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	03/11/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 10 residents (Resident# 43, Resident #80, and Resident #114) reviewed for ADL care. The facility failed to ensure Resident# 43, Resident #80, and Resident #114 was groomed and did not have unwanted facial hair. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem.Findings included: 1. Record review of Resident #43's face sheet, dated 03/10/2026, reflected a [AGE] year-old female. s admitted [DATE]. Resident #43's diagnoses included dementia (memory, thinking, difficulty), type 2 diabetes mellitus with unspecified complications (high blood sugar), hyperlipidemia (high cholesterol), muscle weakness, lack of coordination and depression. Record review of Resident #43's Quarterly MDS Assessment, dated 01/14/2026, reflected Resident #43 had a BIMS score of 0 indicating severe cognitive impairment. Resident #43 required- supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently). Record review of Resident #43's Comprehensive Care Plan, dated 01/22/2026, reflected Resident #43 had an ADL self-care performance deficit related to dementia with interventions including observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. During an observation of Resident #43 on 03/09/2026 at 10:32 a.m., Resident #43 was walking down the hall. She had facial hair on her chin. During an interview with Resident #43 on 03/09/2026 at 10:34 a.m. she said she was fine and walked off. She did not answer any questions about the facial hair; she just kept walking. During an observation of Resident #43 on 03/10/2026 at 10:57 a.m., she had facial hair on her chin. During an interview on 03/10/2026 at 4:28 p.m., Resident #43's RP said Resident #43 would shave every day. She said Resident #43 would be embarrassed if she was cognitive enough to know she had hair on her chin. 2. Record review of Resident #80's face sheet, dated 03/10/2026, reflected an [AGE] year-old female. admitted [DATE]. Resident #80's diagnoses included dementia (memory, thinking, difficulty), major depressive disorder (mental health disorder characterized by persistent depressed mood), anxiety (feeling of uneasiness or worry), muscle weakness, anemia (not enough healthy red blood cells), and weakness. Record review of Resident #80's Quarterly MDS Assessment, dated 02/04/2026, reflected Resident #80 had a BIMS score of 2 indicating severe cognitive impairment. The MDS also revealed Resident #80 had substantial/maximal assistance indicating the helper does more than half the effort and lifts or holds trunk or limbs for personal hygiene. Record review of Resident #80's Comprehensive Care Plan, dated 09/16/2025, reflected the resident had an ADL self-care performance deficit related to dementia. Care planned interventions for PERSONAL HYGIENE/ORAL CARE indicated Resident #80 was able to set up and required prn assistance. During an observation on 03/09/2026 at 10:55 a.m., Resident #80 was lying in her bed. Resident #80 had hair on her chin. During an interview on 03/09/2026 at 10:56 a.m., Resident #80 said she was fine. When asked about the hair on her chin she said her kids were good. She could not answer the questions about the hair on her chin. During an observation on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/10/2026 at 4:01 p.m., Resident #80 was sitting in the dining room. Resident #80 had facial hair on her chin. 3. Record review of Resident #114's face sheet, dated 03/10/2026, reflected a [AGE] year-old female, admitted [DATE]. Resident #114's diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental function), dementia (memory, thinking, difficulty), muscle weakness, lack of coordination and abnormalities of gait and mobility. Record review of Resident #114's Quarterly MDS Assessment, dated 02/04/2026, reflected Resident #114 had a BIMS score of 6 indicating severe cognitive impairment. The MDS also revealed Resident #114 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity and helper assists only prior to or following the activity) with personal care. Record review of Resident #114's Comprehensive Care Plan, dated 09/16/2025, reflected Resident #114 has an ADL self-care performance deficit related to decreased mobility. Interventions were Resident #114 required set up assistance, by one staff with personal hygiene and oral care. During an observation on 03/10/2026 at 4:07 p.m., Resident #114 was walking in the hall. She was looking for a nurse to help her. She had facial hair on her chin. During an interview with Resident #114 on 03/11/2026 at 4:16 p.m., she said she wanted to have her facial hair shaved or have the facial hair pulled. She said the facial hair drives her crazy. She said staff never offered her assistance with removal of the facial hair. She said she wished she had something to pull the facial hair. She said if she had something to pull the facial hair, she could pull it herself. She said she did not like having hair on her face. She said she did not want to look like a man. During an interview with LVN D on 03/11/2026 at 11:29 a.m., said she was trained on ADL care. She said staff were to follow the policy, so the residents received the care they needed. She said the ADL care was tailored to the resident. She said the ADL care should be done every day. She said the CNAs were responsible for ensuring residents were shaven and groomed. She said if a female resident had facial hair the resident may feel embarrassed or feel like they were not well groomed. She said the charge nurse was responsible for ensuring the CNAs groomed and shaved the residents who wanted to be shaven. She said the nurse monitored by doing observations. She said she did not know why Resident #43 and Resident #80 had facial hair. She said Resident #114's facial hair blended in with the resident's skin tone. During an interview with CNA F on 03/11/2026 at 11:43 a.m., she said she was trained on providing ADL care. She said the policy for providing ADL care to residents was to keep the residents clean and well groomed. She said the staff member who was caring for the resident was responsible for ensuring the resident was shaved and well groomed. She said if a female resident was not shaved the resident may feel bad and it would affect the resident's dignity. She said the nurse monitored to ensure the CNAs cleaned and groomed the residents. She said the nurse monitored by observations and checking the shower sheets the CNAs filled out. She said she did not know why Resident #43, Resident #80 and Resident #114 had facial hair that was not removed. During an interview with the MCD on 03/11/2026 at 11:53 a.m., she said she did not do resident care anymore. She said she did not know what the policy was for ADL care. She said she expected staff to keep the residents clean and well groomed. She said the CNAs were responsible for ensuring the residents were shaven and groomed. She said staff wanted the residents to appear nice because it showed respect towards the residents. The MCD said if a female resident had facial hair the resident may feel upset. She said the residents in the memory care were not aware of how they looked. She said there were a few male residents who wanted to be shaven and feel well-groomed and the CNAs stepped in to help those residents. She said the nurses and the MCD was responsible for monitoring to ensure the residents were well groomed. She said the nurses and the MCD monitored through charting on a resident and the shower sheets that were filled out when the resident was given a shower. She said she did not know Resident #43, Resident #80 and Resident #114 had facial hair. Record review of the facility's Activities of Daily Living (ADL) Policy, dated 12/01/2025, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.1. Bathing, dressing, grooming and oral care.2. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Transfer and ambulation.3. Toileting.4. Eating to include meals and snacks; and5. Using speech, language, or other functional communication systems.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's bedside, toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 3 of 8 residents (Resident #16, Resident #22, and Resident #81) reviewed for resident call system .The facility failed to provide a working communication system, which was easily at reach, which would allow Resident #16, Resident #22, and Resident #81 the ability to safely call for staff for assistance.This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living.Findings included:Record review of Resident #16's Face Sheet dated 03.09.26, reflected a [AGE] year-old female admitted [DATE]. Resident #16 had diagnoses which included Chronic Respiratory Failure with hypoxia (do not have enough oxygen in the blood), Type 2 Diabetes Mellitus with Hyperglycemia (elevated blood sugar levels), Hypertensive Heart Disease with Heart failure (high blood pressure cause of heart failure), lack of coordination, and muscle weakness. Record review of Resident #16's Quarterly MDS, dated [DATE], reflected Resident #16 had a BIMS Score of 0, which indicated severe cognitive impairment problems with thinking and memory. The MDS further reflected Resident #16 needed the assistance of two or more helpers for his activities of daily living, bed mobility, and transfers, and she used a wheelchair for mobility.Record record review of Resident #16's Care Plan, dated 12/15/25, Be sure Resident #16's call light was within reach and encourage the resident to use it for assistance as needed. Resident #16 needed prompt response to all requests for assistance.Record review of Resident #22's Face Sheet, dated 03/09/26, revealed an [AGE] year-old malewas admitted [DATE]. Resident #22's diagnoses included senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond normal aging, affecting memory, cognition, and behavior), vascular dementia(a type of cognitive decline caused by damage to the blood vessels in the brain), adjustment disorder (excessive emotional or behavioral responses to identifiable stressors) with anxiety (feelings of fear or apprehension about what's to come and persistent and excessive worry).Record review of Resident #22's Quarterly MDS, dated [DATE], reflected Resident #22 had a BIMS Score of 02, which indicated severe cognitive impairment problems with thinking and memory. The MDS further reflected Resident #22 was dependent on staff for his activities of daily living, bed mobility, and transfers, and assistance of two or more helpers is required for the resident to complete the activity.Record review of Resident #22's Care Plan, dated 01/22/26, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.The resident needs prompt response to all requests for assistance. Record review of Resident #81's Face Sheet, dated 03/09/26, revealed a [AGE] year-old female who was admitted [DATE]. Resident #81's diagnoses included acute respiratory failure with hypoxia (do not have enough oxygen in the blood, gastrostomy status (surgically placed gastrostomy tube for direct access to the stomach for nutrition, hydration, or medication), furuncle of buttock (a painful, pus-filled bump caused by a bacterial infection of hair follicle).Record review of Resident #81's Quarterly MDS, dated [DATE], reflected Resident #81 had a BIMS Score of 0, which indicated severe cognitive impairment. The MDS further reflected Resident #81 was dependent on staff for all her activities of daily living, bed mobility, and transfers, and he used a wheelchair for mobility.Record review of Resident #81's Care Plan, dated 02/22/26, Be sure Resident #81's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.During an interview and observation of Resident #81'ss on 03/09/26 at 10:12 a.m., revealed that she could not verbally communicate her needs and her call light was not within reach of the resident. Observation revealed the call light was located to the left of Resident #81 and hanging off the bed. During an observation on 03/10/26 at 11:44 a.m., Resident #16's call light was wound (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around the upper right bedframe and it was not located within reach by resident. During an interview and observation on 03/09/26 at 11:03 a.m., it was revealed that Resident # 22 did not know his call light was twisted around the bed frame. During an observation on 3/09/26 at 11:03 a.m., the call light was not within reach of the resident. During an observation on 03/10/26 at 12:36 p.m., Resident #22's call light was observed tied to the upper bed frame and it was hanging off the left side of the bed, not within reach of Resident # 22. During an observation on 03/11/2026 9:22 a.m., Resident #22's call light was located to the left of resident hanging off the bed and not within reach of resident.During an observation of Resident #81's call light, 03/09/2026 10:38 a.m., revealed that her call light was tied to the right side of the bed frame and it was hanging 15 inches off the bed, and it was not within reach of resident.During an interview with CNA B on 03/11/2026 10:09 a.m., she stated she was trained on resident rights. She said the policy was the call light had to be always within the resident's reach. She said the call light should be within reach any time the resident was in bed or in their room. She said if the call light was not in the resident's reach the resident would not be able to get the help they need. She said that the CNAs were responsible for ensuring the call light was within reach. She said when the CNAs did their rounds, they were supposed to check the call light and make sure it was in the resident's reach. She said she did not know why the residents' call lights were not in reach.During an interview with LVN A on 03/11/2026 9:41 a.m., it was revealed that she had been trained on resident rights. She said that the call light was supposed to be where the resident could reach it. She also said that there are alternative types of call lights that can be used for residents with limited mobility or limited range of motion. She said all staff were responsible for ensuring the call light was within reach. She said if the call light was not within the resident's reach that the resident could fall or get hurt. She also said that the nurses and CNAs were responsible for ensuring the call lights were within the resident's reach. She said the CNAs and nurses monitor the call lights by doing rounds and will put the call light in the resident's reach if it was not in their reach. She said that she was not aware of any call lights that were not within residents' reach. She stated interventions can be used by leaving a resident's door open. During an interview with the RT on 03/11/2026 1:36 p.m., it was revealed that he had been trained on resident rights. He stated the policy was that each resident should have call light within reach and call light should remain within reach of the resident. He stated, care givers are all responsible for making sure the call light is within the residents' reach. He stated, Resident # 81 would not be able to request assistance if the call light is not within reach. He said call lights were monitored by doing rounds. He said he was not sure why the call light was not in reach of Resident # 81. He said he may have taken the call light off Resident # 16's bed prior to caring for her and he might not have repositioned it when he was done. During an interview with ADON on 03/11/26 at 2:15 p.m., it was revealed that she had been trained in resident rights. She said that the call light was supposed to be within the resident's reach. She also said that if anyone saw the call light not in reach the staff member was responsible for putting it within the residents' reach. He said if the call light were not within the resident's reach that the resident could not let staff know what they needed or communicate with the staff. She also said that all staff were responsible for ensuring the call lights were within the residents' reach. She said call lights were monitored by doing rounds. She said she did not know why the call light was not in reach of three residents.During an interview with the ADM on 03/11/2026 at 4:12 p.m., revealed that he and staff had been trained on resident rights. He said that the call light was supposed to be within the resident's reach. He also said that primarily the care giver was responsible for putting the call light within the resident's reach. He said if the call light were not within the resident's reach that the resident could not call for help when they needed it. He also said that care givers and management were responsible for ensuring the call lights were within the resident's reach. He said call lights were monitored by doing rounds. He said he did not know why the call light was not in reach. He stated, we can try to provide a touch pad for Resident # 16.Record Review of the facility policy titled, Call Lights: Accessibility and Timely Response, ,dated 10/01/25 and policy review date 12/01/25, revealed, Policy Explanation and Compliance GuidelinesEach (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident will be evaluated for unique needs and preferences to determine any special accommodation that may be needed in order for the resident to utilize the call system.Special accommodations will be identified on the resident's person - centered plan of care and provided accordingly.The call light system will be accessible to the residents at each toilet and bath or shower facility. The call system will be accessible to residents while in their bed or other sleeping accommodations.

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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** Based on observation, interview, and record review, the facility failed to establish a system of accurate reconciliation, determine that drug records were in order, an account of all controlled drugs was maintained and periodically reconciled for 1 of 4 medication carts (Medication Cart #1-700 Hall) in the facility effecting 1 of 20 residents (Resident #105) reviewed for pharmacy services and failed to provide pharmaceutical services including procedures that assure the accurate acquiring of all drugs and biologicals by monitoring for expiration dates in 1 of 2 medication rooms reviewed for pharmacy storage. The facility failed to ensure LVN D and the LVN E accurately reconciled Resident #105's narcotic medication log when LVN D administered but did not sign for Resident #105's Hydrocodone-Acetaminophen 5-325 MG 1 tablet on 03/10/2026 at a.m. (unknow exact time of administration) and at 2:00 p.m. during shift change the LVN E did not reconciled the correct medication count of Resident #105's Hydrocodone-Acetaminophen 5-325 MG. 2. The facility failed to ensure the removal of expired medications from the medication room [ROOM NUMBER]'s refrigerator: Heparin Sodium injections 5000/ML expired on 03/09/2026 and Bisacodyl 10mg expired 4/2025. These failures could place residents at risk of not receiving their prescribed and emergency medications, risk of drug diversion and at risk of receiving expired medications which could result in delayed healing. Findings included: 1.During an observation of Medication Cart #1's reconciliation with LVN E on 03/10/2026 at 3:57 p.m., LVN E opened med cart #1. The reconciliation of controlled medications on med cart #1 revealed the blister pack with Hydrocodone-Acetaminophen tablets 5-325 MG for Resident #105 contained 34 tablets with count of 35 tablets on the controlled medication log. During an interview on 03/10/2026 at 3:59 p.m., LVN E stated she did not administer Hydrocodone-Acetaminophen 5-325 MG to Resident #105, but LVN D, who was working on this cart 6:00 a.m. - 2:00 p.m. shift, administered it to Resident #105 this morning. LVN E stated that not documenting the narcotic medication when administered could cause a discrepancy since someone would not know residents had already received narcotic medication. LVN E stated she missed this discrepancy during the shift change count as tablets were not pushed in order on the blister pack. During an interview on 03/10/2026 at 4:02 p.m., LVN D stated he administered Hydrocodone-Acetaminophen 5-325 MG one tablet PRN dose today around noon to Resident #105 but forgot to sign the controlled log as a lot was going on at that time. He stated he counted controlled medications at the end of his shift at 2:00 p.m. with LVN E and they both did not notice a discrepancy in the count. During an interview on 03/11/2026 at 3:33 p.m., LVN E stated she changed her previous statement on 03/10/2026 and stated that she knew about the discrepancy during the count with LVN D and before the med cart #1's reconciliation with state surveyor. She stated LVN D forgot to sign during their count as he did not have a pen with him. She stated that the nurse who worked on the cart was responsible for that med cart and she was responsible when she accepted the key for med cart #1. Record review of Resident #105's face sheet, dated 03/10/2026, indicated a [AGE] year-old male, admitted [DATE] with diagnoses which included hemiplegia affecting left nondominant side (a severe or total loss of motor function on one side of the body caused by brain damage), pain, and type 2 Diabetes mellitus (a chronic metabolic disorder where cells resist insulin, causing high blood sugar). Record review of Resident #105's Annual MDS assessment, dated 11/30/2025, indicated a BIMS score of 13 which indicated intact cognition. The MDS assessment indicated Resident #105 received PRN opioid pain medication to treat his pain. Record review of Resident #105's comprehensive care plan, dated 12/15/2025, indicated Resident #105 had pain medications PRN ordered with interventions screen for pain on admission and daily. Assess to determine if experiencing pain. If pain is present, conduct and document pain assessment. Discuss with resident and family/caregivers any adverse effects of unrelieved pain or side effects of pain medications. Record review of Resident #105's order (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summary report, dated 03/11/2026, indicated an order, starting date on 06/03/2025, for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give one tablet by mouth every six hours as needed for chronic back pain and right hip pain. Record review of Resident #105's MAR for 03/10/2026 indicated Resident #105 received Hydrocodone-Acetaminophen Oral one tablet 5-325 MG on 03/10/26 (unspecified time) a.m. when medication was not documented in the controlled medication administration log. 2.During an observation of Med room [ROOM NUMBER]'s refrigerator for Halls 500, 600, 700 and 800 on 3/10/2026 at 4:15 p.m., eight Heparin Sodium injections vials 5000/ML each (to decrease the clotting ability of the blood and help prevent harmful clots from forming in blood vessels) labeled with sent for regular Ekit replacement expired on 03/09/2026 and two boxes of Bisacodyl with 24 capsules 10 MG each capsule (stimulant laxative suppository) expired 4/2025. During an interview on 03/11/2026 at 3:36 p.m., the ADON stated she had Medication Administration, controlled medication, and medication storage in-services monthly and skilled check-off was completed at the end of February of 2026. She stated all nursing staff in the facility were trained annually and on as needed basis. She stated she provided in-services to nursing staff on these topics monthly and as needed. She stated ADONs were responsible for auditing med rooms on each side and med cart audit. She stated each charge nurse or medication aide was responsible for their medication carts and counting controlled medication at shift change. The ADON stated that signing for controlled medication should be immediate after administration She stated that it could cause medication errors. She stated the facility's-controlled medication administration policy was to count controlled meds with upcoming shift and signing administered medications right away. She stated not signing after administration of medication could cause overdosing and medication error. During an interview on 03/11/2026 at 3:41 p.m., the DON stated she had medication administration, controlled medication, and medication storage in-services in the last 6 months. She stated that all nursing staff in the facility had this training annually and on as needed basis. She stated that ADONs and herself were doing the random med rooms and med cart audits. She stated that each charge nurse or med aide was responsible for their medication carts and counting controlled medication at shift change. The DON stated that signing for controlled medication should be immediate after administration and if not signed, the next nurse or medication aide would not know if residents received the medication. She stated that it could cause medication errors. She stated that expired medications if not removed from med rooms and administered to residents, could have reduced intended therapeutic benefits for residents. During an interview on 03/11/2026 at 4:22 p.m., the ADM stated he was trained in medication administration and storage today on 03/11/2026. He stated he was not sure when controlled medication had to be signed for, but he thought it should be immediately after administration. He stated that DON, ADONs, charge nurses, and medication aides were responsible for counting controlled medications at shift change and monitoring for medication discrepancies especially with controlled medication to prevent drug diversion. He stated the DON and ADONs randomly audited med carts and med rooms for expired medications. He stated if discrepancies were noted, nurses or med aides were responsible to notify the ADON and DON. He stated that if not monitored and properly counted, it would potentially harmful affect residents. He stated that nursing staff received medication administration in-services on 3/11/2026, quarterly, and annually. Record review of facility's Medication Administration policy, dated revised 11/01/2025, indicated that .19. Sign MAR after administering medication. 20. If medication is a controlled substance, sign narcotic book. Record review of facility's Medication Storage policy, dated revised 12/01/2025, indicated that 8. all medication rooms are routinely inspected by consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our destruction of unused drugs policy. Record review of facility's In-Services for last 12 months did not reveal any record of completed nursing staff training on medication storage and labeling. Record review of facility's In-Services for last 12 months reveal the Medication Administration in-service, dated 03/02/2026, completed and signed by seven members of nursing staff including LVN D but not LVN E.

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	03/11/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 23 residents (Resident #2 and Resident #42) reviewed for infection control. The facility failed to ensure LVN C followed proper infection control procedures after completing the wound care for Resident #2, removing biohazardous trash from Resident #2's room and did not sanitize her hands after removing gloves and before touching clean supplies on her treatment cart. The facility failed to ensure LVN D followed proper infection control procedures after completing blood sugar check for Resident #42, exiting Resident #42's room, using the same gloves to open nursing cart, removed the insulin storage box for multiple residents on 700 Hall, and withdrew insulin from vial for Resident #42, and walked back to Resident #42's room to administer his insulin without changing gloves and sanitizing hands. These failures could place the residents at risk of infection transmission, sepsis, and hospitalization.Findings included: 1. During an observation on 03/11/2026 at 9:48 a.m. of wound care for Resident #2, LVN C did not take her gloves off after completing the wound care for Resident #2, removed biohazardous trash (dirty wound care supplies she removed during wound care) from Resident #2's room, and did not sanitize her hands after removing gloves and before touching clean supplies on her treatment cart. During an interview on 03/11/2026 at 10:06 a.m. LVN C stated she received hand hygiene and infection control in-services at the beginning of March 2026, and the training covered the proper infection control steps and when the nursing staff should wash hands/sanitized hands. LVN C stated she was supposed to wash hands before starting residents' care/wound care procedure, between changing gloves, and before exiting the room and touching her treatment court. She stated that she did not wash her hands before exiting Resident #2's room as she forgot to do it. She stated potential risk for residents if not following proper infection control measures could be the spread of infection. During observation and interview of Resident #42 on 3/11/2026 at 10:06 a.m., he did not appear in distress and did not voice any complaints. Record review of Resident #2's face sheet, dated 3/11/2026, revealed a [AGE] year-old female admitted [DATE]. Her diagnoses included Alzheimer's disease (a progressive, irreversible brain disorder that causes dementia, it slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks), Type 2 Diabetes Mellitus (a chronic metabolic disorder where cells resist insulin, causing high blood sugar), and pressure ulcer of right heel, stage 4 (painful damage to skin and underlying tissue caused by prolonged pressure, friction, or shear, often over bony areas like the hips or heels). Record review of Resident #2's Quarterly MDS assessment, dated 01/22/2026, revealed Resident #2's BIMS score of 3 indicating severe cognitive impairment. Record review of Resident #2's Care Plan, dated 1/07/2026, reflected: Resident #2 had a risk of developing pressure ulcer/injuries with current stage 4 pressure ulcers which was present upon admission with a goal of MDRO (germs, primarily bacteria, resistant to many commonly used antibiotics, making infections difficult to treat. They usually spread via direct contact, often in healthcare settings, and are managed through strict infection control, hand hygiene, and antimicrobial stewardship) reduction over next 90 days with implementation of Enhanced Barrier Precautions and monitoring for signs and symptoms of infection and wound care with application of dressing to right foot. Record review of current orders for Resident #2 revealed the wound care order, dated 03/11/2026, right heel pressure injury: clean with Dakins 1/2 strength solution, pat dry. Pack with calcium alginate and cover wound bed, apply honey fiber to slough. Apply no-sting preparation to peri (around) wound, cover with ABD pad (highly absorbent, sterile, multilayered dressings designed for heavily draining wounds, post-surgical incisions, and trauma injuries) and secure with rolled gauze. 2. During an observation of blood sugar check and insulin administration for Resident #42 on 3/11/2026 at 11:59 a.m., revealed LVN D did not take his gloves off after completing blood sugar check for Resident #42, exiting Resident #42's room, (continued on next page)

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	676471	A. Building B. Wing	03/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used the same gloves to open nursing cart and removed the insulin storage box for multiple residents on 700 Hall and supplies for insulin administration for Resident #42, and walked back to Resident #42's room to administer his insulin without changing gloves and sanitizing hands. During observation and interview of Resident #42 on 3/11/2026 at 11:59 a.m., he did not appear in distress and did not voice any complaints. Record review of Resident #42's face sheet, dated 3/11/2026, revealed a [AGE] year-old male admitted [DATE] and readmitted on [DATE]. His diagnoses included type 2 Diabetes Mellitus (a chronic metabolic disorder where cells resist insulin, causing high blood sugar), legal blindness (a government-defined, non-medical status indicating severe visual impairment that qualifies individuals for benefits and services), chronic kidney disease, stage 4 (severe). Record review of Resident #42's admission MDS assessment, dated 12/16/2026, revealed Resident #42's BIMS score of 15 indicating intact cognition. Record review of Resident #42's Care Plan, dated 12/21/2025, reflected Resident #42 had the diagnosis of type 2 Diabetes Mellitus with interventions in place: Diabetes medication as ordered by doctor. During an interview on 03/11/2026 at 12:05 p.m., LVN D stated he had an in-service on hand hygiene not too long ago. He stated that according to the facility's policy he was supposed to sanitize his hands between each resident's tray during meal tray pass. He stated that not sanitizing his hands properly could lead to potential cross contamination. During an interview on 3/11/2026 at 3:36 p.m., the ADON stated charge nurses should monitor how staff were conducting hand hygiene and following infection control measures, and the ADONs and the DON conducted oversight. The ADON further stated the facility policy on hand hygiene during residents' perineal care (cleaning the genital and anal areas to prevent infection, odors, and skin breakdown, particularly for patients with incontinence or catheters), wound care, and urinary catheter care was to conduct handwashing before nursing staff come out of resident rooms. The ADON stated she was trained on infection control and hand hygiene monthly and the potential negative outcome for the residents when not practicing good hand hygiene was cross-contamination. During an interview on 03/11/26 at 3:41 p.m., the DON stated the DON and ADONs were responsible for ensuring all staff was conducting proper hand hygiene/following infection control measures when providing care including wound care for the residents. She stated she and ADONs conducted periodic audits and provided hand hygiene in-services to staff. She stated the policy on hand hygiene, providing peri-care, wound care, and urinary catheter care was to conduct hand hygiene before going in the room, between dirty and clean area, between changing gloves and before coming out of the room. The DON stated training on infection control and hand hygiene was taught during annual skills training. The DON stated a potential negative outcome for the residents could be cross contamination. During an interview on 3/11/2026 at 4:22 p.m., the ADM stated he had hand hygiene training sometimes today, quarterly, and annually which covered the policy for conducting the proper handwashing/hand hygiene before/after conducting the care for residents including the wound care and passing meal trays. He stated a negative outcome to the residents could be the risk of cross contamination. Record review of Hand Hygiene Policy, dated 12/01/2025, revealed, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. 6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.