident #73's FM stated that the facility had replaced her top denture previously as it was lost, but Resident #73 does not like to wear it. FM stated that Resident's bottom dentures are permanent and that they were loose. FM stated that Resident #73 does not have interest in doing anything. (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview of 01/17/2025 at 10:48 AM, CNA B stated she has seen Resident #73 with dentures once and her bottom dentures she believes were permanent. During an interview on 01/17/2025 at 11:06 AM, LVN C stated Resident #73 will do some activities, but she gets confused easily. LVN C stated that Resident #73 had permanent dentures on the bottom. Review of Resident #97 face sheet revealed an [AGE] year-old woman admitted on [DATE] with diagnoses of cerebral infarction, unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels), other lack of coordination (a condition that causes uncoordinated movement), and cognitive communication deficit (a difficulty with communication caused by a cognitive impairment). Review of Resident #97 quarterly MDS dated [DATE] required supervision or touching assistance and required verbal cues or steading as Resident completed the activity for upper and lower body dressing. Resident required set up assistance for putting on and taking off footwear. Review of Resident #97's undated care plan revealed no activity preferences. During an interview on 01/17/25 at 10:12 AM, CNA A stated Resident #97 does not stay in one area and her attention span is was very short. She stated she may participate in activity for a short bit but then she will leave. CNA A stated Resident #97 enjoys to walking around. CNA A stated Resident #97 had no issues getting dressed daily but she does usually take her clothes off and staff often had to redirect her because she will remove her clothing in the hallway. During an interview on 01/17/25 at 10:48 AM CNA B on days they have coloring activity Resident #97 would color. CNA B stated some days she would try to do cross word puzzles. CNA B stated when they had group activities, she would do balloon toss with someone sitting next to her providing cues. CNA B stated Resident #97 had to maintain that focus, or she will leave the activity. CNA B stated sometimes Resident #97 does better when she is help but most of the days she is wandering around. During an interview on 01/17/25 at 11:06 AM, LVN C stated Resident #97 liked to dance for activities, music and coloring. During an interview on 01/17/25 at 03:11 PM LVN D stated it was important for a resident to participate in activities for well-being and improve their mood and keeps them moving. LVN D stated if they had behaviors, it may distract them as well. During an interview on 01/17/25 at 03:26 PM LD stated Resident #97 liked to do matching games, folding activities, get fresh air, listen to oldies music and rock and roll. LD stated that Resident #73 loved to play with a baby doll, participate in manicures, get hand massages, listen to music, and play darts. LD stated that nursing was responsible to update the activities section of care plans for residents. Review of Resident #3 face sheet revealed an [AGE] year-old female admitted on [DATE] with diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss and a decline in thinking skills), unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), other lack of coordination (a condition that causes uncoordinated movement), and need for assistance with personal care. (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3 health record revealed Resident #3 had no care plan in place. During an interview on 01/17/2025 at 4:13 PM MDS H stated she stated she does the skilled side, and her partner does the long-term side of care plans. MDS H she stated she would think that activities would complete the activities portion of the care plan. MDS H stated she does not enter that information into the care plan. MDS H stated she was not sure how activity preferences make it into the care plan. MDS H stated she was responsible for care planning, and she got the information from the MDS care area assessment. She stated she is responsible for nursing part of the care plans and activities would be responsible for activities care plan. MDS H stated if anyone is responsible to go behind other staff and ensure their part is on the care plan, it would be MDS coordinators. MDS H stated a care plan is a working document and it should be updated as needed with any changes. MDS H stated information for care plan comes from the resident, family, IDT team, and dietary nurse manager. MDS H stated Resident #3 did not have a comprehensive care plan in place and it should essentially get a care plan when they walk through the door. During an interview on 01/17/25 at 04:59 PM DON stated the responsibility of who was responsible for updating care plans depends on what it was. DON stated activities should be updated by the LD. DON stated activities should be on the care plan. DON stated if a resident had dentures or missing teeth that would be found on the care plan. DON stated it should be on the care plan so staff could know how to care for the resident or brush their teeth. DON stated behaviors should be on the care plan. She stated it was important for a care plan to ensure it accurately reflected a resident's status so staff could get a full picture of what and how to care for a resident. DON stated a comprehensive care plan should be completed within 14 to 21 days but if they are short term, it should be done sooner. She stated it was important for a resident to have a care plan in place because it gave staff the picture of what the residents needs were. DON stated if it was not completed within that timeframe staff may not be aware of interventions that help a resident. During an interview on 01/17/25 at 05:53 PM, ADM stated care plans are a multi-person responsibility and the IDT was also responsible for updating the care plan. ADM stated activity trends should be updated by the LD or MDS nurse and something they can do together. ADM stated dental status should also be included on the care plan. ADM stated it was important to ensure the care plan accurately reflected a resident's status to know what their needs and wants were and to coordinate care. ADM stated that a comprehensive care plan should be completed within 14 days. ADM stated it was important for a resident to have a care plan in place so staff could know what their needs were and care for them properly. ADM stated if it was not completed timely staff could miss and issues that needed to be addressed. Review of facility policy titled Care Plans, Comprehensive Person-Centered dated March 2022 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment and no more than 21 days after admission. Further review revealed the care plan should describe services to attain to maintain the resident's highest practicable physical, mental, and psychosocial well-being and also describes services that would otherwise not be provided due to a resident exercising his rights including the right to refuse treatment.

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	676471	A. Building B. Wing	01/18/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 50472 Based on observation, interview, and record review the facility failed to ensure residents environment remained free of accident and hazards to prevent avoidable accidents for 1 (Resident #28) of 1 resident reviewed for safe transfers. The facility failed to ensure mechanical lift #1 was removed from the floor after it was deemed out of order on 01/03/2025. The facility failed to ensure mechanical lift #2 was in working order prior to Resident #28's transfer. The mechanical lift fell on top of Resident #28 and Resident #28 fell to the floor from the lift which resulted in Resident #28 being transferred to the ER to be treated for a lumbar fracture and hemorrhage on 01/03/2025. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 01/15/2025 at 6:15 PM. While the IJ was removed on 01/18/2025 at 6:15 PM, the facility remained at a level of no actual harm at a scope of isolated that is was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents who require a mechanical lift for transfers at risk for falls and/or serious injury or death. Findings included: Review of Resident #28 face sheet revealed a [AGE] year-old female admitted on [DATE] with diagnoses of wedge compression fracture of second lumbar vertebra (break in the front of the vertebra that causes it to collapse into a wedge shape), memory deficit following cerebral infarction (common cognitive impairment that can affect memory, attention, concentration, and language), Traumatic subarachnoid hemorrhage without loss of consciousness (type of brain injury that occurs when there's bleeding between the brain and skull) and multiple sclerosis (a chronic disease that damages the central nervous system). Review of Resident #28 significant change MDS dated [DATE] revealed, Resident #28 had a fracture and major injury. Further review revealed Resident #28 was dependent on staff for chair to bed and bed to chair transfers. Review of Resident #28 undated care plan revealed Resident #28 was dependent on staff for transfers and required a mechanical lift. Further review revealed Resident #28 fell from mechanical lift on 01/03/2025 with interventions to keep area free of obstructions to reduce the risk of falls or injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #28 nursing progress note dated 01/03/2025 revealed LVN D was called to Resident #28's room and Resident #28 was on the floor. Progress note revealed CNA N and CNA O tried to transfer Resident #28 from bed to her wheelchair and stated that she fell from lift and laid on the floor. Resident #28 stated she bit her tongue and small amount of blood was noted. Resident #28 stated she hit her head. NP was notified and provided order to send to ER. Review of Resident #28 nursing progress note dated 01/04/2025 revealed Resident arrived back to facility with diagnosis of lumbar spine fracture and subarachnoid hemorrhage. During an interview on 1/15/2024 at 12:02PM Resident # 28 started she remembered falling to the floor after staff tried to get her to her bed with the lift. Resident #28 stated she was scared, screamed and bit her tongue. She stated when she hit the floor, she thought she had broken her back. Resident #28 stated she did not remember going to the hospital or if she had any injuries. During an interview on 1/15/2024 at 1:40pm LVN D she stated she was working on 1/03/2025 and was called to the Resident #28's room. LVN D stated upon arrival Resident #28 was on the floor and he two aides (CNA N and CNA O) told her they tried to transfer Resident #28 from bed to her wheelchair and that Resident #28 fell from the mechanical lift and laid on the floor. She stated Resident #28 was alert and the resident told LVN D that she bit her tongue. LVN D stated she did notice a small amount of blood that stopped bleeding by itself, and that Resident #28 told LVN D she hit her head. LVN D stated she completed vitals and called the NP, which gave the order to send out Resident #28 to the ER for further evaluation. LVN D stated she also called and informed Resident #28's son. During an interview 1/15/2024 at 1:54PM CNA N stated, she worked 6:00 am to 2:00 pm on 01/03/2024 and at 10:00 am she and CNA N went to Resident #28's room to get her out of bed for activities. CNA N stated they had already used the mechanical lift at 6:00 am on Resident #28 and with two other residents without problems and did not have any knowledge of the mechanical lift being out of order. CNA N stated when they moved the mechanical lift from the bed, the top of the mechanical lift fell on top of Resident #28. CNA N stated, Resident #28 screamed out loud when she fell to the floor and fell on her back. CNA N stated that Resident #28 stated she bit her tongue and saw it was bleeding. CNA N stated she ran to contact the charge nurse LVN N and stated LVN N came to the room and completed vitals and Resident #28 was sent to the ER because she hit her head. During an interview on 1/15/2025 at 2:05PM CNA O she stated as they pulled the mechanical lift away from the bed the top of the lift fell on top of Resident #28, and she fell on her back to the floor. CNA O stated Resident #28 screamed out due to the impact. CNA O stated she stayed with the resident while CNA O when to get the nurse. She stated LVN D came immediately. (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/15/2025 at 3:05 PM MD stated that the company who serviced mechanical lifts came out earlier in the day on 1/03/2025. He stated that the technician stated he left an out of order sign on a mechanical lift. MD stated he did not confirm there was a sign on the mechanical lift and that later he heard a resident fell . MD stated that the service provider does not inspect the mechanical lift he only calibrates the scale. MD stated that upon his inspection after the fall he saw that a washer separated from the bolt which caused it to come out and what caused the mechanical lift to fall onto the resident. MD stated that he removed the mechanical lift from the floor after the incident. MD stated that he inspected each mechanical lift weekly and the service provide calibrates mechanical lifts monthly. MD stated he does not document his weekly inspections. MD stated that there used to be an app the staff could report issues, but it did not work out and there are maintenance binders that staff write down issues in. During an interview on 01/15/2025 at 3:20 PM DON stated she was not working when the fall happened with Resident #28. DON stated she returned to work on 1/06/2025. DON stated mechanical lift training was completed on 12/24/2024 with staff, but not again after the incident with Resident #28. DON stated no additional training was done regarding safe transfers and it was her intention to do it, but it did not happen. During an interview on 01/15/2025 at 3:57 PM ADM stated that staff said they were transferring Resident #28 and the central arm came loose and she fell off the bed and onto the floor and was between the legs of the lift. ADM stated Resident #28 was sent to the hospital. ADM stated that when the service provider come to service the mechanical lift, they calibrate the lift and do not inspect it. He stated there was not routine maintenance done unless something is was wrong with the lift. He stated that the MD inspected lifts routinely but not in a formalized process. He stated that the service provider was out earlier in the day on 1/03/2025. He stated he had not heard that they marked a mechanical lift out of order. ADM stated they used it for Resident #28's shower earlier in the day and two other residents before her fall. ADM stated that the only thing that was not working was the battery in the scale but that was for weighing purposes. ADM stated if someone stated that there was something wrong with mechanical lift, he would have expected it to be taken it off the floor. ADM stated if the mechanical lift was out of order and used it would risk of someone getting hurt and stated that someone did get hurt, but depended on if something was truly wrong with it. ADM stated he was not sure if he had a policy on servicing mechanical lift. ADM stated he expected service providers to notify management of any issues with equipment so it could be pulled off the floor. In a subsequent interview on 01/15/2025, ADM stated that the service report for the mechanical lift serviced on 01/03/2025 was different than the lift that fell on Resident #28. During an interview on 01/15/2025 at 05:30 PM DON stated all staff should report mechanical lift issues to MD and if it was after his working hours, the staff should inform the immediate nurse and they should contact MD. DON stated all staff were responsible for removing a non-working mechanical lifts from resident care areas. During an interview on 01/15/2025 at 5:30 pm CNA P stated that if the equipment was not working, he would have been able to tell when he felt it not working like it used to. CNA P stated he did not know what the policy was for reporting broken equipment, but stated he would report it to his chain of command. CNA stated he would not know a mechanical lift was broken from the look of it. CNA P stated if it was broken someone could get hurt. (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 01/15/2025 at 5:35 PM revealed a second mechanical lift with an orange sign on it wheeled into MD's office that had do not use on it. MD stated that this lift was on the floor and that ADM would have to be asked about if it was being used. MD stated it apparently already had the sign on it not to use but he was unsure where it was and to ask ADM. During an interview 01/15/25 at 5:35 PM, MA Q stated she would not know if equipment were broken unless they put a sign on it. She would not be able to identify something was broken until it was not working properly. MA Q stated if she needed to report it, she would have reported it to her charge nurse. MA Q stated if they used broken equipment, they could hurt themselves or others. During an interview on 01/15/2025 at 5:43 PM, CNA R stated if equipment was not working properly, she would let the nurse know and would write a sign and remove it. CNA R stated she would move the equipment outside the area. CNA R stated if she used a piece of equipment that was broken, it could hurt herself or another resident. During an interview on 01/15/2025 at 5:44 PM, service provider supervisor stated that the company only calibrates the scales on the mechanical lifts. He stated that if there was an issue with the lift, they would notify management. He stated that they would normally not tag the lift that it was out of order and if it was not functioning, they would notify management. During an interview on 01/15/2025 at 5:50 PM, LVN S stated she was a charge nurse. LVN S stated if a piece of equipment was broken a CNA would let her know. LVN S stated she normally worked 10:00 PM - 6:00 AM and they did not use a lot of equipment. She stated they would scan the QR Code that was implemented in May 2024 to notify the MD. LVN S stated CNAs would let us know and then they would go through the steps of reporting. LVN S stated they would remove the equipment, put a sign on it and push it to the back on in a closet if it was not working. During an interview on 01/23/2025 at 11:54 AM, representative from mechanical lift manufacturer stated that it was advised to do at least a monthly inspection of the mechanical lifts to look around for normal wear and tear. Representative recommended that a day be set aside once a month to inspect the lift. Review of service report dated 01/03/2025 revealed mechanical lift #1's serial number matched the service report, and it was serviced on 01/03/2025. Further review revealed service reported noted motor that spreads wheels does not work but scale is accurate left out of tag order on lift. Further review revealed service provider emailed MD a copy of the service report on 01/06/2025. Review of technician kiosk sign in and out information revealed service provider technical checked in at 01/03/2025 at 9:05 am and check out of the facility at 9:58 AM. Resident #28 was reported to have incident at 10:00 AM. Review of undated facility investigation pictures of mechanical lift #2 revealed differing serial number than serial number of mechanical lift #1. Observation on 01/16/2025 at 3:30 PM revealed mechanical lift #2 revealed differing serial number than lift that was serviced on 01/03/2025. (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility accident/incident report dated 01/03/2025 revealed equipment as fall contributing factors. Review of manufacture owner's manual titled Battery Operated Patient Lift dated 03/01/2022 revealed the operator of the lift is to inspect the mechanical before each use and included to check all bolts and nuts are tight. Further review revealed at least once a month, the lift should be thoroughly inspected to recognize any signs of wear, and/or looseness of bolts or parts and to replace any worn parts immediately. Review of facility policy dated July 2017 titled Lifting Machine, using a Mechanical revealed make sure that all necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition. Further review revealed to test control and ensure emergency release feature works. ADM and DON were notified on 01/15/2025 at 7:17 PM that an Immediate Jeopardy (IJ) had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 01/17/2025 at 4:52 PM: F689 This is to confirm the submission of our Plan of Removal provided by this facility. For F689 IJ. The submission of this POR does not constitute an admission on the part of the facility as to accuracy of the surveyor's findings, the conclusion drawn from there, nor is the scope and or severity regarding any deficiency cited applied correctly. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident went sent to the ER for further evaluation and treatment on 1/3/2025. The resident was treated for L2 transverse fracture and monitored for brain bleed and resolved. On 1/4/2025 Resident returned to the facility at her previous level of care with no changes and remains a two-person mechanical lift assist for transfers. How the facility will identify other residents having the potential to be affected by the same deficient practice; Residents who require a two person assistance with mechanical lifts have the potential to be affected. On 1/16/2025 Administrator reviewed last twelve months of incident reports with no instances mechanical lift malfunction with residents. There have been no other incidents with mechanical lift malfunctions. The mechanical lift used in the incident with this resident (serial number ending 50) was removed from service on 1/3/2025, secured and made inoperable for further use. The mechanical lift noted by the service technician as motor that spreads the wheels does not work (serial number ending 26) has been removed from service and secured from use on 1/15/25. As of 1/16/24 Administrator validated there are three Mechanical lifts in use; lift with serial number ending 35, lift with number ending 79, lift with number ending 500. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/16/25 Area Lead Maintenance Director completed a re-inspection of all mechanical lifts on site, all lifts in use are functioning properly. 1/16/25 Administrator and Area Lead Maintenance Director confirmed Director confirmed the two other lifts remain removed from service and secured. On 1/15/24 Maintenance director has been relieved of duty by Administrator pending investigation, retraining, and demonstrated skills competency by VP of Plant Operations. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; On and beginning 1/15/25 the Director of Nursing and Administrator will conduct re-education including post test with direct care staff on safe transfer and lift operation, and reporting any operational concerns to management. On 01/15/2025 the Director of Regulatory Compliance in-serviced the Administrator and Director of Nursing on Abuse, Neglect, and Resident Rights. Administrator or designees initiated in-servicing all staff on Abuse, Neglect, and Resident Rights on 1/16/2025. Any staff who are not present to complete the in-servicing by 1/18/25 or new staff after that date will be required to complete the in-servicing at the start of their next shift before beginning work. Revised Lift Maintenance and Inspection policies and practices including documentation, and revised lock-out tag-out procedures will be implemented on 1/16/2025 to ensure continued safe operation of lift equipment. Any staff -including maintenance director who are not present to complete the in-servicing by 1/18/25 or new staff after that date will be required to complete the in-servicing at the start of their next shift before beginning work. Administrator and DON in-serviced by Lead Area Maintenance Director 1/17/25. Service provider will be notified of new requirement to personally review all lift inspections with the Administrator or Director of Nursing while on-site completion date 1/17/25. How the facility plans to monitor its performance to make sure that solutions are sustained. Administrator will directly review all mechanical lift inspections weekly for four weeks. Then bi-weekly for two months. Beginning 1/16/25 and ongoing. Beginning 1/16/25 and ongoing Area Lead Maintenance Director will conduct maintenance and safety inspections on all mechanical lifts monthly for three months then monthly thereafter by facility maintenance director . These inspections will be reviewed with Administrator while on-site. Beginning 1/17/25 Nurse Managers will observe five direct care staff a week for four weeks, during care, of residents who require mechanical lifts, to ensure that staff demonstrate competencies with re-education as needed. Then bi-weekly for two months. The Maintenance and Inspection logs, and results of observations will be reviewed at the monthly QAPI meetings for 3 months beginning with 1/17/25 and ongoing. The Administrator is was responsible for implementing the acceptable plan of correction. The POR was monitored from 01/16/2025 to 01/18/2025 as follows: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/16/2025 at 3:32 PM, ADM stated that the lift serviced on 01/03/2025 was identified as mechanical lift #1 and the serial number on the service report was different that mechanical lift #2 which is the lift that was used during the transfer with Resident #28. ADM stated that the lift in the service report was supposedly marked out of order but he was unsure who the technician check out with and notified of this. ADM stated that the lift in the report (mechanical lift #1) was pulled off the floor on 01/15/2025 and marked out of order. ADM stated he had not been made aware that there was an issue with mechanical lift #1 until then. ADM stated that the lift involved in Resident #28's fall was a different lift and had last been serviced on 11/05/2024. ADM stated that normally the MD would be responsible for repairing and ordering parts to service the lift outside of scale calibration. Observation on 01/16/2025 revealed mechanical lift #1 and mechanical lift #2 marks identified as out of order and zip tie through battery compartment to prevent use. Observation on 01/18/2025 of a locked maintenance closet revealed mechanical lift #1 and mechanical lift #2 were stored and tagged as inoperable with a zip tie through the battery compartment and no batteries attached. During an interview with the ADM on 1/18/2025 at 12:15pm he stated that any staff not completing the in-servicing by 1/18/2024 would not be permitted to work until they are in-serviced over the topics related to the IJ. He stated for new hires, nurses would get the change in condition, PHC trainings, and aides would receive the mechanical lift, and flu trainings. During interviews on 01/18/2025 from 12:55pm-3:00pm, the DON, two RN's and four CNA's from both shifts stated they were in-serviced on infection control, the order of donning: sanitize hands, apply gown, apply mask, apply shield, then gloves and once done with their task they must do everything in reverse order, dispose of the PPE, sanitize their hands and put on new mask. They were in-serviced on reporting of ANE, including the ANE coordinator being the Administrator. They were taught that all mechanical lifts are to be used by 2 people at a time, how to identify a resident needing mechanical lift transfers by the electronic record, and how to properly ensure working order and then use of the mechanical lift. They also revealed knowledge of using Proactive Health check in the residents' EMR. During an interview with the DON on 1/18/2025 at 3:45pm she stated she received training from the DCS regarding influenza and infection control, what signs and symptoms need to be reported, change in condition must be reported to the MD, RP, and clinical staff working with the resident. Mechanical lift in-servicing, how to properly don/doff PPE, and that the ADM is the abuse coordinator. The DON, ADM, and DCS had been taking turns providing the mechanical lift, proactive health check, proper PPE application and removal, and outbreak in-services to direct care staff. The DON revealed she will be responsible for providing in-servicing for new hires and any PRN staff must complete the training before working the floor. Review of a inspection log labeled [Mechanical] Lift Preventative Maintenance Inspection Log, reflected 5 lifts were documented as inspected on 1/16/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a policy titled Mechanical Lift Maintenance and Inspection Policies dated revised 1/16/2025 reflected maintenance director will complete a visual and function inspection of all lifts weekly. If any area does not pass inspection, the lift with be removed from the service area, and a lock out/tag-out indicator affixed so as to prevent unauthorized use. Review of an email from the ADM to a scale inspector dated 1/17/2025 revealed that the inspector must notify the ADM and be accompanied by the ADM throughout a service technician's inspection of lifts at the facility. Review of document title Mechanical Lift Audit by Nurse Manager 5 per week for 4 weeks revealed an audit conducted on 1/17/2025 by the DCS. Review of in-service titled Abuse/Neglect & Resident Rights reflected it was presented by DCS dated 1/17/2025 was provided to the ADM and the DON. While the IJ was removed on 01/18/2025 at 6:16 PM, the facility remained at a level of no actual harm with the potential for more than minimal harm that is was not immediate due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for one (Resident #159) of eight residents reviewed for nutrition status maintenance. The facility failed to obtain consistent weights of Resident #159. The facility failed to update the care plan to reflect the needs of Resident #159 The facility failed to keep accurate record of Resident #159's food intake. This failure could place residents at risk of further weight loss, malnutrition, and decreased quality of life. Findings included: Record review of Resident #159's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included a fracture of right femur and orthopedic aftercare, hypertension, congestive heart failure, mild intermittent asthma, vascular dementia, repeated falls, presence of an implantable cardiac defibrillator (a pacemaker , non-Hodgkin lymphoma (lymph cancer) , coronary atherosclerosis due to calcified coronary lesion (heart disease with plaque buildup), pneumonia, urinary tract infection, depression, and anxiety. Record review of Resident #159's MDS reflected a BIMS score of 3, indicating severe cognitive impairment, and a complete dependence for ADL's. Record review of Resident #159's Care Plan dated 12/10/24 reflected: o A potential for fluid volume overload related to Congestive heart failure, with a goal stating she would be free from signs and symptoms of fluid volume overload. Interventions included administering diuretics and monitor for side effects, assess for breath sounds and observe for labored breathing, encourage adequate fluid intake within restrictions as ordered, keep head of bed elevated, monitor for signs and symptoms of fluid overload such as edema, shortness of breath, and report to physician and turn and reposition every 2 hours and as needed. Has a history of anemia and is at risk for weakness, encourage diet as ordered . There was no care plan for weight loss. Record review of Resident #159's Physician Orders reflected: o 01/14/25 - Regular Ground Continuous diet There were no orders for weights in the care plan. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #159's Weights reflected: 85.8 pounds 01/17/2025 100.4 pounds on 01/04/2025 100.6 pounds on 12/31/2024 101 pounds on 12/25/2024 103.6 pounds on 12/10/2024 Record review of Resident #159's food logs dated 01/17/25 reflected: 01/07/25 at 12:42 pm: Resident at 100% of Breakfast and Lunch 01/07/25 at 8:36 pm resident ate 75% of dinner 01/08/25 at 9:46 am resident ate 50% of both breakfast and lunch. -no dinner was logged 01/09/25 at 10:57 am resident ate less than 25% of breakfast and lunch. -No dinner was logged 01/10/25 at 10:57 am resident ate 50% of breakfast and 25% of lunch. 01/10/25 at 9:04 pm resident ate 100% of dinner 01/11/25 No Food Intakes were logged 01/12/25 at 8 am resident ate 25% of lunch. 01/12/25 at 10:17 am resident ate 75% of breakfast. 01/12/25 at 9:12 pm resident ate less than 25% of her dinner 01/13/25 at 8:15 am resident ate 100% of both breakfast and lunch -No dinner was logged 01/14/25 at 10:26 am resident at 0% of breakfast 01/14/25 at 12:44 pm resident ate less than 25% of lunch 01/14/25 at 4:45 pm resident ate 75% of dinner (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/15/25 at 9:31 am resident ate 100% of breakfast and 25% of Lunch 01/15/25 at 8:43 pm resident ate 50% of dinner No further food intake was noted. Record Review of facilities mealtimes revealed: Breakfast at 7:30 am Lunch at 11:30 am Dinner at 4:30 pm Observation of resident #159 on 01/14/25 at 9:35 am revealed the resident groaning in her bed and stated she did not feel well. Resident's eyes were severely sunken, resident's color was pale, and the muscles on her temples had severely atrophied. Observation of resident #159 on 01/15/25 at 11:35 am revealed the resident alone in her room, sitting up in wheelchair, with her food set up to eat. The resident seemed unable to bring the fork to her mouth and was picking at her food. Observation of resident #159 on 01/15/25 at 12:35 pm revealed the resident's plate on the cart outside her room with less than 10% of meal eaten. Observation of resident #159 on 01/17/25 at 2:45 pm revealed resident's RP was feeding her a protein smoothie that he had brought to the facility. In an interview with CMA Y on 01/16/25 at 4:45 pm she stated she was familiar with Resident #159 and knew she needed help eating. She stated sometimes she would feed her or sometimes she would pass off to another aid. She stated it was expected to log into the healthcare record and log food intake. She stated she didn't realize the resident was eating less and losing weight. She stated a restorative aid was responsible for weighing the residents. If someone did not want to eat, she would come back later to try again. She would ask them if they wanted a substitute and would bring them more food that they liked . She stated the residents could lose their quality of life if they lost a lot of weight. In an interview with SLP 01/17/25 at 10:35 am she revealed that Resident #159 had had poor meal intake since her return from the hospital in December. She had evaluated the resident for dysphagia (lack of swallowing ability) and had recently downgraded her diet to a ground diet. She stated that the restorative aids are supposed to weigh the resident and report any weight loss. She realized the resident had lost some weight but did not know how much or if it was significant. She did not speak with any members of her team about it or notify the doctor or dietitian. She knew that the dietitian had placed her on some supplement but did not know which one. She did speak to the family about her dysphagia screening at the care plan meeting, but it was not put on her care plan. She believed someone should have been sitting with the resident to feed her but had not seen anyone do it recently . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Valley Inn Health Center	17751 Park Valley Drive Round Rock, TX 78681

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RDN on 01/17/25 at 2:30 pm revealed that she had completed her nutrition consultation on 12/23/24 virtually and had not seen the resident or contacted the family while conducting her consultation. She stated she had been at the facility for the last 3 weeks but had not gone to visit the resident or see her in person. She stated the resident had been referred for being underweight but not for weight loss. Although, at the time of her assessment she had a 3.6% weight loss in less than a week, according to her record. She stated that she put the resident on a small dose oral nutrition supplement to help boost her calorie intake. If the resident has unintended weight loss at a severe level, she would monitor their weights and intake weekly and add nutrition supplements with meals as indicated. She believed it was nursing standard that people with CHF and weight loss or gain should be monitored . Interview with the DON on 01/17/25 at 5:00 pm revealed that she was aware that Resident #159 was having a decline in her food intake, and they were tracking her as a potential hospice resident. She was unaware that they had not been weighing the resident in the last two weeks or that she had lost 14.8 pounds in 13 days. She stated that people with congestive heart failure should have been weighed daily and if they were flagged for losing weight the resident should have been weighed weekly. She was unsure about why there was no order for weights in her record. She believed if they had weighed her weekly, they could have made a difference in her weight loss. The DON stated that if a resident's food intake trends downwards the healthcare record system will send them an alert. She stated that the nursing aids should sit with the residents to feed them. She expected to be notified of any change of condition or a significant deterioration of a resident's condition . Interview with the NP on 01/24/25 at 10:03 am revealed that the facility had notified him of the resident's weight loss on 01/07/25. He ordered a 120 ml high calorie drink to be given at med pass and placed her on an appetite stimulant. He did not place an order to weigh the resident because he expected the facility to weigh the resident once a week. He used those weights to monitor his interventions. He stated doing weekly weights would have helped monitor her treatments more effectively. He stated he was notified again on 01/22/25 of her further weight loss but the resident had been discharged by that point. He stated that adding in an additional high calorie shake with meals could have helped the resident and prevent weight loss. He expected the facility to notify him if a resident has a weight loss of more than 5 pounds in a week or for people with congestive heart failure a weight loss of more than 3 pounds in a day. He stated the facility should have been updating care plans for people with unintended weight loss or were underweight that need intervention . Call with the RP for resident #159 on 01/24/25 at 10:38 am revealed the RP saw the resident on 01/17/25 and her condition had rapidly deteriorated since he saw her last on 01/10/25. He stated that when he came to visit the nurses were putting a tray in front of the resident and not assisting the resident with meals. He went to the facility on [DATE] and the resident's meal tray was not the ordered diet. He had to request a new tray. He believed that the facility was not providing the oversite necessary to ensure she maintained her weight . The RP stated he moved his mother to an assisted living where the facility was helping her eat daily. Review of Evidence Based Practice Guidelines of Unintended Weight Loss in Older Adults from the Academy of Nutrition and Dietetics dated 01/04/16 states, Strong Imperative for Monitoring and Evaluating Anthropometric Measurements. The Registered Dietitian should monitor and evaluate weekly body weights of older adults with unintended weight loss until the body weight has been stabilized to determine effectiveness of medical nutrition therapy. Studies support an associate between unintended weight loss and increased mortality.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Based on observations, interviews, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 2 of 5 residents (Resident #31 and Resident #35) reviewed for pharmaceutical services. The facility failed to remove discontinued controlled medications from the medication cart for Resident #31 and Resident #35. The facility failed to ensure proper reconciliation for drugs and investigate errors. This failure leaves residents vulnerable to medication errors. Resident #31 Record review of Resident #31's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included end-stage Alzheimer's disease and receiving hospice services, dementia, metabolic encephalopathy (a brain disease that causes altered mental status), repeated falls, anxiety disorder, muscle weakness, pain, abnormality of gait and mobility, dyspnea (the inability to coordinate breathing), gastro-esophageal reflux, feeding difficulties, and need for assistance with personal care. Record review of Resident #31's Quarterly MDS assessment, dated 10/06/23 reflected a BIMS score of 2, indicating his cognition was moderately to severely affected. Further review of the MDS revealed Resident #31 required total assistance for activities of daily living, and he used a wheelchair. Record review of Resident #31's Care Plan dated 01/17/25 reflected he required hospice as evidenced by terminal illness of end-stage Alzheimer's disease. The goal was dignity would be maintained and Resident #31 would be kept comfortable and pain free within one hour of intervention over the next 90 days. Intervention included nursing to monitor for signs and symptoms of increased pain, discomfort, and give medication and treatments for relief. Record review of a Clinical Note entry dated 08/15/24 for Resident #31 reflected a new order from hospice to discontinue Klonopin (clonazepam) due to recent fall. Record review of a Medication Administration Record for Resident #31 reflected: o Start date of 07/25/24 for Tramadol 5mg/mL oral solution (10mL) every 6 hours had been discontinued, and o Start date of 07/29/24 for Lorazepam 0.5mg tablet PRN every 4 hours for 14 days had been completed, and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Start date of 07/30/24 for Klonopin (clonazepam) 0.5mg 1 tablet twice daily had been discontinued. Record review of controlled medication administration log dated 03/11/24 revealed the last medication count of the bottle was on 08/18/24 and had 22 pills left in the bottle. Observation of medication cart on 01/17/25 at 12:00 pm revealed a bottle of Clonazepam dated 08/12/24 with 21 pills left in the bottle. Observation of the medication cart on 01/17/25 at 12:10 pm revealed the DON counted the pill bottle and viewed the missing medications from the medication punch card in front of the state surveyor. Resident #35 Record review of Resident #35's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hypertension, fracture of left femur with encounter for orthopedic aftercare, muscle weakness, dementia, cognitive communication deficit, hypothyroidism, depression, and urinary tract infection. Record review of Resident #35 's MDS assessment, dated 02/09/25 reflected a BIMS score of 0, indicating her cognition was moderately to severely affected. Further review of the MDS revealed Resident #35 required total assistance for her activities of daily living, and she used a wheelchair. Record review of Resident #35's Care Plan dated 01/17/25 reflected Resident #35 was not able to complete a Brief Interview for Mental Status. Further review of the MDS revealed Resident #35 required moderate assistance for her activities of daily living, and she used a manual wheelchair. Record review of Resident #35's Physician Orders reflected an order date of 01/15/25 for Tramadol 50mg 1 tablet every 6 hours as needed, and a discontinued date of 05/06/24 for Tramadol 50mg 1 tablet every 6 hours as needed. Record review of Controlled Drug Receipt and Record revealed the last administration of Tramadol 50 mg was on 09/16/24 with a final count of 30 pills. Observation on 01/17/25 at 12:00 pm of medication cart reconciliation revealed 26 pills of Tramadol 50 mg left in the container. In an interview with Nurse LVN Z on 01/17/25 at 12:10 pm she stated that she did not administer the medication because it was not the specific one prescribed for the residents. She stated that she did not know why it wasn't disposed of. She stated she should have notified the DON and waited for an investigation to take place before leaving the facility . She did not count the medicine on that shift. She did not dispose of the medicine because it was another LVN's cart. In an interview on 01/17/25 at 12:10 pm the DON stated she was unaware of the situation for the missing medications and confirmed that the medication was missing for both residents. She stated the bottle had been discontinued and resided in the RN's controlled drug box . She stated she expected to be notified immediately of any issues with counting the controlled medication. She expected the medication to be disposed of immediately after the medication was discontinued by the doctor. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN W on 01/17/25 at 4:22 pm she stated she was working that shift but did not remember any discrepancies. She remembered that Resident #31's went down to PRN and later in the month they discontinued it because they thought it was contributing to her falls. She stated that she hadn't given Resident #35's PRN Tramadol since earlier in the summer. She stated she had reduced the frequency after she was healed from her surgery. She did not remember administering any doses to her in August. She stated that if she found a discrepancy she would ask the nurse, then notify the DON, and they would notify the doctor. In an interview with the DON on 01/17/25 at 5:00 pm she stated that the results of their investigation were inconclusive, and she did not have any idea what happened to the medications. She expected to be notified of any significant medication error or discrepancy. She allowed for late entries after shift if she was notified, but that was not the case in this situation. She stated she has conducted in-services on how to complete late documentation. Review of the facility policy titled Management of Controlled Medications stated that the DON would log discontinued controlled medications on the Destruction log. If a discrepancy was found and the cause could not be located, it must be reported immediately to the DON. The staff member must stay in the facility during the investigation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50472 Based on observation, interview and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen observed for food storage, preparation, and distribution. 1. The facility failed to ensure [NAME] I wore a hair restraint that full covered her hair on 01/14/2025 while preparing food. 2. The facility failed to ensure [NAME] I performed hand hygiene when preparing food on 01/14/2025. These failures could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings included: Observation on 01/14/2025 at 7:06 AM revealed [NAME] I wore surgical mask around neck and hair fell out from hair net. Further review revealed DA K not wearing mask. Observation on 01/14/2025 at 7:18 AM revealed NSS L in kitchen with no mask on. Observation on 01/14/2025 at 10:09 AM revealed [NAME] I wore glove with hole on left hand. [NAME] L had hair sticking out of restraint and continued to wear mask around neck while she prepped food. Observation on 01/14/2025 at 10:11 AM revealed [NAME] I removed gloves and mixed puree bread without performing hand hygiene. Observation on 01/14/2025 at 10:12 AM revealed [NAME] I put new gloves on without performing hand hygiene. Observation on 01/14/2025 at 10:13 AM revealed [NAME] I removed gloves and put in new gloves without performing hand hygiene. Observation on 01/14/2025 at 10:19 AM revealed [NAME] I pushed washed trays out of dishwasher with gloves on. Observation on 01/14/2025 at 10:22 AM revealed [NAME] I donned new gloves without performing hand hygiene. Observation on 01/14/2025 at 10:24 AM revealed [NAME] I removed gloves and donned new gloves without hand hygiene. Observation on 01/14/2025 at 10:26 AM revealed [NAME] I removed gloves and put on new gloves without performing hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 01/14/2025 at 10:33 AM revealed [NAME] I left stove after prepping water for macaroni and grabbed chicken from warmer and put chicken in blender with same gloves on. Observation on 01/14/2025 at 10:35 AM revealed [NAME] I removed gloves and put new gloves without performing hand hygiene. Observation on 01/14/2025 at 10:36 AM revealed [NAME] I wiped gloves on apron and kept gloves on and did not perform hand hygiene. Observation on 01/14/2025 at 10:43 AM revealed [NAME] I donned new gloves without hand hygiene. Further observation revealed glove torn with [NAME] I's nail. [NAME] I kept gloves and proceeded to prepare macaroni. Observation on 01/14/2025 at 11:14 AM revealed [NAME] I's left glove was torn on palm while stirring macaroni. [NAME] I kept torn glove on. During an interview on 01/17/2025 at 2:38 PM DA K stared that hair restraints should be covering all of the hair. She stated if it wasn't hair could fall into the food. DA K stated hand hygiene should be performed when you entered the kitchen, move to a new area and before putting on gloves and before handling food. During an interview on 01/17/2025 at 2:41 PM NSS L stated hair restraints should be worn to ensure hair is all the way in hair net with no hair sticking out. NSS L stated if hair restraints were not on all the way, hair could get in food and contaminate food. NSS L stated hand hygiene should be performed when changing stations, taking off gloves. NSS L stated staff should wash hands before going back to preparing food. NSS L stated if there was a hole in glove staff should remove those, dispose gloves, wash hands and put on new one gloves. He stated if food is prepared with a hole in gloves or hand hygiene was not performed it could cause cross contamination. During an interview on 01/17/2025 at 2:44 PM NSS M stated staff should wash hands when they first hit door, and should constantly wash their hands. NSS M stated if stated touched something or move something they should wash hands. NSS M stated when you change gloves, before putting on new gloves you should wash your hands. NSS stated residents could get sick, cause outbreak spread bacteria if hands are not washed. NSS stated hair restraints should be worn in the kitchen and hair should be all under the hair net with no hair hanging out as it could contaminate and fall into food and make residents sick. If there is a hole in gloves, staff should remove, wash hands and replace gloves. During an interview on 01/17/2025 at 2:46 PM, [NAME] J stated hand hygiene should be performed when she started work and as soon as she walked into the kitchen, she washed her hands immediately. [NAME] J stated you should wash hands before and after changing gloves, so you do not cross contaminate. [NAME] J stated staff were supposed to wash hands when you leave your food preparation area and when you started a new task. [NAME] J stated hair nets should be work covering all of the hair. [NAME] J stated if she had a tear in gloves, she would remove gloves and wash her hands and stated prepped food may need to be thrown away as food could be contaminated depending on how the glove tore. [NAME] J stated if you do not wash your hands, you could cause issues with food and have food contaminated. She stated if hair was sticking out of the hair restraint, it could get food and she would notify her supervisor if she saw this. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/17/25 at 06:01 PM ADM stated he expected hand hygiene in kitchen to be performed numerous times. He stated hand hygiene should be performed after touching anything unclean or anything off the line. ADM Stated if gloves were ripped and hygiene should be performed, and new gloves should be put on. ADM stated hand hygiene should been performed before changing gloves. ADM stated that hair restraints should be worn with all of the hair inside. He stated if not, hair could get into the food. Review of facility policy titled Use of Plastic Golves dated November 3, 2004, revealed hands are to be washed when entering the kitchen and before putting on the gloves. Further review revealed anytime a contaminated surface is touch, the gloves must be changed. Review of facility policy titled Hand Washing dated November 3, 2004, revealed before starting work, after removing gloves and other times hand have been soiled. Review of facility in-service dated 01/06/2025 revealed topic covered was cross contamination prevention. Summary of training included hand hygiene is part of standard and transmission-based precautions. Sanitize or wash hands before applying gloves.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50472 Intake #557738 Based on observations, interviews, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 7 of 29 residents (Resident #1, Resident #17, Resident #68, Resident #39, Resident #80, Resident #159, Resident #21) reviewed for infection control. 1.The facility failed to test all residents who had flu like symptoms. 2. The facility failed to put place residents on quarantine or droplet precautions when indicated. An IJ was identified on 01/15/25 at 4:45 pm. The IJ template was provided to the facility on [DATE] at 7:15 pm. The plan of removal was accepted on 01/17/25 4:52 pm. While the IJ was removed on 01/17/25 at 5:30 pm the facility remained out of compliance at a scope of pattern and a severity of no actual harm identified as patterned due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. 4. LVN E did not follow Enhanced Barrier Precautions by not putting on a gown when conducting medication administration via gastrostomy tube for Resident #17. 5. The SC did not follow Enhanced Barrier Precautions by not putting on a gown before providing peri-care and assistance during wound care for Resident #1. These failures placed the residents at risk of infection transmission, respiratory distress, hospitalization , and even death. Findings included: Resident #68 Record review of Resident #68's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included an acute upper respiratory infection, chronic pain syndrome, heart failure, hyperlipidemia, depression, seasonal allergic rhinitis, arthritis, shortness of breath, dementia, Vitamin D deficiency, and Vitamin B deficiency. Record review of Resident #68's Quarterly MDS assessment, dated 01/09/25 reflected a BIMS score of 15, indicating her cognition was mildly affected. Further review of the MDS revealed Resident #68 required set-up or clean up assistance for meals and oral hygiene, and partial/moderate assistance for her activities of daily living. Further review of the MDS reflected Resident #68 used a manual wheelchair for mobility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #68's Care Plan dated 01/17/25 reflected she has episodes of shortness of breath and was at risk for respiratory distress. The goal indicated decreased episodes of shortness of breath, and no signs or symptoms of respiratory distress/failure over the next 90 days. Interventions included use of oxygen and take slow deep breaths, nursing to monitor for signs of relief from shortness of breath and provide respiratory treatments per orders, administer medications as ordered, and assess respiratory status by checking breath sounds, respiratory rate, skin color and notify physician of abnormal findings. Record review of Resident #68's Clinical Notes reflected: o 01/13/25 at 02:01 PM - Resident #68 refused to take geri-tussin 10 mL. o 01/13/25 at 04:25 PM - X-ray result came back and notified Nurse Practitioner, who ordered Tamiflu 75mg PO BID x 5 days. Carried out order and faxed to pharmacy. Called her RP and left a message. o 01/13/25 at 05:53 PRM - Nurse Practitioner ordered Influenza testing. Scheduled with [Company Name] to come onsite to get the test, in-house Influenza testing kit is out. Scheduled 01/14/25. No Test Results were available. Observation of resident's room on 01/14/25 at 4:50 pm revealed no airborne precautions or PPE signage outside the door. Observation on 01/14/25 at 12:45 pm revealed CNA N passing out trays to resident #68 room without donning proper PPE. Resident #39 Record review of Resident #39's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic pain due to trauma, a contusion of head, wedge compression fracture 3rd lumbar vertebrae, rheumatoid arthritis, fracture of left femur and nasal bones, repeated falls, severe protein-calorie malnutrition, hypotension, nausea, Record review of Resident #39's Quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating her cognition was intact. Further review of the MDS revealed Resident #39 required moderate to substantial assistance for her activities of daily living, and she used a wheelchair. Record review of Resident #39's Care Plan dated 12/10/24 reflected she was at risk for allergic reaction related to allergies to codeine and gluten. The goal was for Resident #39 to not have an allergic reaction for the next 90 days. Interventions included a review of listed allergies prior to giving new medications, review of diet for food allergies, notify physician if Resident #39 has an allergic reaction to new medications or foods, and document signs and symptoms of allergic reaction. Record review of a Clinical Note for Resident #39 dated 01/12/25 at 12:54 AM reflected Resident #39 felt as if she was getting sick or it may be allergies. Resident #39 denied any pain after the nurse offered her pain meds. Resident #39 stated she was going to continue without any medication and if it becomes worse she would ask for something. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Clinical Note for Resident #39 dated 01/16/25 at 03:13 PM reflected a Rapid Flu Test Procedure Card showed a negative test result and NP would be notified about negative test . Observation of resident #39's door on 01/14/25 revealed no PPE or airborne precaution signage Observation on 01/14/25 at 12:45 pm revealed CNA N passing out trays to resident #39 without donning proper PPE. Resident #80 Record review of Resident #80's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included syncope and collapse, urinary tract infection, diabetes mellitus type 2, seizures, encephalopathy, altered mental status, legal blindness, hyperlipidemia, hypertensive heart disease, cerebrovascular disease, and personal history of malignant neoplasm of organs and systems. Record review of Resident #80's 5-day MDS assessment, dated 12/22/24 reflected a BIMS score of 10, indicating her cognition mildly to moderately affected. Further review of the MDS revealed Resident #80 required partial/moderate assistance for her activities of daily living, and she used a walker and a wheelchair. Record review of Resident #80's Care Plan dated 01/16/25 reflected Resident #80 required extensive assistance with bed mobility, bathing, hygiene, dressing and grooming. The goals were for Resident #80 to be odor free, dressed and out of bed daily over the next 90 days, and Resident #80 would assist with her activities of daily living to the highest degree possible. The interventions included transfer status with gait belt with one staff assist and set up assist with her meals . Record review of resident's progress notes revealed no notification between the staff and doctor. Observation of Resident #80's room revealed no signage of PPE outside the room. Observation in resident #80's room on 01/14/25 at 07:25 am revealed RN U entering room to provide a head to toe assessment for resident 80. Observation on 01/14/25 at 12:45 pm revealed CNA N passing out trays to resident #80 room without donning proper PPE. Observation in resident #80's room on 01/15/25 at 12:15 pm revealed CNA N entered room with only a surgical mask on. Interview with Resident #80 on 01/15/25 at 12:15 revealed the resident had been feeling ill over the weekend. She reported symptoms of diarrhea, cough and congestion and body aches. She was not offered a flu shot or flu test. Resident #159 - (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #159's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included a fracture of right femur and orthopedic aftercare, hypertension, congestive heart failure, mild intermittent asthma, vascular dementia, repeated falls, presence of an implantable cardiac defibrillator, non-Hodgkin lymphoma, coronary atherosclerosis due to calcified coronary lesion, pneumonia, urinary tract infection, depression, and anxiety. Record review of Resident #159's MDS revealed a BIMS of 0 indicating severe cognitive impairment. Record review of Resident #159's Care Plan dated 12/10/24 reflected: o A diagnosis of asthma and she was at risk for shortness of breath and respiratory failure. The goal was for asthma to be relieved by medication within 30 minutes of administration over the next 90 days, and interventions included monitoring for shortness of breath, notify physician of shortness of breath that is not relieved by medication, and administer oxygen for unrelieved shortness of breath. o A potential for fluid volume overload related to Congestive heart failure, with a goal stating she would be free from signs and symptoms of fluid volume overload. Interventions included administering diuretics and monitor for side effects, assess for breath sounds and observe for labored breathing, encourage adequate fluid intake within restrictions as ordered, keep head of bed elevated, monitor for signs and symptoms of fluid overload such as edema, shortness of breath, and report to physician. and turn and reposition every 2 hours and as needed. Record review of Resident #159's Physician Orders reflected: o 12/10/24 - Take vital signs by shift, o 01/14/25 - Regular Ground Continuous diet, o 01/15/25 - Pulse Oximetry every shift, and o 01/17/25 - Droplet Isolation Precautions every shift for 6 days, and a Proactive Health Check (Covid/RTA Prevention) every shift. Observation on 01/14/25 at 12:45 pm revealed CNA N passing out trays to resident #159 room without donning proper PPE. Observation on 01/15/25 at 11:30 am revealed no signage on the door for PPE Precautions. Observation on 01/16/25 at 3:30 pm revealed airborne precaution signage on the resident's door. Interview with Resident #159 on 01/14/25 at 7:30 am stated that they felt very poorly. Resident was moaning in between words and could not answer any further questions. Interview with RN U on 01/17/25 at 4:00 pm revealed that he notified the doctor that day. Resident #159 had been tested for the flu and was positive . Resident #21 (continued on next page)

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	676471	A. Building B. Wing	01/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Residents admission sheet showed an [AGE] year-old female admitted to the facility on [DATE]. Pertinent diagnoses included coronary artery disease (heart disease), Type 2 diabetes, Dementia, and Heart Failure. Record review of Resident #21's MDS revealed resident had a BIMS score of 06 which indicated severe cognitive impairment and partial to moderate assistance with ADL's Record review on 01/15/24 nursing notes revealed that family had called into the facility and reported that the resident was experiencing flu like symptoms and went to the ER. Observation on 01/15/24 at 12:30 pm of Resident#21 revealed no signage of PPE outside the door . Observation on 01/14/25 at 12:45 pm revealed CNA N passing out trays to all residents on the 700 and 800 halls without donning proper PPE for residents suspected of having the flu. Interview with CNA N on 01/16/25 at 4:45 pm stated that she noticed Sunday evening the residents were not feeling good. She stated that she had talked to the nurse about it and the nurse had given the residents fever and pain reducing medications. Interview with RN U on 01/14/24 at 8:35 am, he stated that when he arrived at work on 01/13/25 he saw multiple people with a decline in condition. He notified the DON and called the NP to get orders for the residents. He began administering PRN fever reducers, cough, and congestion medicine. He did not focus on putting proper PPE signage on the door because he assumed that was the job of the DON or ADON. He stated he retrieved masks and began to wear a mask while providing care to the residents. He stated that if he did not wear proper PPE the residents could get more sick. Record review of the facility's Performance Improvement Plan dated 1/13/25 reflected the problem area was Resident #21 had tested positive for the flu at the hospital, which initiated an outbreak. Changes implemented to reach baseline: 1. Monitor all residents for signs and symptoms of flu initially and daily. 2. tested symptomatic patients. 3. Notified Medical Director- plan to treat patients prophylactically and standing orders giving based on lab results. 4. Inservice staff on hand hygiene and flu 5. Deep clean all resident rooms to include side rails and overbed tables. 6. Place all positive patients on droplet precautions 7. Encourage all staff to wear mask, mandatory for unvaccinated staff during flu season. 8. Monitor all positive patients for serious complications - notify Medical Director and /or providers if found. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the DON Interview on 01/15/25 at 09:55 AM with IP/ADON who revealed she had worked a double shift on the east unit, which included the 600 and 700 halls. The IP/ADON stated the first case of Influenza in the facility was on Sunday, 01/13/25. She stated around 10:00 AM many of the residents on the 700/800 halls were sleeping in, and during breakfast she started hearing some of the residents coughing and having congestion. Around noon, the diarrhea and vomiting started. She stated very few residents ate dinner on Sunday. Many had very low appetites. She stated she knew something was going on with the residents, but it was hard to tell because it was a variety of symptoms. Guidance from the DON was to write down resident symptoms as the day went on. She stated she did not contact the doctor and they only tested people who were very sick for the flu because the facility ran out of flu shots . Interview with NP on 12/15/25 at 1:42 pm revealed that he or his doctor had not been contacted by the facility on Sunday, 01/12/2025, when the symptoms had begun. They contacted him Monday morning 01/13/2025 with the symptoms and I directed them to do testing and start treatment. If they were running a fever with cough and congestion, he started them on Tamiflu. Without a fever he wanted to look at them and see what's going on. He expected them to report the symptoms immediately. He reported that they sent two to the hospital with respiratory distress but couldn't recall directly which residents . Interview on 01/15/25 at 04:24 PM with ADM revealed Resident #21 had been out on pass with her family, and they took her to the hospital for flu-like symptoms. The ADM stated Resident #43 had developed upper respiratory symptoms and went to the hospital. He further stated on Monday 01/14/25 the committee had a quick QA meeting and consulted with the physician for parameters for monitoring residents for flu-like symptoms. The ADM stated that he was notified of an Influenza outbreak on Sunday night, 01/13/25. The ADM stated his expectations were for all residents testing positive for influenza and flu-like symptoms to be placed on isolation precautions or cohorted with other residents with similar flu-like symptoms . Interview with LVN V on 01/17/25 at 4:40 pm revealed that she had been in-serviced on outbreak standards, PPE usage, and reportable incidences on 01/16/25. Interview with CNA R 01/17/25 at 4:45 pm revealed that she had been in-serviced on outbreak standards, PPE, and reportable incidences on 01/16/25. Record review of Infection Control Policy of Type and Duration of Precautions recommended for Selected Infections Appendix A stated Human Seasonal Influenza stated single patient room when available cohort mask patient when transported out of the room and give vaccine to control outbreaks. Use gown and gloves according to standard precautions. Duration of precautions for immunocompromised patients cannot be defined. Isolation duration of five days. Review of facility policy titled quick reference for isolation precautions states, in addition to Standard Precautions, use Droplet Precautions for Patients known or suspected to have serious illnesses transmitted by large particle droplets. Examples of such illnesses include: o Adenovirus (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Influenza o Mumps o Parvovirus B 19 o Rubella Record review of an in-service report dated 1/13/25 covered the topics of the flu with droplet and contact precautions washing hands with soap and water and wearing masks. Record review of an in service on 01/06/25 with the topic of cross contamination prevention that covered: -Hand hygiene as a part of standard and transmission-based precautions. -Sanitize or wash hands with soap and water before and after resident care serving meals applied gloves restroom renews eating etcetera . Plan of Removal This is to confirm the submission of our Plan of Removal provided by this facility. For F880 IJ. The submission of this POR does not constitute an admission on the part of the facility as to accuracy of the surveyor's findings, the conclusion drawn from there, nor is the scope and or severity regarding any deficiency cited applied correctly. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Nursing and Administrator will be inserviced on 1/16/25 by the Regional Director of Clinical Services on Influenza Outbreak Management in Long Term Care. On 1/16/25 at 1238 PM the Medical Director and patients assigned providers were updated on all patients with flu symptoms and on all patients that were positive by the DON. All licensed staff to be inserviced on notifying providers of changes in condition to include a pre/post test by the Regional Director of Clinical Services and/or Director of Nursing Services beginning 1/16/25 with a completion date of 1/17/2025. All staff to be educated on Influenza and Outbreak Management in long term care to include a pre/posttest by the Regional Director of Clinical Services and/or Director of Nursing beginning 1/16/25 with a completion date of 1/17/2025. Inservice will include signs and symptoms, precautions to take, prevention measures, isolation and outbreak management. All licensed staff will be inserviced on Proactive Healthcheck orders by the Regional Director of Clinical Services and/or Director of Nursing beginning 1/16/25 with a completion date of 1/17/2025 . The licensed nurse will enter this order for all patients to capture any flu signs and symptoms. The Proactive Healthcheck will be utilized through the remaining of the flu season. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	How the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/16/25-The Regional Director of Clinical Services completed a 100% chart audit, identifying all residents with flu symptoms to ensure the providers were notified. This was completed on 1/16/2025. All providers were notified by the Director of Nursing Services of all patients with symptoms. On 1/16/25-An audit was conducted by the Regional Director of Clinical Services identifying all patients with active flu and flu symptoms to ensure they were isolated according to the CDC guidelines. Completed 1/16/2025- all patients verified to have the correct precautions in place. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur; On 1/16/2025-Facility is utilizing the PHC Proactive Health Check daily -EHR tool which monitors for abnormal symptoms that may indicate a condition change and other possible illnesses in the residents. The symptoms monitored include-abdominal pain, chills or repeated shaking with chills, diarrhea or other GI upset, headache, loss of smell, loss of taste, muscle pain, nausea, Oxygen saturation, red shadowed eyes or pink eyes, shortness of breath, sore throat, and tingling sensation in face or hands. The PHC dashboard will be reviewed daily during stand up by the DON and/or ED. DON and ED were in serviced on 1/16/2025. This will monitoring will be on going. How the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 1/16/2025. The Director of Nursing Services and/or designee (ADON, UM, ED) will review the 24 hour report (nursing documentation) daily during the clinical stand up meeting with staff monitoring for patient change of conditions and ensuring notification to providers was done. This process will be ongoing. The Sr. Regional Director of Clinical Services will review the 24 hour report (nursing documentation) weekly for four weeks beginning 1/20/2025 to monitor for patient change of conditions and ensure notification to providers was done. The DON and/or designee (ADON and/or IP) will perform a minimum audit of 3 random audits on different hallways daily for 1 week, the bi - weekly for 4 weeks beginning 1/17/2025 to monitor for PPE compliance. Compliance concerns to be addressed immediately by the DON and/or designee. Results of audits and reviews will be reported to and reviewed by QAPI committee monthly for three months. The state surveyor monitored the POR on 01/18/2025 as followed: Observation of exterior of the 11 resident's rooms' who tested positive for influenza reveal donning/doffing PPE outside the doors with signs that instruct how to properly don and doff PPE as well as signs that read, STOP droplet Precautions, everyone must clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, and mouth are fully covered before room entry. Remove face protection before room exit-CDC. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 01/18/2025 at 1:45pm revealed CNA A and CNA B donning PPE before entering a resident's room. CNA A said she was in-serviced on how to properly don/doff PPE, and how to notice a change in condition and report it to their charge nurse. Interview with the ADM on 1/18/2025 at 12:15pm revealed that any staff not completing the in-servicing by 1/18/2024 will not be permitted to work until they are in-serviced over the topics related to the IJ. For new hires, nurses would get the change in condition, PHC trainings, and aides would receive the mechanical lift, and flu trainings. During interviews on 01/18/2025 from 12:55pm-3:00pm, the DON, two RN's and four CNA's from both shifts stated they were in-serviced on infection control, the order of donning: sanitize hands, apply gown, apply mask, apply shield, then gloves and once done with their task they must do everything in reverse order, dispose of the PPE, sanitize their hands and put on new mask. They were in-serviced on reporting of ANE, including the ANE coordinator being the Administrator. They also revealed knowledge of using Proactive Health check in the residents' EMR . Interview with the DON on 1/18/2025 at 3:45pm revealed that she received training from the DCS regarding influenza and infection control, what signs and symptoms need to be reported, change in condition must be reported to the MD, RP, and clinical staff working with the resident. How to properly don/doff PPE, and that the ADM is the abuse coordinator. The DON, ADM, and DCS had been taking turns providing proactive health check, proper PPE application and removal, and outbreak in-services to direct care staff. The DON revealed she will be responsible for providing in-servicing for new hires and any PRN staff must complete the training before working the floor. Review of in-service titled Abuse/Neglect & Resident Rights reflected it was presented by DCS dated 1/17/2025 was provided to the ADM and the DON Review of in-service titled PHC checks should be done once a shift during outbreak. Notify MD/NP of any abnormal findings. Ensure all new admissions have orders for PHC checks once daily while in outbreak. Presented by the DCS dated 1/16/2025 reflected it was provided to nursing staff. Review of in-service titled Donning/doffing. Influenza symptoms, management, preventing spread of. Droplet precautions. When you exit a room with droplet precautions, you must sanitize your hands, dispose of old mask, sanitize hands, put on clean mask. reflected it was presented by the DCS dated 1/16/2025- ongoing. Review of PHC dashboard dated 1/16/2025 and 1/17/2025 reflected audits conducted by the ADM. Review of in-service titled, Proactive Health Check Monitoring, Clinical notes review, auditing PPE compliance reflected it was presented by the DCS to the ADM and the DON dated 1/16/2025. Review of PPE Observation Audit log dated 1/17/2025 reflected no issues. The ADMIN and the DON were informed the Immediate Jeopardy (IJ) was removed on 01/17/24 at 5:30 pm. The facility remained out of compliance at a severity of no actual harm that was not an immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 Record review of Resident #1's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (pathologic process that results in an area of necrotic tissue in the brain), vascular dementia (a type of dementia cause by brain damage from impaired blood flow), hemiplegia affecting right dominant side (occurs when parts of the brain that control movement become damaged, affecting muscles on right side of the body), aphasia (a communication disorder caused by brain damage that affects verbal and written language), dysarthria (a motor speech disorder that makes it difficult to form and pronounce words due to nervous system damage), anemia, diabetes mellitus type 2, reduced mobility, and expressive language disorder(a communication disorder in which there are difficulties with verbal and written expression). Record review of Resident #1's Quarterly MDS assessment, dated 12/12/24 reflected a BIMS Score of 9, indicating her cognition was moderately impaired. Further review of the MDS revealed Resident #1 required substantial/maximal assistance for her activities of daily living, and she used a wheelchair. Record review of Resident #1's Care Plan dated 01/16/25 reflected Resident #1 was transferred to and from her bed, chair and wheelchair and was totally dependent on staff. Her goal was to be out of bed daily as tolerated, and interventions included transfer with mechanical lift, and quarter rails as enabler to assist with bed mobility and transfer. Observation on 01/16/25 at 12:40 PM revealed the SC did not follow Enhanced Barrier Precautions by not putting on a gown before providing peri-care and assistance during wound care for Resident #1 . There was no signage on the resident's door for PPE. An interview on 01/16/25 at 1:05 PM revealed the SC had forgotten to put on a gown before providing care to Resident #1. The SC stated the importance of following Enhanced Barrier Precautions was to reduce the spread of infection to the residents. Resident #17 Record review of Resident #17's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included spastic quadriplegic cerebral palsy (neurological disorder characterized by the permanent stiffness of all four limbs, which can lead to a loss of motor function and mobility), microcephaly (neurological condition where a child has a smaller head and brain than normal), anemia, muscle weakness, dysphagia (difficulty swallowing), epilepsy (seizure disorder), aphasia (a communication disorder caused by brain damage that affects verbal and written language), gastroparesis (a condition that affects the normal muscle movements of the stomach), and gastrostomy status (creation of an artificial external opening into the stomach for nutritional support or gastric decompression). Record review of Resident #17's Annual MDS assessment, dated 11/15/24 did not have a BIMS Score, indicating her cognition was moderately impaired. The MDS indicated Resident #17 had a diagnosis of cerebral palsy and received nutrition and medication via a gastrostomy tube. Further review of the MDS revealed Resident #17 required substantial/maximal assistance for her activities of daily living, and she used a modified wheelchair. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #17's Care Plan dated 01/17/25 reflected Resident #17 was transferred to and from her bed, chair and wheelchair, and was totally dependent on staff. Her care plan further stated she was at risk for impaired nutritional status due to being dependent for enteral feeding, with goal that Resident #17 will not exhibit signs and symptoms of formula intolerance over the next 90 days. Intervention included implementation of Enhance Barrier Precautions. Record review of Resident #17's Physician Orders dated 01/14/25 reflected infection or colonization with an MDRO and requirements included: 1. Gowns and gloves are recommended when performing high-contact resident care activities. 2. Residents are not restricted to their rooms and do not require placement in a private room. 3. Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be a longer-term approach. Observation on 01/16/25 at 12:59 PM with LVN E revealed he did not put on a gown prior to administering medication via gastrostomy tube for Resident #17. Observation on 01/16/25 at 12:59 pm revealed no PPE signage on the door to the resident' room. Interview on 01/16/25 at 01:16 PM with LVN E revealed he should have put on a gown before administering medication to Resident #17. LVN E further stated it was important to follow Enhanced Barrier Precautions when providing care, and following Infection Control protocols was to help stop the spread of infection to the residents.